Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees And Providers?

A cautionary tale from the Show-Me State, where deep Medicaid cuts affected both patients and providers but didn't slow spending as much as was hoped.

by Stephen Zuckerman, Dawn M. Miller, and Emily Shelton Pape

ABSTRACT: In 2005, Missouri adopted sweeping Medicaid cutbacks. More than 100,000 people lost coverage, and many more faced reduced benefits and higher cost sharing. Using a range of data sources, we show that the cutbacks were followed by a major increase in the numbers of uninsured people, greater uncompensated care burden on hospitals, and revenue shortfalls that forced community health centers to obtain larger state grants and charge patients more. Competing demands on state budgets and the need to balance budgets even during recessions could result in policies that disadvantage those with great needs as well as the providers who serve them. [*Health Affairs* 28, no. 2 (2009): w335–w345 (published online 18 February 2009; 10.1377/hlthaff.28.2.w335)]

IN THE FIRST DECADE OF THE TWENTY-FIRST CENTURY, Missouri, like many other states affected by the recession, faced one of its worst budget crises since World War II. Between 2001 and 2004, Missouri faced $2.4 billion in shortfalls and chose to address its budget shortfalls differently than other states did.[1] Other states addressed shortfalls primarily with temporary revenue actions and made relatively small changes to their Medicaid programs.[2] Missouri made large, sweeping changes to Medicaid eligibility, cost sharing, and benefits. The impact of these policy changes can serve as an example to other states that in times of economic downturn and fiscal pressure may consider similar cutbacks.

For this analysis, we combined administrative data and provider utilization and financial reports with a series of telephone case-study interviews to trace the effects of Missouri's cutbacks on beneficiaries, former beneficiaries, and providers. Where appropriate, we compare Missouri Medicaid trends to with those of other payers and with national trends.

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Details Of Policy Changes

■ **Eligibility changes.** Prior to 2005, parents in families with incomes up to 75 percent of the federal poverty level, or about $14,500 in 2005 for a family of four, could qualify for coverage through Medicaid.[3] Missouri reduced the eligibility cutoff for parents to Temporary Assistance for Needy Families (TANF) income levels (17–22 percent of poverty, after income disregards).[4] Elderly and disabled people with incomes of 85–100 percent of poverty and temporarily disabled people also lost Medicaid eligibility. In addition, eligibility for all groups for whom coverage is not federally mandated (for example, the medically needy and pregnant women with incomes above 133 percent of poverty) was made "subject to appropriation" by the state each year.[5]

■ **State Children's Health Insurance Program.** Families with incomes above 150 percent of poverty were required to pay premiums of 1–5 percent of family income for their children's coverage.[6] For example, the premium for each child in a family of four with income of 150 percent of poverty ($29,025) would be $24. Before this legislation, only families with incomes above 225 percent of poverty had to pay premiums. With the new policy, families who did not pay their premiums would be disqualified from the program for six months.[7] The state also introduced an "affordability test" for families with incomes above 150 percent of poverty that made them ineligible for the State Children's Health Insurance Program (SCHIP) if they had access to employer health insurance costing up to $335 per month ($4,020 per year). For some families, signing up for employer coverage deemed affordable by the state would have entailed spending nearly 17 percent of their income on health insurance.[8]

■ **Medical Assistance for Workers with Disabilities (MAWD).** Starting in 2003, Missouri offered Medical Assistance for Workers with Disabilities (MAWD), a Medicaid buy-in program, to workers with disabilities with gross earnings of up to 250 percent of poverty. MAWD attracted both new enrollees and enrollees previously in the state's Medicaid spend-down program, who found MAWD's monthly buy-in premium (which ranged from $0 to $133) to be less costly than the spend-down amount. Missouri accounted for almost one-quarter of the national enrollment in these types of Medicaid buy-in programs for workers with disabilities.[9] The 2005 Missouri legislation eliminated the MAWD program.

