PRELIMINARY ANALYSIS OF SENATE BILL 28 (Committee Substitute)

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Summary: This paper briefly describes and analyzes Senate Bill 28, which was recently voted out of the Senate Seniors, Families and Children Committee. It does not take a position on the passage or defeat of the proposed legislation

This legislation requires the Missouri Department of Social Services to seek "capped" federal funding in place of the current federal-state matching structure, and later develop a program that meets broad legislative goals (e.g., implementing a patient-centered, sustainable, and cost-effective market-based health care system), under the oversight of the Joint Committee on Public Assistance. The primary immediate objective of the legislation is for Missouri to obtain federal approval to place a cap on Missouri's *federal* funding.

The bill's broad policy objectives are unrelated to the request for a global cap, and could well be achieved without a cap on federal funding. The bill requires that a waiver application be developed later on but any waivers would have to be granted by the federal government consistent with its waiver authority. There is no authority to waive the current federal-state matching structure of the Medicaid program.

Because specific program changes are not described in the bill, the most significant potential impact would be the imposition of capped federal Medicaid financing. Under the current system, federal payments increase or decrease with state spending in response to the level of need. The proposed cap would likely create financial pressures on the State, resulting in reductions in eligibility, services or provider payments, or alternatively, increased state spending. The cap would not bring additional flexibility to design a program that meets the needs of Missourians. It would only limit the federal funding flowing into the state. The cap proposal also does not require specific measures to "bend the cost curve" or otherwise combat the cost of health care; it simply ensures that *whatever the State spends*, federal matching funds will be limited to the capped amount.[1]

While federal block grant or per capita cap proposals may be introduced in Congress, this legislation would not exempt or protect Missouri from any formulas enacted by the federal government. The bill's capped funding mechanism terminates if the federal government enacts these reforms.

Global Waiver and Capped Block Grant: The bill would require the Department of Social Services to seek federal approval for a "global waiver" that includes a request to receive funding mechanisms "similar to a federally capped block grant."[2] Like the original bill, the Committee Substitute does not define the term "block grant" but indicates that such funding mechanisms "may" include capped per capita allocations, capped allotments or shared savings based on per-enrollee spending targets.[3] While these other options are mentioned, the only funding strategy the bill actually *requires* is capped federal financing.

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. Many factors

could increase the cost of the Medicaid program including an increase in elderly beneficiaries due to an aging population, the discovery of an expensive life-saving drug, increased enrollment due to a recession, and a flu pandemic or other public health crisis. In these circumstances under a block grant, federal funding would remain the same and Missouri would bear the increased costs alone. As discussed below, Medicaid block grant proposals may include some general inflationary adjustments but are typically designed to reduce federal Medicaid spending in comparison to what is allowed under current law.

In the current Medicaid program, the federal government pays a share of the costs each year with no upper limit on the total amount of federal funds received. The federal government currently pays 63% of the cost of covering Missouri Medicaid (MO HealthNet) participants.[4] Since Medicaid normally has no cap, this percentage remains true regardless of the total cost of care. By contrast, under a block grant, the federal contribution cannot exceed the cap.

Because the current federal Medicaid matching structure cannot be waived, there is no federal authority for any *one* state to implement a true Medicaid block grant. A true "block grant" would cap federal spending and do away with the Medicaid matching structure. Thus, a "block grant" (if allowed through a federal waiver) would more likely involve some sort of capped federal financing on top of the *existing* federal matching structure, which could be quite complicated. Indeed, the State of Rhode Island previously had a "global cap" on its Medicaid program – not a block grant – but opted to eliminate that cap when it renewed its Medicaid waiver in 2013.[5] None of the recent Section 1115 Medicaid expansion waivers approved by federal Department of Health and Human Services (HHS) have included a block grant or global cap.

