Issues in Missouri Health Care 2011

The State of Health in Missouri:
Coverage, Access, and Health Status

Acknowledgement

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm, and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, tmcauliffe@mffh.org.

Issue Statement

How does Missouri rank nationally on key indicators of health? What opportunities does federal health care reform offer Missouri to improve health care coverage, access, and the health status of its residents?

Background

On two well recognized state health rankings, Missouri ranked in the bottom third. According to the 20th annual report, America's Health Rankings: A Call to Action for Individuals and Their Communities, 2009 Edition, Missouri ranked 38th overall on a wide range of public and environmental health issues, clinical indicators, and health outcomes from a variety of national sources.[1] From The Commonwealth Fund's State Scorecard on Health System Performance, 2009, Missouri ranked 36th in the country on measures of coverage, access, quality and equity.[2] The Kaiser Family Foundation also provides the most up-to-date measures of state health indicators through its interactive website, www.statehealthfacts.org, for which rankings on a variety of health status measures show Missouri in the bottom quartile of states. A selection of indicators behind these rankings is explored in this brief.

With the recent passage of national health care reform, known as the Patient Protection and Affordable Care Act (ACA), Missouri has a number of opportunities to leverage federal resources to improve population health and its state health ranking, particularly in access to care and healthy living, two areas where the state is underperforming.

Key Indicators

The following section highlights key indicators of health insurance coverage, access to care and health status in Missouri, relative to the United States, and how Missouri ranks among states.

Insurance Coverage

Insurance coverage increases, but does not guarantee, access to needed health care. Rates of insurance coverage in Missouri are similar to those of the U.S. overall (Figure 1). The rate of employer-based coverage is slightly higher in Missouri than the U.S. rate (57.1% v. 55.8%), and this likely contributes to Missouri's lower uninsured rate compared to the U.S. (15.3% v. 16.7%).[3] With 914,000 of Missouri's 5.97 million residents uninsured—15.3 percent of the state's

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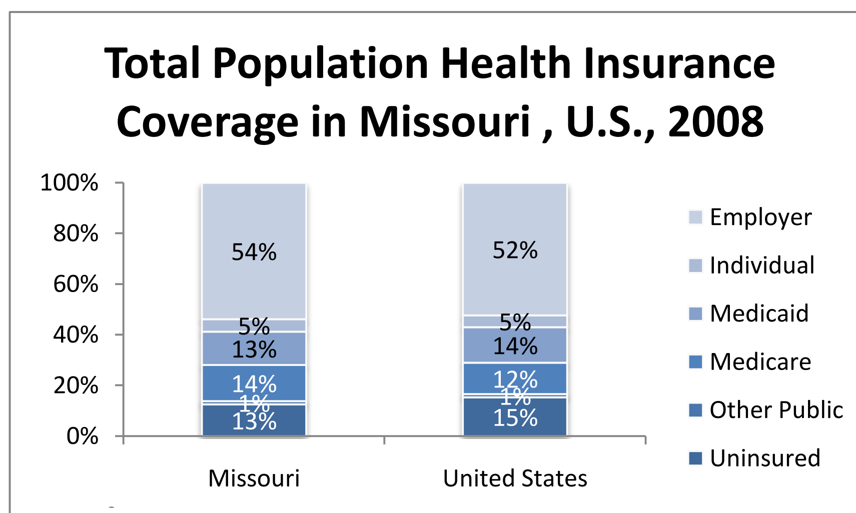
1 United Health Foundation. 2009. The report draws on data from a variety of federal agencies, including but not limited to the Centers for Disease Control and Prevention (CDC) and the Census Bureau, as well as the American Medical Association. See http://www.americashealthrankings.org/.

2 The Commonwealth Fund. 2009. The scorecard includes measures of health care access, quality, avoidable use of services, and healthy lives. See http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/
Oct/2009-State-Scorecard.aspx.