■ **Benefit changes.** For adult enrollees who were neither blind, pregnant, nor in a nursing facility, the Missouri Medicaid cuts eliminated coverage of an array of health care services and, instead, made them subject to budget appropriations. These included dental services, dentures, podiatry, orthopedic devices, hearing aids, eyeglasses, optometric services, prosthetics, wheelchairs, comprehensive day rehabilitation services (for adults with head injuries), hospice, durable medical equipment (DME), and rehabilitative therapy.[10] The 2005 legislation also expanded copayments, ranging from $0.50 to $3.00, to nearly all Medicaid-covered services and prescription drugs.[11]

■ **Annual reinvestigation.** Despite not necessarily having enough caseworkers to carry out the policy literally, the Missouri legislation required that annual reinvestigations to verify and document income should be a higher priority than they had been before. The state estimated that more than 13,000 Missourians would lose coverage as a result of the new procedures, including about 9,000 children. Some of these people might actually be eligible for coverage but would lose it because of these new paperwork requirements.[12]

Study Data And Methods

Given that there is no comprehensive data set to use in examining the impact of the 2005 Missouri Medicaid cuts, we used data from a variety of sources.

■ **Administrative enrollment data.** We used administrative data from reports compiled by Health Management Associates (HMA) to track Medicaid and SCHIP enrollment trends. We combined several enrollment categories for this analysis. The category "children" includes children eligible for poverty-related reasons and those categorized as "homeless, dependent, and needy children." The category "other eligibles" includes unborn children, refugees, children with developmental disabilities, individuals with presumptive eligibility, and those eligible for services through the breast and cervical cancer program.[13]

■ **Current Population Survey.** Data on changes in health insurance coverage are from the 2005 and 2007 March Current Population Survey (CPS), reflecting coverage in calendar years 2004 and 2006. Respondents reporting more than one type of coverage during the year are assigned to a single coverage category based on a hierarchy.[14] Income in the CPS is based on the health insurance unit (HIU)—the members of a nuclear family who may be eligible for a family health insurance plan (that is, parents, children under age eighteen, and full-time students under age twenty-three).[15]

■ **Community health center data.** We drew on data from the Uniform Data System (UDS) collected by the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) from all Section 330 grantees (Section 330 was the authorizing legislation creating the federal health center program). In 2004 and 2005 Missouri had seventeen grantees; in 2006 it had nineteen. Many grantees operated multiple health centers. There are now more than 120 community health centers (CHCs) in Missouri.[16] Revenue data include both revenue received related to services for specific patients and revenue received as grants from federal, state, and local governments and private sources. Patient data include demographics and payer types, such as sliding-scale self-pay, Medicaid, or private insurance.

■ **Hospital data.** We obtained data on Missouri's hospital utilization and finances from the Missouri Hospital Association. The monthly hospital utilization data include counts, by payer, of outpatient surgery visits, inpatient discharges, and emergency department (ED) visits for 121 acute care hospitals in Missouri for 2004 and 2006. We excluded all psychiatric and rehabilitative facilities.[17] The data also in-

clude each hospital's total annual bad debt, charity care, expenses, and charges as well as bed size and shares of discharges attributable to patients covered by Medicaid and Medicare.

■ **Structured interviews.** Interviews were conducted in early 2008 with provider representatives, beneficiary advocates, and others having knowledge of Missouri's health care system and the Medicaid policy changes. We used structured interview protocols to collect information on how the changes in Missouri Medicaid affected program enrollment, sources of health care revenue, and patient caseloads.

Study Results

■ **Medicaid and SCHIP enrollment.** Combined Medicaid and SCHIP enrollment in Missouri fell by 15.4 percent between 2004 and 2006, representing a drop in monthly enrollment of about 147,000 people (Exhibit 1). The greatest reduction in enrollment occurred within the TANF categories as a result of the tighter eligibility rules for parents and their children. However, almost all children whose parents lost eligibility remained in Medicaid through poverty-related eligibility rules. Similarly, some parents who lost eligibility through TANF rules were retained in the program if they were pregnant.

