Medicaid Block Grants, Per Capita Caps, and Missouri: Early Observations

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After the recent presidential election, there is much discussion of the potential repeal of the Affordable Care Act (ACA) and what might be offered to replace it. Beyond ACA repeal, there are also major proposals for restructuring entitlements, including Medicaid. The most prominent idea is replacing the current funding mechanism with a Medicaid "block grant" or "per capita caps." Indeed, Speaker Ryan's "A Better Way" proposal for replacing the ACA included a block grant option for states along with the option of accepting a per capita cap.[1] Prior House budget proposals also have included significant Medicaid spending reductions to be achieved through block grants or per capita caps.[2] The President-elect has also expressed support for a Medicaid block grant.[3] As discussed below, all of these proposals would involve a significant reduction in federal funding to the states. This paper provides a brief analysis of the potential impact of such a block grant or per capita cap on the State of Missouri and the Medicaid beneficiaries who depend on the program.

How does a block grant work?

Under block grant programs, states typically receive a *capped* amount of federal money each year and are at financial risk if actual costs exceed what is allowed under the cap. In the current Medicaid program, there is a shared federal and state fiscal commitment to Medicaid, with the federal government paying a share of the costs for every dollar that the State spends on the program. Under a block grant, federal funding would not increase when more people need coverage (e.g., due to a recession or natural disasters) or to accommodate health care inflation due to innovative surgical procedures, new drugs, or other factors, thus creating pressure to cut eligibility or services.

What about per capita caps?

Per capita caps also limit federal Medicaid funding. Like block grants, per capita cap proposals historically have been designed with explicit upfront cuts to federal Medicaid funding and with allocation formulas that create greater funding shortfalls over time.

They differ from block grants in that they impose a per enrollee cap, rather than a global cap, on federal Medicaid spending. States could spend no more than a certain amount of federal dollars for each individual enrolled in the program, but could still increase Medicaid expenditures (with increased federal matching funds) to account for increased enrollment, such as in times of recession, or to respond to overall population growth. However, like block grants, per capita caps would create pressure to cut eligibility because the federal government would not increase funding to accommodate non-enrollment-related spending increases, such as those caused by health care inflation or the development of new drugs.

What is the impact of block grants or per capita caps?

In Missouri, the federal government currently pays 63% of the cost of covering the State's Medicaid (MO HealthNet) participants. The federal government pays a larger share of state costs for the new adult expansion group in those states that expand Medicaid (100%, gradually reduced to 90% over time). Missouri has not adopted the Medicaid expansion option. Under the current Medicaid financing structure, this shared financing arrangement remains true regardless of the total cost of care. Federal Medicaid spending increases as additional individuals enroll in the program (e.g., in an economic downturn) or to accommodate non-enrollment-related spending increases, such as health care cost inflation, or the adoption of more advanced treatment protocols.

By contrast, under a block grant, the federal contribution cannot exceed the cap regardless of any increased need or unanticipated costs. A block grant or per capita cap creates two potential risks for Missouri: (1) depending on the initial funding level, the grant could provide less federal funding for current enrollees than under the current uncapped program, creating a budgetary shortfall for the State; and, (2) depending on how future allocations are designed (e.g., what inflationary adjustments are incorporated into the formula), the State could face continued and increasing budget shortfalls if federal allocations to the block grant or per capita cap fail to keep pace with the current level of federal funding.

It is highly unlikely that any formula designed to determine states' funding levels under a Medicaid block grant could adequately mitigate against these risks. Among the issues to be addressed are: (1) the size of the block grant/cap; (2) the method for determining that amount (e.g., would it be based on the number of people in Missouri, the number of participants in the current MO HealthNet program, or some other factor?); (3) the annual growth rate for the block grant and basis for that rate (e.g., would there be adjustments for more people coming into the program, adjustments for health care inflation, etc.?).