3 U.S. Census Bureau, Current Population Survey. 2010, Health Insurance Coverage Status and Type of Coverage by State and Age for All People, 2009. Available at
http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm.

population—Missouri ranks 24th in the percentage of total population uninsured, one of the few measures examined that ranks it in the top half of states.[4]

Figure 1. Insurance coverage in Missouri and U.S., 2008



Uninsured rates are higher for the non-elderly adult population than the general population because Medicare provides universal coverage to individuals age 65 and older. Uninsured rates are lower for children because of access to Medicaid, the federal-state low-income insurance program, and the Children's Health Insurance Program (CHIP) for low-income children who do not qualify for Medicaid. Across both age groups, uninsured rates are lower in Missouri than for the U.S. (Table 1).[5]

Table 1. Uninsured rates for non-elderly adults and children, Missouri and U.S., 2008

Population	Missouri	U.S.
Non-elderly Adults (19-64)	14.4%	17.4%
Below 133% FPL	39.4%	43.7%
Above 400% FPL	3.9%	5.3%
Children (0-18)	8.7%	10.3%

Insurance coverage is inversely related to income. Among non-elderly adults, 40 percent of those under 133 percent of the federal poverty level (FPL) are uninsured in Missouri, compared to only 4 percent of those with incomes above 400 percent of FPL. Comparable rates for the U.S. are 43.7 percent and 5.3 percent, respectively.

4 Kaiser Family Foundation (KFF). Retrieved October 10, 2010, from http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=27. Rate is based on average for 2007-2008.
5 Ibid.

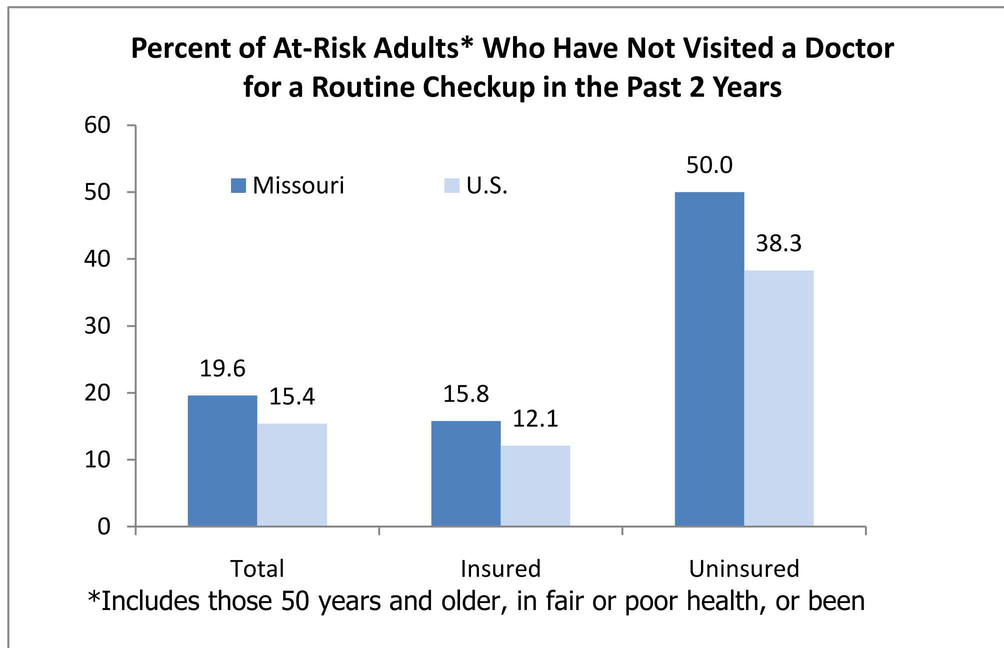
Most uninsured people are part of working families. As with the U.S. generally, two thirds (66.5%) of uninsured, non-elderly Missourians have at least one full-time worker in their families, but they were not offered or could not afford coverage through the workplace.

