



**Missouri Foundation for Health's Efforts to Improve Health Policy
2003-2018**

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Chapter 1. In the Beginning: Health Policy Becomes a Foundation Priority

On December 21, 2000, Missouri residents got an early Christmas present as the Attorney General's office transferred 14,982,500 shares of RightChoice stock worth \$483 million as well as \$12.8 million in cash to the newly created Missouri Foundation for Health. The transfer capped six years of a bruising legal battle that began in April 1994 when the nonprofit Blue Cross and Blue Shield of Missouri (Blue Cross) announced its plans to transfer most of its assets to a new for-profit subsidiary, RightChoice Managed Care, and to keep the proceeds for itself. When consumer advocates, such as Missouri Consumers Health Care Watch and Consumers Union, a national organization that challenged transactions such as this in many states, got wind of the proposed transaction, they raised a storm of protest. They argued that, under state law, a nonprofit corporation—which, after all, had benefitted for years from the tax advantages accruing to nonprofits—could not magically transform itself into a for-profit company and use the assets to award huge bonuses and stock options to its executives. “The money belongs to the public and should be put into a new foundation devoted to improving the health of Missouri residents,” said attorney Joel Ferber, a leading consumer advocate opposing the transaction and later a member of the Foundation's Community Advisory Council.

The controversy led to extensive coverage in the media and a public outcry. Missouri's Insurance Commissioner, Jay Angoff, who had initially approved the transaction, changed course after discovering that Blue Cross had failed to disclose relevant materials. Toward the end of 1995, he stated that Blue Cross had violated state law and threatened to revoke its license. The Missouri Department of Insurance's stance triggered a lawsuit by Blue Cross in the Cole County Circuit Court, followed by a countersuit, and a series of appeals. Even as the matter was being litigated and a special master appointed by the judge overseeing the case was doing his investigation, settlement negotiations involving Attorney General Jay Nixon, Insurance Commissioner Angoff, the consumer groups, and Blue Cross were taking place.

By August 1998, the negotiators had reached a tentative settlement. Under its terms, Blue Cross, whose new president, John O'Rourke, had actively sought to defuse the situation, agreed to create a nonprofit health care foundation, with the initial Board chosen by a Community Advisory Council appointed by Governor Mel Carnahan and Attorney General Nixon. The settlement was subject to approval by the Circuit Court of Cole County where the matter had begun and whose judge, Thomas Brown III, wanted the court, not a foundation, to have control of the money. Finally, in December 1999, the Missouri Supreme Court ruled that the parties could settle the lawsuit themselves, without judicial approval. This gave the green light to the creation of Missouri Foundation for Health.

Governor Carnahan died in a plane crash in October 2000, and it fell to Attorney General Nixon to oversee the formation of the foundation. The following month, he appointed a nominating committee that recommended thirty-five candidates for the Board. Nixon named fifteen of them as the initial Directors. The nominating committee then dissolved, and its members became the Community Advisory Council.¹ In September 2001, the Foundation hired James Kimmey, a noted public health physician, as its first president and CEO.

Even before Kimmey had assumed office, the Board, in August 2001, had agreed that the Foundation “may elect to develop an internal capacity for policy analysis and publications.” But it’s one thing to have a vague policy statement; it’s an entirely different matter for the Board to actually make policy a Foundation priority and invest Foundation resources. The matter came to a head in February 2002 when the Board and Community Advisory Council considered a proposal to allocate 5 percent of the Foundation’s payout to policy analysis, innovation, and communications activities. “There was widespread skepticism,” said Will Ross, a nephrologist and former chairman of the St. Louis Board of Health, who joined the Board in 2004 and served as chairman of the Health Policy Committee. The skeptics argued that the Foundation had been established to provide health care to those most in need, and making small grants to community organizations could best achieve that. Proponents of a policy approach argued, in the words of Steve Pu, a surgeon from Kennett who was the first chair of the Health Policy Committee, “No matter how much money we gave away, we would not have the impact we wanted, and that to have real impact, we should try to bring about policy change.”

The debate was settled in July 2002 when the Board agreed to allocate 5 percent of its payout to policy and advocacy. The same year, the Foundation hired its first policy staff members: Leslie Reed, who had been a health services researcher with The California Endowment, the foundation whose creation had sparked that of Missouri Foundation for Health, as its Director of Health Policy², and Ryan Barker, as its Policy Associate. Barker, whose background includes graduate degrees in social work and public policy, work with homeless youth, and program experience with mental health and substance abuse, now serves as the Foundation’s Vice President of Health Policy. The Foundation made its first policy grants in 2003.

¹ From that point on, the Community Advisory Council recommended candidates to the Board, which elected the directors.

² Reed later became the Vice President of Health Policy, a position she held through 2008.

Chapter 2. Maintaining a Nonpartisan Stance in a Partisan Political Environment

Created amid legal controversy, the Foundation's policy work has taken place in an atmosphere of political controversy. The Foundation's first Board was appointed by a Democratic Attorney General at a time when Republicans were just beginning their ascendancy in the state and the partisanship that characterizes today's politics—what the *New York Times* recently referred to as “the raw culture war battles that plague the state”—was just heating up.³

During the Foundation's early years, some Republicans in the Missouri House of Representatives, who viewed the Foundation and its grantees as overly liberal and who argued that the assets belonged to the public, made several attempts to take over the Foundation's endowment. In December 2007, Governor Matt Blunt, a Republican, tried to engineer a state takeover of the Foundation's grant budget. Steve Pu recalls a meeting that Kimmey and he had with Governor Blunt. “Once the pleasantries were dispensed with, the Governor pulled out a letter requesting that the Foundation devote nearly its entire grantmaking budget to state agencies, even specifying how much money the Foundation should give to each of them. He said that it was the taxpayers' money, and as such, the Governor should have the right to decide how to spend it. Dr. Kimmey politely told the Governor that we would take the request into consideration.” The next month, Kimmey responded in writing and turned down the Governor's request. The Governor then attacked the Foundation publicly, and continued the attacks until the middle of 2008 when the race for governor drowned out the matter. Democratic Attorney General Nixon won the election for Governor and held the position through 2016.

Recognizing that to be effective, it would have to carefully tread among warring political factions, the Foundation has taken pains to present itself as, and to be in practice, strictly nonpartisan. “Health care should not be partisan,” Kimmey said. “We were dealing with facts and with research that dealt with health. We were trying to get the best information out there, which policymakers could accept or oppose.” The articles of incorporation reinforce the importance of nonpartisanship. Although the Foundation, as a 501(c)(4) corporation, is legally permitted to lobby, the articles state that it is prohibited from “carrying on propaganda or otherwise attempting to influence legislation” and that it must conduct itself as a 501(c)(3) corporation. Furthermore, given its creation from assets that belonged to the public, the

³ In 2000, Democrats controlled not only the Attorney General's office but that of the Governor and the House as well. Republicans also controlled the Senate in 2000, and by 2003 had gained control of the House as well. Republicans have maintained their majority in both chambers since that time, holding a veto-proof majority in both houses since 2010.

Foundation has always seen itself as being responsive to the people of the state and open in letting the public know what it is doing.

Chapter 3. Getting Started: 2003-2004

As is the case with all new philanthropies, the Foundation spent the first couple of years figuring out where it could have the most impact and which organizations and agencies it could work with most effectively. Moreover, it wanted to get money out the door. In 2003, the Board set a policy goal of “leading efforts to attain a future in which all residents have equal access to high-quality and cost-effective preventive services without regard to any factor except their need.” It established five broad priority areas to guide its policy work: (1) universal coverage; (2) emergency medical care; (3) community-based prevention; (4) children’s health; and (5) disparities. The Foundation soon eliminated community-based prevention and children’s health as priorities, but expanding coverage and achieving health equity have remained its two principal areas of focus over time and up to the present. Although not as consistently high a level of priority as equity and coverage, the Foundation strove to foster a coordinated system of emergency medical care for many years.

Given the Foundation’s controversial birth, the suspicion among Republicans that it was controlled by Democrats, and the increasingly red hue of the General Assembly, the Foundation believed it was important to establish itself quickly as a trustworthy source of nonpartisan information on health. Its research and reports would have to be credible on both sides of the aisle.