For Medicaid beneficiaries, a block grant means an elimination of the federal guarantee of coverage for people who meet the eligibility requirements of the program and elimination or substantial modification of most rules governing the provision of Medicaid services by states. It would also most likely mean elimination or substantial modification of the rules governing Medicaid payment to providers, such as the requirement that payments to managed care plans be "actuarially sound" or that reimbursement be sufficient to ensure "equal access" to providers in the Medicaid program.[4] The federal guarantee of coverage could potentially be preserved under a per capita cap but most likely without the same federal requirements governing services and provider payments. The financial strain on the program (discussed below) would make it extremely difficult to maintain current protections.

Would there be a cut in funding with a block grant or per capita cap?

As noted above, the level of funding would need to be established as would any inflationary adjustments, but it is almost certain that either approach would provide Missouri with significantly less federal financing than that provided under current funding. These federal

Medicaid proposals are designed to *reduce* federal funding for states as compared to current Medicaid law.

In the past, Medicaid block grant proposals have sought to set the *base year* of funding using current or previous Medicaid spending levels (e.g., from an earlier budget year in which expenditures were lower).[5] However, even if the *initial* level of federal funding is the same as current funding, any inflationary adjustment methodology used would lead to future cuts relative to the current law. Previous proposals suggest that the annual funding adjustment would be based on a general inflationary index like the consumer price index. Such an indicator would not keep up with the costs of health care inflation or unanticipated new medical expenditures such as new drugs or treatments to address epidemics or disease outbreaks as occurred with treatment for HIV in the 1980s.[6]

For example, the prior House block grant proposal referenced above would have increased funding annually based on projected population growth and the consumer price index. These growth rates combined were far below the expected rate of growth of federal Medicaid spending, thereby enabling the federal government to achieve significant savings and shifting the responsibility for these costs to the states.[7] This federal funding cut would occur despite the fact that Medicaid spending is growing slower than spending on private health insurance.[8] A 2016 House budget proposal would have allowed federal Medicaid caps to rise by an estimated 1.8 percentage points less per year over the coming decade than the rate of growth per beneficiary projected by the Congressional Budget office (CBO) under the current Medicaid program – because the general inflation rate does not keep up with health care inflation.[9] As noted by the Urban Institute, "in all public proposals in which a growth rate has been specified, the block grant approach has been designed to reduce federal expenditures below that projected by the Congressional Budget Office or the Centers for Medicare and Medicaid Services."[10]

The House Republican budget plan for fiscal year 2017 would have cut federal Medicaid funding by $1 trillion or nearly 25% over ten years relative to current law– on top of the cuts the plan would secure from repealing the Medicaid expansion.[11] States would also experience a 33% cut in the tenth year, 2026. A similar block grant proposal from then-Chairman Paul Ryan in 2012 would have cut federal Medicaid funding by $810 billion – or 22 percent of the fiscal years 2013-2022.[12] A state-by-state analysis concluded that that if the Ryan block grant had been effect in 2001-2010, **Missouri would have experienced a nearly $15.8 billion (39%) reduction in federal spending over that time period** and a $2.3 billion (45%) cut in federal spending in 2010 alone.[13]

Thus, whatever formula or proposal is adopted, the impact would be major reductions in federal Medicaid spending on the Medicaid program and reduced federal funding coming into Missouri.

What about the *formula* and the loss of federal matching funds: Are there particular concerns for Missouri?

As referenced above, if the federal government were to set a block grant or per capita cap in Medicaid, it would have to set a formula for determining the allocation of Medicaid funds that each state would receive. It is most likely that the formula would be based on the current

Medicaid allocation among the states. Missouri is one of nineteen states that did not expand Medicaid under the Affordable Care Act. Many of the states (16 of 32, including the District of Columbia) that have expanded Medicaid have Republican Governors who will presumably want to protect that expansion and the substantial federal dollars currently flowing into those states through the enhanced Medicaid funds provided for Medicaid expansion. Indeed, Speaker Ryan's "Better Way" proposal states:

> For states that have not expanded Medicaid under Obamacare as of January 1, 2016, under this per capita allotment approach they would not be able to do so. States that already expanded Medicaid would be given new authorities to better manage the health care, and better control the costs, of the expansion population. In 2019, states that have already expanded Medicaid under Obamacare would receive the same amount of dollars they receive today under the plan. However, the state would also have flexibility to shift dollars from less needy populations to target more funding to help those who need it the most.[14]

If current Medicaid spending is the basis for a federal block grant formula, then Missouri's lower federal spending will be locked in to the formula going forward and will not only diminish the possibility of a future Medicaid expansion but will disadvantage Missouri in terms of future Medicaid spending for the *existing* Medicaid population.

