SHOW-ME INSTITUTE
WHERE LIBERTY COMES FIRST

REPORT

JANUARY 2020

MEDICAID IN MISSOURI AND ITS BUDGETARY IMPACT

By Elias Tsapelas

KEY FINDINGS

- Medicaid is Missouri's single largest government-run program, and like other government programs it has experienced tremendous cost growth over the past decade. The program is growing faster than the state's budget. If this trend continues, it could prove disastrous for the state and other public policy priorities.
- In 2019, Medicaid enrollment was lower than it was in 2004, yet the cost of the program is nearly twice as high.
- Although Missouri's officials now expect to spend more on Medicaid than ever before, there is little data to suggest the state's recipients are seeing corresponding improvements in health outcomes. Policymakers should consider implementing value-based payment initiatives that would incentivize health care providers to prescribe care that improves health at the lowest overall cost.
- Missouri should reform its Medicaid program to ensure the continued financial stability of the state. Free-market reforms would empower the individual recipients of Medicaid services, contain the program's continually growing costs, and improve health outcomes for Missouri's population.

ADVANCING LIBERTY WITH RESPONSIBILITY
BY PROMOTING MARKET SOLUTIONS
FOR MISSOURI PUBLIC POLICY

INTRODUCTION

Medicaid is the largest non-contributory entitlement program in the country.* The program is a state–federal partnership that finances health coverage and long-term care services for low-income individuals. Medicaid was established (along with Medicare) by the federal government in 1965 as part of Title XIX of the Social Security Act.[1] Nationally, the Medicaid program and the Children's Health Insurance Program (CHIP) together provide health coverage to more than 73 million Americans.[2] In Missouri, as of November 2019, there are over 850,000 Medicaid recipients, more than 500,000 of whom are children.[3] And even though program enrollment in 2019 is lower than it was in 2004, the cost of the program is nearly twice as high.[4]

As a state, Missouri is spending more money than ever, with 2020 marking the passage of the seventh consecutive record-breaking budget. Since fiscal year 2008, Missouri's budget has grown by more than one fourth (26%), which vastly outpaces inflation.[5] What's more, the state's Medicaid program is growing even faster. Medicaid is the largest government-run program in Missouri, and next year the program could end up consuming more than 40 percent of the state's budget. To make things worse, all of this has occurred in a period with minimal state population growth and without any major expansion of services. A trend of cost growth outpacing Missouri's economic growth will eventually prove unsustainable for the state.

This essay provides an overview of Missouri's Medicaid program and the impact it has had on the state's budget. I outline the major functions of the state's largest program, with special attention paid to the cost of each component. I also use the state's own assessment of the Medicaid program to chart a path toward cost sustainability through free-market approaches for reform in Missouri.

*In this case, non-contributory means that recipients of the entitlement program are not required to pay anything to receive benefits. Programs such as Social Security or Medicare are technically more expensive (and larger) than Medicaid, but they require recipient contributions before receiving benefits.

MISSOURI'S BUDGET AND MEDICAID'S IMPACT

Each year, Missouri's elected officials meet in Jefferson City to put together and pass a constitutionally required balanced budget. This requirement means the state government cannot plan to spend more money in a given year than it expects to take in. The amount of revenue the state receives fluctuates from year to year, but over the past decade, the cost of Medicaid has required the use of more and more state funds.

Missouri's budget includes three major types of funds: general revenue, federal funds, and other funds.† Figure 1 shows how both Medicaid and the state's overall budget have grown over the past decade, but to get a better picture of the overall growth it's helpful to look at how the expenditures from each fund type have changed (Figure 2).

For state policymakers, general revenue is considered the most important fund, because it is where individual income and sales tax collections are deposited. General revenue is the primary funding source for many of the state's public policy priorities (including education), but it also serves as a way for Missouri to receive matching federal dollars to help cover the costs of Medicaid-covered services. Reliance on general revenue to fund such priorities comes with some risk. There is only so much money Missouri's government can budget to spend in a given year, and no matter the federal return on state Medicaid spending, the amount of available general revenue depends on the amount of yearly taxes collected, which in turn depends on the health of the state's economy.

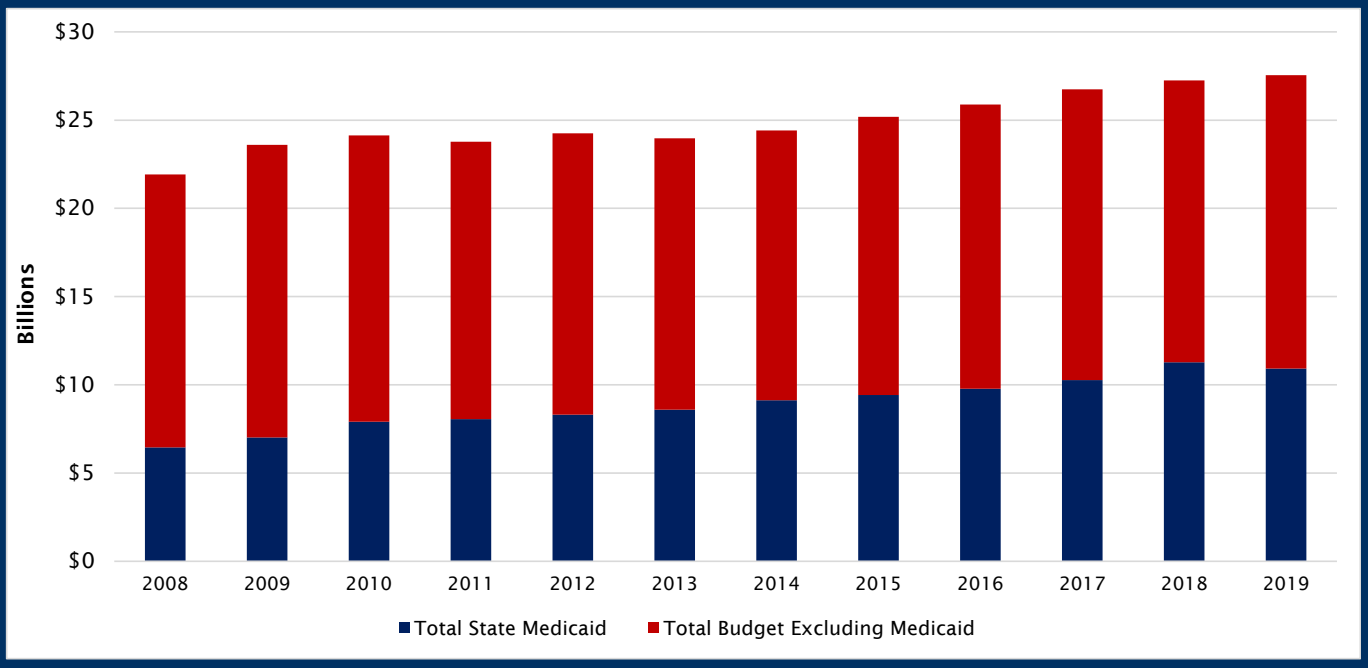
The competition for available general revenue combined with the potential volatility of said funding is a cause for concern for many state programs, and the problem gets worse when revenues are down. This is especially true for Medicaid. The Medicaid program is considered "countercyclical," which means that costs are expected to increase when the economy is performing poorly. During

†General revenue is almost entirely funded by tax dollars but is also where any other money received by the state is deposited unless those funds are required by statute or constitution to be deposited elsewhere. Federal funds are monies from the federal government to be spent on a specified program, such as Medicaid. Other funds are a catch-all for the remaining funds that serve specific purposes as outlined in state statute or in the State Constitution.

Figure 1:

Medicaid as a Share of the Total State Budget

Over the past decade, Medicaid has grown at a faster rate than that of the state's overall budget.