Access to Care

- *Financial and Insurance Barriers to Care:* Uninsured adults are less likely to obtain needed care than those with insurance. Although Missouri has lower uninsured rates than the U.S., adults who are uninsured in Missouri, particularly those at risk for needing medical care, have less access to needed care than uninsured adults in the U.S.[6]

  While a similarly low percentage of adults with insurance in Missouri and the U.S. could not see a doctor in the past year because of cost (9% v. 8%), a much higher rate of uninsured adults faced financial barriers to care in Missouri compared to the U. S. (50% v. 42% in 2006-2007). At-risk, uninsured adults in Missouri were also much less likely to have obtained a routine checkup than uninsured adults in the U.S. (50% v. 38%), as shown in Figure 2. In addition, Missouri's ranking on this measure declined from 23rd in 1999-2000 to 48th in 2006-2007.[7]

Figure 2.



6 Defined as those 50 years and older, in fair or poor health, or diagnosed with a chronic disease such as asthma, diabetes or pre-diabetes, acute, myocardial infarction, heart disease, or stroke.

7 The Commonwealth Fund. State Scorecard Data Tables, October 2009, Supplement to: Aiming Higher: Results from a State Scorecard on Health System Performance, 2009, Tables 5B.2 and 5B.3. Retrieved 10/11/10 from www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Oct/State_Scorecard_data_tables_2009_COMPLETE_v2.pdf.

- *Preventive Care for Pregnant Women and Children:* Missouri has made strides to ensure that pregnant women and children receive recommended preventive care. With nearly nine out of 10 pregnant women (87.2 percent) receiving prenatal care in the first trimester, Missouri ranked 3rd in the nation in 2006, just after Massachusetts and Maine; the U.S. rate was 83.2 percent.[8]

  On the other hand, there is room for improvement on immunization rates. Seventy-six percent of Missouri's children aged 19 months to 35 months were current on recommended immunizations in 2008, ranking the state 35th. The U.S. rate is 78 percent.[9]

- *Appropriate and High Quality Care:* Missouri is in the top ten states—ranked 6th—in providing access to needed mental health care for children. The percentage of children in Missouri, ages 2 to 17, with emotional, mental or behavioral health needs who received mental health care or counseling in the past year (2007) was 73.9 percent compared to the U.S rate of 60 percent.[10]

  Missouri has improved on its rate of "preventable" hospitalizations, an indicator of access to appropriate primary care for individuals with asthma, diabetes and other chronic conditions. In 2006-2007 the state's preventable hospitalization rate was 72.6 per 1,000 Medicare enrollees, compared to 77.7 in 2003-2004. With a national rate of 62.9 per 1,000 Medicare enrollees, Missouri's current rank is 36th.[11]

  The 30-day hospital readmission rate is a quality indicator of care coordination between hospital discharge and outpatient follow-up care. Better coordination is associated with fewer readmissions. Missouri's 30-day hospital readmission rate for Medicare patients was 18.3 percent of admissions in 2006-2007, similar to the U.S. rate of 18.4, and unchanged from 2003-2004. The state's current ranking is 29th.[12]

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8 KFF. Retrieved October 14, 2010, from http://www.statehealthfacts.org/comparemaptable.jsp?typ=2&ind=44&cat=2&sub=12&sortc=1&o=a.

9 United Health Foundation, 2009. America's Health Rankings: A Call to Action for Individuals and Their Communities, 2009 Edition. Data for Missouri v. U.S. comparisons retrieved October 19, 2010, from: http://www.americashealthrankings.org/statecompare/2009/MO/zUS.aspx.

10 KFF. Op cit. http://www.statehealthfacts.org/comparemaptable.jsp?ind=53&cat=2&sub=14.

11 The Commonwealth Fund. Op cit. Table 4.4.

12 Ibid. Table 4.5.

Table 2. Indicators of appropriate and high quality care in Missouri and the U.S.