This was a tall order, and the Foundation quickly set in motion what was to become a major effort to conduct research on health policy and disseminate the results. “There was a lack of knowledge about health in the state,” Barker said. “We decided we were going to fill gaps in the data. We saw a lack of data on Medicaid and insurance, and we focused on them. But we also saw the need for good data on equity, where there was a lack of digestible information. So we did our reports on African-American and Latino disparities, which morphed into our *Health Equity Series*.”

In 2003-2004, the Foundation, through its policy unit, commissioned respected health policy researchers to analyze Missouri’s health insurance and delivery systems, with a particular focus on Medicaid. These appeared primarily in a series of *Show Me* reports issued in 2004 and 2005 that included:

- A report on health care expenditures and insurance in Missouri by Emory University professor Kenneth Thorpe.

- An examination of survey data on Missouri’s uninsured population by then St. Louis University professor and current Washington University professor Timothy McBride.
- A poll of the public’s opinion on Medicaid by the survey research firm, Lake, Snell, Perry & Associates.
- A survey on employer-based coverage by the Health Research & Educational Trust.
- A report on the economic and health benefits of Medicaid by Legal Services of Eastern Missouri.

Although most of the research and reports authorized in 2003-2004 were directed toward health insurance coverage, the roots of the Foundation’s work to reduce disparities can be traced to this period as well. In the winter of 2003, it made a grant to the Missouri Department of Health and Senior Services to produce a report on African-American health disparities. The next year, it commissioned the department to do a follow-up report on disparities affecting Hispanics. Additionally, the Foundation awarded funds to the University of Missouri-Columbia and Washington University for a report on confronting health care disparities in the state.

At the same time, the Foundation was beginning its support of the advocacy community. “We convened an advocacy retreat in 2003 with about thirty-five advocacy groups,” said Barker. “What we found was a group of advocacy organizations that distrusted each other, and had turf problems. They didn’t work collaboratively, and could often be easily dismissed by the legislature.” So the Foundation began its efforts to strengthen the advocacy organizations and encourage them to work in a coordinated fashion. In addition to awarding grants to organizations that allowed them to carry out specific advocacy tasks, it began its General Support of Advocacy program in 2004. This provided core support to the recipients, thus relieving the pressure to compete with one another for funds. The Foundation also began funding annual Advocacy Retreats in Jefferson City.

Additionally, the Foundation began its longstanding relationship with David Winton, a partner in Penman & Winton, a lobbying firm that mainly represents clients in the not-for-profit sector. In fact, Winton does not do any lobbying for the Foundation—and is prohibited from doing so by the articles of incorporation. Instead, he keeps his finger on the pulse of politics and policy in Jefferson City: tracking pending legislation, keeping the Foundation and the advocates up to date on what’s going on in the state capital, providing information on health care to interested legislators, and advising the Foundation on policy strategies.

Chapter 4. Health Insurance Coverage

On January 10, 2005, Matt Blunt was sworn in as Missouri’s fifty-fourth governor. In addition to capturing the statehouse, Republicans controlled both the Missouri Senate and the House of Representatives. In his state-of-the-state address later in the month, Governor Blunt announced his plan to dramatically reduce Medicaid spending to help make up for a \$600 million budget shortfall. The cuts, which were passed in short order by the General Assembly, affected both eligibility and benefits. More than 100,000 people lost Medicaid coverage due to tightened eligibility requirements. Among the benefits cut were adult dental care, hospice, podiatry, and rehabilitation therapy—even batteries for wheelchairs.

The General Assembly also declared that the Medicaid program would end and be replaced by an entirely new one within three years. This happened in 2007 with the creation of MO HealthNet, which retained the strict eligibility requirements. Services such as physical therapy, podiatry, hearing aids, and adult dental care remained uncovered.

Informing Policymakers and the Public

“2005 was a watershed year for us,” Barker said. “It gave us the opportunity to become and to be seen as experts in Medicaid and a source of data useful to the advocacy community, policymakers, and the public. We now had something concrete to focus on: research and analysis on Medicaid—things like what is the impact of these cuts.” The Policy Department redoubled its research and dissemination efforts.

Missouri Medicaid Basics first appeared in the winter of 2005. Using data provided by the Department of Social Services, the booklet provided readers with a clear, easy-to-understand, and comprehensive description of this important program that covers one out of every six Missourians, or nearly a million people. Updated periodically (most recently in 2017), *Missouri Medicaid Basics* became the Foundation’s most popular publication. The 2017 version was distributed, at last count, to more than 2,500 organizations and the entire General Assembly.

Building on its *Missouri Medicaid Basics* and its *Show Me* series, the Foundation funded additional studies examining the state’s Medicaid program and, more broadly, explaining health insurance in the state and the nation:

- Washington University prepared analyses of how the 2005 Medicaid reforms had affected coverage and care and examined the barriers to accessing Medicaid services.

- The *Health Policy Publications* series, mainly written by Barker and the policy staff, explored a variety of issues, including pay for performance, long-term care, and medical homes.
- Through the Cover Missouri project the Foundation issued reports and fact sheets ranging from the state of Missouri's health to a summary of U.S. health care coverage and from covering employees of small businesses to children's health. Some of the reports were prepared internally, while others were done under contracts with groups such as Community Catalyst and Families USA.
- Health Management Associates issued a series of reports examining the effect of Medicaid reform on the safety net, how Medicaid reimbursement rates influenced participation by providers, and strategies to offset the cost of premiums in public health coverage initiatives.
- The St. Louis Area Business Health Coalition explored charity care at Missouri hospitals.

During the period 2005-2008, the prospects for health reform at the federal level were dim, and attention had turned to state governments. Many states were experimenting with plans to expand coverage, most notably Massachusetts, which had passed its widely publicized health care reform in 2006. In this environment, the Foundation, too, looked for ways to achieve universal or near-universal coverage in the state. It asked Timothy McBride and his colleagues at St. Louis University to analyze health care reform in Massachusetts; Kenneth Thorpe at Emory University to examine ways to finance health care for Missouri's uninsured population; Health Management Associates to analyze Medicaid reforms in Idaho, Kansas, Kentucky, and West Virginia; and Washington University to analyze what impact the proposed 2007 Missouri Medicaid reforms were likely to have.

The Foundation also commissioned the Urban Institute, a respected health policy research organization located in Washington, DC, to prepare a series of studies that would provide a roadmap to health reform in Missouri. The Institute's reports, fact sheets, and data books covered just about every aspect of health reform, with particular attention to Medicaid expansion. The studies were published as part of the *Cover Missouri* series between 2006 and 2008.

In addition, the Foundation sought to make health care understandable to the public, primarily through the Missouri Health Care Journalist Scholarship Program at the Association for Healthcare Journalists, which began in 2005 and continues to the present. The Foundation has also supported public radio KBIA's Health and Wealth Desk at the University of Missouri-

Columbia since 2013 and to the St. Louis American Foundation for health and disparities reporting.

It is difficult to know with any certainty how much influence the Foundation's research and publications had. Since the Foundation has not systematically tracked the number of print publications it has distributed or who receives them, it is hard to get a good idea of readership. Among those people interviewed for this report who had an opinion on the question, the consensus was that the publications are highly respected as informative and unbiased, that *Medicaid Basics* is considered invaluable by those who have an interest in Medicaid, and that people read a publication, either in print or online, when they need information on a topic. Whatever their influence on policy, the Foundation's research and publications gave the Foundation credibility. "Clear and nonpartisan policy work elevated the Foundation more than anything else," former Board member Will Ross said. "We just gave them the facts and laid out the options. The Foundation became trusted and respected as a reliable source of nonpartisan information."

With the election of Barack Obama as president in 2008 and his announced intention to do something about health reform quickly, all eyes turned to Washington. In Missouri, the newly elected Democratic governor, Jay Nixon, like other state governors, waited to see what the federal government would do. Both the state Senate and House of Representatives retained Republican majorities.

Explaining Health Reform

In Washington, the year 2009 saw a flurry of health reform proposals, competing bills, and contentious hearings in half a dozen House and Senate committees. Nobody but the most dedicated health policy experts understood what was in the different bills or what they meant. That left an opening for the Foundation's Policy Unit. "We were already positioned as health policy experts in Missouri," Barker said. "So at that point, we went out and made presentations explaining the various proposals and what they meant." The "we" refers to Barker and Thomas McAuliffe, a former seminarian who taught in Japan, worked as a manual laborer, and holds a master's degree in political science from Purdue University. He joined the Foundation in 2005 as a Policy Analyst and is currently its Director of Health Policy.