Program Requirements and Waivers: As noted above, the bill outlines only broad policy objectives to be achieved with the new global waiver. The bill requires the State to develop a waiver application that will "maximize the flexibility of the state" to implement a patient-centered, sustainable, and cost-effective market-based health care system that emphasizes competitive and value-based purchasing.[6] Such flexibility "<u>may</u>" include: (1) eligibility determinations that include work requirements for certain able-bodied adults; (2) initiatives to promote healthy outcomes personal responsibility, including co-payments, premiums, and health savings accounts;[7] (3) Measures to improve the quality and to lower the cost of health care through policies such as selective contracting and competitive bidding, preferred provider networks, and health outcome-based provider reimbursement (a new provision in the committee substitute); and (4) accountability and transparency measures "designed to promote interdepartmental cooperation and coordination while eliminating redundancies."[8]

How these goals would be effectuated is left for a later date. The Department of Social Services would be required to develop a waiver application and submit it to the Joint Committee on Public Assistance, which would then hold a public hearing on the application and hear testimony from the directors of the Missouri Department of Social Services and MO HealthNet Division, as well as public testimony. Within thirty days of the hearing, the Joint Committee must accept or reject the proposed waiver application and, if necessary, propose modifications to or recommendations for the waiver application.[9] If the waiver application is accepted by the federal government, the Department must propose the necessary statutory changes to implement the waiver. Until the

proposed changes are enacted by the General Assembly, *existing Missouri Medicaid laws would remain in effect*. The version that was recently passed out of Committee makes it clear that some statutory changes will be required but does not indicate what those changes will be.[10] The Joint Committee would again be required to hold public hearings and receive public testimony regarding proposed statutory changes to determine if they satisfy the goals of this act and would "result in substantial new opportunities for the MO HealthNet program on a cost-neutral basis."[11]

Because the substance of Missouri's Medicaid program would be developed at a later date, it is difficult to determine whether the State could secure a federal waiver or other approval by CMS. A waiver to implement a pure block grant (with no federal strings) is beyond CMS's statutory authority and does not the meet the parameters set out by the federal government for Section 1115 waivers, which provide the most expansive waiver authority available to states. Section 1115 waivers may be granted for "experimental, pilot, or demonstration" projects, which in the view of the Secretary of HHS, are "likely to assist in promoting the objectives" of the program.[12] These waivers are the basis for many of the reforms being implemented by a variety of states in conjunction with their Medicaid expansion.

Because the contours of a revised Missouri Medicaid program are unknown, the primary impact of the legislation would be to cap *federal* financing of the program.

Agency Discretion: The bill would grant the Department wide discretion to design a program, negotiate a waiver with the federal government, and implement a new program, without full legislative approval, except in areas in which the waiver requires changes in state law. Even then, the Department can request and negotiate a waiver before the General Assembly has agreed to any of the proposed reforms and statutory revisions, including the funding cap methodology. Future state budgets would be dependent on the waiver financing negotiated by the Department.

This approach is very different from prior efforts to reform Missouri's Medicaid program. In 2005, the General Assembly created a joint legislative "Medicaid Reform Commission" and even imposed a sunset date on the program.[13] The joint legislative commission and the executive branch then issued reports that proposed recommendations to reform the Medicaid program. The legislature came back in 2007, and debated and enacted comprehensive legislation to create the "MO HealthNet" program (as opposed to allowing either set of recommendations to become law without full legislative approval).[14] In contrast, SB 28 appears to allow the Department to design a new program and negotiate a comprehensive waiver with the federal government without approval from the General Assembly as a whole. Only those portions of the waiver requiring statutory changes are explicitly made contingent on legislative approval, and only after the waiver has already been negotiated with the federal government.[15]

Financial Impact of a "capped Block grant: A "block grant" or cap would create two risks for the state: (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; (2) depending on how future "block grant" allocations are designed, the State could face continued and increasing budget shortfalls if federal "block grant" allocations fail to keep pace with the current level of federal funding and necessary inflation adjustments.

Savings could materialize from the "block grant" if the federal funding level is set high enough, while the "block grant" could result in losses if the federal funding level is set too low or health care costs increase faster than the "block grant" inflation adjustment. As discussed below, however, any block grant is more likely to be designed to reduce federal funding. Therefore, any savings would likely be achieved by reducing coverage, services and/or provider payments.