Indicator	State Rank	Missouri	U.S.
% of children ages 2-17 with mental/behavioral health needs who received mental health care or counseling in the past year (2007)	6	73.9	60.0
Preventable hospitalization rate per 1,000 Medicare enrollees (2006-7)	36	72.6	62.9
30-day hospital readmission rates per 1,000 Medicare enrollees (2006-7)	29	18.3	18.4

Health Status

- *Healthy Living:* Missouri lags behind or is just even with the U.S. on a number of healthy lifestyle indicators associated with morbidity and mortality. Smoking rates were the most troubling: one quarter of Missouri adults smoked in 2008, ranking the state 48th in the nation.[13]

  Missouri obesity rates were above the U.S. average for adults (63.8% v. 60.8%) in 2009 and similar to the national rate for children (31.0% v. 31.6%). The percentage of adults in Missouri who ate three or more vegetable servings each day was lower than the national rate (27.3% v. 32.5%), but Missouri was even with the U.S. rate on the percentage of adults who engage in moderate or vigorous physical activity three to five times per week (49.9% v. 50.1%).[14]

Table 3. Indicators of healthy living in Missouri and the U.S.

Indicator	State Rank	Missouri	U.S.
% of Adults who Smoke (2008)	48	24.9	18.3
% Adults Overweight/Obese (2009)	42	63.8	60.8
% Children (ages 10-17) Overweight/Obese (2007)	27	31.0	31.6
% Adults who Eat 2 or More Fruit Servings/Day (2009)	39	27.3	32.5
% Adults who Regularly Engage in Moderate to Vigorous Exercise Each Week (2009)	30	49.9	50.1

13 KFF. Op cit. http://www.statehealthfacts.org/comparemaptable.jsp?ind=80&cat=2.

14 Ibid. http://www.statehealthfacts.org/comparecat.jsp?cat=2&rgn=27&rgn=1.

- *Quality of Life:* Adults in Missouri experienced an average of 3.4 days with limited activity due to health difficulties per 30 days in 2007, lower than the national rate of 3.6 days. The state was ranked 26th.[15]

  Missouri ranked 44th, however, on a mental health quality-of-life indicator. The 2007 rate for adults who reported having poor mental health between one and 30 days in the past 30 days was 35.5 percent in Missouri, compared to the national rate of 33.3 percent.[16]

- *Mortality:* Missouri has a mixed record in reducing rates of premature mortality in recent years. Even where progress has been made, its standing generally remains in the bottom third of state mortality rankings.

  For example, Missouri's infant mortality rate dropped from 8.5 deaths in the first year of life per 1,000 live births, to 7.5 between 2003 and 2005, but the current rate remains above the U.S. rate of 6.8, placing the state's ranking at 35th, up from 42nd.[17]

  On breast cancer mortality, Missouri slipped from 26.1 deaths per 100,000 women in 2003 to 28 per 100,000 in 2005. The state is currently ranked 49th, just ahead of Louisiana and the District of Columbia.[18]

  On a composite indicator of mortality amenable to health care, Missouri has shown improvement, with a drop in deaths from 112.9 per 100,000 population in 2001-2002, to 103.0 in 2004-2005. Missouri is currently ranked 36th.[19]

Federal Health Care Reform

The goal of national health care reform is to ensure that all Americans get the care they need to help them live to their fullest potential. ACA includes provisions to expand coverage, reform health insurance markets, increase access to appropriate and affordable health care, promote understanding of cost-effective care and the use of evidence-based medicine, and support states and communities in advancing healthy living and preventive health practices.

Although ACA is national in scope, implementation will rely heavily on the states.[20] In addition to new regulations and state requirements, ACA calls for tens of millions of dollars in federal

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15 Ibid. http://www.statehealthfacts.org/comparemaptable.jsp?ind=120&cat=2.

16 Ibid. http://www.statehealthfacts.org/comparemaptable.jsp?ind=93&cat=2.

17 The Commonwealth Fund. Op. cit. Table 6.3.

18 Ibid. Table 6.4. Rates are for the population ages 0–74, standardized on US 2000 standard population. Causes of death considered amenable to health care: intestinal infections, tuberculosis, other infections, whooping cough, septicaemia, measles, malignant neoplasm of colon, rectum, skin, breast, cervix, uterus, or testis, Hodgkin's disease leukemia, thyroid disease, diabetes mellitus, epilepsy, chronic rheumatic heart disease, hypertensive disease, cerebrovascular disease, all respiratory diseases, influenza, pneumonia, peptic ulcer, appendicitis, abdominal hernia, cholelithiasis and cholecystitis, nephritis and nephrosis, benign prostatic hyperplasia, maternal death, congenital cardiovascular anomalies, perinatal deaths, medical errors, and ischaemic heart disease.