EXHIBIT 1
Characteristics Of Those Eligible For Missouri Medicaid And The State Children's Health Insurance Program (SCHIP), June 2004 And June 2006

Category	June 2004	June 2006	Percent change
Age 65 and older (aged)	74,001	69,985	−6.8
TANF and TANF-related	498,657	257,842	−48.3
Adults	166,803	66,655	−60.0
Children	331,854	191,187	−42.4
Blind and disabled	129,729	137,963	6.3
Foster care	12,697	14,620	15.1
Qualified Medicare Beneficiaries	5,529	8,743	58.1
Medicaid for pregnant women	11,628	18,054	55.3
Children[a]	115,569	239,278	107.0
Other eligibles[b]	4,680	5,078	8.5
Medical assistance for workers with disabilities (premium and nonpremium)	16,811	–[c]	−100.0
Adult Section 1115 waiver	2,347	–[c]	−100.0
Total Medicaid	871,648	750,563	−13.9
SCHIP	87,527	61,217	−30.1
Total Medicaid + SCHIP	959,175	811,816	−15.4

SOURCE: Urban Institute calculations based on administrative data collected by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.

NOTES: Excludes family-planning Section 1115 waiver enrollees. TANF is Temporary Assistance for Needy Families.

[a] Includes poverty-related eligible children and those categorized as "homeless, dependent, and needy."

[b] Includes those eligible for services related to breast or cervical cancer, unborn children, refugees, children with developmental disabilities, and those with presumptive eligibility.

[c] Part of the 2005 cuts.

Although several interviewees indicated that the state did not expect SCHIP enrollment to drop significantly as a result of the new premiums and the "affordability test," the data show that it fell 30 percent between June 2004 and June 2006. Nationally, SCHIP enrollment rose 3.4 percent over the same time period.[18] Missouri's enrollment decline is consistent with research showing that the imposition of higher premiums would lead to lower caseloads. Genevieve Kenney and colleagues found that in one state, an 18 percent decline in enrollment could be attributed to the introduction of a $20 premium for some families.[19]

The elimination of MAWD had an effect, but not as large as the 17,357 reduction in enrollees might suggest. Almost 40 percent of these people were picked up in other coverage categories.[20] Similarly, some of the aged who lost full Medicaid coverage appear to have retained partial Medicaid coverage by shifting into Qualified Medicare Beneficiary (QMB) status.[21] The combined impact of the changes in Medicaid was a drop in total monthly enrollment of about 14 percent (121,000 enrollees) between 2004 and 2006.

In addition, the lower income eligibility forced people who qualified for the program because of their high health care expenses to spend more out of pocket before Medicaid would begin covering their costs. Mental health centers, in particular, suggested that beneficiaries had a difficult time paying the additional out-of-pocket expenses and that as a result, many people had to be treated as "charity" patients.

■ **Insurance coverage.** Although the CPS estimates (Exhibit 2) do not line up precisely with the administrative data, the trends are consistent. About 20 percent fewer nonelderly Missourians had Medicaid or SCHIP coverage in 2006 than in 2004, with adults accounting for most of this reduction. Although there was an increase in the numbers with nongroup private health insurance, the number of uninsured people rose between 2004 and 2006 by 103,500 (data not shown), or about 1.7 percentage points. The subgroup that accounted for more than half of the decline in Medicaid or SCHIP enrollment and almost three-quarters of this increase in the uninsured was low-income adults (calculation not shown)—the group most directly affected by the Medicaid cuts. Also, the share of low-income children with Medicaid or SCHIP coverage fell from 50.2 percent in 2004 to 40.5 percent in 2006, but increases in other types of insurance coverage prevented an increase in the share that were uninsured.

■ **Hospital utilization and uncompensated care.** We found virtually no change in the share of hospital discharges in Missouri paid for by Medicaid and only a small reduction in the Medicaid share of outpatient surgery visits between 2004 and 2006 (Exhibit 3). However, although the total number of ED visits increased by about 167,000 from 2004 to 2006, Medicaid-covered visits fell by about 30,000, and the number of uninsured (that is, self-pay) visits increased by about 85,000. Thus, the restrictions on Medicaid eligibility and services were followed by a decrease in ED visits paid for by Medicaid and an increase in visits made by the uninsured.