Indeed, there is a significant possibility that a block grant or per capita cap proposal will try to lock in place current state spending levels as the basis for any formula regardless of inflation. Yet, a recent report from the Urban Institute notes that spending per low-income person varies by a factor of at least 5 to 1 across states and spending per enrollee varies by a factor of at least 2 to 1.[15] Thus, "high spending states, such as the District of Columbia ($11,917 per low-income resident), Vermont ($5,438), New York ($6,646) and Connecticut ($4,432), would get a rich amount of federal dollars per low-income person. This funding level provides them a greater opportunity to sustain most of the comprehensive coverage and benefits that they provide, at least in the near term, until the predetermined slower federal spending began to bite."[16] **Missouri, on the other hand, would receive less than half as much per low-income resident ($2,606) as New York** if the formula is pegged to current state spending levels.

If separate formulas were used for different populations instead of a single aggregate one, there would be similar variability in funding allocated to states. For example, spending on the elderly and disabled varies significantly ($40,757 per low-income resident in the District of Columbia, $23,100 in New York to $9,442 in Missouri, with a national average of $10,986 per person). For adults and children, Missouri spent $1,033 per low-income resident, much closer to the national average of $1,188 but still much lower than a large number of states, including New York ($2,201) and the District of Columbia ($4,894).[17]

Thus, there would certainly be consequences for Missouri and other states if the formula is set based on *current* funding levels. States that currently receive higher levels of federal spending would likely resist efforts to reallocate funding to make the formula more equitable in the future. Missouri's relatively low spending in Medicaid to this point would thus result in lower funding levels under a capped financing structure, thus limiting the State's flexibility to explore

expanding the populations that it serves, the types of service it offers, or improvements to systems and processes even as new advances in health care are achieved. And as discussed below, this lower funding would create significant pressure to cut eligibility and services in Missouri's Medicaid program.

What about the elimination of the current Medicaid financing system: Are there particular concerns for Missouri?

As noted earlier, Missouri currently receives federal matching funds at a rate of about 63% for its Medicaid spending.[18] In fact, state general revenue is only a portion of the "state match" (along with various provider taxes and other funding streams) in the program. State general revenue constitutes about 17% of the Medicaid budget and just over 5% of the overall state budget.[19] Under a block grant, Missouri will receive a fixed amount of federal funding which may or may not be tied to what the State now spends on its Medicaid program. Congress would also likely re-write the rules about state spending in a new block granted Medicaid program. Certainly the TANF block grant has a state "maintenance-of-effort" requirement that requires Missouri and other states to spend a specified aggregate amount of money each year to draw down its federal dollars. Per capita caps would present many of the same problems as a block grant.

A Medicaid block grant or per capita cap would likely require a certain amount of state spending, but it is not clear that all current forms of spending would count under the new framework. If the new formula were based on current *state* spending (as well as federal spending), **it is not clear that the same state spending that counts today, such as provider taxes, would count as state spending in determining the formula**, given that provider taxes and other expenditures are not uniformly relied on by states and are disfavored by some policymakers.