19 Ibid. Table 6.2.

grants and funding for improvements and demonstration projects, beginning this year, for which states and communities may compete. Highlighted below are examples of provisions in the ACA that will impact Missouri—and other states—on insurance coverage and access to care, as well as provide opportunities to improve quality and reduce or prevent chronic illness.[21]

Expanding Insurance Coverage

The new law contains a range of provisions for expanding access to private and public sources of insurance coverage. The most significant change is that most individuals (with some exceptions) will be required to have health insurance beginning in 2014 (Section 1501). Employer-based insurance will remain the primary source of coverage for the non-elderly population; however, individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health insurance exchange ("Exchange") with premium and cost-sharing credits available to eligible individuals and families with incomes up to 400 percent of the FPL (Sections 1311-1313, 1322, 10104).[22]

Small businesses will be able to purchase coverage through a separate Exchange. Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers (Section 1421). New insurance regulations are also designed to make care more affordable and obtainable, regardless of one's health status or gender. Between now and 2014, the ACA provides individuals with pre-existing conditions who have been uninsured for at least six months an opportunity for coverage through state-sponsored high-risk insurance pools and subsidized premiums (Section 1101). After 2014, they will be eligible to purchase insurance through the Exchange.

The Congressional Budget Office estimates that by 2019, after the insurance provisions have been in effect for five years, ACA will reduce the number of uninsured Americans by 32 million.[23] Half of this reduction will come from an expansion of income eligibility for Medicaid to 133 percent of FPL ($14,404 for an individual and $29,327 for a family of four in 2009) for all non-Medicare individuals under age 65 (Section 2001).

Public Insurance Coverage

The expansion of eligibility for Medicaid has particular significance for states like Missouri, and several of its neighbors (e.g., Arkansas and Kansas), which currently have relatively restrictive

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20 Moody, G., Rodin D., Silow-Carroll, S. 2010. "States in Action - How States Are Preparing to Implement National Health Reform." Retrieved October 18, 2010, from http://www.healthmanagement.com/files/2010_08_10_StatesInAction.pdf.

21 Unless otherwise referenced, descriptions of provisions in this brief have been summarized by HMA from the published legislation, retrieved April 14, 2010, from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf.

22 KFF. 2010. Summary of Coverage Provisions in the Patient Protection and Affordable Care Act. Retrieved October 12, 2010, from http://www.kff.org/healthreform/upload/8023-R.pdf.

23 Ibid.

income eligibility requirements for jobless parents (19% of FPL) and working parents (25% FPL), and no coverage for childless adults.[24]

The Urban Institute projects that more than 207,000 uninsured adults in Missouri will gain coverage through Medicaid by 2019—a 45 percent reduction in uninsured adults from 2014.[25] The federal government will fund 95.5 percent of the costs for the Medicaid expansion in Missouri. In addition, Medicaid payments to doctors for primary care services will be increased to 100 percent of Medicare payment rates in 2013 and 2014, with 100 percent federal financing. The ACA also provides funding for the CHIP program through 2015, and continues the authority of the program through 2019 (Sections 2101, 2102).

Because Missouri's Medicaid program already extends coverage to children up to at least 150 percent of FPL, the Medicaid expansion will have a more limited impact on children's coverage. However, coverage for children who are eligible for, but not enrolled in, Medicaid or CHIP is likely to expand as parents become eligible for Medicaid, or gain access to coverage through a health insurance exchange.[26]

Access to Care

ACA includes a number of provisions to improve access to care in several dimensions. For example, the new law provides opportunities to reduce financial barriers to needed care—a particular area of concern for uninsured Missourians, and even those with coverage—and to make preventive and primary care more accessible to vulnerable populations. ACA places a heavy emphasis on increasing the use of appropriate, cost-effective care based on evidence-based medicine. Missouri is performing well by some measures, and generally better for children than adults. The law aims to make the delivery of health care uniformly appropriate, timely and cost-effective.

