

Issues in Missouri Health Care 2009

Executive Summaries

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The summaries that follow are intended to accompany the series of papers titled “Issues in Missouri Health Care 2009” prepared by Health Management Associates, Inc., a national health care policy consulting and research firm, with financial support from the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City.

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Diagnosis: What the Data Say About the State of Missourians' Health

According to the current Census Bureau figures, 45.7 million Americans were uninsured in 2007. Another 25 million are estimated to be “underinsured,” a 60 percent increase since 2003.¹ In Missouri, the number of uninsured rose from 668,000 in 2006 to 729,000 in 2008, or from 11.7 percent of the population to 12.4 percent.² This compares to about 15 percent uninsured nationwide. The increase in the number of uninsured in Missouri can be traced to a decline in employer-sponsored health coverage and reductions in eligibility levels for the Medicaid program. The proportion of the population enrolled in Medicare is higher in Missouri than in the country as a whole, 14 percent versus 12 percent, and roughly the same proportion is in Medicaid (12 percent in Missouri, 13 percent nationwide).³

Missouri spends about \$31 billion a year on health care, amounting to roughly 16 percent of the state's total economy. In 2006, premiums for employer-sponsored health coverage averaged \$3,958 for single coverage and \$11,171 for family coverage. These premium levels were slightly below the national averages of \$4,118 for single coverage and \$11,381 for family coverage. Missouri employers pay a slightly higher proportion of the premium for family coverage (77 percent versus 75 percent), but about the same proportion for individual coverage.⁴

The uninsured are mostly a working population, with many in households headed by someone working full-time or part-time for a small company. Nearly two-thirds of uninsured workers are not offered coverage from their employers. The others are about equally divided between those ineligible for their employers' plan (e.g., because they do not work enough hours per week) and those who turn down coverage because they cannot afford their contribution. Large numbers of adults living in poverty are excluded from Medicaid because they do not have dependent children. Others are excluded because of their immigrant status. Many young adults do not get health insurance. People with serious medical conditions are frequently priced out of the private insurance market or

¹ C. Schoen et al. “How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007. *Health Affairs Web Exclusive*. Vol. 27, Nos. 3-4. P. w298.

² www.covermissouri.org; compiled from Census Bureau data.

³ www.statehealthfacts.org.

⁴ www.statehealthfacts.org.

turned down when they apply. Policy reforms must address these basic facts about the uninsured.

It is important to understand that Missouri is already paying for the problem of the uninsured. Missourians pay taxes to support safety net programs for the uninsured. Employers and employees face higher premiums because of the uninsured. Of course, the most serious burden of all is borne by the uninsured themselves and their families. The uninsured get only about half the health care that they need, and they frequently receive late-stage diagnoses of cancer and other life-threatening diseases. Addressing this serious problem is in the interest of all parties involved.

Prescription: Policy Options for Covering the Uninsured

Missouri has a number of options for providing health coverage to its approximately 729,000 state residents who are uninsured. These options range from incremental steps designed to shore up and expand the private insurance market and restore Medicaid coverage for parents living in poverty to a statewide insurance exchange and requirements placed on individuals and employers to participate in the health coverage system. Missouri could also try new approaches to enrolling more children who are eligible for but not participating in public programs.

Options include:

- Automatic enrollment of lower-income children into SCHIP based on participation in other means-tested government programs.
- Strengthening the state's requirement that insurers allow parents to keep young adult children on their private health insurance policies.
- Increasing Medicaid eligibility for parents, which currently allows participation only for those with incomes below 20 percent of the poverty line, or less than \$5,000 a year for a family of four.
- Obtaining federal permission to enroll poor adults without children in Medicaid.
- Premium assistance to help lower-income workers afford their share of employment-based coverage.
- Further strengthening of the state's high-risk pool to make coverage more affordable for the medically uninsurable.
- A reinsurance program to lower premiums in the private market.
- An insurance exchange offering a choice of health plans with sliding scale subsidies.
- A requirement that parents cover their children, which could set the stage for a later and stronger requirement that everyone obtain at least basic health insurance.

- A requirement that all employers contribute at least a modest amount to health care.
- Health savings accounts (HSAs).