Missouri would seem particularly vulnerable in any formula given its heavy reliance on disproportionate share hospital (DSH) payments, the federal reimbursement allowance, and other types of provider taxes to help fund its Medicaid program. Indeed, there have been prior attempts from the federal government to limit Missouri's reliance on these funding mechanisms, including an attempt by the Bush Administration to get Missouri to pay back more than $1.6 billion in provider taxes to the federal government.[20] If Medicaid federal funding is changed to a block grant or per capita cap, then the entire matching structure and the ability to secure federal matching funds with a provider tax likely goes away with it. There could also be adjustments to the formula for states that did not rely so heavily on DSH spending and provider taxes. Certainly, states that do <u>not</u> rely so heavily on DSH spending and provider taxes could argue that states like Missouri should not be allowed to benefit from their heavy reliance on such financing schemes.

In fact, the appeal of the current provider tax is based on the existing federal matching structure. Providers currently support the provider tax because it helps increase federal funds coming into Missouri's health care system by the way of the federal match. Block grants and per capita caps could effectively eliminate the connection between the provider tax and federal matching funds coming into Missouri. Eliminating the connection between the provider tax and federal matching funds would likely erode provider support for maintaining any type of provider tax. If provider taxes were eliminated, Missouri would be struck with an additional shortfall of <u>state</u>

funding on top of the expected shortfall in federal funding produced by the change to a block grant or per capita cap. To address the shortfall caused by elimination of the provider tax, Missouri would likely either have to cut services/beneficiaries at a higher rate than states that were less reliant upon provider tax or raise taxes to a greater extent than those states.

How might a Medicaid Block Grant or Per Capita Cap affect Missouri's Medicaid program?

Missouri would need to adapt to the aforementioned reductions in federal Medicaid spending. This change in funding would almost certainly mean reductions in Medicaid eligibility and services.

To give some additional context, under the TANF block grant (which replaced the AFDC cash assistance program), there is no federal guarantee of coverage and states, including Missouri, have implemented wide-ranging restrictions on the receipt of cash assistance. Indeed under TANF, Missouri has never adjusted the TANF cash grant ($292 per month for a family of three) for inflation and has reduced eligibility by imposing three-year time limits and additional sanctions for noncompliance with work and drug-testing requirements. While a Medicaid block grant or per capita cap would almost certainly include an adjustment for inflation, the capped funding would still be far less than projected increases under the current program, thereby creating significant pressure to reduce coverage and services.

In analyzing Speaker Ryan's prior Medicaid block grant proposal, the Congressional Budget Office concluded that "the magnitude of the reduction in spending . . . means that states would need to increase their spending on these program, make considerable cutbacks in them, or both. Cutbacks might involve reduced eligibility, coverage of fewer services, lower payments to providers, or increased cost-sharing by beneficiaries – all of which would reduce access to care."[21] CBO's conclusion portends the likely impact of any block grant proposal on Missouri's Medicaid program.

Coverage and services likely to be affected: In assessing the impact of a block grant or per capita cap, it is important to recognize what the current Medicaid program covers. Presently, Medicaid covers a wide variety of populations and services in Missouri. Some of these groups and service categories are mandatory under current rules while others are optional. To give just a few examples, the Missouri Medicaid program (MO HealthNet) covers:

- Over 979,000 people[22] (or about 16% of all Missourians)[23]
- 32% of Missouri's children
- 8% of Missouri seniors over age 65[24]
- 40% of all births[25]
- 63% of all nursing home care in the state[26]
- Medicare cost-sharing (premiums, deductibles, and coinsurance) for eligible seniors and people with disabilities.

In 2016, MO HealthNet accounted for roughly 31 percent of Missouri's total budget.[27] However, state spending on Medicaid constitutes only 25.3 percent of all state spending (only a portion of that spending is general revenue).[28] Meanwhile, **federal Medicaid funds are the**

largest source of federal revenue to Missouri, roughly 60 percent of all federal grants to the State. Much of this funding supports services for seniors and people with disabilities (who constitute under 27 percent of the program enrollees, but account for 66 percent of Medicaid spending).[29]

Coverage and services for all populations are likely to be affected if Medicaid is block-granted or capped. However, the above mentioned data suggest that capped federal Medicaid funding would require significant cuts among the elderly and disabled or, alternatively, even more significant cuts among children and non-elderly adults (such as pregnant women) without disabilities.