EXHIBIT 2
Health Insurance Coverage Distribution Among The Nonelderly Population In Missouri, By Age And Health Insurance Unit Income, 2004–2006

	All nonelderly			Adults			Children		
	Coverage distribution within income category		Change (percentage points)	Coverage distribution within income category		Change (percentage points)	Coverage distribution within income category		Change (percentage points)
	2004	2006		2004	2006		2004	2006	
All incomes (millions)	4.9	5.0		3.4	3.6		1.5	1.5	
Employer	66.2%	64.9%	−1.3	67.1%	66.3%	−0.8	64.3%	61.7%	−2.6
Medicaid and state	12.7	9.8	−2.8**	8.2	4.9	−3.2**	22.9	21.6	−1.3
TRICARE/Medicare	2.0	2.9	0.9	2.6	3.9	1.3*	0.7	0.6	−0.1
Private nongroup	5.5	7.1	1.5*	5.9	7.1	1.2	4.6	7.0	2.4*
Uninsured	13.6	15.3	1.7	16.2	17.8	1.6	7.5	9.1	1.6
Less than 200% of poverty (millions)	1.6	1.8		1.0	1.1		0.6	0.7	
Employer	31.3%	33.7%	2.5	31.0%	31.3%	0.4	31.8%	37.9%	6.0
Medicaid and state	33.1	24.2	−8.9**	23.3	14.8	−8.5**	50.2	40.5	−9.7**
TRICARE/Medicare	3.6	5.4	1.8	5.8	8.4	2.6	0.0	0.4	0.4
Private nongroup	6.7	8.4	1.8	8.1	9.8	1.7	4.3	6.2	1.9
Uninsured	25.3	28.2	2.9	31.9	35.7	3.8	13.7	15.1	1.4
200% of poverty or more (millions)	3.3	3.2		2.4	2.4		0.9	0.8	
Employer	83.3%	81.9%	−1.4	82.5%	82.4%	−0.1	85.6%	80.5%	−5.1
Medicaid and state	2.6	2.0	−0.6	1.7	0.4	−1.3**	5.0	6.7	1.7
TRICARE/Medicare	1.3	1.6	0.3	1.3	1.8	0.5	1.2	0.8	−0.4
Private nongroup	5.0	6.3	1.4	5.0	5.9	0.8	4.8	7.7	2.9
Uninsured	7.8	8.2	0.4	9.5	9.6	0.1	3.5	4.3	0.8

SOURCE: Urban Institute, 2007, based on data from the 2005 and 2007 Annual Social and Economic Supplement to the Current Population Survey.
NOTES: Excludes people age 65 and older and people in the armed forces. A health insurance unit is those who are eligible as a group for family coverage in a health plan.
*$p < 0.10$ **$p < 0.05$

In 2004, hospitals' costs for uncompensated care were about $429 million in Missouri; they increased to $591 million in 2006 (data not shown). The uncompensated care burden—the ratio of uncompensated care expenses to total expenses—was 4.2 percent in 2006, an increase from 3.6 percent in 2004. Nationally, the uncompensated care burden was stable around 5.6 percent between 2001 and 2005.[22] According to our interviewees, the overall increase in uncompensated care did not translate into serious financial pressure on hospitals, because inpatient Medicaid volume held steady and the flow of Medicaid supplemental payments continued.[23]

■ **Community health centers.** CHCs in the state also saw a shift in patients from those covered by Medicaid to those who were uninsured (Exhibit 4). The drop-off was most pronounced for SCHIP. After providing about 12,000 SCHIP visits a year in 2004, clinics saw that number fall to about 9,000 in 2006—a reduction of about 25 percent. The number of visits by uninsured patients increased 29 per-

EXHIBIT 3
Distribution Of Hospital Inpatient Discharges, Emergency Department (ED) Visits, And Outpatient Surgery Visits In Missouri, By Payer, 2004–2006