The Patient Protection and Affordable Care Act (ACA), which passed Congress without a single Republican vote, was signed into law on March 23, 2010. It triggered a furious response by opponents who were determined either to repeal it or impede its implementation. The most serious challenge was a lawsuit to have the ACA (or, more precisely, the individual mandate

requiring everybody to have health insurance) declared unconstitutional. The U.S. Supreme Court decided the case, *National Federation of Independent Business v. Sebelius*, in 2012. Writing for a narrow majority, Chief Justice John Roberts upheld the law's constitutionality as within Congress's taxing power. This cleared the way for "exchanges" or "marketplaces" to begin offering subsidized health insurance policies to individuals who qualified. At the same time, the Supreme Court ruled that Congress did not have the authority to *require* states to expand Medicaid eligibility.

Signaling their opposition to the ACA, Missouri voters passed statewide propositions in 2010 and 2012 and the General Assembly passed a law in 2012 that, in their totality, prohibited the government from establishing a state-run marketplace and from using state funds to enroll people in the [federally operated] Missouri Marketplace.⁴ Furthermore, the legislature refused to expand Medicaid eligibility.

Passage of the ACA energized the policy department. "We now had a purpose, a unifying theory," McAuliffe said. He and Barker ramped up their public speaking engagements. They made hundreds of presentations to community groups around the state. They gave frequent interviews to the media. The goal of the public speaking: to make this complex piece of legislation and its implications for Missouri understandable to the lay public and to policymakers. "The staff [Barker and McAuliffe] spent a lot of time going around the state and talking about the ACA," said Wayne Goode, who served in the General Assembly for forty-two years and later on the Foundation's Community Advisory Council and Board. "They did amazingly well in keeping the presentations as nonpartisan as possible, and not appear to be advocates. They would open with, 'We are going to talk to you about what is in the ACA as well as what is not. It is up to you to determine if it is what you want.' That approach kept arguments to a minimum."

The Foundation's ambitious research and publications program picked up even more steam, but the emphasis now shifted to the ACA and its meaning for Missourians. Between 2010 and 2012, the Foundation issued, among others, the following:

- *An Overview of Federal Health Reform*
- *A Quick Guide to Health Reform*

⁴ Proposition C (2010) would, if constitutional, have exempted Missouri from the ACA's requirement that individuals buy health insurance. Senate Bill 464 (2012) prohibited the establishment of a state exchange and forbade state agencies and employees from participating in the federal exchange. In Proposition E (2012) the voters overwhelmingly approved a ballot initiative that prohibited the establishment of a state exchange in Missouri.

- *Acronyms and Abbreviations in the Affordable Care Act*
- *Women’s Health Coverage and the ACA*
- *The U.S. Supreme Court’s 2012 Ruling*
- *Views of Missouri Voters on Issues Relating to Health Care Reform* (subsequently published every two years)

Through 2018, the Foundation’s reports, data sheets, fact books, and briefs touched on just about every aspect of health that might interest policymakers and the public: the safety net; long-term care; the state of Missouri’s health (published every two years): ways to “bend the cost curve”; characteristics of the uninsured; and Medicaid work requirements, among others. The Foundation’s staff wrote some pieces; it commissioned outside experts, such as Lewin Associates, Health Management Associates, and Lake Associates, to do others.

Enrolling People in the Missouri Marketplace: The Cover Missouri Coalition and the Expanding Coverage Through Consumer Assistance Program

Even as it was working to educate the public and policymakers about health reform and its meaning for Missouri, the Foundation was working with non-profit organizations to fill a major gap created by the state’s refusal to have anything to do with the marketplace mandated by the ACA: the lack of trained people to help individuals and families enroll in the Missouri Marketplace.

As part of the ACA, the federal government employed trained “navigators” to assist people to enroll in an exchange. But there simply were not enough of them. So in 2012, at the urging of Robert Hughes, a former Vice President of the Robert Wood Johnson Foundation who had become the Foundation’s second President and CEO earlier that year, the Foundation decided to rebrand the Cover Missouri project as the Cover Missouri Coalition and to shift its focus to enrollment. In the summer of 2013, the Cover Missouri Coalition became a membership organization consisting of community health centers, hospitals, health systems, and community organizations. Currently numbering 1,000 members from 300 different organizations, the Cover Missouri Coalition serves as an umbrella group overseeing enrollment activities in the state. It has a website that explains the ACA and allows people to find in-person assistance with enrollment in the Marketplace (and, when applicants qualify, Medicaid).

To compensate for the lack of enrollment specialists, the Foundation funded a separate program under the Cover Missouri Coalition. The Expanding Coverage Through Consumer Assistance program trains Certified Application Counselors, who, working through health

centers, health systems, and community organizations, help people enroll in the Missouri Marketplace (and Medicaid when applicants qualify).

The Foundation's goal was to reduce the uninsured rate in the state from 15 percent in 2014, when the Missouri Marketplace opened, to 5 percent by 2018. In fact, the percentage of uninsured dropped to less than 10 percent by 2018. Nancy Kelley, a Foundation Program Director in charge of its enrollment programs, said, "Five percent was not possible to reach without Medicaid expansion"—something that some of the Foundation-funded advocacy grantees have been working on.

Many Board members and grantees interviewed in the course of this report cited the Foundation's enrollment activities as singularly effective. One Board member told us, "I think the Foundation's enrollment strategy was brilliant, and the work of the Cover Missouri Coalition was also brilliant." Another said simply, "I'd give the Cover Missouri Coalition and the enrollment assisters an A-plus." How much did the Foundation's enrollment assistance contribute to the decline of those without health insurance from 15 percent to less than 10 percent? "We can't know at this time," said Timothy McBride, the Washington University policy expert who monitors enrollment in his role as chairman of the MO HealthNet Oversight Committee. "The best we can do is to make a circumstantial case by comparing Missouri to other states."

Medicaid Coverage of Adult Dental Care and Restoration of State Dental Director Position

Funding of adult dental care was cut from Medicaid in Missouri in 2005. This benefit was restored in 2016, due largely to the leadership of the Missouri Coalition for Oral Health, which has been supported by the Foundation, other health foundations, private donations, and memberships. Moreover, through the Coalition's efforts, the position of state Dental Director, which had been vacant since 2003, was finally filled, enabling Missouri to receive oral health funds from the CDC and greatly increasing the likelihood of securing funds for oral health initiatives from other federal government sources. The Coalition also worked with legislative champions to establish the Oral Health Caucus, the first in the state's history.

The Foundation had been working for many years to improve oral health in the state, making grants as early as 2005 to establish and operate the Missouri Coalition for Oral Health.⁵ Due to lack of direction, the Coalition nearly folded in 2010. With funding from REACH Healthcare Foundation, Health Care Foundation of Greater Kansas City, and Missouri Foundation for

⁵ The Foundation also co-funded the establishment of the A.T. Still Dental School in St. Louis. It named oral health as a targeted initiative in 2012.

Health, it was reorganized in 2011 under the leadership of Gary Harbison, with a new emphasis on health policy.

The Coalition set a number of priorities, including establishment of a legislative Oral Health Caucus and filling the state Dental Director position. The initial priorities did not include reinstatement of adult dental benefits, given the opposition in the legislature to any new government spending on social programs. However, as the Coalition reached out to legislators, it found many of them—particularly rural, conservative legislators—acutely aware of oral health challenges in the communities they represented. “Several of them told me, ‘It’s too bad we can’t do something about adult dental,’” Harbison said.

The Coalition quickly adapted and added restoration of adult dental benefits as a goal. It crafted a strategy that would be likely to resonate with conservatives, including framing the issue in terms of employment, education, and system efficiency. The Coalition requested that the Department of Health and Senior Services produce a report on emergency room and inpatient hospitalization usage for non-traumatic dental conditions. This report, which found that \$17 million was wasted annually treating non-traumatic dental conditions in emergency rooms, proved to be pivotal in generating interest in making changes.