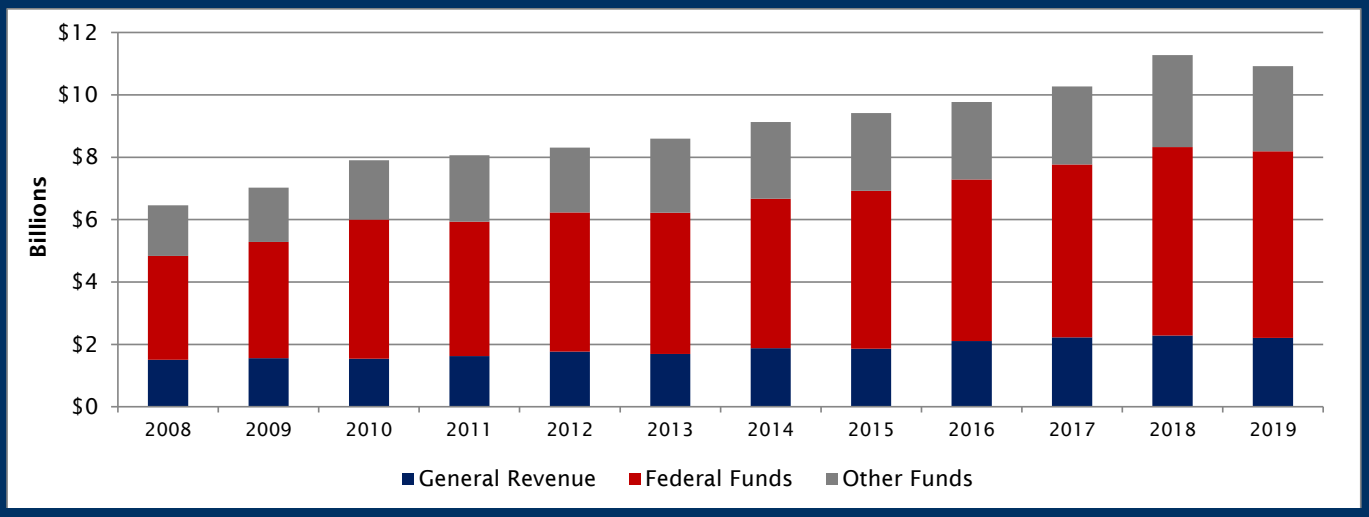


Source: Missouri House of Representatives Budget Fast Facts.

Figure 2:

Medicaid Costs, 2008 to 2019

Medicaid's costs have increased by nearly 75 percent in the past decade.



Source: Missouri House of Representatives Budget Fast Facts.
Note: Data are not adjusted for inflation.

a recessionary period the unemployment rate goes up, which means that more individuals will have incomes low enough to become eligible for Medicaid—thus increasing the program's costs. However, at that same time there will be less general revenue collected through income taxes because fewer people will be employed. Missouri's own Department of Social Services recently completed an assessment of the Medicaid program and estimated that the state's next economic downturn could result in Medicaid consuming over 50 percent of the overall budget.[6]

The growth of Medicaid hasn't been limited to recessionary periods. The most recent national recession ended in 2009, but the effects were felt in Missouri for many years afterward. State general revenue collections were still $600,000 lower in State Fiscal Year (SFY) 2014 than they were when the recession began in SFY 2008.[7] Between those years, the general revenue cost of Medicaid increased by more than $365 million. In effect, during a period where the state's economy was climbing out of a recession, Missouri's elected officials had to cut hundreds of millions of dollars from other public policy priorities to cover increases in the cost of Medicaid. Budgets reflect a government's priorities, but when Medicaid grows like this, it leaves policymakers with less discretion in choosing which priorities can receive the limited amount of available funds. Beyond Medicaid's impact on funding for other state programs, the program's growth has also changed the way the state budgets pay for the same services.

In SFY2019, the state's Medicaid program spent more than $2 billion more federal dollars than it spent 10 years prior, and nearly $1 billion more in other funds. Part of the increase in federal funds can be attributed to a short-term increase in the rate of federal reimbursement approved with the Affordable Care Act in 2010.[8] Another major driver of the increase in federal and other funds is the state's increased reliance on provider taxes. Provider taxes are explained in more detail in the next section, but in short, they are a way for states to increase the amount of funding they have available to pay for Medicaid-covered services using the provider's own funds instead of state tax dollars.

The total cost of Medicaid and how that cost is budgeted are important for the long-term financial stability of the state, in part because of the relationship between each type of state fund. While the state was recovering from the last recession, the increased costs of Medicaid put more pressure not only on the state's general revenue fund, but also on federal and other funds. These pressures were the result of an effort to continue funding the same level of services for Medicaid recipients while enrollment was growing, but this decision has now left Missouri underprepared for an outside shock that results in higher program costs or enrollment. Missouri's budget preparers have been able to accommodate the Medicaid program's growth over the past decade without sacrificing the state's credit rating, but how long can this trend be sustained?

MEDICAID FINANCING

Medicaid has the largest budget of any government program in Missouri, not only because of the costs for the services available and their use, but also because of the way the services it provides are financed.[9] The Medicaid program functions essentially as an open-ended entitlement. This means the program has no structural cap to contain the amount of people enrolled or how much the state spends. This arrangement creates a vicious cycle where the more money the state spends on the program, the more money it can receive from the federal government. Even though the cost is borne by Missourians, who are both state and federal taxpayers, the true cost of any Medicaid program is distorted to provide an illusion of savings as the state is only on the hook for around a third of the total required program expenditures.

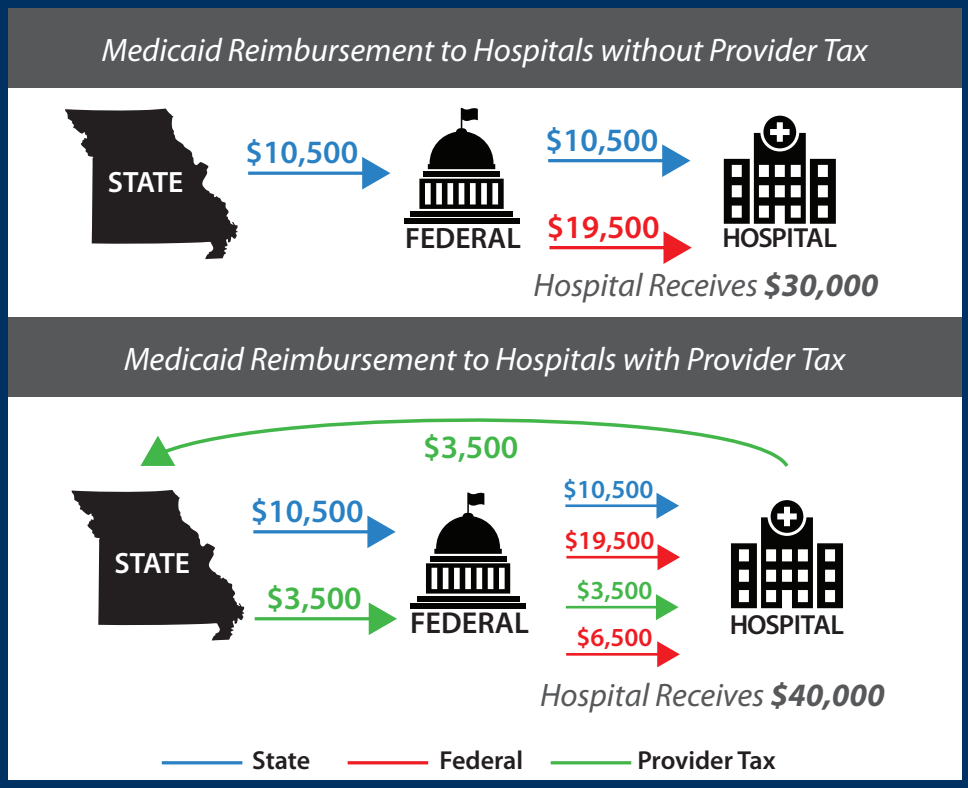
Most federal funding comes to the state in what is called the Federal Medical Assistance Percentage (FMAP).[10] With a floor of 50 percent, the percentage of approved Medicaid costs covered by the federal government is adjusted each year according to each state's relative personal income growth.[11] Missouri's FMAP for the current federal fiscal year is 65.65 percent which ranks 35th among states (only 15 states are experiencing worse income growth).[12] An easy way to think about how the FMAP works is that for each dollar spent on Medicaid, Missouri pays $0.35 and the federal government picks up the remaining $0.65. There are other programs, such as CHIP, that receive higher rates of federal reimbursement, but the process for receiving federal funding works in a similar way.