SB 28 does not address: (1) the size of the initial "block grant"/cap or (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?).

The bill includes broad language regarding the *annual growth* rate for the "block grant," stating that the capped block grant "may" be adjusted for inflation, state gross domestic product, state population growth, natural disasters, man-made disasters, or extensive economic downturns, and other economic and demographic factors, for the duration of the waiver. The bill does not require such adjustments or make the block grant contingent on federal approval of these inflationary adjustment measures.

HHS would have to agree to any such inflationary adjustment, but federal Medicaid block grant proposals have used general inflationary adjustment methodologies like the consumer price index to achieve funding cuts relative to the current law. Such indicators 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.[16] 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."[17]

It is unknown precisely how HHS would fund the proposed "block grant," but there is no reason to assume that it would provide Missouri with greater federal financing through a "block grant" or cap than it would provide under the current Medicaid program. All recent federal Medicaid block grant or per capita cap proposals have been designed to reduce the federal contribution to the Medicaid program rather stabilize or increase federal spending.

For example, 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 (with a 33% cut in the tenth year).[18] A prior 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.[19] A state-by-state analysis concluded that if the Ryan block grant had been in 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.[20] Moreover, a budget plan proposed by House budget-Chair and nominee for Secretary of the Department of Health And Human Services, Tom Price for 2015, included a similar block grant with an even larger federal Medicaid cut.[21]

Thus, it is far more likely that HHS would want any block grant or cap to limit federal funding for Missouri, rather than increase it.

Coverage and services affected by a global cap or block grant: The Missouri Medicaid program covers a wide variety of populations and services in Missouri. SB 28 seeks to "block grant" or cap the entire Missouri Medicaid program – which includes individuals who are aged, disabled, blind, people receiving home and community based services, and people in nursing homes, as well as children and families. If costs increase for any of these populations, Missouri would face the increased cost without any additional federal funding above the cap.

Much of Missouri's Medicaid spending supports services for seniors and people with disabilities (who constitute fewer than 27 percent of the program enrollees, but account for 66 percent of Medicaid spending).[22] Medicaid also pays for 63% of all nursing home care in the state.[23] Therefore, capped federal Medicaid funding could 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, or increases in state spending. Indeed, analysis of other block grants assume major cuts to Medicaid 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."[24] CBO's conclusion portends the likely impact of a cap on Missouri's federal financing.

Indeed in 2005, when Missouri faced a budget shortfall, the State 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 (including but not limited dental, vision, podiatry, hearing aids, most durable medical equipment) for over 350,000 low-income adults (including adults with disabilities). Reduced federal funding under a cap could well create similar pressure to cut eligibility and services.

As noted above, analyses of recent federal Medicaid block grant proposals have assumed significant reductions in coverage and services. 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.[25] Moreover, 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.[26]

Based on prior Missouri experience and analysis of federal block grant proposals, the capped federal financing under SB 28 could lead to significant reductions in eligibility and services.

State flexibility: As mentioned above, the legislation directs the State to develop a waiver application that would "maximize" the state's flexibility. However, *capped* federal financing does not guarantee greater flexibility. Without changes in federal law, any new flexibility would

depend upon the "waivers" the State receives from the federal government (i.e., what aspects of federal law are waived by HHS). Receipt of such waivers, however, is not contingent on the "block granted" funding mechanism that the bill proposes.

The current federal-state matching structure already provides 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, 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. Missouri has also chosen to cover individuals who are blind at greater income levels than seniors and people with disabilities without the need for a waiver.[27]

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.[28] CMS has given states (such as Arkansas, Iowa, and Indiana) significant latitude to develop their own approaches to Medicaid expansion and reform through the Section 1115 waiver process. 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. The new Administration could well adjust the 1115 waiver process to provide even greater flexibility than is available now.

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.[29] A block grant or cap would likely eliminate this flexibility.

While states already have significant flexibility, the "capped block grant" approach would essentially give the State only one kind of flexibility – to reduce coverage and services due to the reduced federal funding.