The Coalition began working with a legislative champion—a Republican representative from a rural district who happened to be a dental hygienist and cared passionately about oral health—and the newly formed Oral Health Caucus. It provided additional factual information that indicated the challenges Missouri faced, including the fact that 64 percent of Medicaid-enrolled children received no dental care and that Missouri ranked forty-seventh out of the fifty states in access to dental care.

The General Assembly ultimately included funding in the fiscal year 2015 budget for reinstatement of adult dental benefits (passed in the 2014 session). Then Governor Nixon—a Democrat who had run partly on reinstatement of the 2005 Medicaid cuts—refused to fund adult dental benefits because of insufficient state revenues. A letter to Gov. Nixon from the Coalition that included the signatures of forty-two other Missouri organizations advocating for health care did not persuade the Governor to change his mind. The following year, the Coalition again worked with the legislature, and again the General Assembly agreed to fund adult oral health care. This time Governor Nixon agreed to fund the benefit once the state had received money from a tax amnesty.

In May 2016, a limited but robust package of adult dental benefits was added to Medicaid. It affected an estimated 350,000 adults, many of whom had not been to a dentist in their adult

lives. Since reinstatement, about \$2 million in dental services have been delivered each month. Due to low dental reimbursement rates, the majority of these services have been delivered through federally qualified health centers. Medicaid adult dental benefits are now a core part of the Missouri budget.

The process of filling the position of state Dental Director followed its own twists and turns. Without state government money, the position had lain vacant for nearly a decade, leaving Missouri ineligible to receive federal oral health funds. The Department of Health and Senior Services, which oversees public health, had recommended that the position remain vacant, demonstrating oral health's low priority. The Department of Social Services, which oversees Medicaid, had maintained a greatly diminished dental director role that primarily functioned to review claims.

In the absence of state government funding for the position, the Coalition sought financing from other sources. Eventually, Delta Dental of Missouri and Missouri Foundation for Health agreed to cover this position until federal funding could be secured. REACH Healthcare Foundation later added funds to the effort.

In 2014, John Dane, a highly regarded dentist from Kansas City, became the state's Dental Director, reporting to two state government departments: the Department of Health and Senior Services and the Department of Social Services. "This has positioned the state Dental Director to deal with two large, complex, and essentially different state agencies," said Harbison. "But it also provides the opportunity for synergy across agencies. Importantly, filling the role of Dental Director has led to securing new funds for oral health and has allowed for much faster generation of oral health data."

While the accomplishments are significant, there is still much to be done. Reimbursement for oral health services is still low, making it difficult, in practice, to find dentists who are willing to see Medicaid patients. Beyond this, there is a shortage of dentists in the state. "As of July 2017, we have 94 counties out of 115 that are designated dental professional health shortage areas," Danes said. "We actually have nine counties in the state of Missouri where there's not a dentist who's licensed in that county with an office address in that county."

Fixing the Medicaid Enrollment System

Among the lesser-known elements of the ACA was a requirement that by January 1, 2014, states have the capacity to process applications for Medicaid online and by telephone.⁶ Missouri was not in a position to meet the deadline. Compliance with the federal mandate would require a major overhaul of the Department of Social Services information technology system. This was easier said than done since the department's Medicaid information technology system—the one that operated on the department's mainframe computer—was programmed in COBOL, a programming language that had long since lapsed into disuse and that almost nobody understood. One of few people who *did* understand COBOL was Dwight Fine, who had recently resigned from the Missouri Hospital Association, where he had worked for the past twenty-five years and had acquired extensive knowledge of the state's Medicaid program.

Coincidentally, the Foundation had already contracted with Fine to help the government figure out some of the technical aspects of setting up a state Marketplace that would comply with the federal government's requirements. However, when the state opted not to develop a state-operated Marketplace and the operation of the Missouri Marketplace defaulted to the federal government, the Foundation redefined Fine's role to include helping the Department of Social Services meet the ACA's Medicaid data-processing requirements. The challenge Fine and the department faced was how to adapt the state's existing system, which relied on COBOL, to meet the ACA's requirements for processing Medicaid applications.

Fine and a few employees from the Department of Social Services with knowledge of the existing state systems and Medicaid requirements formed the nucleus of a team charged with developing a plan for complying with the ACA's requirements. "When we looked at the federal requirements for processing an application, we didn't have many options," Fine said.

The Department of Social Services and the state Information Technology Support Division established a working group to draft specifications for bids to develop a new enrollment system, called MEDES (Missouri Eligibility Determination and Enrollment System), that would interface with the existing state systems. The department elected to purchase an off-the-shelf software package owned by IBM. "The software package contained many required features outlined in the ACA," Fine said. "However, many configurations had to be made to the software in order to fully meet Missouri's needs."

⁶ Additionally, the ACA required states to be able to determine Medicaid eligibility, verify information from applicants electronically, develop an application that accounts for multiple sources of coverage, and exchange information with the federal Marketplace.

One problem: there was no government money to pay for a new information technology system. “The legislature refused to accept the federal money designated for the purpose, and would not appropriate state funds for its development either,” Ryan Barker said. “In 2013, with the clock running down, Democratic Governor Nixon and the Republican-controlled General Assembly reached a compromise whereby the government would accept federal funds to develop a Medicaid enrollment system but would, in return, cut some staff.” The funds became available in the summer of 2013, leaving only six months for the team to develop a system and have it up and running by the January 1, 2014, deadline.

The Department of Social Services asked Fine to reach out to providers—the community health centers, hospitals, physicians, and community organizations that were helping people enroll in Medicaid—and engage them as partners. With the help of these partners, the system was in place and accepting Medicaid applications electronically on October 1, 2013, and it had installed rules to determine eligibility for coverage by January 1, 2014.

Like the federal ACA enrollment system, the rollout was hardly perfect at first—far from it, in fact. “Fifty thousand people were dropped from Medicaid,” Barker recalled. “Delays in covering kids and pregnant women led to a huge outcry.” Fine and his team, along with the providers, made changes in the system to speed up the process. A Medicaid Advisory Group, which consisted of providers and advocates—as well as representatives of the Department of Social Services—was created to find ways to continue improving the processing performance. “The director came and brought his staff,” Barker said. “To this day, we meet monthly, and the Department of Social Services continues to attend.”

Meanwhile, Fine, supported by the Foundation, continues to consult with the Department of Social Services. Given the progress that has been made, Fine is now training departmental staff members to take over his responsibilities. This is expected to happen in 2019. “There is now a structure in place to facilitate continuous quality improvement for the processing of Medicaid applications,” Fine said. “The Department of Social Services is fully committed to continuing what we started.”

Bringing Rate Review to Missouri

Prior to 2016, Missouri had been the only state where government officials did not review proposed rates by health insurers. By law, in such a case, the federal Department of Health and Human Services assumes responsibility for reviewing proposed rates. Under a grant from the Foundation, the Consumers Council of Missouri contracted with the former Insurance

Commissioner Jay Angoff to review the proposed rates based on filings submitted to HHS, which he did in 2015 and 2016. This made it possible for the Consumers Council, in the absence of an official rate review by the Missouri Department of Insurance, to publish an unofficial rate review.

At about the same time, Missouri Health Care for All, another Foundation grantee, started a renewed push for rate review in the state. “We decided to integrate the issue of rate review in 2016 in part because it is important and in part because legislators would no longer meet with us just about Medicaid expansion,” said Jen Bersdale, the executive director of Missouri Health Care for All. The organization worked with legislators on both sides of the aisle and mobilized its considerable grassroots constituency in support of the issue. In 2016, the General Assembly passed SB 865, adopting rate review in the state. Although an improvement over the past, the law was still somewhat tepid: it required insurers to file their proposed rates with the Department of Insurance, but it did not give the department the power to demand rate reductions. The Consumers Council of Missouri continues to conduct parallel rate reviews and offer its judgment about whether the proposed rates are justified (its 2018 report card deemed all of them to be “unreasonable”).

Government Relations in Jefferson City

For many years, Thomas McAuliffe gave the Foundation a visible presence in Jefferson City, spending much of his time in the capital. “I was used to meeting the state’s policymakers, pushing policy conversations, and talking with legislators in Jeff City and in their home districts,” he said. When the Foundation lost a number of its policy staff and he was promoted from Policy Analyst to Policy Director, McAuliffe had to spend more time in St. Louis. Alexandra Rankin, a lawyer by training, joined the Foundation in 2015 as the Government Affairs Manager, and she became the liaison with members of the General Assembly.