This financial arrangement between states and the federal government may lead to an incentive structure that rewards providing a higher quantity of services over actually improving the recipient's health. Since there is no cap on the amount of federal dollars that states can receive, the only limit to the overall cost of Medicaid is the number of services for which states are willing to provide their share of funding. This relationship effectively disincentivizes states from taking active measures to control the cost of their contributions, as would otherwise be required, to continue funding the same level of services, because there is an incentive to find ways to maintain the status quo with additional federal dollars.

Figure 3:

Provider Tax Illustration

In this example, hospitals use a provider tax to increase the reimbursement they receive by $6,500 without any additional state spending.



Note: This figure is purely an illustration to show how provider taxes can increase the Medicaid reimbursements a hospital can receive without changing the state's share of expenditures. The total cost was adjusted using Missouri's 2019 Federal Medical Assistance Percentage to demonstrate the shares paid by both federal and state governments, but do not represent the cost of any actual service provided a Missouri hospital. Additionally, the share of reimbursement shown as provider tax from the hospital is purely for illustration purposes. For 2019, Missouri's hospital provider tax was levied at a rate of 5.6% of net inpatient and outpatient revenues.

Missouri is one of the leading states in the country when it comes to finding ways to receive additional federal support without adding to the expenditures made from the state's tax base. A 2014 report from the United States Government Accountability Office stated that Missouri uses the highest share in the nation of nonfederal funds from providers and other sources to fund Medicaid, totaling near 53%.[13] This total is above and beyond what the rest of the country is doing, where only two other states are in the 40% range, and Missouri's neighbors Kansas and Nebraska come in at less than 5%. The most popular source of nonfederal share is seen in what are called provider taxes.[14] These "taxes" (explained in Figure 3) are fees that providers of Medicaid services are willing to pay to the state in an effort to extract additional federal tax dollars. The taxes work through a budgeting gimmick, where the revenues generated by the tax are then used as state funds to draw down the federal match as outlined above, to then once again be paid back to the same providers. There is no formal limit to the amount of state money that is eligible for a matching contribution from the federal government. However, even though the state gets nearly two federal dollars for each state dollar it spends on Medicaid, there are only so many dollars the state can afford to invest in the program. Providers are the

eventual recipients of most Medicaid dollars, and thus have an incentive to maximize the amount of state money that is matched by the federal government. A provider-tax "investment" can generate a nearly threefold return if the money paid becomes part of the state's Medicaid contribution.

Gimmicks such as provider taxes are effective at shifting some of the state's Medicaid burden to the federal government, but they do not lower Medicaid's overall costs.[15] And like many other government programs, once implemented they are difficult to transition away from. A recent report from Missouri's Department of Social Services estimated that the SFY2020 Medicaid budget will include over $4 billion generated from provider taxes, which includes the total amount of taxes levied along with the federal matching funds those taxes are used as state share to receive.[16] If the taxes were removed, and for Medicaid to continue providing the same level of services as they are today, Missouri taxpayers would need to come up with an additional $1.4 billion for the state share of the total. That is a one-year increase to the state cost of Medicaid of over 60%.

Missouri is not alone in its use of provider taxes, but it is one of the most aggressive states in their use.[17] Missouri currently employs five separate provider taxes, and the state legislature has considered adding another.[18] It is easy to dismiss the costs from provider taxes as federal funds, but Missouri taxpayers are still federal taxpayers. The Bush and Obama administrations proposed limiting the use of these taxes, and any efforts to change Missouri's Medicaid financing arrangement with the federal government (e.g., block-grants or per-capita caps) would likely involve provider tax reform.[19] For the continued financial stability of Missouri, it is important that policymakers consider reducing the state's reliance on these types of budgetary gimmicks.

Mechanics

To better understand why Missouri's Medicaid costs are so high and still growing, it is instructive to look specifically at how each piece of the program functions.

Eligibility

Eligibility for Medicaid can be divided into three major categories: Children, ABD (Aged, Blind, and Disabled), and Adults. The eligibility criteria for each of these groups are based on income levels that correspond with poverty guidelines established by the federal government each year.[20] Table 1 shows Missouri's current eligibility criteria.

Roughly one in seven Missourians receives health coverage through Medicaid, and more than half of recipients are children. In fact, nearly 40 percent of the state's population under the age of 18 is enrolled in the program.[21] Since the eligibility requirements for children are the most lenient, it's possible a significant portion of the enrollment disparity among eligibility groups could be explained by the income requirements. Though as seen in Figure 4, enrollment may not always correlate with leniency of eligibility.

As mentioned previously, Medicaid is considered a countercyclical program.[22] Missouri's Medicaid enrollment increased by nearly 200,000 in the years following the 2008 recession, and more than a decade later is just beginning to return to pre-recession levels. This increase in enrollment and the associated cost growth over the past decade indicates the potential scale of what could be in store for Missouri upon the next economic downturn.

Between 2013 and 2018, total Medicaid enrollment in Missouri increased by more than 13 percent even though the state's economy was growing, albeit slowly.[23] The growth in enrollment in the years following 2014 is most likely related to the opening of the Affordable Care Act health insurance marketplace. Once the marketplace opened, many of the people who signed up for coverage who were determined eligible for Medicaid were redirected from their intended insurance plan to enroll with the state's Medicaid agency. The biggest enrollment percentage increase was seen in custodial parents, although the largest total increase to the Medicaid rolls was the addition of nearly 90,000 children.

Cost

A key to understanding the state's Medicaid expenditures lies in the categorical breakdown of enrollment and each

Table 1:
Medicaid Eligibility Thresholds by Recipient Category

		2019 Income Threshold in Dollars by Family Size			
	Income Threshold as % of Federal Poverty Level	1	2	3	4
Children	305%	$38,095	$51,576	$65,057	$78,538
Pregnant Women	200%	$24,980	$33,820	$42,660	$51,500
Blind	100%	$12,490	$16,910	$21,330	$25,750
Aged (65 and older)	85%	$10,617	$14,374	$18,131	$21,888
Individuals with Disability	85%	$10,617	$14,374	$18,131	$21,888
Adults with Dependent(s)	22%	$2,748	$3,720	$4,693	$5,665

Source: https://aspe.hhs.gov/2019-poverty-guidelines.

Note: Aged, Blind, and Disabled populations have asset tests along with their other eligibility guidelines but are eligible to spend down their income to qualify for Medicaid.

group's corresponding costs. As seen in Figure 5 and Table 2, Medicaid costs do not appear to be strongly related to enrollment shares.

The elderly and disabled account for more than 60% of the Medicaid program's yearly spending despite making up less than 25% of total program enrollment. The remaining eligibility categories require less spending than their enrollment proportion would suggest, but that is not to say their total costs aren't substantial. For example, Missouri's Medicaid program covers an estimated one-third of all child births in the state each year.[24]

The extraordinary amount of health care spending on the elderly and disabled indicates that efforts to substantially address Medicaid's overall costs should focus on the