	2004		2006		Change, 2004–2006	
Payer	Number	Percent	Number	Percent	Number	Percentage points
Hospital inpatient discharges	882,597	100.0	901,417	100.0	18,820	
Medicare	357,555	40.5	366,367	40.6	8,812	0.1
Medicaid	171,277	19.4	174,487	19.4	3,210	0.0
Commercial	290,636	32.9	291,610	32.4	974	−0.6
Other	27,427	3.1	25,099	2.8	−2,328	−0.3
Self-pay	35,702	4.0	43,854	4.9	8,152	0.8
ED visits	2,223,040	100.0	2,390,423	100.0	167,383	
Medicare	314,841	14.2	369,951	15.5	55,110	1.3
Medicaid	688,604	31.0	658,496	27.5	−30,108	−3.4
Commercial	799,098	35.9	856,012	35.8	56,914	−0.1
Other	120,037	5.4	120,516	5.0	479	−0.4
Self-pay	300,460	13.5	385,448	16.1	84,988	2.6
Outpatient surgery visits	614,786	100.0	586,298	100.0	−28,488	
Medicare	198,687	32.3	202,079	34.5	3,392	2.1
Medicaid	75,669	12.3	67,865	11.6	−7,804	−0.7
Commercial	266,695	43.4	260,546	44.4	−6,149	1.1
Other	50,888	8.3	36,309	6.2	−14,579	−2.1
Self-pay	22,847	3.7	19,499	3.3	−3,348	−0.4

SOURCE: Urban Institute estimates based on data from the Missouri Hospital Association, 2004–2006.

cent during that period.

The share of clinic revenues coming from Medicaid patients fell from 2004 to 2006 (Exhibit 5). In anticipation of this, clinics sought and received more than $8 million in additional state grants, accounting for about 11 percent of clinic revenues in 2006. Some of the projected Medicaid savings that the state had hoped to achieve were offset by this increase in grants to clinics. CHCs also collected more

EXHIBIT 4
Distribution Of Community Health Center Patients In Missouri, By Principal Third-Party Insurance Source, 2004–2006

	2004		2006		Change	
Insurance source	Number	Percent of total	Number	Percent of total	Number	Percentage points
Total Medicaid	115,671	42.8	113,373	36.7	−2,298	−6.0
Regular Medicaid (Title XIX)	103,528	38.3	104,215	33.7	687	−4.5
SCHIP Medicaid	12,143	4.5	9,158	3.0	−2,985	−1.5
None/uninsured	97,323	36.0	125,527	40.7	28,204	4.7
Private insurance	36,790	13.6	41,957	13.6	5,167	0.0
Medicare	20,716	7.7	27,936	9.0	7,220	1.4
Total	270,500	100.0	308,793	100.0	38,293	

SOURCE: Urban Institute calculations based on Uniform Data Set (UDS) State Rollups, 2004–2006.
NOTE: SCHIP is State Children's Health Insurance Program.

EXHIBIT 5
Total Revenue Received By Community Health Centers In Missouri, By Revenue Source, 2004–2006

	2004		2006		Change	
Source of revenue	Millions of dollars	Percent of total	Millions of dollars	Percent of total	Millions of dollars	Percentage points
Grant revenue	53.7	39.3	75.9	44.6	22.2	5.4
Federal	38.4	28.1	44.4	26.1	5.9	−2.0
BPHC grants	36.4	26.6	37.7	22.1	1.3	−4.5
Other federal grants	2.1	1.5	6.7	3.9	4.6	2.4
Nonfederal	15.2	11.1	31.5	18.5	16.3	7.4
State and local grants/contracts	9.6	7.0	19.4	11.4	9.8	4.4
Foundation/private grants/contracts	5.7	4.1	12.2	7.2	6.5	3.0
Revenue from service to patients	76.7	56.1	88.6	52.1	11.9	−4.0
Patient self-pay	8.1	5.9	13.2	7.7	5.0	1.8
Third-party payers	68.5	50.1	75.4	44.3	6.9	−5.8
Medicaid	54.1	39.5	56.1	33.0	2.0	−6.6
Medicare	7.0	5.1	10.0	5.9	3.0	0.8
Other public	0.0	0.0	0.0	0.0	0.0	0.0
Other (private) third party	7.4	5.4	9.3	5.5	1.9	0.0
Revenue from indigent care programs	1.8	1.3	2.5	1.5	0.8	0.2
Other revenue	4.6	3.4	3.1	1.8	−1.6	−1.6
Total revenue	136.7	100.0	170.1	100.0	33.3	0.0
Total revenue per patient (dollars)	$505		$551		$46	9.1
Total expenses per patient (dollars)[a]	$484		$539		$55	11.4