As block grant or per capita cap funds prove insufficient to meet rising health care costs or enrollment needs, all of the above populations and services could face reductions. To better illustrate how this might play out, one only has to look at what happened to the Missouri Medicaid program in 2005 when Missouri faced a budget shortfall and attempted to limit or eliminate coverage of most "optional services" and optional eligibility groups. In that year, the State eliminated coverage for over 90,000 individuals, including 68,000 low-income parents, and cut "optional" services for over 350,000 low-income adults (including but not limited to dental, vision, podiatry, hearing aids, most durable medical equipment).

Under a block grant or a per capita cap, it is unlikely that there would be any mandatory eligibility groups, so the State could further cut eligibility for low-income parents, children, seniors, and people with disabilities. Indeed an analysis of the 2012 House Medicaid block grant proposal estimated that 243,000-357,000 Missourians would lose coverage due to the implementation of a Medicaid block grant.[30]

Moreover, instead of limiting service reduction to such items as dental, vision, or podiatry, the State could eliminate or reduce services that are now mandatory. These currently mandatory services include in-patient (and out-patient) hospitalization, nursing home services, physician visits, comprehensive pediatric -- "EPSDT" (Early Periodic Screening, Diagnostic and Treatment) services for children, nonemergency medical transportation, emergency ambulance services. The State could also choose to dramatically limit the amount, duration and scope of any or all of these services. Indeed, an analysis of the House 2012 House block grant proposal by the Urban Institute found that **Medicaid payments to Missouri hospitals would be reduced by $7 billion over a 10-year period (2013-2022) while nursing home payments would be reduced by $3.4 billion over that same period**.[31]

Missouri could well be allowed to cut services that courts have previously determined were required, such as medically necessary equipment and supplies. In 2006, a federal court held that it was impermissible to cover wheel chairs without the batteries to run them or oxygen without the breathing equipment to deliver the oxygen, or to eliminate coverage of canes, catheters, walkers and feeding tubes.[32] Missouri could also impose waiting lists for coverage, cap enrollment, or impose work requirements as a condition of eligibility for health coverage. Missouri could remove an entire family's health coverage (including children's coverage) based on their parents' failure to comply with work requirements, as is the case in the current Missouri TANF program.

What about state flexibility?

The current Medicaid program and its federal-state matching structure provide significant flexibility for states regarding coverage and services. While there is a minimum group of beneficiaries that must be covered (e.g., very low-income parents, people with disabilities and seniors below certain incomes), and a limited number of mandatory services, (e.g., physician visits, in-patient and out-patient hospital services, physician visits, nursing home services), states have wide-ranging flexibility to design their own Medicaid programs, including implementation of risk-based managed care and other forms of care management without any waivers and home and community based services with or without federal waivers.

Furthermore, Section 1115 research and demonstration waivers provide additional flexibility that Missouri and many other states have exercised to promote and implement new health care initiatives. Missouri previously exercised this authority to cover low-income parents up to 100 percent of the federal poverty level in the late 1990s, but was able to reduce such coverage in 2002 and 2005 to cover only people with significantly lower incomes. A bi-partisan group of state leaders recently indicated that the type of increased flexibility they were in favor of included "quicker action and more open consideration of requests for waivers from existing Medicaid rules about how to cover and pay for services," rather than more flexibility to limit Medicaid eligibility and services with reduced federal funding.[33] The new Administration could well adjust the 1115 waiver process to ensure that state leaders have the type of flexibility they are looking for.

States also have the option to expand coverage to additional low-income adults without a waiver with enhanced federal matching funds (90% or greater). Missouri has chosen to cover individuals who are blind at greater income levels than seniors and people with disabilities without the need for a waiver. Missouri and other states have also had the ability to receive federal matching funds at a 90% rate for the administrative costs of revamping and modernizing their computer systems for public benefits programs, including Medicaid.