Whoever the Foundation’s link with the legislature might be, it was a tough assignment in an environment where few in the Republican caucus knew much about health care and even those who did know resisted any proposal that would increase state government spending. Furthermore, as one interviewee told us, “Any measure that did not arise from a Republican legislator was dead on arrival.”

These political realities led the Policy Department to craft a strategy that would give leading Republicans in the legislature, starting with the House, a greater understanding of health care and the issues surrounding it. Foundation staff members, along with David Winton, the Foundation’s eyes and ears in the capital, went to the Speaker of the House and asked whether

he would consider giving some of his members—current and potential leaders—genuine health care expertise by having them take a training course offered by the Foundation. The speaker readily accepted, and he recommended six members of the Republican caucus to attend.

As of January 2019, eleven Republican House members had participated in the first two cohorts of the Health Care Learning Institute in 2017 and 2018. At the training sessions, which are a full day and take place four or five times over the summer, the House members have the opportunity to hear and to converse with national and state health policy experts on topics such as the health care system, the substance of the ACA, health insurance, and others of interest. Representative David Wood—who chairs the House Subcommittee on Appropriations: Health, Mental Health, and Social Services—participated in the first cohort. “The Foundation brought in experts who presented information in a nonpartisan way. They gave us data and facts,” he said. “For many of my colleagues, who are not as familiar with health care as I am, it was eye-opening.” He added, “We now have a better legislature because of this training; my colleagues are far more knowledgeable about health issues than they were. And we know we can call on the Foundation for information or briefs on issues.”

Playing Small Ball

In 2012, the Policy Department turned its attention to expanding Medicaid in the state. Many of the Foundation-supported advocacy groups stepped up their efforts as well. Amy Blouin, who heads the Missouri Budget Project, a long-time Foundation grantee, said, “We have a broad coalition that is supporting Medicaid expansion.”

The Foundation realized, however, that Medicaid expansion was all but impossible in the current political environment. So even as it continued to pursue Medicaid expansion as a matter of principle, the Foundation looked for smaller, less controversial areas where the chances of success were better—such as restoring the 2005 cuts to Medicaid. As McAuliffe summarized the change, “In 2015 and 2016, when we looked around and saw that Medicaid expansion was never going to happen legislatively in Missouri, we thought about what we could do that will have impact on people’s lives that doesn’t involve Medicaid expansion. Collectively we came up with a ‘small ball’ strategy that involved administrative decisions or minor changes that might have significant impact.”

This decision signaled a noteworthy strategic shift. It affected both the Foundation itself and some advocacy grantees, which accelerated their efforts to restore the 2005 Medicaid cuts. Although cause and effect cannot be established, there was change in areas targeted by the advocates: adult dental benefits were restored; asset levels for elderly and disabled people to

qualify for Medicaid were raised; and the duration of substance abuse treatment for addicted pregnant women and new mothers was increased.

Chapter 5. Health Equity

Like coverage, health equity was one of the Foundation’s earliest priorities, and it has remained a priority throughout the life of the Foundation.⁷ Unlike health insurance, health equity does not generate a partisan divide between Democrats and Republicans. But even though the party politics may not be as intense, achieving health equity requires overcoming deeply rooted attitudes and prejudices dating back to the nation’s founding—if anything, an even more daunting challenge.

Gathering and Sharing Information About Health Disparities

In trying to improve health equity, the Foundation has followed a path similar to the one it has taken with health insurance coverage: commission and disseminate research and data analysis—in this case research and data analysis that would let Missouri policymakers and the public understand just how great the health disparities were. The Foundation’s first grant in the health equity area, made in December 2003, was to the Department of Health and Senior Services to analyze the data in its system and to draft a data book on health disparities between African Americans and White Americans. The data book, which appeared in 2004, became the first in what was to become the Foundation’s *Health Equity Series*, and it was followed the next year by a companion publication that examined health disparities involving Hispanics.⁸

The Foundation again funded the Department of Health and Senior Services to produce data books for both African Americans and Hispanics in 2009 and 2013. They contained a wealth of solid data upon which rational policy decisions could be based. The 2013 publications contained graphs that allowed readers to chart progress, or lack of it, over the ten-year period. Beginning in 2012, as the Foundation’s interest in other populations expanded, so did the subjects of the *Health Equity Series*. In 2011, the Foundation produced a data book on disparities affecting the LGBT community, which appeared the next year as *Responding to LGBT Health Disparities*, and in 2014, it published *Older Adult Health Disparities in Missouri*.

⁷ “Improving health equity” and “reducing health disparities” have both been used when referring to this general area. Some Foundation staff members contend that disparities refers to equality of results while equity refers to equality of opportunity, and that the two are quite distinct. Others suggest that it is a distinction without a difference and that the two are interchangeable. The topic has generated debate in the policy world beyond the Foundation. For the sake of consistency, this report uses health equity when faced with a choice of wording.

⁸ The Foundation awarded grants in 2011 and 2012 to the Casa de Salud, a free clinic housed at St. Louis University, to do research on health disparities affecting Latinos.

The following year, 2015, as the Foundation’s interest in the social determinants of health increased, it published a *Health Equity Series* report on food insecurity, followed by fact sheets and analyses of other societal factors that influence health equity, such as transportation and housing. In 2018, the Policy Department staff authored a series of information-packed briefs exploring topics that particularly affect lower-income Missourians, such as the Earned Income Tax Credit and safety-net institutions.

Although the extent to which the Foundation’s publications are read or the influence they have is not known, interviewees told us that through its *Health Equity Series* and other publications, the Foundation gained credibility as a trusted source of reliable information on health equity—much as it had with its health insurance publications. To an extent, its reports, data books, and briefs have established the Foundation as *the* source of well-grounded information on health equity. Beyond that, by giving health equity such prominence, the Foundation sent a signal that health equity is an important issue, one that deserves the attention of the public and policymakers.

Research, Training, and Coalition-Building: The Missouri Health Equity Collaborative

In 2005, the Foundation made the first in a series of grants to University of Missouri-Columbia to enable its Center for Health Policy to establish the Missouri Health Equity Collaborative (MOHEC) with the goal of empowering Missourians to eliminate racial and ethnic disparities. Over the years, the work of MOHEC has evolved as it sought new ways to advance health equity for all Missourians.

In its earliest stage, MOHEC concentrated largely on disparities research. “At first, we didn’t have much data,” said Stan Hudson, the center’s associate director. “So we worked together with Washington University. They were more data oriented, and we were more community oriented.”⁹ The researchers gathered disparities data from St. Louis and the Bootheel region in southeastern Missouri in order to be able to make comparisons between urban and rural areas.

The second stage, which began early in 2007, expanded MOHEC’s research to the entire state and focused on building a collaborative network where researchers could meet and share data and ideas with providers and practitioners. MOHEC organized meetings in Springfield, St. Louis, and Kansas City. As a result, through both in-person conferences and an online portal accessible

⁹ The Foundation’s first grant was to support researchers at both the University of Missouri-Columbia and Washington University. Later, MOHEC became centralized at the University of Missouri-Columbia. Health Care Foundation of Greater Kansas City has also supported MOHEC.

to researchers and practitioners working on health equity issues, a statewide network began to take shape.

In succeeding years, MOHEC's emphasis shifted to collaboration, training, and working with communities to adopt best practices—in Barker's words, "It has moved beyond research into action." More specifically, MOHEC developed three overarching aims:

- Promote inclusive health and health care environments. To accomplish this, MOHEC developed training programs for hospitals, health care systems, and providers. It worked with its partners to improve demographic data collection practices and policies. It held conferences, retreats, and workshops. Its annual Inclusion Institute for Healthcare is a three-day skill-building immersion workshop for health care leaders and stakeholders, followed by two days of professional development.
- Support and strengthen Missouri's health equity movement. To reach this aim, MOHEC has moved into community work—offering training on diversity and cultural competency. "Over the past four years, we've tried to create community conversations," Hudson said. "An emphasis on grassroots engagement became a focus as awareness of marginalized, unheard voices within communities emerged. We've attempted to engage communities in finding what they want." To continue building a structure around a health equity movement, MOHEC holds a statewide Health Equity Conference every two years; the most recent one attracted more than 150 participants.
- Develop and disseminate evidence-based health equity tools and practices. In this regard, MOHEC is identifying best practices to promote health equity and sharing them with its network of researchers and practitioners.

