THE JOINT LEGISLATIVE / EXECUTIVE

DEPARTMENT OF HEALTH REVIEW COMMITTEE

Final Report

to the

Joint Labor, Health and Social Services Interim Committee,

Joint Appropriations Interim Committee

and

Governor Dave Freudenthal

September 2005

Contents

Executive Summary

Medicaid costs are growing at high rates across the nation. The nature and rules of that entitlement program, along with escalating healthcare system costs that far outpace the general economy, combine to form a budget buster for many states. Wyoming's mineral based economy is healthy, but is cyclical and cannot be counted on forever to accommodate the cost increases the State is experiencing.

The Governor and legislative leadership in 2005 were concerned with the seemingly out of control escalation of the health department's budget and in particular the Medicaid portion. A bill was passed which authorized the formation of a Joint Legislative – Executive Committee to study the health department with emphasis on organization, budgeting and cost control. The Committee met four times following the 2005 legislative session to review the department of health as directed by the legislation. The Committee was assisted in its early study and deliberations by highly rated Medicaid directors from three other states.

The findings and recommendations of the Committee are delineated in this report.

Beginning in late 2004, significant strengthening in the department's organization has resulted in tighter control and better understanding of the budget and budget process. The Committee supports these changes and looks forward to better clarity and control of this substantial piece of the State's budget. No further organizational changes are recommended.

The Medicaid program will continue to be a major portion of the Wyoming state budget. The Committee believes that some changes in approach and administration can result in modest improvements, but substantial improvement can only be achieved by changes that will require agreement with the federal government to waive some of the Medicaid requirements and replace them with Wyoming-specific solutions. The primary recommendation is a study and realignment of benefits to better serve more needy citizens in a cost effective, medically superior way. Data is currently being gathered which will support this study and the Committee heartily endorses continuation and expansion of this effort.

I. **Overview**

2005 Wyoming Session Laws, Chapter 182 (HB0338/HEA0099), established a Joint Legislative Executive Committee[1] ("the Committee") to conduct a review of the Department of Health ("the Department"). Also in that act, the Legislature:

- found that the Department's budget has increased significantly in the last few biennia, particularly in the area of healthcare;
- found that the current budget review process within the executive branch appears to be inadequate to assess the increasing costs and to determine an accurate forecast for budgetary planning;
- charged the Committee with analyzing the fiscal, budget and management policies of the Department and with conducting an in-depth analysis of the Medicaid program, its structure and its policies;
- required a report from the Committee to the Joint Appropriations and Joint Labor, Health and Social Services Interim Committees by September 1, 2005.

The Committee was formed as provided in the statute and met four times between May 18, 2005 and August 29, 2005. The Committee membership is listed in Appendix A.

The Committee has been impressed throughout its meetings with the dedication and hard work of all involved in providing a constantly improving healthcare system for the citizens of Wyoming.

[1] The Committee was comprised of three members each from the Wyoming Senate and House of Representatives, plus five members appointed by the Governor, including two representatives of the private sector and one each from the Governor's Office, the Department of Administration and Information and the State Auditor's Office. Seventy-five thousand dollars was appropriated to fund the Committee's work.

In particular, the Committee expresses its gratitude to the many representatives of the Governor's Office, the Department of Health and the public who have assisted the Committee in completing its assigned tasks. They have provided invaluable information and insight, without which this challenging assignment could not have been accomplished.

The Committee's principal recommendation involves redesigning the Medicaid benefits structure and operations. Only by escaping the "all or nothing" benefit approach of the basic Medicaid program can Wyoming begin to serve more needy individuals and families with economy and improved quality of care. It is also apparent that changes in incentives for providers and patients are necessary to make these improvements work for the betterment of care and for reduction of unnecessary medical costs. Appendix B illustrates the needs that individuals have for various levels of healthcare services, the costs of those services and that funding is much greater on the acute end of the continuum, with the most cost effective services receiving only a tiny percent of funds. This suggests that more money spent on preventative and cognitive care would greatly reduce the funds required for acute treatment.

If significant savings can be achieved through this effort, monies will become available for other purposes. The Committee recommends that, first, provider reimbursements be improved in order to provide further support for medical doctors and other medical care providers. Second, a limited Medicaid benefit should be provided for the low income employed in order to reduce the number of uninsured people in the State. However, until the cost escalation in the Medicaid program can be reduced, undertaking such an expansion would be fiscally irresponsible.