Some combination of new subsidies and required participation will likely be needed to cover most of the uninsured in Missouri. Incremental steps could provide short-term assistance in reducing the number of uninsured Missourians.

When Basic Benefits Aren't Enough: Caring for Missourians with Chronic Conditions

This paper describes the importance of addressing issues relating to chronic and disabling health conditions as Missouri considers strategies to cover the uninsured. The problems resulting from chronic disease affect many people. There were an estimated 465,000 working age adults in Missouri with a disability in 2004, or 13.3 percent of all adults age 18 to 65. Only 21 percent of Missourians with a disability in this age group were employed.

People having a chronic disease are more likely to be uninsured. Lack of insurance is especially a problem for older adults, who are more likely to have a chronic condition. The practices of commercial insurers tend to make it more difficult for people with chronic conditions—who are necessarily more likely to need expensive medical services—to find affordable coverage. In the individual market, a person deemed to be high risk will be charged a relatively high premium, which may be unaffordable, or may be denied coverage entirely. In the small-group market, when an employer group includes people with chronic conditions, the premiums for that group will be higher because of their participation in the insurance program, which may make coverage unaffordable not only for the high-risk people in the group but also those of average risk.

In Missouri, as in all states, Medicaid has become the primary insurer of people whose medical conditions result in disability and the inability to work. However, not everyone with chronic health conditions is disabled, and not everyone with a disability lives in a family whose income qualifies under basic Medicaid income standards. Of course, providing coverage for people with chronic conditions is more expensive than providing coverage for the rest of the Medicaid population. Missouri has tried to address the cost problem in a number of ways, including enrolling such people in managed care plans, employing disease management strategies targeting specific conditions, and making better use of information technology to improve outcomes and reduce costs.

The policy options for providing affordable coverage for those with chronic conditions who still remain uninsured fall into several broad categories. One approach is to alter the insurance market rules to ensure that risks are broadly spread among the healthy and the not-so-healthy people in the risk pool. But this approach can create situations in which lower-risk people find coverage a poorer value and drop out of the insurance pool, which raises the cost of insurance for those remaining in the risk pool. Another approach is to subsidize the cost of private insurance for high-risk people, for example, through the establishment of well-funded high-risk pools. The third basic approach is to expand public programs to make more people with chronic conditions eligible.

Wiring Missouri’s Health Care: Electronic Health Records and Health Information Exchange

The American health care system offers some of the most advanced and effective care in the world, but it is also inefficient, does not emphasize quality, and makes it difficult for consumers to compare price and quality. Modern health information technology offers unprecedented opportunities to improve health care for Americans and promises quality care at a lower cost.

Governors, legislators, and policymakers from all spheres have demonstrated a strong interest in using electronic health records (EHR) and electronic health information exchange (HIE) to reform the health system. Evidence suggests the use of secure, standards-based Health Information Technology (HIT) and the timely, electronic exchange of health information could significantly improve patient care and increase efficiency.

However, there are significant barriers to adopting EHRs and electronic HIE. The technology exists, but it remains far from universally deployed throughout the health care system. Barriers to adoption include questions about return on investment, privacy and security concerns, and health care consent requirements that make it difficult to share data. The federal government has set a goal that most Americans have EHRs within the next ten years. The ultimate goal is to use interoperable EHRs and electronic HIE to create a “network of networks” that connect providers, health systems, consumers, and communities to electronically share health information. The system is intended to improve care for individual patients and population health overall.

Most states are actively promoting the use of HIT and HIE. Consensus among states has emerged that, despite implementation challenges, e-health initiatives are worth the effort. Across the nation, electronic health information exchanges are at the of top governor’s e-

health priorities. Nearly all state Medicaid agencies are pursuing e-health initiatives, and nearly all state public health agencies operate one or more electronic registries.

States can do still more to drive health system reforms. They can provide leadership and support for e-health initiatives, address privacy and security concerns, promote interoperable technology, and leverage publicly funded health programs to drive HIT and HIE initiatives. These strategies accelerate the adoption of interoperable EHRs and electronic HIE, and have the potential to transform the American health care system to improve care, increase quality, and reduce costs for individual patients and the nation overall.