Through its long-term support of MOHEC at the Center for Health Policy at the University of Missouri-Columbia, the Foundation has helped to develop an institution that is both a trusted partner and a resource for health equity data, research, collaboration, and training.

Health Equity for the LGBTQ Community: PROMO Fund

When the Foundation needed data on LGBT disparities for its 2012 *Health Equity Series* booklet and fact sheet, it turned to PROMO Fund, the leading LGBT policy organization in the state, for help.¹⁰ "The data was clear that it wasn't just about access to care," recalled Steph Perkins, the executive director of PROMO Fund. "It was also about policy—marriage equality, spousal

¹⁰ In May 2018, PROMO Fund changed "LGBT" to "LGBTQ," which the organization's website notes is "a more accurate and inclusive description of our population."

benefits, and lack of nondiscrimination protections, for example—linked to health and wellbeing.”

Shortly after, PROMO Fund approached the Foundation with the idea of doing something to improve Missouri’s scores on the Healthcare Equality Index.¹¹ In an earlier study, PROMO Fund had found that only two hospitals in the state had policies that allowed them to be named as Healthcare Equality Leaders. Perkins thought they could do better. This led to the Foundation’s awarding a grant to PROMO Fund to help health care systems and hospitals to improve their policies and practices toward LGBT Missourians. PROMO Fund worked with seventy health care systems and hospitals, and within one year, eighteen had strengthened their policies sufficiently to be named Healthcare Equality Leaders. Missouri moved from thirty-seventh to sixth in the country and first in the Midwest in the 2014 Healthcare Equality Index.

Other Foundation grants followed. With Foundation funding, PROMO Fund has done, and continues to do, a great deal of training, primarily to health care organizations but also to government agencies. The hope is that training health care organizations will lead to policy change within the institutions. “Our primary audience is health care providers, both big and small.” In 2015, PROMO merged with the local SAGE affiliate¹² and worked with it to train 3,500 SSM Health hospital employees. PROMO Fund has also trained employees and staff members of Affinia Healthcare, CenterPointe Hospital, and Fulton State Hospital.

“We start all of our training by giving a basic foundation of language: who LGBTQ people are, what their experiences are, and the like. Getting on the same page has been helpful,” Perkins said. “Then we typically go into basic standards related to the LGBTQ community, tailoring the session so that we talk about the policies we promote: nondiscrimination, including sexual orientation and gender, for employees, patients or clients, and visitors. We customize the training to celebrate existing policies, point out areas of potential improvement, and teach staff members best practices to put those policies into action.” PROMO Fund also urges the institution to provide non-discrimination training to its staff.

In terms of policy change, the largest health care organizations have been the most receptive to PROMO Fund’s message. However, while a recent PROMO Fund report noted that many of the largest hospital systems in the region had policies that protect LGBTQ people, it also found that the policies were largely unknown within those systems. This led PROMO Fund to concentrate

¹¹ The Healthcare Equality Index is a tool developed by the Human Rights Campaign to measure health care facilities’ policies and practices related to the equity and inclusion of their LGBTQ patients, visitors, and employees. Those institutions that score highly enough are designated as “Healthcare Equality Leaders.”

¹² SAGE (Service and Advocacy for LGBTQ Elders) originally focused on the health and social services needs of an aging LGBTQ community. It has considerable experience in cultural competency training.

not only on instituting policies but also on educating staff about enforcing them. Recently, PROMO Fund has turned its attention to federally qualified health centers.

Looking back on the Foundation's support of PROMO Fund, it is evident that the Foundation was ahead of the curve in giving attention to a group that is often overlooked in discussions of health equity—the LGBTQ community. Moreover, as noted earlier, once an organization as influential as the Missouri Foundation for Health recognizes the significance of an issue or a particular population, it sends a signal to others that it is important.

Health Equity for African Americans: For the Sake of All, Ferguson, and Its Aftermath

In late 2012, Jason Purnell, a psychologist and professor at Washington University whose specialty is the socioeconomic determinants of health, met with Ryan Barker. Representing half a dozen distinguished African-American professors from Washington University and St. Louis University, he proposed that the group do a series of policy briefs and a final report that would provide a basis for action to address the health and racial disparities facing African-Americans in St. Louis. The strategy, as the proposal stated, would be to “develop policy alternatives and strategies linked to socioeconomic risk factors for health and to engage community stakeholders in the development of...solutions to persistent regional health disparities.”

The Foundation approved the proposal, called For the Sake of All, in March 2013 and awarded funds to Washington University to carry out the first phase, the policy-research and community-support phase. Between August and December of that same year, the team produced five policy briefs. They examined poverty, education, mental health, residential segregation, and chronic disease. But the project was not just about writing briefs. It was also about building support in the community for change. So in the course of developing the reports, the For the Sake of All team held community meetings; made presentations to groups ranging from the Boys & Girls Club to the staff of the Governor's office; engaged community leaders; established a website; and publicized its findings through the *St. Louis Beacon* (which merged with St. Louis Public Radio) and the *St. Louis American*. The final report was issued in May 2014, timed to coincide with the sixtieth anniversary of the landmark decision, *Brown v. the Board of Education*.

In August 2014, Michael Brown was killed and Ferguson erupted. This was a traumatic event for St. Louis, for Missouri, and for the nation. Governor Nixon announced the formation of the Ferguson Commission in November. Its charge was to conduct “a thorough, wide-ranging, and unflinching study of the social and economic conditions that impede progress, equality, and safety in the St. Louis region.” The Foundation funded part of its work. The *For the Sake of All*

report, which was fresh in people’s minds, figured prominently in the Commission’s deliberations. “It had already gotten a lot of publicity,” Purnell said, “but obviously Ferguson magnified its impact. The report was a key resource for the Ferguson Commission. Most of our recommendations ended up in the report.”

The Ferguson Commission issued its report in November 2015. It contained 189 policy recommendations. Given the importance of the report to the Foundation’s equity work, it was apparent that the Foundation would do something to further the Commission’s recommendations. Barker and Stacey Easterling, the Foundation’s Vice President of Programs, identified six health-related areas and asked the Board to authorize \$6 million to fund them under the name Ferguson and Beyond. The Board approved the request, for the following:

- For the Sake of All, renamed Health Equity Works. This provided additional funds for phase 2 of the project—the implementation phase. In the second phase, the For the Sake of All coalition mobilized community members, business and political leaders, faith organizations, and the media to implement the recommendations in its report, especially the three areas that had gained the most traction: (1) school-based health centers, (2) coordinated school health, and (3) affordable housing.
- Toxic stress and trauma. A newly created group called Alive and Well STL, created by the Regional Health Commission, worked with the media, community volunteers, and practitioners to raise consciousness of the damaging effect of adverse childhood experiences on individuals.
- Grassroots advocacy. The Foundation sought to support smaller African-American advocacy groups that could mobilize people around issues of health and racial equity.
- Food insecurity. The Foundation supported a number of small groups striving to combat hunger, increase access to healthy food, and improve the quality of school meals.
- Gun violence. The Foundation connected different organizations and encouraged conversations across sectors.
- Juvenile behavioral health and justice. Ferguson and Beyond led to a panoply of related projects that explored different approaches to addressing the disproportionate number of African-American students suspended or expelled from the public schools, or the “school-to-prison pipeline.” Some of the projects were funded under Ferguson and Beyond, while others were generated by the Policy Department. They included awards to:
 - The Greater St. Louis Community Foundation for Shut It Down. The Foundation joined other funders in a project that offered principals, teachers, and administrators in seven predominately African-American public elementary schools

- in St. Louis training to develop fairer suspension policies and practices. One school reported a nearly 90 percent drop in suspensions the first year.
- Legal Services of Eastern Missouri, in collaboration with the Children’s Legal Alliance, for legal work around the issue of the school-to-prison pipeline.
 - The American Civil Liberties Union of Missouri for Ending the School-to-Prison Pipeline—a collaboration with five largely African-American school districts to develop policies that aim to keep kids in school and reduce the number of times young Black students are sent from school to the juvenile justice system.
 - The University of Missouri for ParentLink: Early Intervention Cradle to Prison Pipeline. The project connected high-risk young people and their families in Columbia, Jefferson City, and Pemiscot County with appropriate resources.