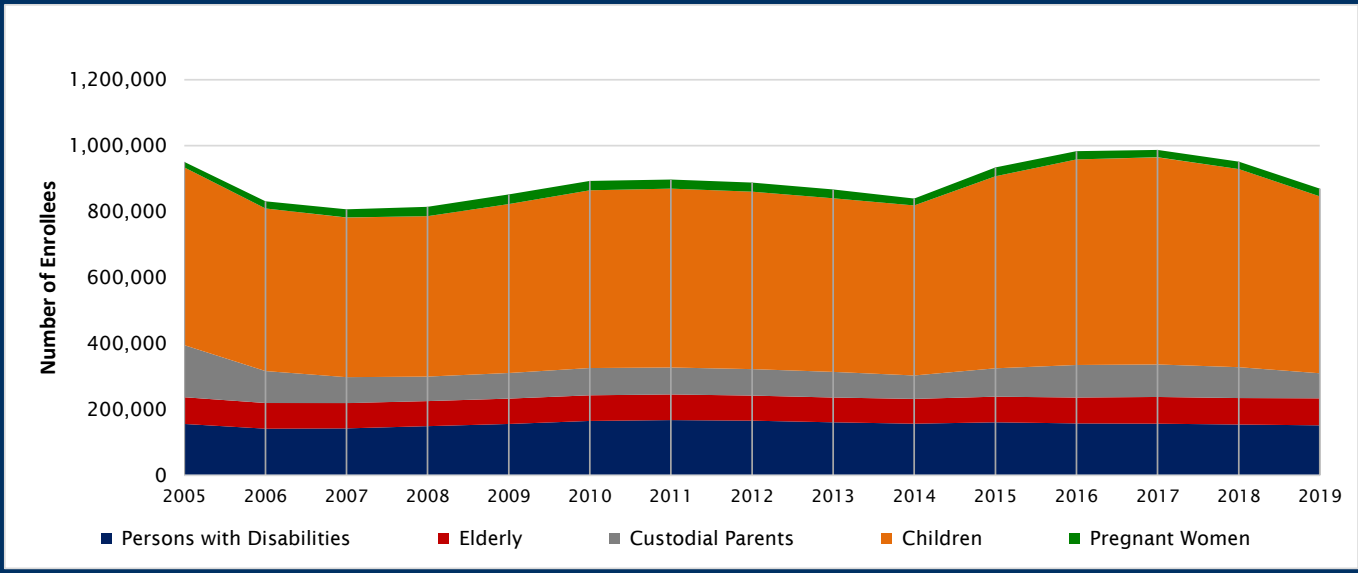
Table 2:
Missouri's Average Monthly Medicaid Expenditures by Population, State Fiscal Year 2018

Population Category	Avg. Expenditure
Children	$321
Adults	$676
Aged (65 & Older)	$1,652
Individuals w/ Disability	$2,315

Source: Missouri Department of Social Services.

Figure 4:
Missouri Medicaid Enrollment

Since 2005, changes in Medicaid enrollment have impacted each eligibility group differently.



Source: Missouri Department of Social Services.

Note: Enrollment data shown in figure reflects the average for each population over the course of a given year. Due to data availability, the enrollment shown for 2019 reflects the average from January to November.

services those individuals receive. This also raises the question of why those participants' services are the responsibility of the state and not covered under Medicare. It is true that many Medicaid participants are also covered by Medicare, but that does not preclude the state's Medicaid program from incurring a share of those health-related costs.

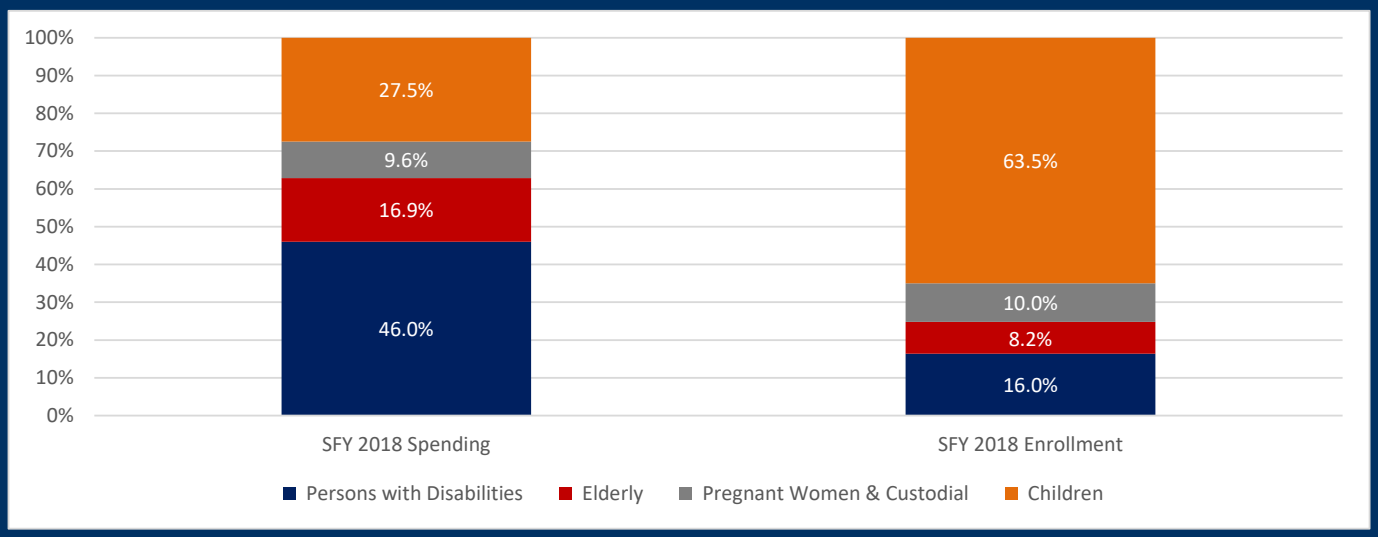
Medicaid and Medicare cover a variety of the same health-related services. The way Medicare functions is more similar to private insurance in that there are often deductibles, copayments, and coinsurance.[25] In the instances where an eligible individual receives services covered by both plans and there are out-of-pocket costs, Medicaid is considered the payer of last resort, which means that Medicare pays first, and then Medicaid picks up the remainder.[26] The key difference is that Medicaid recipients cannot be required to provide payment to receive medical services.

There are then a variety of services that state Medicaid programs cover that Medicare does not. One of the most common, and costly, is the provision of long-term care services.[27] Many Medicaid participants, especially members of the elderly and disabled populations, at times require services over an extended period of time, such as skilled nursing home care. When those individuals are eligible for both programs, Medicare often covers hospitals stays up to 150 days and skilled nursing home care for the first 100, but pays only a portion of the associated costs.[28] After those thresholds are met, the state is responsible for the rest, totaling nearly $600 million for nursing facility payments each year. One estimate suggests that Missouri's taxpayers covered the bill for 65% of all nursing home residents in the state during 2016.[29]

Figure 5:

Missouri's Medicaid Enrollment Shares As Compared To Their Associated Costs

Share of enrollment in Medicaid does not correlate with share of spending.



Source: Missouri Department of Social Services.

Missouri's Covered Services

Recent Medicaid expenditure growth has outpaced both enrollment and medical inflation.‡ If Missouri's Medicaid costs had kept pace with medical inflation, costs would be nearly 16 percent higher in 2018 than they were in 2013.[30] Instead, the costs of Missouri's Medicaid program have grown by more than 31 percent, or nearly double the rate of inflation. As the program continues to grow it is important to look at the specific services covered by Missouri's Medicaid program, not just who they are provided to, to get a better idea of where costs are growing and where there may be potential for savings.

Medicaid's federal funding comes with "strings attached," as there are guidelines that require a minimum set of services states must provide to receive those funds.[31] Beyond the mandated services, states have the opportunity to offer additional coverage, and upon federal approval can receive funding for those as well.[32] The mandatory and optional services listed in Box 1 account for over 95 percent of all Medicaid expenditures in Missouri.

Since states are required to cover the cost for all mandatory services, there is little flexibility for expenditure control outside of changing the amount paid for each service or implementing incentives to alter utilization. In both cases, such changes are often easier said than done due to various laws and regulations.

When discussing the services that are covered under Medicaid, it's important to keep in mind the role of government in their provision. State Medicaid agencies do not prescribe care for program recipients, they simply pay for the care that is provided. It may seem intuitive that access to health coverage implies the improvement of health-related outcomes, but research has shown the connection is less clear. The Oregon Health Insurance Experiment, conducted over a decade ago, suggested that access to Medicaid coverage does not improve physical

‡ Medical inflation, as used in this paper, refers to a subset of the Consumer Price Index that is based solely on .the cost of medical care. The change in prices for medical care often vary substantially from those of all consumer goods and services in the economy, so for the purposes of this paper, medical inflation is the more appropriate measure of reference.