Compliance: Myths and Facts About Medicaid Fraud and Abuse

Missouri's Medicaid program, known as MO HealthNet, covers close to 1 out of every 7 Missourians, 34 percent of Missouri's children, and 1 out of every 10 seniors over age 65. The Missouri budget for state fiscal year (SFY) 2008 appropriated approximately \$5.4 billion for Medicaid and although the majority of people enrolled in Missouri Medicaid are families and children, the majority of expenditures pay for services to the aged, blind, and disabled.⁵ While only \$2.5 billion of the overall \$6.5 billion Medicaid budget comes from state general revenue in a time of budget constraints every dollar counts. Missouri, like 31 other states, is expected to have a budget shortfall and can ill-afford any portion of its Medicaid budget misdirected to anyone who would defraud the Medicaid program.⁶

The types of Medicaid fraud are only limited by the creativity of those who would target the program. Examples include:

- Upcoding for services more expensive than those provided.
- Fabricated claims from nonexistent clinics, nonexistent patients, or deceased patients.
- Claims for durable medical equipment that was never received.
- Providers who pay enrollees who are healthy to make unnecessary visits.
- Claims for unnecessary surgical procedures.
- Nonprofessionals providing services without proper licenses.
- Multiple prescriptions for controlled substances obtained by patients who doctor-shop or bounce from one doctor to another.

⁵ Missouri Medicaid Basics, Winter 2008, Missouri Foundation for Health.

⁶ 29 States Faced Total Budget Shortfall of at Least \$48 Billion in 2009, Elizabeth C. McNichol and Iris J. Lav, Center on Budget and Policy Priorities, August 8, 2008.

The cost of fraud is unclear. Some estimates indicate that around 10 percent of total Medicaid payments are fraudulent.⁷ Many states continue to struggle with identifying and rooting out fraud from their Medicaid programs. A 2005 New York Times article stated that New York had been mispending billions of dollars annually because of Medicaid fraud, waste, and profiteering.⁸

The fact that MO HealthNet services are vital to Missourians and the budget is not unlimited requires that action be taken to reduce fraud through an integrated and coordinated approach that does not create strong disincentives for provider participation or onerous hurdles for recipient enrollment. A strategic plan to combat fraud that includes integrating electronic fraud and abuse detection systems, provider education, legal measures, public education on how Medicaid fraud directly impacts each citizen, and coordination between federal and state agencies is critical to ensuring that Medicaid can provide the necessary and appropriate health services to hundreds of thousands of Missourians and be accountable to the taxpayers of the state.

Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-term Care

Long-term care services refer to health and social services and supports to individuals who have lost some capacity for self-care. These services consist predominantly of assistance with essential, routine tasks of life. Those in need of long-term care services include the elderly and persons with physical, mental or developmental disabilities.

One of the driving forces behind the projected increased demand for long-term care services over the next 20 years is the aging of Baby Boomers.⁹ It is estimated that by 2010, 14.9 percent of Missouri's population will be 65 years of age or older. By the year 2020, Missourians aged 65 and over are projected to be 18.2 percent of the population.¹⁰ The most dramatic increase will be in the population of Missourians aged 85 years of age and older, who are most likely to need long-term care services. In 1990, approximately 80,000 persons were age 85 and older. By the year 2020, this number is estimated to reach 129,000, or 2 percent, of Missouri's total population.¹¹

⁷ General Accounting Office. Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse. Washington, D.C.: General Accounting Office; 1992:2.

⁸ New York Medicaid Fraud May Reach Into Billions, Clifford J. Levy and Michael Luo, New York Times, July 18 2005.

⁹ Baby boomer describes a person born between 1946 and 1964.