II. Committee Focus - Medicaid

The Committee considered all subjects required by the enabling legislation, however it focused its attention mainly on the Medicaid program. The Medicaid program represents a substantial majority of the Department's budget. That budget has grown significantly in recent years and has expanded at a rate of 16% per year since 2000. At this pace the Medicaid budget will displace other governmental functions, which the public reasonably expects to be appropriately funded. The Medicaid increase is currently masked by the boom in Wyoming's economy and State revenues, but could become an acute problem once the boom ends. Because Medicaid by federal mandate is an entitlement program, its growth cannot be controlled by simply reducing its State appropriation, as is done for other programs. For these reasons, because this Committee was specifically directed to conduct an in-depth review of the Medicaid program, and because other legislative Committees are charged with studying other Department functions, this Committee decided to focus its efforts primarily on the Medicaid program.

III. Department Organization

The Committee reviewed the Department's organizational structure. The Department has undergone significant organizational changes in recent months and has substantially enhanced its fiscal and executive management functions. The Committee believes that, at this point, maintaining stability in the organizational structure is more important than any benefit that further changes might bring. Stability allows individuals to thoroughly learn their jobs, building effective long-term working relationships with others in the organization, while facilitating the long-term accountability of individuals and groups. The Committee, therefore, does not recommend any organizational changes.

IV. Budget and Budget Presentation

The Committee recognizes the Department's efforts with respect to stewardship and cost containment and endorses the continuation of those efforts.

It appears that the Governor and the Department, working together, are resolving many of the budget process problems that were present when the legislation establishing this Committee was passed. Significantly, the Department recently created and filled, as part of its senior management team, the position of chief financial officer. New data collection and fiscal reporting systems are being created; further improvements are still needed. A clear understanding of program costs, particularly in the Medicaid program, is key to better forecasting of budget requirements. Dr. Harold Gardner, under contract with the Governor's Office, has collected benefit payment data from various State agencies, especially the Department, and created very useful databases with that data. The Committee recommends that effort be maintained and used, along with the Medicaid Decision Support System and other analytical tools of the Medicaid program, to help understand Medicaid costs. The Committee recommends that the Department of Health revise its contracts with service providers, particularly mental health and substance abuse providers, so that all bills for client services utilize the Departments' Medicaid Management Information System ("MMIS"). This will facilitate appropriate monitoring of the specific services utilized by clients in order to assure appropriate service utilization. The Committee applauds the Department's efforts to improve data collection and reporting in this area; consistent use of the MMIS will further those efforts.

The Department is also in the process of developing a new presentation format for its budget, with Medicaid costs itemized separately but also included within functional categories. The Committee finds the new format adds substantial clarity, making the budget much more comprehensible than in the past. The Committee endorses the continuation of this development.

Although the Department and the Governor are resolving the budgeting process issues, monitoring, analysis and action steps are not yet in place to compare actual revenues and expenditures against those budgeted. The Department has a history of cost overruns. A budget is only meaningful if actual revenues and expenditures are controlled. The Committee recommends that the Department on a monthly basis compare the budget to actual expenditures and make appropriate and timely adjustments. An oversight Committee should also be established to meet with the Department and review the financial statements to ensure the budget is being followed. The oversight Committee is an executive branch function and should be structured as the Director and the Governor determine. In addition to being a good basic business practice, this process will clearly demonstrate the Department's and the State's commitment to fiscal responsibility.

V. The State Training School and the Adult Developmental Disabilities Program

The Committee received testimony regarding underutilization of services provided at the Wyoming State Training School ("WSTS"). Historically, services to persons with developmental disabilities in Wyoming were primarily provided in a residential setting at WSTS. Over the last ten years, partly as a result of court decisions, many of the services for those

persons have been shifted to local community service providers. In general, the Committee believes that the change from the training school to community providers has been beneficial for all parties. However, it is possible this process has gone one step too far and, while WSTS has continued to evolve and improve, its services are not being fairly offered to clients and their families. For the most severe cases, it appears difficult for the community programs to provide adequate services and to do so in a cost effective way. For some individuals the ability of WSTS to provide a range of complex services may actually offer the recipients a better quality of life. In addition it appears that, given the current fixed and variable cost structure at the training school, cost savings can be realized by offering a small number of clients the option to be served at the training school. A Department review of the 100 most expensive adult developmental disability waiver cases (as ranked by annual expenditure) identified thirty-eight that might be accommodated at the training school. The training school could absorb about twenty of these clients without additional staffing, for an annual savings to the State of $2.4 million.[2] The client should have the option of remaining in or choosing the training school if such a placement is indicated by medical necessity and rehabilitative appropriateness. So that all involved can make informed placement decisions, the Department should standardize the criteria and procedure for determining medical necessity and rehabilitative appropriateness.