SOURCE: Urban Institute calculations based on Uniform Data Set (UDS) State Rollups, 2004–2006.
NOTE: BPHC is Bureau of Primary Health Care, Health Resources and Services Administration.
[a] 2006 value is extrapolated from 2005 and 2007 figures.

revenues through their sliding-scale fees for services provided to self-pay (uninsured) patients. Between 2004 and 2006, the increase in uninsured visits produced a $5 million increase in collections from these fees. Some clinics also felt forced to raise their sliding-scale fees. Overall, total revenue per patient rose from $505 to $551 (9 percent) between 2004 and 2006, but CHCs' expenses per patient grew 11.4 percent.[24] Although CHCs were able to increase revenue per patient through additional grants and fees, the additional revenue did not keep up with costs.

CHCs cut back on staffing where they could. Medical care providers were retained, but cuts were made in support staff and those providing enabling services (such as transportation, translation, case management, and social services). Because of the cutback in coverage of adult dental care, some clinics used their excess dental capacity to expand provision of care to children, for whom dental care remained a covered service. However, when adults continued seeking dental care and Medicaid was no longer a payer, clinics struggled financially.

Mental health centers were reluctant to let their Medicaid patients stop treatments. As a result, newly uninsured patients often went to waiting lists. Some

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centers helped their Medicaid patients sign up for pharmaceutical companies' Patient Assistance Programs, but this imposed high administrative costs by diverting nurses' time. It also led to medication changes based on the available programs. Mental health centers reported that some patients even quit work to remain in Medicaid and retain access to medications.

■ **Benefit changes.** By removing coverage of some services from guaranteed Medicaid, the benefit cuts affected 370,000 enrollees who otherwise retained coverage.[25] Several lawsuits were brought in response the cutbacks. For example, a court ruled in 2006 that the state's limited coverage of DME was "unreasonable" (in *Lankford v. Sherman*), and DME was reinstated as a required service. In 2007 and 2008, Missouri also funded several of the services left to the appropriations process—for example, optometric service, wheelchairs, prosthetics, and eyeglasses. However, leaving coverage decisions to the appropriations process has meant that the package of benefits can vary from year to year, making coverage less stable for those who have remained eligible.

Discussion

The data show that the 2005 cutbacks in Missouri's Medicaid program had important effects on enrollment and coverage. As a result, the burden of uncompensated care on hospitals grew, and clinics were forced to seek additional sources of grant revenue and raise patient fees. Dissatisfaction with the Medicaid cuts was widespread. A poll showed that 57 percent of Missourians opposed Missouri's new approach to government-funded health care for the poor.[26]

In 2007 Missouri continued Medicaid reform by adopting a new program called MO HealthNet.[27] To its credit, MO HealthNet extended eligibility to adolescents who were aging out of foster care, replaced MAWD with a new Ticket to Work Program, offered a limited benefit package of well-woman services to some low-income women, and restored coverage for certain services.[28] The legislation also relaxed the SCHIP affordability test, excluding insurance that did not cover a child's pre-existing conditions from being considered "affordable" and defining "affordable" at lower premium levels. However, this legislation did not fully restore Medicaid eligibility and coverage.[29] At this point, the jury is out on how MO HealthNet will work. Based on our interviews, expectations for it were not high.[30]

Other states are now facing the prospect of decreased tax revenues in this economic downturn, but few are considering cutbacks in Medicaid as severe as those implemented in Missouri in 2005. All states are required to balance their budgets each year, and each has to cope with competing budgetary demands. Consideration of Medicaid cuts is unavoidable. In fact, forty-three states have already indi-

cated that they will try to cut spending to some degree in 2009.[31]

However, states recognize that achieving substantial savings in Medicaid will be difficult. Despite making deep cuts in enrollment and service coverage, Missouri's Medicaid spending growth slowed after 2005 but did not fall.[32] The challenges states face could motivate federal policymakers to introduce countercyclical financing measures. For example, in 2003 the federal government provided state fiscal relief through a temporary increase in the Medicaid matching rate for those states that did not cut program eligibility levels. This type of federal response could ease budgetary pressures and deep cuts in Medicaid that, as this work has shown, can limit insurance coverage, inflict financial stress on providers, and curtail access for patients.