¹⁰ "Missouri State Plan on Aging" *Division of Senior and Disability Services*. 27 September 2007 , pg 4

¹¹ "Missouri State Plan on Aging" *Division of Senior and Disability Services*. 27 September 2007 , pg 5

Most individuals want to receive long-term care services in their own home or in a community-based residential setting. Missouri's 2007 State Plan on Aging defines these as "services such as personal care, homemaker, chore, nursing, respite, adult day health care, counseling, and consumer-directed services are made available to the elderly and persons with disabilities in their homes."¹² A 2005 survey of its Missouri members, AARP found that 97 percent of the membership wanted to be cared for in their homes or other community settings. Through various initiatives, grants, and federal waivers, Missouri has taken steps toward building a system of care that begins shifting from an institutional to home and community-based care model. In Missouri, several state agencies share the responsibility for various programs and services that fund, regulate, and coordinate the state's long-term system of care.

Promoting Choice, Providing Options

- In 1999, a U.S. Supreme Court decision interpreted the Americans with Disabilities Act (ADA) to mean that individuals with disabilities have the right to receive care in the most integrated setting appropriate to the individual's needs and that unnecessary institutionalization is a violation of the ADA (*Olmstead*¹³). All states are required to comply with this court decision.
- Federal grants, waivers, demonstration programs, and other incentives have been offered to states to provide a wider array of options for receiving long-term care services. Some states have established state-funded programs.
- Missouri has taken advantage of some of the aforementioned options and is in the process of reviewing additional opportunities to provide more home and community-based long-term care services.

Improving Access, Reducing Fragmentation

- The responsibility for long-term care services is divided among multiple state agencies by funding source, diagnosis, age, and type of disability, therefore coordination of care can be challenging.
- The multitude of agencies can make it difficult for an individual who needs long-term care to identify the services they need to maintain their independence, the services for which they may be eligible, and the availability of those services in their community.

¹² Ibid, pg 14.

¹³ The case of *Olmstead v. L.C. and E.W.* involved the state of Georgia's appeal to enforce the institutionalization of persons with disabilities. The lower courts ruled the state violated the ADA's "integration mandate" and Georgia appealed, claiming the ruling could lead to the closing of all state hospitals and disruption of state funding of services to people with mental disabilities.

- Missouri has formed the Comprehensive Entry Point System Subcommittee (CEP) to make recommendations for improving access to and the array of long-term care services.

Paying for Long-Term Care

- Most long-term care is provided by family and friends at home or in another residential or community setting.¹⁴
- Public funding for long-term care services has historically favored institutional care, but through the use of waivers and other mechanisms,¹⁵ some funding is shifting to home and community-based care.
- Eligibility for public funding is based on income and asset criteria and often requires individuals to spend their savings and assets. There is increased interest in promoting the purchase of long-term care insurance policies to help mitigate the effects of increased demand on public funds and to avoid spending down assets.

Treating the Whole Missourian: Mental Health and Substance Abuse

Mental health is fundamental to overall health. Yet, mental health and substance abuse services (collectively referred to as behavioral health) are commonly provided and paid for separately from other health care services. This fact increases the chance that behavioral health issues will be overlooked or marginalized in public policy discussions concerning health care. Failing to acknowledge the critical role that behavioral health plays in overall health care can put health system reform or improvement strategies at risk by failing to account for a significant driver of health care costs and utilization.

Behavioral health is an umbrella term that refers to both mental health and mental illness and substance abuse disorders. Behavioral health disorders include mental health disorders such as depression, bipolar disorder, anxiety disorders, schizophrenia and attention deficit hyperactivity disorder, as well as substance abuse disorders, such as alcoholism and drug abuse.

Behavioral health disorders are common in Missouri. In any year, 1 in 4 Missourians (1.45 million people) are impacted by mental health disorders. Of these, 6 percent

¹⁴ “NFCSP Complete Resource Guide” *Administration on Aging*. 9 September 2004. Accessed September 2008. (http://www.aoa.gov/prof/aoaprof/caregiver/careprof/progguidance/resources/nfcsp_resources_guide.aspx)

¹⁵ See HMA Issue Brief on waivers.

(348,000) face the challenge of serious mental illnesses. In addition, almost half a million Missourians have substance abuse disorders.¹⁶

While behavioral health disorders can be treated successfully, people face significant challenges to obtaining the treatment they need. The challenges include:

- Barriers to access to behavioral health services.
- Barriers to access to physical health care.
- Lack of or inadequate coverage within private health insurance or Medicaid benefits.
- Lack of services because of workforce issues.
- The stigma associated with mental disorders.