Reducing Financial and Insurance Barriers

In addition to the coverage provisions described above, ACA requires sliding-scale premium credits for individuals to purchase insurance through a health insurance exchange, and limits the cost-sharing requirements and out-of-pocket expenses of individuals purchasing these plans (Sections 1401, 1402).

The new law allows the federal government to increase by one percentage point the portion of expenses it covers in state Medicaid programs, called the Federal Medical Assistance Percentage (FMAP), to states that cover certain evidence-based preventive services, including immunizations and tobacco cessation products, with no cost-sharing to Medicaid enrollees (section 4106).

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24 KFF. 2009. Medicaid and state funded coverage income eligibility limits for low-income adults. 2009. Retrieved October 14, 2010, from http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4.

25 Holahan J., Headen I. 2010. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Retrieved October 14, 2010, from http://www.kff.org/healthreform/8076.cfm.

26 Kenny G., Pelletier J. 2010. How Will the Patient Protection and Affordable Care Act of 2010 Affect Children? Retrieved October 14, 2010, from http://www.urban.org/uploadedpdf/412129-PPACA-affect-children.pdf.

States will also be able to compete for participation in a national demonstration project to provide access to comprehensive health care services to the uninsured at reduced fees. Up to $2 million will be available to 10 states (Section 10504).

Improving Access to Maternal, Infant and Child Health Care
The ACA stipulates spending $1.5 billion over five years in competitively awarded grants to states to implement home-visiting programs in communities identified with relatively high rates of medically indigent and vulnerable mothers and children (Section 2951).

In addition, a demonstration program of the Centers for Disease Control and Prevention (CDC) will award grants to states to improve immunization rates for children, adolescents and adults (Section 4204).

Increasing the Appropriateness and Quality of Care
The ACA creates a Patient-Centered Outcomes Research Institute, a nonprofit corporation, to identify research priorities and conduct research that compares the clinical effectiveness of medical interventions and programs for diseases, disorders and health conditions (Section 6301). A number of Medicare and Medicaid pilot or demonstration programs will inform the work of the Institute. These programs focus on expanding the quality of primary care, increasing coordination of care for chronically ill individuals, and improving care transitions between acute and post-acute care—three major themes of quality improvement in federal health care reform. These efforts use enhanced federal payment rates to states, or new payment methods designed to reward quality rather than quantity of care. Several examples for which Missouri's Medicaid program and the state's providers may seek participation are summarized in Table 3.

Table 4. Provisions in ACA to foster cost-effective primary and coordinated care through Medicaid and CHIP

Brief Descriptions of Select ACA Provisions in Medicaid and Medicare	ACA Section	Year to Begin
Medicaid Health Home for Chronically Ill. Up to $25 million in planning grants to be awarded per state to support health homes for enrollees with chronic conditions. The federal government will match states' payments at a 90 percent rate.	2703	2011
Medicaid Integrated Care. Up to 8 states to be selected for a demonstration project that uses "bundled payments" to promote integration of primary and acute care for hospital admissions related to specific conditions.	2704	2012
Medicaid Global Payment System. Up to 5 states to be selected for a demonstration project allowing large, safety-net hospital systems or networks to alter reimbursement from fee-for-service to capitated, global payments.	2705	2010
Medicaid - Pediatric Accountable Care Organization. A four-year demonstration project that will allow pediatric providers to organize into a new structure that promotes physician and hospital collaboration by rewarding providers with a share of federal and state cost savings that they generate under Medicaid from efficiencies and quality improvements.	2706	2012
Medicare Home-Based Chronic Care Program. A five-year chronic care management pilot program to promote use of home-based primary care services to the highest-cost Medicare beneficiaries with multiple chronic conditions.	3026	2011
Medicare Home-Based Primary Care Services. A five-year, $5 million demonstration program to allow primary care teams to provide high-need Medicare enrollees with primary care services in their homes.	3024	2010

In addition, ACA, through the federal Agency for Healthcare Research and Quality (AHRQ), will provide $120 million per year in grants to states for two years to establish Primary Care Extension Program "hubs" to train and educate primary care providers on evidence-based and evidence-informed therapies and techniques concerning preventive medicine, health promotion, chronic disease management, and mental and behavioral health services, including substance abuse prevention and treatment (Section 5405).