Box 1:

Medicaid Services: Mandatory and Optional

Mandatory Medicaid Services	Optional Services
Inpatient hospital services	Prescription drugs
Outpatient hospital services	Mental health services
Nursing facility and home health services	Rehabilitation and specialty services
Physician services	Podiatrist
Lab and X-Ray services	Psychiatric care
Rural health clinic services	In-home care
Family planning services	Chiropractic care
Medical and surgical services of a dentist	Dental services
Non-emergency medical transportation	Optometrist
EPSDT: Early and periodic screening, diagnostic, and treatment services	Psychologist
Nurse-midwife, certified pediatric and family nurse practitioner services	Hospice

Source: Centers for Medicare & Medicaid Services.

health or labor market outcomes.[33] The only discernable improvement the Oregon experiment attributed to Medicaid was the mental health benefit that comes from the peace of mind of knowing the next catastrophic medical event won't lead to bankruptcy. Similar to the RAND Health Insurance Experiment from over 40 years ago, both studies have found that the availability of health coverage without any cost to the consumer significantly increases use.[34] In terms of services, one of the most costly problems is the over-usage of emergency rooms.[35] In order to control this specific cost, states would need the power to incentivize appropriate use of the available services. But once again, the federal government has the discretion to approve such things, which makes the implementation of various reforms ultimately a federal decision.

The state has more flexibility with regard to the provision of optional services, such as limiting availability to certain eligibility groups, but these changes must be approved by the federal government as well.[36] Many of the currently covered optional services were approved to coordinate with other mandated services, or the promise of monetary savings achieved by better health management through preventive care or other available services.[37] The most recent such example is the expansion of coverage for chiropractic care, which had the explicit purpose of lowering rehabilitation costs for Medicaid recipients with chronic pain or injuries. After implementation, there is no formal system in place to track whether these optional services are delivering the cost savings that were expected when the decision was made to begin offering them. This is why Missouri should follow in the steps of states like Alaska and offer a yearly report of the costs and savings realized by each optional Medicaid service.[38] Services such as optometry and dentistry for adults are again offered in Missouri today after being removed from coverage more

than a decade ago due to cost considerations.[39] It is unclear whether those services are more successful at improving associated health outcomes or realizing savings now than they were when previously offered.

Some optional services, such as pharmacy, are almost universally offered by states, but others are not. For example, chiropractic care is only offered in twenty-four other states.[40] As health care expenditures continue to rise, it is more essential than ever to ensure that each covered service is being used appropriately and improving health outcomes as intended.

Costs

In 2018, nearly 80% of Missouri's Medicaid expenditures went toward hospitals, pharmacies, managed care companies, nursing facilities, physician services, and mental health services. Of those, only pharmacy services and potentially a subset of the mental health expenditures were considered optional by the federal government. See Table 3 for examples of how the expenditures have changed.

Table 3 shows how both programs experienced growing costs[41] over the past five years, but one much more than the other. These expenditure amounts do not illustrate whether the increases were a result of more frequent use of services or growing cost of the services themselves. Though it is often helpful to compare expenditure growth to medical inflation as a benchmark, it can also be useful to see how the cost of each specific service has grown across the country to compare to Missouri's experience. Medical inflation over the included years was nearly 16%, so while pharmacy costs greatly exceeded that benchmark, nursing facility expenditures grew at less than half the rate of inflation.

As shown in Figure 6, the national Medicaid cost for pharmaceuticals has grown substantially but erratically over the past few years, which indicates that Missouri is not alone in struggling to deal with the increase in expenditures.[42] Though not explicitly shown in the graph, the sharp increase in Medicaid spending on prescription drugs suggests the growth cannot be explained solely by increased use, because the total amount of prescriptions has been much more level.[43] This suggests that Missouri has been hit especially hard by the growing cost of pharmaceuticals from the manufacturers and how often they are prescribed to Missouri's Medicaid recipients.

For nursing facilities, due to the way they are funded (explained in more detail in the next section), the change in cost is more easily explainable. The number of Medicaid recipients in Missouri receiving care in nursing facilities has remained stable at roughly 24,000 per month for the past five years. But the rate of reimbursement paid by the state has changed multiple times over the same period.[44] Nationally, nursing facility costs have grown faster than those in Missouri, which can be attributed to increased enrollment among elderly individuals that hasn't matched our state's experience.[45]

Table 3:
Medicaid Expenditures, Nursing/Pharmacy, 2013 to 2018

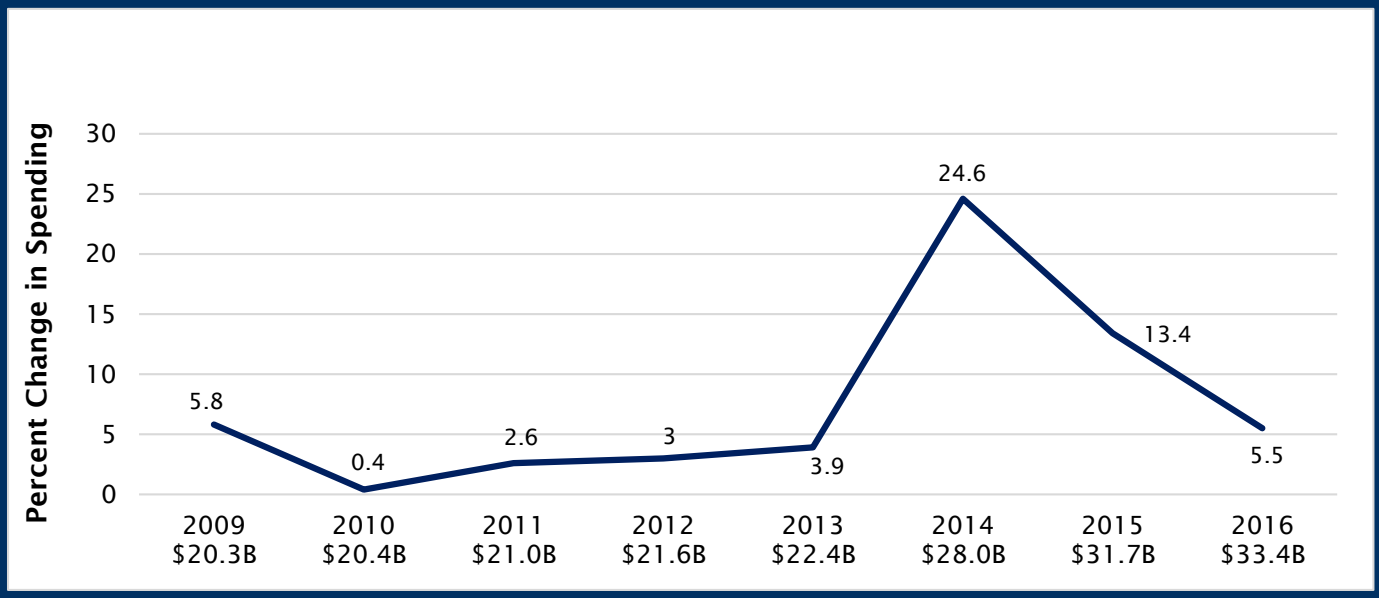
Year	Nursing Facility	Pharmacy
2013	$552,824,449	$911,085,866
2014	$577,493,965	$950,464,657
2015	$559,605,747	$1,062,107,480
2016	$611,932,979	$1,175,682,544
2017	$645,145,957	$1,218,855,833
2018	$594,273,388	$1,274,026,805
Change	7.50%	39.84%

Source: Missouri Department of Social Services.

Figure 6:

Annual Growth in National Medicaid Spending on Prescription Drugs, 2008 to 2016

Medicaid spending on prescription drugs nationwide grew substantially between 2009 and 2015.



Source: CMS National Health Expenditure Accounts.

Delivery Systems

Beyond the topic of Medicaid-covered services and what they cost is the issue of how the providers of those services are paid. The way these services are reimbursed can generally be divided into two benefit types: primary/acute care, and long-term care. Primary and acute care includes physician, laboratory, pharmacy, preventive, and other services. Long-term services include different levels of facility- or community-based care along with other supports for individuals with chronic or disabling conditions.

Primary & Acute Care

The services delivered under the primary and acute care umbrella are covered under two payment systems in Missouri: fee-for-service, and managed care. Medicaid participants who are part of the aged, blind, and disabled (ABD) population are covered under fee-for-service, while the rest are covered under managed care.