Policy options to address these barriers include:

- Integrated physical and behavioral health care.
- Improving access to public and private health coverage.
- Strategies to promote prevention, early intervention and disease management.

Medication Marketplace: Getting the Best Price on Prescription Drugs for Missourians

The Medicare Modernization Act required individuals enrolled in both Medicare and Medicaid (known as “dual eligibles”) to transition from Medicaid to Medicare prescription drug coverage in 2006. The resulting 50 percent drop in the number of Medicaid prescriptions in Missouri did not simplify administration of the state Medicaid pharmacy benefit or its reimbursement methodology. Historically-used pricing indices, particularly Average Wholesale Price (AWP), are currently under close scrutiny. Federal and state investigators have found significant spreads between AWP and actual pharmacy costs, which has prompted litigation against manufacturers for falsely reporting AWP. In the Deficit Reduction Act of 2005, Congress adopted an alternative pricing strategy for multiple-source drugs based on Average Manufacturer Price (AMP) which was previously confidential and used only in the federal manufacturer rebate program. Some states also have indicated interest in extending AMP methodologies to other drugs. Pharmacies, fearful that AMP-based rates would not cover their drug acquisition costs, sued the Centers for Medicare and Medicaid Services and petitioned Congress for relief. In July 2008, the Medicare Improvement for Patients and Providers Act of 2008 prohibited implementation of the AMP-based rates prior to October 1, 2009.

¹⁶ Missouri prevalence figures extrapolated from national prevalence data cited in: National Institute of Mental Health, *The Numbers Count: Mental Disorder in America*. <http://www.nimh.nih.gov/health/publications>. Retrieved 9/12/08.

In spite of ongoing product cost issues, Missouri has been able to implement an innovative provider tax that leverages additional federal matching funds for pharmacy reimbursement. The tax allows the state to sustain one of the highest pharmacy dispensing fees in the nation and recognize reimbursement for medication management therapy to promote better health outcomes. Although Missouri has had success with this approach, it must remain poised to face upcoming challenges dealing with AWP product cost reimbursement and sustaining its generous prescription drug reimbursement that pharmacies have come to expect.

Buying Value: Improving the Quality of Missourians' Health Care

Missouri spends \$31 billion on health care each year, or \$5,444 per person, slightly more than the U.S. average of \$5,283. Despite a sizable expenditure, Missouri ranks in the bottom third of states on quality of care and health outcomes. By leveraging its role as health care purchaser and regulator more fully, Missouri could improve the quality of care and the health outcomes of its citizens to get more value for its health care investment.

Missouri has made considerable progress in recent years to promote quality improvement and patient safety through various pieces of legislation, including the Missouri Health Improvement Act of 2007 (S.B. 577), which seeks to make MO HealthNet a prudent purchaser of high quality care, and the Missouri Health Transformation Act of 2008 (S.B. 1230), which requires hospitals to report adverse events and the state to publicly report results annually. The Governor's Office launched a study in 2004 that resulted in the creation of the Missouri Center for Patient Safety and initiated a comprehensive assessment of the health information technology and exchange needs of the state in 2006. To achieve health outcomes comparable to those of the highest ranked states in the country, Missouri will have to pursue policy options which show promise in other states, and build on the state's recent progress to improve quality of care and patient safety. The options have two themes in common: leveraging the state's significant influence as a purchaser and regulator; and collaborating with others in the health sector to coordinate efforts and reduce duplication. Missouri may wish to consider three policy directions for improving quality of care and patient safety:

- Standardizing quality measurement and improvement efforts statewide by aligning the state's own purchasing strategies, including MO HealthNet, the state employee benefit program, and other agencies that purchase health care services. Back up priorities by aligning financial incentives in support of quality goals.

- Raising public and health sector awareness of quality problems and the need for improvement by creating state reporting systems. Report on quality and patient safety, which will mobilize the medical community to improve.
- Supporting the use of innovative technology and the exchange of information across health care settings to improve quality and reduce errors.