One of the most significant types of flexibility states now have is the flexibility to address increased need caused by economic downturns or natural disasters (such as the 2011 tornado in Joplin, Missouri) with additional federal funding for each beneficiary that comes onto the program.

Finally, as noted above, Missouri has taken ample advantage of the significant flexibility under the current Medicaid financing structure to meet "state match" requirements through a variety of means other than state general revenue spending, particularly through the federal reimbursement allowance (FRA) and other provider taxes that may well not continue under a block grant or per capita cap structure.

During the aforementioned dispute with the federal government over Missouri's provider tax, Missouri state officials successfully opposed an attempt by CMS to impose a per capita cap on the State of Missouri, noting that such an arrangement would not keep up with health care inflation and would result in a "lower level of service, and more costs to Missouri taxpayers."[34]

While states already have significant flexibility, the block grant or per capita cap approach would essentially give the states only one kind of flexibility – to reduce coverage and services due to the reduced funding, but likely without the federal standards that govern the current Medicaid program. Under either approach, individuals would likely no longer have a right to the minimum benefits that they receive now. There would also be no minimum federal standards for the amount, duration, or scope of any benefits provided. Under current law, states must provide "medically necessary" services within the services that they choose to cover but, without federal protections, states could choose to cover only minimal services in any one category rather the services that are medically necessary for a particular individual. Thus, the block grant or per capita cap creates significant flexibility to eliminate services and implement eligibility reductions but little flexibility to meet an increased need for services or coverage.

Conclusion

As discussed above, either Medicaid block grants or per capita caps would have a significant financial impact on Missouri's Medicaid program. The reduced funding and fewer legal protections under these mechanisms would likely create significant pressure to limit eligibility and services at the state level.

Notes

[1] P. Ryan, *A Better Way: Our Vision for a Confident America*, June 2016, p. 26.

[2] See Edwin Park, *Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured.*, Center on Budget and Policy Priorities, November 30, 2016.

[3]See President-elect Donald J. Trump's Campaign Website, https://www.donaldjtrump.com/policies/health-care/.

[4] See 81 Fed. Reg. 27,858 May 6, 2016 (to be codified at 42 C.F.R. §438.4(a)) ("Actuarially sound capitation rates are projected to provide for all reasonable, appropriated, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract"). The "equal access" provision requires that payments to Medicaid providers "be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population" in that same area. 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §447.204.

[5] For example, a 2015 block grant proposal would have created block grants tied to 2014 Medicaid spending. Sara Rosenbaum et al, *What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?*, The Commonwealth Fund, November 2016, p. 4. Speaker Ryan's Better Way proposal would implement a formula for new federal caps that would take effect in 2019 but would be calculated based on enrollment and costs in 2016 – three years earlier. *Id.*, p. 5.

[6] Health care costs have risen consistently faster than the overall inflation rate, in part because of medical advances that improve health and prolong lives but add costs. Edwin Park and Judith Solomon, *Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs*, Center on Budget and Policy Priorities, June 22, 2016, p. 2.

[7] John Holohan and Matthew Buettgens, *Block Grants and Per Capita Caps: The Problem of Funding Disparities Among States*, Urban Institute, September 2016, p. 3.

[8]Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP, June 2016, p. 8, available at https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-

on-Medicaid-and-CHIP.pdf. See also Lisa Clemans-Cope and John Holahan, Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence, Kaiser Commission on Medicaid and the Uninsured, April 2016, available at http://files.kff.org/attachment/issue-brief-medicaid-spending-growth-compared-to-other-payers-a-look-at-the-evidence.

[9] Park and Solomon, supra, n. 6.

[10] John Holohan et al, *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*, The Urban Institute, Kaiser Commission on Medicaid and the Uninsured, October 2012, p. 3.

[11] Edwin Park, *Proposed Medicaid Block Grant would Add Millions to Uninsured and Underinsured*, Center on Budget and Policy Priorities, March 17, 2015. The House Republican budget plan for fiscal year 2017, would have cut federal Medicaid funding by $1 trillion or nearly 25% over ten years relative to current law– on top of the cuts the plan would secure from repealing the Medicaid expansion. Edwin Park, *n. 2,* supra, November 30, 2016.