Fee-for-service is a system in which the state sets a fee schedule for covered services, then once an eligible Medicaid recipient receives that service, the state reimburses the provider at the agreed upon rate. The system is relatively straightforward and has historically been the most popular Medicaid delivery system across the country, but concerns with the model have led many states to begin shifting toward alternatives.[46]

Perhaps the biggest concern with the system is its inability to incentivize the containment of health care costs. Under fee-for-service, Medicaid participants have little incentive to responsibly control their use of available services because the state covers the cost regardless of the necessity. This has led to the overuse of emergency departments for primary care services.[47] The system also incentivizes providers to bill for additional services and tests that may not be necessary or fiscally prudent. Additionally, the

fee-for-service system leaves the government in charge of rate-setting for a large variety of health-related services, which moves away from a more efficient market-based price-setting arrangement.

The other system, managed care, is becoming more popular across the country and reflects an attempt to improve on the shortcomings of the fee-for-service system. In Missouri, managed care companies cover the majority of the state's Medicaid population.[48] Managed care is a system where the state purchases compliant health coverage that is at least as comprehensive as available under fee-for-service from contracted health insurance companies. The state then pays monthly rates, just like private insurance, to the contracted companies, leaving the companies to set the rates with providers and reimburse for each specific covered service. In Missouri, pharmacy costs have been carved out of the managed care contracts and are reimbursed on a fee-for-service basis for the entire Medicaid population.

The idea behind shifting to a managed care delivery system is that allowing companies already in the health care industry to negotiate rates and coordinate care, as is done for private insurance, should allow for better care at a lower price. The potential downsides of the system include the potential inability of state governments to adequately negotiate contracts with managed care companies that result in taxpayer savings, and the possibility that monthly coverage payments could end up being more expensive for healthy individuals who require little care as opposed to systems (like fee-for-service) where only individual services are reimbursed.

Long-Term Services

Many Medicaid recipients require more intensive services than are encompassed by primary or acute care or require services over a longer period. Some of these services are covered under Medicaid for individuals with certain chronic or disabling conditions and are reimbursed in a system outside of those previously discussed.

Long-term services can typically be classified as facility- or community-based care for extended periods of time. The level of care provided to each Medicaid participant in these environments varies, as does the payment structure. In many cases, the reimbursement is a set amount per day with guidelines for the services that are expected to be provided over that duration. These types of services are rarely covered by private insurance and are only covered by Medicare for a short period.[49] In part due to the relatively high proportion of Medicaid costs incurred by the population requiring long-term services, the cost as it relates to health outcomes is critically important.

Costs

The pros and cons of Medicaid delivery systems all relate to incentives. Research has consistently shown that Medicaid does a poor job of improving health outcomes and that the program is prone to inefficient utilization of services.[50] It can be difficult to find the right balance among delivery system options because many participants have complex ailments that may require coverage for many years. Often, it is more fiscally prudent to initially pay a higher amount to treat current ailments in order to prevent them from becoming more costly later. For example, many new initiatives are being implemented across the country to control or better manage diabetes and childhood obesity among Medicaid recipients.[51] The question then becomes: What system provides the best incentives for personal health management now, while also ensuring the lowest long-term cost?

There are also alternative payment models being tested across the country in an attempt to find new ways to encourage better outcomes and realize cost savings for Medicaid. The fee-for-service system is considered a volume-based care approach to health care reimbursement, because it pays providers for the amount of services they provide regardless of the outcome. Currently, multiple states are exploring a transition to a more value-based approach, which would tie provider reimbursement more closely to the health outcomes that providers achieve. A more value-centric system would incentivize providers to provide the best possible care at the least expensive overall price. Examples of value-based payment models include incentive payments for treatment of illnesses less expensively than anticipated, or a reduction in payments for provider-attributed hospital readmissions after treatment. Alternative payment models could have tremendous upside for Missouri and are still being developed; perhaps Missouri can more aggressively research these methods or look to other states for potential

savings.

At the very least, it's safe to say Missouri has room to improve upon the status quo. Missouri's own study of the managed-care program has estimated that, in comparison to fee-for-service, a "mature" program should be 2 to 6 percent cheaper per year.[52] Additionally, it is easier for managed care companies to implement more innovative payment structures for Medicaid-covered services because the companies are responsible for setting rates with each accepted care provider. Given the incentive structures described above, it's extremely unlikely, given the current arrangement in which managed care covers the relatively healthy population and fee-for-service covers the more expensive groups along with pharmaceutical costs, that Missouri currently has an optimally run Medicaid program. This is all the more reason that Missouri's policymakers should be seriously considering large-scale programmatic reform.

Reforms: A Path Forward

Missouri's Department of Social Services' recent assessment[53] of the Medicaid program delivered some harsh truths to policymakers, concluding: "Without significant changes, Medicaid spending may increase from 24% of state general revenues in SFY 2018 to 30% of state general revenues by SFY2023. Significant cost savings would be necessary to bring growth of Medicaid spending in line with the level of economic growth of the state, while preserving access to care for participants."

The audit also offered six areas where the program could be improved [p.16]:

- Dollars spent in the program are not well aligned with value received from delivery system
- Specifically, methods to pay providers lack incentives to contain costs or enhance quality
- Approaches to utilization management; eligibility management; fraud, waste, and abuse; and third-party liability are limited, partially due to limitations of the MMIS (Missouri Medicaid Information System)
- Programs for special needs populations are fragmented
- There is no substantial measurement nor transparency of outcomes of care
- Service levels to consumers and providers could be improved, including reductions in average wait times for handling questions, as well as increased service channels.

These areas for improvement, further outlined in the audit, offer a place to start for a larger Medicaid reform discussion in Missouri. Most of the audit's suggestions are in line with the concerns explained earlier in this paper.

BUDGET/FINANCING

Missouri's Medicaid program is on an unsustainable cost trajectory, and the first step toward reform requires correcting that course. The most substantial change Missouri's policymakers could make to ensure the financial stability of the state would be to move the Medicaid program to a fixed-payment structure. A fixed payment structure, such as federal block grants or per-capita caps in funding, would incentivize the state to obtain greater value from current Medicaid spending. Ending the open-ended funding arrangement with the federal government would place additional pressure on policymakers to monitor whether currently offered services are improving health outcomes and at what price to Missouri taxpayers. Constant scrutiny regarding Medicaid's effectiveness and efficiency would lead to substantial program improvement because there would be an increased incentive for policymakers to address long-term programmatic concerns. A fixed payment structure would also create incentives for reform of the state's current delivery systems and provider taxes. As of the time of this essay's publication, multiple states are developing proposals that would change the way they receive federal Medicaid funds, and there is much optimism for swift federal approval of their plans.

Missouri cannot keep paying more for Medicaid without seeing improvement in health-related outcomes. The state's audit noted that the dollars spent in the program aren't well aligned with the value received from the delivery system. To improve health outcomes and contain costs, policymakers should expand on value-based payment

initiatives. These would include incentives for Medicaid-participating providers to treat recipients in the most cost-effective manner and would allow for higher or lower reimbursement based on whether the desired health outcome was achieved. Further, Missouri's Department of Social Services previously concluded that the managed-care system would save the state money. If this is still true, policymakers should explore expanding the program to cover pharmaceuticals and the populations currently covered under fee-for-service.

To address the cost and care of those receiving long-term care services, policymakers should look into alternative payment models. Currently, Missouri's nursing facility rates are based on historical costs, which aren't adjusted according to the varying levels of health care needs among patients or the associated health-related outcomes from the services provided. The state could realize savings by including incentives that adjust payment according to the quality of care provided and desired health outcomes achieved. Additionally, the program's audit noted that Missouri has a relatively high proportion of nursing facility residents with low care needs. Nursing facilities are typically the most expensive location outside of hospitals for Medicaid recipients to reside, so there could be further savings realized by transitioning many of the low-care individuals to alternative home-based care settings. Home- and community-based services are typically less expensive and much more desirable environments for Medicaid recipients. Because this population constitutes the largest proportion of state Medicaid spending, taking steps to address their costs would be one of the most important reforms to effectively contain Missouri's budgetary growth.