For the Foundation, Ferguson represented, in the words of Thomas McAuliffe “an existential moment.” It forced the Foundation to consider the extent to which it would support programs to address education, housing, transportation, poverty, and other societal factors that influence health as recommended by For the Sake of All and the Ferguson Commission reports.

After Ferguson, the Foundation decided to allocate some funding to promote policies and practices aimed at improving the external factors that affect health. The decision generated little Board discussion. “It was the right thing to do,” said Darin Pries, the former chair of the Foundation’s Board. “We decided to dip our toes in the water but not to go crazy.” Although it had touched on such factors in the past by supporting PROMO’s work to change anti-discrimination policies aimed at LGBTQs and For the Sake of All’s broad examination of the social determinants of health, Ferguson and Beyond deepened its commitment to look at equity in the context of the social determinants of health. With reference to juvenile behavioral health and justice for example, the Foundation President and CEO Hughes wrote in a blog post, “Health and justice are inextricably linked. In a fundamental sense, we can’t have a healthy and vibrant community until we have a fair and just community...Poor health contributes to being incarcerated, and being incarcerated contributes to poor health.”

The response to Ferguson also led the Foundation to modify its internal grantmaking processes. Traditionally, the Policy Department and the Program Department operated independently. Their work rarely intersected, and their approaches differed; the Policy Department was even located on a separate floor from the rest of the Foundation. The Program side sent out requests for proposals, analyzed them, and made recommendations to the Board. The Policy side was more freewheeling: it devised priority areas, sought grantees that could carry out the work, and made recommendations to the Board. In the follow up to Ferguson, the Foundation created teams composed of both Program and Policy staff members to develop and monitor programs

under the initiative. “The intent is to have integration exist across the entire organization,” said Hughes. “This includes Policy, Program, Finance and Administration, Strategy, and Strategic Communications.”

Chapter 6. Emergency Medical Care: Time-Critical Diagnosis

In the Foundation's earliest days, the staff noticed it was receiving a lot of requests for ambulances. This led the Board to ask whether the Foundation might do some policy work to address the underlying problems in emergency medical care. At roughly the same time, William Jermyn, an emergency physician at Barnes-Jewish Hospital, was actively promoting the idea of developing a better system to handle emergencies involving heart attacks and strokes, where time was of the essence. Jermyn had in mind a system modeled on trauma care that had long been in place in Missouri, where ambulances took people with traumatic injuries to the hospital with the capability to care for them. The system Jermyn had in mind, called Time-Critical Diagnosis (TCD), would have been a dramatic change from the one then in place where ambulances took people suffering strokes and heart attacks to the nearest hospital.

Using Foundation funds and under Jermyn's leadership (he was named the Medical Director of Emergency Medical Care Services in the Department of Health and Senior Services), a roughly 400-person task force, representing hospitals, physicians, emergency care specialists, and clinics, was formed to determine what to do and how to do it. "The idea of creating a TCD system was daunting. We had no playbook. Only a few states had such a system," said Kelly Ferrara, a communications specialist then with the Vandiver Group, who organized and oversaw the task force meetings. "We ended up breaking the coalition into three working groups—stroke, heart attack, and transport—each led by an expert in the area." The task force was not an easy one to manage. "I had to remind members that they were not representing their home organizations but rather people in the back of an ambulance needing care quickly," Ferrara recalled.

Over the course of 2005 and into 2006, the coalition reached a consensus that the two highest priority time-critical emergencies were stroke and STEMI (short for ST-Elevation Myocardial Infarction, the term cardiologists use to describe a classic heart attack where an artery is clogged) and that the key was developing a transport system in which ambulances would take patients to a hospital that could offer the appropriate level of care: from level 1, where full care was available from an experienced team that could be assembled quickly day or night, to level 4 centers, often located in rural areas, with fewer capabilities. "The right care, at the right time, at the right place," Jermyn phrased it.

In 2006, the Department of Health and Senior Services and coalition members drafted a plan for a coordinated system of emergency medical care. The following year, Governor Blunt approved draft legislation that needed to be passed by the General Assembly for TCD to

become a reality. But who would approach the legislators and find a sponsor for the bill? The Foundation could not do it, since it was prohibited from lobbying for a specific bill. In the end, Jermyn and leaders of the coalition made contact with legislators. Penman & Winton composed informational material. On the last day of the legislative session in May 2008, the General Assembly unanimously passed House Bill 1790 authorizing establishment of the TCD. Sadly, Jermyn died shortly before the bill was passed. The Governor signed the bill into law in July 2008.

In May 2011, Samar Muzaffar, a critical care physician with a master's degree in public health, became the Medical Director of Emergency Medical Care Services of the Department of Health and Senior Services. She led the time-consuming and difficult process of developing the regulations to establish and implement the new system, appointing two statewide task forces that made recommendation on how to establish the TCD system and holding statewide and regional consultations. "What we did was model the stroke [and later the STEMI] system after the trauma system," Muzaffar said. "We used research to determine what capabilities a level 1, 2, 3, and 4 center must have. Individual hospitals decided if they wanted to be a certain level, and they applied to the Department of Health and Senior Services." STEMI regulations went into effect in July 2013, stroke regulations in February 2018.

Chapter 7. Policy Components of Other Foundation Programs

Although the Foundation now encourages the incorporation of policy into its programmatic work and is emphasizing inter-departmental collaboration, it is hardly uncharted territory. The Foundation's tobacco-control effort offers a prime example, as, to a lesser extent, does its program to combat childhood obesity.

The Tobacco Control and Prevention Initiative

The Foundation's first long-term targeted initiative was a nine-year, \$40 million program to reduce smoking in Missouri. Approved in late-2003, the Tobacco Control and Prevention Initiative (TCPI) aimed, in large part, at bringing about policy changes at the local level—changes such as raising the cigarette tax or requiring smoke-free workplaces. At the time the Board approved the initiative, Missouri had the nation's third-highest smoking prevalence and one of the lowest tobacco-tax rates in the country. The government allocated *no* money to tobacco control and prevention, and the state's voters had just defeated an initiative to raise the tax on tobacco.¹³

During the TCPI's first years (2004-2006), the Foundation made a series of grants mainly to regional organizations and also to community organizations. The regional grants provided funds for broad-based programs and collaboratives with established community-based programs. The regional grantees provided technical assistance to community grantees to increase the reach of their programs throughout the state. The funds could be used to (1) educate Missourians about the importance of increasing tobacco taxes or (2) promote smoke-free workplaces or encourage school-based prevention programs.

In 2007, the Foundation shifted the emphasis of the TCPI away from regional grantees and toward community-based prevention and cessation efforts. "We did a refresh and decided to focus on policy, specifically to raise the price on tobacco products and to create smoke-free environments at the community level," recalled Matthew Kuhlenbeck, the Program Director who oversaw the program, in close collaboration with McAuliffe and Deena Lauver Scotti, who is currently the Foundation's Director of Grants Management.

Between 2007 and 2014, when the last grant ended, the Foundation supported policy changes at the community level through two main approaches: grants targeted specifically at tobacco-

¹³ Missouri voters narrowly rejected three different initiatives to increase the state's tobacco tax, in 2002, 2006, and 2012.

policy changes and grants to encourage grantees to incorporate policy into their work. (In addition, the TCPI supported non-policy elements of the TCPI, such as a telephone quitline.)

What were the results in terms of policy change? An evaluation by Washington University in 2015, after the initiative had ended, concluded, “TCPI grantees...succeeded in assisting with passing 197 policies over the course of TCPI. The policy changes were primarily smoke-free workplace policies, but included school and cessation-related policies as well. Out of the 197 tobacco-related policies passed, 17 were community-wide smoke-free policies.” The evaluation went on to find that because of these, 42 percent of the state’s population was protected by a smoke-free policy. Smoking in the state decreased at a significantly faster rate than it did nationally. In 2010, there were 124,000 fewer smokers than there were in 2004. “The TCPI has been one of the most important public health initiatives during the last decade in Missouri,” the evaluation concluded.