Better coordination of primary and behavioral health care is also a goal of federal health care reform. Local communities will have an opportunity to compete for grants to promote coordinated and integrated services to select populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings (Section 5604).

Health Status

Among the many provisions in ACA related to improving health, several offer states opportunities to leverage community assets within and beyond traditional medical settings in order to promote healthy living. The law also provides resources to improve quality of life for individuals with psychiatric care needs, and targets resources to prevent conditions and illnesses associated with premature mortality. Several examples are provided below.

- *Promoting Healthy Living:* Community-focused efforts in health care reform are designed to encourage a holistic approach to prevention and wellness. For example, the CDC will award competitive Community Transformation Grants to state and local governments to encourage development and improvement of community infrastructure and evidence-based prevention programs that support healthy lifestyles in neighborhoods, schools, worksites, and other non-health care settings (Section 4201).

  State and local health departments will have an opportunity to compete for grant funding in a five-year pilot program, "Healthy Again, Living Well," which supports community-based interventions, screenings, and clinical referrals as needed for individuals between the ages of 55 and 64 (Section 4202). Grants will also be made available to small businesses to provide comprehensive workplace wellness programs (Section 10408).

  State Medicaid programs will be recipients of federal funding to promote healthy behaviors and disease prevention. Between 2011 and 2016, $100 million in grants will be available to incentivize Medicaid programs to adopt evidence-based programs for tobacco cessation, weight control, and cholesterol and blood pressure management, among others (Section 4108). The ACA also requires states to cover comprehensive smoking cessation programs for pregnant women, and smoking cessation drugs for other covered members.

  The ACA also promotes health and wellness at a national level through creation of the National Prevention, Heath Promotion and Public Health Council. The Council's role is to coordinate and promote health-related polices across multiple sectors and agencies at the federal level—including health, agriculture, education, labor, and transportation (Section 4001).[27] The new law also creates a Prevention and Public Health Fund, which is to be appropriated $7 billion from 2010 through 2015, and $2 billion each year thereafter to promote health and wellness (Section 4002).

27 Andrulis DP, Siddiqui NJ, Purtle J, Duchon L. 2010. Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations. Washington, DC: Joint Center for Political and Economic Studies.

- *Improving Quality of Life:* Several provisions in the ACA focus on improvement of care for people with mental health conditions, an area where indicators suggest Missouri has room for improvement. Grant funding will be provided to establish at least 20 Centers of Excellence for Depressive Disorders to improve the effectiveness of treatment for these diseases (Section 10410). In addition, up to $75 million will be made available in Medicaid payments to psychiatric institutions to care for adults who require stabilization from an emergency psychiatric condition (Section 2707).
- *Reducing Risks for Premature Mortality:* ACA includes $9 billion in funding for an educational campaign to increase knowledge about breast health, and reduce mortality from breast cancer (Section 10413).[28] As noted earlier, Missouri's breast cancer mortality rate is one of the highest in the nation.

  The ACA also targets other risk factors for premature mortality, including obesity and diabetes. From 2010 through 2014, $25 million will be made available to fund demonstration projects developing comprehensive models for reducing childhood obesity. In addition, the CDC will establish a National Diabetes Prevention Program to support community-based prevention initiatives.

Conclusion

With a focus on health coverage, access and health status, this issue brief highlighted some of Missouri's strengths and challenges in promoting the health of its residents. Federal health care reform offers a wide range of opportunities for the state and its communities to expand coverage, improve access to appropriate, coordinated care, and increase the opportunities for individuals to make healthy choices that can reduce the prevalence of conditions and diseases that contribute to poor health and early mortality. The road ahead will be bumpy and often difficult to navigate. Beyond implementing federal requirements, which will be enormously challenging, a major task for state and community leaders in Missouri and all states will be prioritizing the opportunities they seek for federal grants and awards that match well with the health needs and challenges of the individuals and families in their states.

28 Ibid.