Policymakers should also work to lessen Missouri's reliance on financing gimmicks. Transitioning to a fixed payment structure would require a change to the state's provider tax regime, but even without such a change, the scaling back of provider taxes would be beneficial to the state's long-term financial stability. Missouri relies more heavily on its provider taxes to fund Medicaid than any other state according to the Government Accountability Office. It is unclear what impact provider tax reform would have on hospitals and nursing facilities across the state, but the benefits of Missouri proactively working to stabilize its financial future would likely outweigh the long-term costs. Missouri's current Medicaid funding arrangement is built like a house of cards, and our state policymakers would be wise to act before it starts to collapse.

PROGRAM INTEGRITY

Further reforming Medicaid will require addressing the waste, fraud, and abuse in the program. Missouri has recently used system automation to better ensure that Medicaid services are provided only to those who are actually eligible to receive them, but efforts should not stop there.[54] The federal Government Accountability Office estimated that over $29 billion in improper payments were billed across the United States in 2015.[55] After ensuring that only qualified recipients are receiving services, policymakers must also ensure that only the proper procedures are being paid for. Steps toward improving program integrity could include increasing coordination and data exchange between state agencies to identify eligible individuals and to determine whether their health needs require additional support.

Policymakers should also consider new initiatives to ensure currently provided services are working as intended. The audit notes that there are no substantial measurements for outcomes of care. Alaska recently implemented a requirement that each year the state's Medicaid program must submit a report which tracks the costs, savings, and outcomes of all provided Medicaid services. Missouri may currently have difficulty completing a similar report due to lack of data, and if the state cannot determine whether the currently provided services are achieving the desired outcomes, Missourians, tax dollars will continue to be wasted.

INDIVIDUAL SERVICES

A 2014 paper published by the Show-Me Institute listed the improvement of services and the empowerment of the individual as two of the most important elements for reforming the state's Medicaid program.[56] The final bullet point of the state's audit suggests that the service levels to consumers and providers could be improved.

The ultimate reform to empower Medicaid recipients would be to transfer their coverage to government-backed health savings accounts (HSAs). The state could fund an HSA to a specified per-capita Medicaid funding level,

which would maintain a catastrophic insurance plan that would protect against any financial hardship. This plan would then allow each recipient to choose how to spend their allocated health care dollars. The government has never been better at prudently spending money than taxpayers, and these HSA's would empower individual recipients to tailor their health care spending to their specific medical needs. Any leftover HSA funds could then be rolled over year-to-year or transferred to the recipient at some discount. This would save the state money and also incentivize participants to use health care services judiciously without the fear of losing funds unnecessarily. Further, this effort would save money by incentivizing the reduction of unnecessary use. It could lower health care prices by introducing additional consumers to the marketplace outside the rigid Medicaid provider network.

Finally, policymakers should implement supply-side reforms to lower the overall cost of health care in Missouri. These changes would improve the health care market in Missouri and in turn lower the cost of coverage for Medicaid approved services. Part of the saving would be achieved by reducing the regulatory burden on service providers. Regulations such as certificate of need (CON) rules, scope of practice (SOP) laws, and telemedicine rules restrict the supply of health care services, and thereby increase costs. Relaxing these regulations is critically important in rural Missouri, where residents already struggle with limited access to health care providers. Allowing the market to work and reducing the regulatory burden on healthcare providers will increase competition in Missouri's health care sector and in time will result in lower costs for everyone.

CONCLUSION

Missouri's Medicaid program is on an unsustainable trajectory, and this essay provides a look at the current state of the program and what levers are immediately available to policymakers offering opportunities for reform. The steps described should not be taken as an exhaustive list, but a direction of inquiry that would harness free market forces in order to improve upon the status quo.

Missouri is not alone in its struggle with Medicaid's high costs and substandard health outcomes. The reforms outlined in this paper offer a path toward sustainably controlling these costs.

There is a path forward for Missouri's Medicaid program where participants have improved health outcomes, better incentives to end their reliance on state-provided coverage, and the associated costs can be more sustainably managed. Now it's time for our policymakers to act.

Elias Tsapelas is a senior analyst at the Show-Me Institute

NOTES

1. Centers for Medicare & Medicaid Services. "History." Retrieved January 14, 2020 from www.cms.gov/About-CMS/Agency-information/History/.

2. Missouri Foundation for Health. "Missouri Medicaid Basics: Spring 2019." Retrieved January 14, 2020 from mffh.org/wordpress/wp-content/uploads/2019/01/2018-Missouri-Medicaid-Basics-web.pdf.

3. Missouri Department of Social Services. "DSS Caseload Counter." Retrieved January 14, 2020 from dss.mo.gov/mis/clcounter/history.htm.

4. National Association of State Budget Officers. "State Expenditure Report 2005 (Fiscal 2004–2006 Data)" Retrieved January 16, 2020 from https://www.nasbo.org/mainsite/reports-data/state-expenditure-report/state-expenditure-archives.

5. "Inflation Rate between 2008 and 2020." Retrieved January 16, 2020 from https://www.in2013dollars.com/us/inflation/2008?amount=21914510500.

6. Missouri Department of Social Services. "Rapid Response Review: Assessment of Missouri Medicaid Program." February 11, 2019. Retrieved January 14, 2020 from https://dss.mo.gov/mhd/mt/docs/mhd-rapid-response-review.pdf.

7. Tsapelas, Elias. "Medicaid Is Stifling Economic Growth in Missouri." Show-Me Institute. December 4, 2018. Retrieved January 14, 2020 from https://showmeinstitute.org/blog/budget/medicaid-stifling-economic-growth-Missouri; "Net General Revenue Collections – Fiscal Years 2008-2019". Retrieved January 16, 2020 from https://oa.mo.gov/budget-explorer/summary-budget-charts.

8. Henry J. Kaiser Family Foundation. "Summary of the 2018 CHIP Funding Extension." January 24, 2018. Retrieved January 14, 2020 from https://www.kff.org/medicaid/fact-sheet/summary-of-the-2018-chip-funding-extension/.

9. Missouri House of Representatives Budget Fast Facts. Retrieved January 14, 2020 from https://house.mo.gov/budget.aspx.

10. Henry J. Kaiser Family Foundation. "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures." ASPE. April 04, 2017. Retrieved January 14, 2020 from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and multiplier/?currentTimeframe=1&sortModel=.

11. Ibid.

12. Ibid.

13. United States Government Accountability Office. "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection." Retrieved January 14, 2020 from https://www.gao.gov/assets/670/665077.pdf.

14. Fowler, Wanda. "Provider Taxes: A Revenue Source for Health Care." Council of State Governments. Retrieved January 14, 2020 from https://knowledgecenter.csg.org/kc/content/provider-taxes-revenue-source-health-care.

15. Blasé, Brian C. "Medicaid Provider Taxes: The Gimmick That Exposes Flaws with Medicaid's Financing." Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, February 2016.

16. Missouri Senate. "Fiscal Note for Perfected SS#3 for SCS for SB 29." April 24, 2019. Retrieved January 14, 2020 from https://www.senate.mo.gov/FiscalNotes/2019-1/0680-09P.ORG.PDF.

17. Henry J. Kaiser Family Foundation. "States and Medicaid Provider Taxes or Fees." November 13, 2018. Retrieved January 14, 2020 from https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

18. Schallhorn, Kaitlyn. "Inside the Senate's FRA Reauthorization Battle." The Missouri Times. April 23, 2019. Retrieved January 14, 2020 from https://themissouritimes.com/60232/inside-the-senates-fra-reauthorization-battle/.

19. Smith, Vernon K. "Can States Survive The Per Capita Medicaid Caps In The AHCA?" Health Affairs. Retrieved January 14, 2020 from https://www.healthaffairs.org/do/10.1377/hblog20170517.060155/full/.

20. Office of the Assistant Secretary for Planning and Evaluation. "2019 Poverty Guidelines." 11 Jan. 2019, Re-

trieved January 14, 2020 from aspe.hhs.gov/2019-poverty-guidelines.

21. Missouri Foundation for Health. "Missouri Medicaid Basics: Spring 2019." Retrieved January 14, 2020 from mffh.org/wordpress/wp-content/uploads/2019/01/2018-Missouri-Medicaid-Basics-web.pdf.