Kicking the Habit: Tobacco Use Prevention and Cessation

Smoking is the leading preventable cause of death in Missouri. Over 400,000 persons die annually from smoking-related causes in the U.S., and 9,600 of them are from Missouri. Smoking causes cancer, including 90 percent of lung cancers in men and almost 80 percent in women.¹⁷ Cigarette smokers also suffer at much higher rates than the general population from coronary heart disease, stroke, and peripheral vascular disease.¹⁸ Cigarette smoking is the major cause of chronic obstructive pulmonary disease (COPD), causing 90 percent of the deaths from this disease.¹⁹ Smoking causes infertility problems, early births and stillbirths, low birth weight babies, and sudden infant death syndrome (SIDS).²⁰ The death toll does not take into account the suffering caused by smoking-related diseases and the potentially productive years that an afflicted person would have lived had he not smoked.

Given the indisputable information on the death, disability, and costs that result from smoking, state leaders are faced with the challenge of designing effective tobacco-control policies. All aspects of the state's tobacco-control policy could be bolstered, including cessation programs, clean indoor air legislation, and tax and regulatory policy.

¹⁷ U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

¹⁸ Ockene IS, Miller NH. Cigarette Smoking, Cardiovascular Disease and Stroke: A Statement for Healthcare Professionals from the American Health Association." *Journal of American Health Association*. 1997;96;3242-3247.

¹⁹ U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

²⁰ U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

By the time Missourians reach adulthood, their smoking rate is 3 percent higher than the national average.²¹ An estimated 1 million Missourians smoke. Half of these persons will die from a smoking-related disease. Nearly 90,000 of Missouri smokers are youth, and their smoking rates exceed the national average. Thirty-eight percent of Missouri sixth graders have tried smoking, a percentage that rises to 60 percent by the eighth grade.²² In Missouri, estimates are that 132,000 years of potential life were lost from smokers' early deaths annually, and annual lost productivity due to tobacco-related disease is estimated to be \$2.4 billion.²³

Transforming Missouri Medicaid: Federal Waiver Options and Processes

Two key programs, Medicaid and the State Children's Health Insurance Program (SCHIP), are important sources of financing for health care services for low-income Missouri adults and children. Both programs are financed jointly by the state and federal governments and operated by states under federal guidelines that are set forth in law, regulation, and policy letters issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees these programs.

Over time, Congress has created a series of waiver options for states. Under a waiver, a state can ask CMS for permission to deviate from statutory and/or regulatory requirements that may stand in the way of service expansion or innovation. Waivers have historically been used to allow states to offer special services to certain vulnerable populations, to pursue cost-containment initiatives such as enrollment of Medicaid beneficiaries into managed care plans, and to expand eligibility.

All states have at least one waiver; many have several. Missouri currently operates nine separate waivers. This issue brief outlines the various types of waiver authorities, their respective benefits and limitations, and the process for obtaining a waiver.

²¹ Kayani NA, Yun S, Shu BP, The Health and Economic Burden of Smoking in Missouri, 2000-2004, *Missouri Medicine*, May/June 2007. p.268.

²² Carter, M. . Tobacco Use Among Middle School Students, 1999. Missouri Department of Health, Division of Chronic Disease and Health Promotion. p.....

²³ Missouri Department of Health and Senior Services, Tobacco State, p.1. www.dhhs.mo.gov

Who Will Care for the Sick: Health Care Workforce Challenges for Missouri

Like other states, Missouri faces the ongoing challenge of training, recruiting, and retaining a health care workforce to meet the changing needs of the state's growing population. That challenge is particularly acute for rural areas, which have difficulty attracting and keeping not only specialists but primary care providers as well. How the state addresses this challenge is critical to access to quality medical care not only for the uninsured and recipients of publicly financed health care services but for those with commercial insurance coverage as well.

States and individual communities have grappled with this challenge using a variety of strategies including:

- Developing reliable data on health care professional supply and demand.
- Targeting funding for graduate medical education.
- Implementing a holistic community approach to attracting needed professionals.
- Developing and sustaining interest in needed health careers.
- Establishing regional collaborations.

Addressing rural Missouri's needs for health care professionals requires a multi-dimensional approach that deploys a wide variety of strategies.