The Committee supports the additional Department efforts to explore new services and to obtain additional licensure for the WSTS that would permit Medicaid recipients and others to obtain long term care services in-state.

[2] Wyoming Department of Health Medicaid Improvement Plan, page 112.

VI. Public Health

The Committee is concerned about the adequacy of the public health services being provided by the Department. The Committee points to the failure of the Department to adequately implement the Public Health Nurse Infant Home Visitation Program enacted in 2000 as evidence of problems in the public health arena. The failure in this area endangers Wyoming's children and young adult populations. The Committee commends the Department's efforts to solve the problems with this program, but recommends increased Department management and legislative attention to this program until its problems are demonstrably solved.

The Committee endorses the return of Wyoming to being a universal vaccination state, ensuring free vaccine access to all Wyoming children. The Committee realizes that a state appropriation (approximately $2.5 million per year) will be necessary for a vaccine program covering the 45% of the child population that is ineligible for the federal program.

The Committee also recommends that the Department, the Wyoming Healthcare Commission, and the Labor, Health and Social Services Committee explore additional public health and safety, wellness and disease prevention opportunities. Data presented to the Committee indicate that additional spending in this area, if appropriately targeted, should yield significant cost savings and improved health for Wyoming citizens.

VII. Medicaid Program Generally

The Committee finds that the primary cause of Medicaid budget increases is increasing utilization of services, particularly those services for the growing population of aged, blind and disabled Medicaid clients. As this population ages[3] there will be increasing financial demands, however, the Committee is unable to quantify those increases.[4] Significant secondary factors include enrollment growth, demographic changes, price increases and reduction in the federal matching rate. Ironically, studies using national and other states' data[5] suggest that increased utilization of healthcare services is not producing significant health benefits and may even be doing more harm than good.

The current benefit design is nearly what one would expect if program benefit designers were asked to design a high cost program. The Committee recommends that the Medicaid benefit system be redesigned to improve efficiency and effectiveness. Careful attention should be given to the incentives given to both patients and providers. The Committee recommends that the benefit redesign be done initially without consideration of federal restrictions. Once that is done, then the federal government should be approached with an appropriate waiver request. Given the federal budget problems and the current timing within the federal election cycle, the coming

[3] Wyoming's population over age 65 will increase by 40% between 2005 and 2015. Source: U.S. Census Bureau, Population Division, "Interim State Population Projections, 2005".

[4] 45% of Wyoming citizens over 65 and 77% of those over 85 have a disability. Source: Center for Personal Assistance Services, *2004 Plan for the Improvement of the Medicaid Program, Legislative Edition – 2005*, 67-68).

[5] See Elliot Fisher, David Wennberg at al., *Annals of Internal Medicine*, 2003, Volume 138, pages 273-287 and 288-298. These articles dealt with Medicare patients but the same results should apply to Medicaid. It showed a 60% variation among Medicare regions in utilization with severity controlled for. The high utilization regions had slightly worse outcomes. Also see Richard D. Lamm, The Brave New World of Health Care, 2003, page 118, Charles Scott, Fixing Our Broken Health Care System, 2004, pages 71-82, and David H. Cutler, Your Money or Your Life: Strong Medicine for America's Health Care System, 2004, page 58.

year should be an opportune time to approach the Department of Health and Human Services management with requests for waivers of problematic federal requirements.

In addition, the declining federal match rate and the claw-back provision which finances Medicare Part D at state expense are bringing the federal share of funding for Wyoming's Medicaid program to a historic low. If the federal government is uncooperative in granting waivers, it may be time to re-examine Wyoming's continued participation in the federal program.

As long as Medicaid contains the features that make it such a high cost program, the Committee recommends that the Wyoming program remain as close to the federal mandatory minimums as possible. The major exception to this principle will continue to be the prescription drug benefit, an optional benefit but one that is essential to an effective program. The Committee is not recommending any changes to the qualification levels or benefits at this time. However, the Committee believes that increased emphasis needs to be placed on initial eligibility determination, as well as continued eligibility reviews. A successful benefit redesign may change this strategy in the future.