22. Snyder, Laura, and Robin Rudowitz. "Medicaid Financing: How Does It Work and What Are the Implications?" Henry J. Kaiser Family Foundation. 21 Dec. 2016, Retrieved January 14, 2020 from www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/.

23. Missouri Department of Economic Development, Economic Research and Information Center. "Gross Domestic Product Data Series." Retrieved January 14, 2020 from www.missourieconomy.org/indicators/gsp/index.stm.

24. Missouri Foundation for Health. "Missouri Medicaid Basics: Spring 2019." Retrieved January 14, 2020 from mffh.org/wordpress/wp-content/uploads/2019/01/2018-Missouri-Medicaid-Basics-web.pdf.

25. eHealthMedicare. "Medicare Premiums and Deductibles - 2019." Retrieved February 12, 2019 from www.ehealthmedicare.com/about-medicare-articles/medicare-premiums-and-deductibles/.

26. Medicaid and CHIP Payment and Access Commission. "How Medicaid Interacts with Other Payers." Retrieved January 14, 2020 from www.macpac.gov/subtopic/how-medicaid-interacts-with-other-payers/.

27. Caring LLC. "How to Pay for Nursing Home Care / Convalescent Care." Retrieved January 14, 2020 from https://www.payingforseniorcare.com/nursing-home.

28. National Council on Aging. "Cost of Medicare Part B & Part A." Retrieved January 14, 2020 from www.mymedicarematters.org/costs/parts-a-b/.

29. Henry J. Kaiser Foundation. "Distribution of Certified Nursing Facility Residents by Primary Payer Source." n.d. Retrieved January 16, 2020 from https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

30. "Inflation Rate for Medical Care between 2013 and 2019." Retrieved January 14, 2020 from www.in2013dollars.com/Medical-care/price-inflation/2013.

31. Centers for Medicare and Medicaid Services. "Mandatory & Optional Medicaid Benefits." Retrieved January 14, 2020 from www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html.

32. Medicaid and CHIP Payment and Access Commission."Federal Requirements and State Options: How States Exercise Flexibility under a Medicaid State Plan." August 2018. Retrieved January 16, 2020 from https://www.macpac.gov/publication/federal-requirements-and-state-options/.

33. National Bureau of Economic Research. "The Oregon Health Insurance Experiment." Retrieved January 14, 2020 from www.nber.org/oregon/1.home.html.

34. RAND Corporation. "RAND Health Insurance Experiment." January 14, 2020 from www.rand.org/health-care/projects/hie.html.

35. United States Department of Health and Human Services, Office of Inspector General. "Use of Emergency Rooms by Medicaid Recipients." March 1992. Retrieved January 14, 2020 from oig.hhs.gov/oei/reports/oei-06-90-00180.pdf.

36. Missouri Department of Social Services. "Public Notice to Amend Missouri's Gateway to Better Health Section 1115 Demonstration Project to Add a Substance Use Treatment Benefit." July 31, 2018. Retrieved January 14, 2020 from dss.mo.gov/mhd/waivers/files/PublicNoticeforGatewaytoBetterHealthSection1115DemonstrationProjecttoAddaSubstanceUseTreatmentBenefit.pdf.

37. Lewin Group. "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs Were Optimally Managed." February 2011. Retrieved January 14, 2020 from http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/MedicaidPharmacySavingsReport_Rev.pdf.

38. Butler, Jay, MD. "AK DHSS Annual Medicaid Reform Report." November 15, 2018. Retrieved January 14, 2020

from http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf.

39. Sussell, Abbey. "Uninsured, Underinsured Patients in Missouri Remain Desperate for Dental Care." Columbia Missourian. September 17, 2013. Retrieved January 14, 2020 from https://www.columbiamissourian.com/news/local/uninsured-underinsured-patients-in-missouri-remain-desperate-for-dental-care/article_edbadc9a-7801-593a-8691-a851a84b47ea.html.

40. Henry J. Kaiser Foundation. "Medicaid Benefits: Chiropractor Services." January 17, 2019. Retrieved January 14, 2020 from https://www.kff.org/medicaid/state-indicator/chiropractor-services/?currentTimeframe=0&sortModel.

41. Young, Katherine, and Rachel Garfield. "Snapshots of Recent State Initiatives in Medicaid Prescription Drug Cost Control." Kaiser Family Foundation. February 21, 2018. Retrieved January 14, 2020 from https://www.kff.org/medicaid/issue-brief/snapshots-of-recent-state-initiatives-in-medicaid-prescription-drug-cost-control/

42. Peterson Center on Healthcare; Henry J. Kaiser Family Foundation. "What Are the Recent and Forecasted Trends in Prescription Drug Spending?" Retrieved January 14, 2020 from https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-annual-growth-in-rx-drug-spending-and-total-health-spending-per-capita_nhe-projections-2018-27.

43. Missouri Office of Administration. 2020 Department Budget Requests. Office of Administration. December 01, 2018. Retrieved January 14, 2020 from https://oa.mo.gov/budget-planning/budget-information/2020-budget-information/2020-department-budget-requests-governors.

44. Ibid.

45. Ibid.

46. Medicaid and CHIP Payment and Access Commission. "Provider Payment and Delivery Systems." Accessed May 31, 2019. Retrieved May 31, 2019 from https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/.

47. Kim, Hyunjee, K. John McConnell, and Benjamin C. Sun. "Comparing Emergency Department Use Among Medicaid and Commercial Patients Using All-Payer All-Claims Data." Population Health Management. August 01, 2017. Retrieved January 14, 2020 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564052/.

48. Missouri Department of Social Services. "DSS Caseload Counter." Retrieved January 14, 2020 from dss.mo.gov/mis/clcounter/history.htm.

49. AARP. "Understanding Long Term Care Insurance." Retrieved January 14, 2020 from https://www.aarp.org/health/health-insurance/info-06-2012/understanding-long-term-care-insurance.html.

50. Bailit, Howard L., and Cary Sennett. "Utilization Management as a Cost-containment Strategy." Health Care Financing Review. March 1992. Retrieved January 14, 2020 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195135/; Duggan Mark, Gupta Atul, Jackson Emilie. "The Impact of the Affordable Care Act: Evidence from California's Hospital Sector" National Bureau of Economic Research. January 2019. Retrieved January 14, 2020 from https://www.nber.org/papers/w25488

51. Maul, Alexandra. "Innovations in Childhood Obesity: Medicaid and Public Health Collaboration to Reduce Obesity in Low-Income Children." Center for Health Care Strategies. May 16, 2019. Retrieved January 14, 2020 from https://www.chcs.org/resource/innovations-in-childhood-obesity/.

52. MoHealthNet. "Comparing Performance: Managed Care and Fee-for-Service." January 2015. Retrieved January 14, 2020 from https://dss.mo.gov/mhd/oversight/pdf/150217-comparing-managed-care-and-fee-for-service.pdf.

53. Missouri Department of Social Services. "Rapid Response Review: Assessment of Missouri Medicaid Program." February 11, 2019. Retrieved January 14, 2020 from https://dss.mo.gov/mhd/mt/docs/mhd-rapid-response-review.pdf.

54. Tsapelas, Elias. "Surprising Change in Medicaid En-

rollment." Show-Me Institute. March 1, 2019. Retrieved January 14, 2020 from https://showmeinstitute.org/blog/health-care/surprising-change-medicaid-enrollment.

55. National Conference of State Legislatures. "Medicaid Fraud and Abuse." Retrieved January 14, 2020 from http://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx.

56. Ishmael, Patrick. "Move Missouri's Medicaid Program Forward, Not Backward." Show-Me Institute. March 14, 2014. Retrieved January 14, 2020 from https://showmeinstitute.org/publication/health-care/move-missouri's-medicaid-program-forward-not-backward.

SHOW-ME INSTITUTE
WHERE LIBERTY COMES FIRST

5297 Washington Place I Saint Louis, MO 63108 I 314-454-0647
3645 Troost Avenue I Kansas City, MO 64109 I 816-561-1777

Visit Us:	Find Us on Facebook:	Follow Us on Twitter:	Watch Us on YouTube:
showmeinstitute.org	Show-Me Institute	@showme	Show-Me Institute