[12]Edwin Park and Matt Broaddus, *What if Chairman Ryan's Medicaid Block Grant Had Taken Effect in 2001?,* Center on Budget and Policy Priorities, April 20, 2012.

[13] *Id.*

[14] P. Ryan, n. 1, supra pp. 26-27.

[15] John Holohan and Matthew Buettgens, *Block Grants and Per Capita Caps: The Problem of Funding Disparities Among States*, Urban Institute, September 2016.

[16]*Id.* p. 5.

[17] *Id.* p. 6-7

[18] 80 Fed. Reg. 73,779 November 25, 2015.

[19]See MO HealthNet Oversight Committee, *SFY-2017 Budget Update for MO Healthnet Oversight Committee,* May 26, 2016, available athttp://dss.mo.gov/mhd/oversight/pdf/160526-MHD%20Budget%20Update.pdf; see also Office of Administration, *FY 2017 Totals by Department*, available at http://oa.mo.gov/sites/default/files/FY_2017_Totals_by_Department.pdf.

[20] Letter from Thomas A. Scully, Administrator, Centers for Medicare and Medicaid Services, United States Department of Health and Human Services, to the Honorable Bob Holden, Governor, November 29, 2001, and attached Draft Audit Report on the State of Missouri. This unsuccessful attempt was resolved with the creation of a "Partnership Agreement" between Missouri and the Centers for Medicare and Medicaid Services under which Missouri was required to be more transparent with the federal government in designating "state matching funds" for the Medicaid program.

[21] Edwin Park, supra, n.2.

[22]MO HealthNet had a caseload of 979,390 people in April 2016., Missouri Department of Social Services, *DSS Caseload Counter*, updated 6/1/16, available at http://dss.mo.gov/mis/clcounter/history.htm.

[23] Id. in conjunction with analysis of U.S. Department of Commerce, U.S. Census Bureau, *Missouri Quick Facts*, July 1, 2015 estimate, available at http://quickfacts.census.gov/qfd/states/29000.html.

[24] The Henry J. Kaiser Family Foundation, State Health Facts, 2014, available at http://kff.org/statedata/?state=MO.

[25] See State of Missouri, Department of Health and Senior Services, MICA data comparing all live births in 2014 (75,104) available at http://health.mo.gov/data/mica/mica/birthmap.php to all live births on Medicaid in 2014 (30, 229) available at http://health.mo.gov/data/mica/mica/birthmap.php.

[26] *Distribution of Certified Nursing Facility Residents by Primary Payor Source,* The Henry J. Kaiser Family Foundation, State Health Facts, 2014, available at http://kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/.

[27] See supra, n. 19.

[28] See The National Association of State Budget Officers, *State Expenditure Report*, 2016, available at https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf

[29] MO HealthNet Oversight Committee, supra, n. 27.

[30] John Holohan et al, *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*, The Urban Institute, Kaiser Commission on Medicaid and the Uninsured, October 2012, p. 15. The lower estimated eligibility decline assumes significant state efficiencies to lower Medicaid spending per-beneficiary. *Id.* at 14. The report found much greater number of enrollment declines if a block grant were implemented along with the repeal of the Affordable Care Act.

[31] John Holohan et al, *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*, The Urban Institute, Kaiser Commission on Medicaid and the Uninsured, October 2012, p.19. These figures include both federal and state spending reductions. *Id.* p. 18.
[32] See *Lankford v. Sherman,* 451 F.3d 496 (8th Cir. 2006).
[33] Christopher Koller, *State Flexibility? How about a Real Partnership?*, Milbank Memorial Fund. December 22, 2016, available at https://www.milbank.org/2016/12/state-flexibility-real-partnership/.
[34] See Letter from Senator Wayne Goode to Kathy Martin, Director, Missouri Department of Social Services, February 12, 2002 and citations in note 20 supra.

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