With the TCPI, the Foundation, and the State of Missouri, reaped the benefit of an early decision to target an important health issue and to commit resources to it over a long period of time. The Foundation maintained its strategic focus, while making tactical changes during the course of the initiative. The TCPI was, in many ways, a precursor of the Foundation’s recent strategy to seek policy change at the community level rather than to attempt major policy change at the state level. It was also an early example of an internal strategy the Foundation is now returning to: encouraging collaboration among the staff of its various departments.

Healthy Schools Healthy Communities

The Healthy Schools Healthy Communities Initiative was similar to the TCPI in that it sought to encourage policy changes at the local level, but unlike it in not employing a partnership between the Policy and Program Departments. To reduce childhood obesity, the Healthy Schools Healthy Communities Initiative promoted policy changes in the thirty-two school districts and communities with which it worked.

Deidre Griffith, the Program Director responsible for Healthy Schools Healthy Communities, observed that the policy changes relate to better nutrition or more physical activity, or both. School district wellness coordinators—often physical education teachers or nurses—are the ones who drive policy change. Policies adopted so far include serving healthier school meals; banning junk food and sugary sodas; increasing physical education; moving recess to before lunch; upgrading playgrounds; improving walking trails; and developing school wellness policies—to name just some. In 2016 alone, the program reported 252 policy, practice, or environmental changes.

Chapter 8. Closing Observations

This review of the Foundation’s efforts to improve health policy in Missouri leads to some observations about the Foundation’s policy work, the challenges that it faced, and how effective it has been overall.

Policy Work

The early Foundation Board showed foresight in making policy a priority and setting aside a specified percentage of its payout—5 percent initially—for policy initiatives. The Board could easily have taken a safer route of supporting community organizations in their good work or conducting noncontroversial research. Rather, the Board recognized that policy change was an effective way to improve the health of large number of Missourians, and it reserved a small percentage of its payout for that purpose. Beginning in 2013, the level devoted to policy activities was increased to 10 percent, where it remained through 2016. In 2017, the Board eliminated a set percentage for health policy, instead determining an amount based on the planned activities and how they fit with other Foundation priorities.

The Foundation has been consistent in maintaining its policy priorities. From the very beginning, increasing health insurance coverage and improving health equity have been its twin goals. Other goals have come and gone, but these two have remained constant. This consistency has allowed the Foundation to focus its efforts over time. Similarly, the Foundation has been consistent in its support of grantees with a strong record of effectiveness. It first funded MOHEC in 2006, for example, and has awarded grants to researchers at Washington University and St. Louis University dating back to 2004. Additionally, its senior staff has been in place for a long time: Ryan Barker since 2002 and Thomas McAuliffe since 2005. This is particularly important in the policy arena, where it takes time to establish trust and credibility and where relationships and experience can be keys to success.

Although the Foundation has pursued its strategic goals with steadfast determination, it has been flexible in adapting its tactics. After Ferguson, for example, the Foundation shifted the emphasis of its equity work and gave more attention to racial justice—supporting the Ferguson Commission and the Ferguson and Beyond projects that followed. Another example of its tactical flexibility is the decision to offer training to Republican House members selected by the Speaker when it became clear that nothing was going to move in the legislature without Republican support.

With regard to internal organization, from the beginning, the Policy Department was a quasi-independent unit, physically isolated from the rest of the organization. In contrast to the Program staff, which relied on a formal request-for-proposal process, the Policy staff looked for grantees that would be able to help it achieve its goals and funded them without going through the same administrative processes. (The tobacco policy work proved to be the exception, as Policy, Program, and Grants Administration staff members worked in partnership.) This has changed somewhat over the past few years. Although the Policy Department maintains its relative independence and its designated budget, its staff and that of the Program Department now collaborate more frequently.

Challenges

Created at a time when the state was moving from purple to bright red, the Foundation has faced the challenge of maintaining its core principle of advancing policies to provide health insurance coverage for all Missourians in a challenging political environment. From the outset, the Foundation decided that the best way to be effective would be to establish itself as a nonpartisan source of reliable information on health care—one that would be trusted by lawmakers on both sides of the aisle. This required the foundation to walk a fine line: being fact-based and impartial enough to gain the respect of Republicans in the General Assembly while still upholding its core principles. By all accounts, the Foundation has succeeded in walking the line.

In its policy work, the Foundation faced other challenges as well:

- How much attention to give the social determinants of health. This became an issue after Ferguson, when the Foundation decided to give limited financial support to areas such as housing and transportation. Some say the Foundation devoted too much to social determinants; others believe it devoted too little. This is an issue that foundations around the country are grappling with, and there is no clear right answer.
- When to reach for hard-to-achieve big policy wins and when to try for smaller, easier-to-achieve gains. When it became clear that the legislature was not going to expand Medicaid, which would have been a big policy win, the Foundation turned to something that was likely to be easier to achieve—restoring some of the cuts made to Medicaid in 2005. Some interviewees questioned whether the Foundation should have given up on Medicaid expansion earlier; others argue that it should never give up—that it's a matter of principle, no matter how quixotic. The Foundation has taken a middle path:

continuing to strive for health insurance coverage for all Missourians while at the same time funding advocates focused on restoring Medicaid cuts.

- Clearly articulating what the Foundation hoped to accomplish in its efforts to bring about health equity. This is in part because health equity is somewhat difficult to define. Does it mean everybody should have the same opportunity or the same results? Is “increasing health equity” the same as “reducing health disparities?” Is it different from “health equality?” Or is it simply introducing and enforcing anti-discrimination policies? Moreover, isn’t equity infused in all of the Foundation’s work to help underserved people in Missouri? The Foundation has grappled for many years with this challenge and has adopted different approaches: providing trustworthy information about disparities; training and coalition-building through MOHEC; promoting institutional anti-discrimination policies through PROMO Fund; and improving the social factors that affect health through Ferguson and Beyond. This is a challenge that transcends any single foundation working in the area.

Effectiveness

In terms of effectiveness, interviewees were nearly unanimous in pointing to two areas: (a) helping people enroll in the Missouri Marketplace and (b) becoming a reliable source of nonpartisan information through research and publications. Although not mentioned as frequently, the Foundation’s work to develop a coordinated emergency medical system for stroke and heart attack victims (Time-Critical Diagnosis), restore Medicaid adult dental benefits and a state Dental Director, reduce smoking in Missouri through local policy changes, and address discrimination against LGBTQ Missourians also deserve to be recognized as achievements.

It is difficult to measure the impact of a Foundation’s policy work under any circumstances. At the most basic level, establishing causality is nearly impossible; multiple factors, many of them beyond a foundation’s control, can lead to or hinder policy change. Determining cause and effect is even more difficult when a foundation is prohibited from lobbying and must remain one step away from those who shape or enact laws. It is possible to demonstrate that a foundation’s actions *contributed* to policy change; it is a leap to *attribute* policy change to a foundation. That said, Missouri Foundation for Health has proven to be an important force for promoting policies to improve the public’s health in a difficult political and social environment.

Appendix: List of People Interviewed

Board and CAC Members, Past and Present

Brenda Battle
Joan Bray
Connie Cunningham
Joel Ferber
Wayne Goode
Mike Peters
Joseph Pierle
Darin Pries
Steve Pu
Steve Renne
Will Ross
Aimee Wehmeier

Staff Members, Past and Present

Ryan Barker
Lyndsey Wilbers Cavender
Kristy Klein Davis
Stacy Easterling
Deidre Griffith
Kathleen Holmes
Robert Hughes
Nancy Kelley
James Kimmey
Matt Kuhlenbeck
Alexandra Rankin
Jessi LaRose
Thomas McAuliffe
Sarah Morrow
Deena Lauver Scotti
Sarah Smith
Courtney Stewart
Rosalyn Crain Tinnin

Beyond the Foundation

Jen Bersdale, Missouri Health Care for All
Amy Blouin, Missouri Budget Project
Kelly Ferrara, StratCommRx
Dwight Fine, Consultant
Gary Harbison, Missouri Coalition for Oral Health
Stan Hudson, MOHEC

Timothy McBride, Professor, Washington University
Samar Muzaffar, Former Medical Director of Emergency Medical Services, DHSS
Steph Perkins, PROMO Fund
Jason Purnell, Professor, Washington University
Richard Von Glahn, Missouri Jobs with Justice
Sidney Watson, Professor, St. Louis University
David Winton, Penman & Winton
David Wood, Representative

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