Given the likely impact of capped financing, it is not surprising that Missouri officials have previously opposed similar caps on Missouri's federal financial participation. During a prior 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."[30]

Impact of Federal Medicaid Proposals: It is possible that Congress will consider legislation to implement Medicaid block grants or per capita caps. As mentioned above, any such federal legislation would likely be designed to reduce federal Medicaid spending and Congress would have to design a formula for allocating reduced federal spending. Such a formula would likely be based on current state spending, which would likely protect "expansion" states that are spending more money proportionately than Missouri[31] and states that generally spend more per

beneficiary than Missouri does. 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.[32]

SB 28 would not protect Missouri or exempt it from these federal proposals in the event that Congress passes such legislation, and the Committee Substitute is very clear on this point. It terminates the new capped funding mechanism if Congress enacts its own block grant legislation.[33]

Conclusion

Senate bill 28 would require the Department of Social Services to seek waivers that cap Missouri's federal Medicaid financing. Programmatic changes would come at a later date but capped federal funding could well limit state flexibility to meet the needs of Missourians, and would not guarantee any particular reforms. The cap on federal financing would likely create pressure for reductions in eligibility, services or provider payments. While a goal of the legislation is to achieve better control of the cost of the Medicaid program, the legislation would only ensure that *whatever the State spends*, federal matching funds will be limited to the capped amount. The bill does not require any particular reforms that bend the cost curve or otherwise reduce the costs of health care. While block grants or caps may be considered in Congress, the proposed State legislation will not protect Missouri's Medicaid financing if such a scenario arises. The Committee Substitute explicitly terminates the bill's financing mechanism if Congress does take action.

Notes

[1]In fact, Medicaid spending is growing slower than spending on private health insurance. 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.

[2] S.B. 28, 99th Gen. Assemb., First Reg. Sess. (Mo. 2017); §§ 208.1205.1; 208.1205.3 (available at: http://www.senate.mo.gov/17info/pdf-bill/comm/SB28.pdf). While the original bill allowed the Department to seek a waiver that included capped financing, the Committee substitute requires it, replacing the word "may" with "shall." § 208.1205.3

[3] 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. "Shared savings" programs generally refer to programs in which the state and federal government share in the savings achieved by state agencies often in the context of "dual eligible" individuals who receive services through both Medicare and Medicaid (in "dual demonstration" projects), or to programs under which the insurer (e.g., Medicare) and providers share in the savings achieved by accountable care organizations. See, e.g., Bailit, et al, *Shared-Savings Payment Arrangements in Health Care: Six Case Studies, the Commonwealth Foundation*, August 2012.
These mechanisms are actually quite different from a block grant approach and, unlike the bill's capped federal financing, are not required by the legislation.

[4] 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).

[5]Rhode Island has operated its Medicaid program under "capped" federal financing but not under a block grant. In Rhode Island, the "cap" was set at an amount much higher than the state would have received under traditional Medicaid financing, and the state had the flexibility to get out from under the "cap" at any time if the state's funding under the cap becomes less than what it would have received under the traditional Medicaid program. See, Jesse Cross-Call and Judith Solomon, "Rhode Island's Global Waiver Not a Model for How States Would Fare Under a Medicaid Block Grant," Center on Budget Policy Priorities, March 22, 2011; Edwin Alan Miller, et al., "Medicaid Block Grants: Lessons from Rhode Island's Global Waiver," State Health Access Reform Evaluation (SHARE), June 2013; The Lewin Group, "An Independent Evaluation of Rhode Island's Global Waiver," December 6, 2011. Rhode Island switched to a per-person cap on federal spending when it renewed its waiver in 2013. See Letter from Cindy Mann, Director, Center for Medicare and Medicaid Services, to Steven Constantino, Secretary, Rhode Island Office of Health and Human Service, December 23, 2013. Vermont has also operated its Medicaid program under a global cap. See Jocelyn Guyer, Vermont's Global Commitment Waiver: Implications for the Medicaid Program, Kaiser Comm'n on Medicaid & the Uninsured, April 2006.

