

Purpose

Currently, Missouri Medicaid is limited in its ability to control costs while improving population health because there is no real opportunity to work on the underlying causes of poor health. Medicaid expansion in Missouri creates an opportunity to improve population health – to move the needle on many metrics for which the state’s ranking has fallen significantly over the past 30 years – by redesigning its program in key ways.

Background

In August 2020, Missouri voters approved a constitutional amendment that expands eligibility for Medicaid coverage to all low-income Missouri citizens. However, even prior to that, there were ongoing efforts at the state level to reform and update the Medicaid program to better serve its beneficiaries. To that end, a 2018 report commissioned by the State by McKinsey & Co. made a set of recommendations that, collectively, are considered a starting point for “Medicaid Transformation” in Missouri. The report recommended that the State change its reimbursement methods in several areas, focusing on value-based payment (VBP), improved care coordination, and reductions in potentially avoidable utilization; all of these imply a focus on the risk factors driving poor health. The State has been pursuing many of the report’s recommendations.

Current Environment

Missouri’s current Medicaid program does not reach low-income individuals until they are already far “downstream” in terms of serious health and/or behavioral health needs. Individuals are eligible for Medicaid through the disability pathway only if they can prove that they have a serious impairment rendering them “permanently and totally disabled.” Low-income parents are only eligible if their earnings are less than \$3,720 per year for a family of two.¹ The majority of parents earning below this level already have mental, behavioral, or physical health problems that make it difficult for them to work, or which require medical care such as prescriptions that would be unaffordable to them if they found jobs and earned income beyond the threshold, as they would then be disqualified for Medicaid.² Childless adults are never eligible on the basis of income.

In short, Missouri Medicaid is limited in its ability to control costs while improving population health because there is no real opportunity to work on the upstream causes. Without such efforts, today’s “expansion” population, consisting of all low-income individuals (below \$23,791 per year for a family of two), will become tomorrow’s “mandatory” population. Unfortunately, longitudinal data show that upward income mobility is limited, and that more than half of individuals in the lowest income quintile will remain in the lowest quintile a decade or more later.^{3,4} For those with health problems, the number is undoubtedly higher.

Value-based payment refers to tying reimbursement to quality and outcomes, rather than to volume alone. This has been a popular strategy in Medicare, among private payers, and within several states’ Medicaid programs. However, a number of articles and policy briefs published recently have summarized the first 10-12 years of VBP as failing to live up to their initial promise, associated with only modest reductions in costs and little improvement in outcomes. In part, this has been due to implementation issues, but it has also been argued that, within the Medicaid population especially, it is critically important that transformational efforts elevate **social determinants of health** (SDOH) in addition to focusing on individuals’ immediate **social needs** (see Box), rather than only addressing typical medical comorbidities. A recent analysis found that “value-based payment models can provide the financial flexibility and accountability that allow healthcare organizations to more easily address social determinants of health at the population level.”⁵

Social Determinants of Health¹²

When the concerns listed below are chronic, pervasive, or systemic, they are known as SDOH. As individual and temporary problems, they are considered “social needs” and may be addressed in limited ways through existing programs. Key concerns include:

- Nutrition
- Access to job and education opportunities
- Quality of education and job training
- Transportation options
- Safe housing
- Language/literacy
- Exposure to violence and other trauma

POLICY BRIEF

To date, VBP models have done little to address the upstream or root causes of poor health. This is because most VBP arrangements are targeted toward hospitals, where the majority of spending occurs, but the upstream cause of poor health outcomes and high hospital spending is often in the outpatient setting, tied to poorly controlled chronic conditions such as diabetes and high blood pressure. This is the product of sporadic access to care and the fact that low-income individuals often have complex social needs that interfere with their ability to focus on health goals. At the individual level, these social needs may be met on a case-by-case, *ad hoc* basis, but even for this to happen, they must first be identified during a patient encounter, and typically the need must be directly tied to a clinical diagnosis. This is true even when the expenditure would provide a positive return on investment.

Moving Forward

Medicaid expansion in Missouri creates an opportunity to improve the health of the state's population – to move the needle on many metrics for which the state's ranking has fallen significantly over the past 30 years. Policymakers working to transform the Medicaid program will be able to focus on truly upstream interventions halting the progression of chronic conditions and addressing behavioral health needs in this pool. Historically, the per capita cost of Missouri's Medicaid population has been well above the national average;⁶ this is explained in part by the fact that enrollees' unmet need is greater by the time they qualify for the program. An emphasis on SDOH in the process of Medicaid transformation, coupled with SDOH-encompassing VBP design, greater transparency, and greater accountability, will produce a positive return on investment while improving the health and wellbeing of low-income individuals and families across the state. In fact, a systemic focus on SDOH can have broad repercussions across the economy; beyond merely meeting social needs, addressing the SDOH is an investment in our citizens. As such, it will likely have payoffs beyond the healthcare sector, boosting productivity and earnings and reducing dependency.

Case Studies: Cost Savings Through Addressing the Social Determinants of Health

Nationwide, health systems are investing heavily in the social determinants of health, both through screening and referral processes and through direct investment in community programs for housing, food, employment, and education, among other areas.⁷ Existing funding streams are often “braided” or “blended” for an integrated approach.

Investments in social services and integrated healthcare models have yielded improvements in health outcomes and reductions in healthcare costs across a range of health systems and settings.⁸ Across 39 SDOH studies, investments in housing, nutrition, care coordination, and community outreach showed particular promise for improving care quality and lowering cost.

For example, the IMPaCT program at the University of Pennsylvania saved the Medicaid program \$1.4 million through a standardized intervention delivered by community health workers to provide support to high-risk patients and address the barriers to health.⁹ This intervention returned \$2.47 to payers for every \$1 spent. A Medicaid accountable care program through Hennepin Health in Minnesota used care coordinators, community health workers, behavioral health staff, and housing and social services navigators to meet patients' social needs. The program resulted in an 11% average annual decline in medical costs from 2012 to 2016, a decrease in ED visits, and increases in the percent of patients receiving optimal care for conditions such as diabetes and asthma.^{10,11}

References

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