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NOTES

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8. Ferber, "Summary of Medicaid Cuts."
9. For enrollment by state 2000–2004, see Exhibit III.2 in S. Liu and H.T. Ireys, "Participation in the Medicaid Buy-In Program: A Statistical Profile from Integrated Data" (Washington: Mathematica Policy Research, May 2006).
10. Ferber, "Summary of Medicaid Cuts."
11. As a federal requirement, pregnant women, children, nursing facility residents, and people who are blind were exempt from both copayments and service coverage reductions. Ibid.
12. Ibid.
13. Unborn children are included in the Medicaid beneficiary count because they are used to establish household size when determining income eligibility.
14. This report uses a hierarchy in which employer coverage is first, followed by Medicaid and state coverage, TRICARE/Medicare coverage, private nongroup coverage, and uninsured. Based on this hierarchy, a person who reports having both Medicaid and employer-sponsored coverage in a single year would be categorized as having employer-sponsored coverage.
15. As compared to household income, HIU income more accurately reflects the income available when pur-

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21. Qualified Medicare Beneficiaries (QMBs) are beneficiaries with incomes up to 100 percent of poverty for whom Medicaid pays Part B premiums as well as all cost sharing required by Medicare.
22. American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet," October 2006, http://www.aha.org/aha/content/2006/pdf/uncompensatedcarefs2006.pdf (accessed 21 October 2008).
23. Supplemental payments, predominantly disproportionate-share hospital (DSH) payments, are made to hospitals in addition to reimbursement for direct service provision. Hospitals designated to receive DSH payments serve a disproportionate number of low-income or uninsured patients.
24. CHC expenses were not available for 2006. We estimated 2006 total expenses per patient by extrapolating from the 2005 and 2007 figures ($154 million and $179 million, respectively).
25. V. Smith et al., "Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a Fifty-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007," October 2006, http://www.kff.org/medicaid/upload/7569.pdf (accessed 26 January 2009).
26. V. Young and J. Mannie, "Healthcare Stance a Liability for Blunt," *St. Louis Post-Dispatch*, 19 November 2007.
27. S. Peterson and R. Ehresman, "Medicaid Becomes MO HealthNet: A Tiny Step on the Road to Real Reform" (Springfield: Missouri Budget Project, 11 June 2007).
28. The Ticket to Work Program and dental and optometric care are both subject to state appropriation. S. Peterson and R. Ehresman, "Missouri Medicaid Becomes MO HealthNet: A Summary of the Truly Agreed to and Finally Passed SB577," 23 May 2007, http://www.mobudget.org/MO%20Health%20Net%20Summary%20May%20_07.pdf (accessed 15 May 2008).
29. T. Kruckmeyer, "Missouri's 2007 Budget Falls Short of Adequately Funding Education, Healthcare" (Springfield: Missouri Budget Project, 22 May 2006).
30. There was more enthusiasm for a proposal called Insure Missouri, but there is doubt that this will play out now that Gov. Matt Blunt (R) has left office. J. Ferber "Insure Missouri: Early Observations" (St. Louis: Legal Services of Eastern Missouri, 11 October 2007).
31. V. Smith et al. "Headed for a Crunch: An Update on Medicaid Coverage, Spending and Policy Heading into an Economic Downturn: Results from a Fifty-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009," September 2008, http://www.kff.org/medicaid/upload/7815.pdf (accessed 26 January 2009).
32. After growing by more than 11 percent annually between 2000 and 2005, Missouri's Medicaid spending growth slowed to less than 4 percent the following two years, according to data reported to the Centers for Medicare and Medicaid Services on Medicaid spending reports.