[6] S.B. 28, 99th Gen. Assemb., First Reg. Sess. (Mo. 2017); § 208.1205.2.

[7]Such initiations "may" include the forgiveness of a patient's co-payments, premiums, or other out-of-pocket obligations or the use of other incentives in exchange for the patient's performance or participation in the health incentive and wellness programs or from choosing lower-cost health care services.

[8] Such measures must also promote the efficient and cost-effective delivery of health care services in a patient-centered approach, including physical and mental health care services.

[9] If the global waiver is suspended or terminated or expires for any reason, the Department must apply for an extension of the waiver or any new waivers that, at a minimum, ensure the continuation of the waiver authorities in place prior to the acceptance of the global waiver. The Department must ensure that any such actions are conducted in accordance with applicable federal statutes and regulations. The Department must, to the fullest extent possible,

ensure that the waiver authorities are reinstated prior to any suspension, termination, or expiration of the global waiver.

[10] S.B. 28, 99th Gen. Assemb., First Reg. Sess. (Mo. 2017); § 208.1210.

[11] The Joint Committee would be authorized to meet at least twice a year to provide oversight on the global waiver; communicate as necessary with departments "within the scope of the MO HealthNet program;" recommend services for the MO HealthNet program; issue subpoenas, subpoenas duces tecum, and orders for production of documents, as necessary; and recommend to the General Assembly any amendments to the waiver or clarifying legislation that may be necessary.

[12] See 42 U.S.C. § 1315.

[13] S.B. 539, 93rd Gen. Assemb., First Reg. Sess. (Mo. 2005); § 208.014.

[14] S.B. 577, 94th Gen. Assemb., First Reg. Sess. (Mo. 2007).

[15] It is not clear how these new provisions would interact with current Missouri law requiring legislative approval of waivers in certain circumstances. See Mo. Rev. Stat. § 208.151.5. That provision reads as follows:

> The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955. **A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote** of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

Mo. Rev. Stat. § 208.151.5 (emphasis added).

[16] 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.

[17] 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 (emphasis added). For example, a prior House block grant proposal 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. John Holohan and Matthew Buettgens, *Block Grants and Per Capita Caps: The Problem of Funding Disparities Among States*, Urban Institute, September 2016, p. 3. 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. Park and Solomon, supra, n. 16.

[18] 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.

[19] 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.

[20] *Id.*

[21] Chairman Price proposed a block grant that would have cut federal Medicaid spending overall by $913 billion over a decade (a nearly 34% cut in federal spending as compared to what states would receive under current law). Edwin Park, supra, n. 18.

[22] See MO HealthNet Oversight Committee, *SFY-2017 Budget Update.*
for MO Healthnet Oversight Committee, May 26, 2016, available at http://dss.mo.gov/mhd/oversight/pdf/160526-MHD%20Budget%20Update.pdf MO

[23] *Distribution of Certified Nursing Facility Residents by Primary Payer 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/.

[24] Edwin Park, supra, n. 18.

[25] 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.* p. 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.

[26] John Holohan et al, supra, n. 25, p.19. These figures include both federal and state spending reductions. *Id.* p. 18.

[27] 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 and other states also 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.

[28] As noted earlier, Section 1115 does not provide the statutory authority to implement a block grant.

[29] As stated previously, the revised bill provides that the annual growth rate may be adjusted for natural disasters but does not require this adjustment, nor make the block grant contingent on federal approval of such inflationary adjustment measures. Furthermore, it is unlikely that any adjustment that takes into consideration these factors could match the real-time responsiveness of the current federal matching system.

[30] See Letter from Senator Wayne Goode to Kathy Martin, Director, Missouri Department of Social Services, February 12, 2002.

[31] 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.

P. Ryan, *A Better Way: Our Vision for a Confident America*, June 2016, pp. 26-27.

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

[33] S.B. 28, 99th Gen. Assemb., First Reg. Sess. (Mo. 2017); § 208.1220.2.