Many states have used a strategy of maximizing federal cost shares in the Medicaid program. Examples of these strategies include intergovernmental transfers, provider taxes, and federal reimbursement for functions the state is committed to undertaking. These strategies can be effective in the short run, but the federal government views many of them as abusive and periodically changes policies to stop them, producing a continued need for fiscal creativity. In

general the Committee does not find this to be an effective strategy, although in some cases specific changes may be advantageous.

Wyoming is one of two states that does not receive Medicaid reimbursement for medical services provided by school districts as part of the special education program. The Committee recommends re-introduction of a bill, which could realize several million dollars in savings to the State, but which failed in the 2004 (SF 65) and 2005 (SF 101) sessions.

The School Health and Related Services Program (SHARS) is reimbursable and available through Medicaid as a coordinated academic and social services special education program. The Committee recommends the Joint Appropriations Committee pursue these available funds through legislative action.

The Committee makes the following recommendations concerning the Medicaid benefit and operations redesign:

1. The redesign should be done with a holistic approach. The Committee recognizes that the current Medicaid health system has overlapping use and cost shift implications for:

- The private health insurance system, including medical malpractice insurance, affecting both the insured and the uninsured;
- The workers' compensation insurance system;
- Other health and social welfare services provided with government and private resources;

- Increased utilization of technical services and decreased patient/physician communication and interaction.

2. In redesigning the benefit program, careful attention should be paid to incentives given to both clients and providers.

3. The all-or-nothing feature of Medicaid should be eliminated where this feature unnecessarily increases costs or gives individuals an incentive to avoid improving their economic status.

4. The Department should explore partial reimbursement of Medicaid childbirth benefits. The Medicaid program pays for nearly half the childbirths in Wyoming – a much higher percentage than the poverty rate would indicate. The Committee is concerned that current eligibility criteria, by not counting the father's income, create an incentive for parents to remain unmarried and not improve their economic status. The Committee recommends recovering a portion of the cost of these deliveries and associated care by a percentage deduction from parents' future earnings, with the percentage varying on a sliding scale with the amount of the earnings.

5. The Department should examine the provision of prenatal services to Medicaid recipients. Data presented to the Committee indicate that not all Medicaid clients are receiving adequate prenatal care, particularly in the first trimester, causing a higher incidence of newborns with expensive health problems.

The data also suggest that the lack of prenatal services in many counties may be associated in part with continuing malpractice insurance cost problems. Seventeen of the twenty-three counties appear to have this problem.[6] With Albany County, students on Medicaid may be returning home for services, independent of the supply in Laramie. With Niobrara County and possibly several other small counties the population is too small to support a doctor or even family practice based obstetrical care. In the other counties it appears that the malpractice crisis is making local obstetrical services unavailable to part of the Medicaid population.

The Committee recommends that the Department of Health, or the Department of Family Services through the Children and Families Initiative, examine this problem to determine its extent and causes as a preliminary step to devising a strategy to solve it. The Committee suggests one or more focus groups with the young mothers involved to determine the practical obstacles to prenatal care.

6. The Committee finds that costs for children's care in the Medicaid program are significantly higher than in the State employees' health insurance program. This is in spite of Medicaid provider reimbursements being significantly less than State insurance reimbursements on a per service basis. The cause appears to be excessive utilization of Medicaid-reimbursed

[6] In counties where a third or more of the Medicaid obstetrical services were obtained outside the county, the difficulty of travel is a probable obstacle to receiving prenatal services for the Medicaid population. The percentage of obstetrical delivery services received outside the recipient's county of residence are:

Albany	46%	Big Horn	100%	Campbell	64%
Carbon	74%	Converse	61%	Crook	100%
Goshen	67%	Hot Springs	53%	Johnson	50%
Lincoln	38%	Niobrara	100%	Platte	61%
Sheridan	47%	Sublette	100%	Teton	33%
Washakie	60%	Weston	96%		

services, or the compounding effect of eligible children being in lower income households and the impact of inadequate early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements for this population. Strategies to reduce the excessive utilization, including appropriate co-payments or co-insurance, are indicated.

The current EPSDT benefit appears to be open to over-utilization. The Department should conduct an analysis to see if this benefit is cost effective. The State does not have the ability to deny treatments recommended by a physician, even very expensive treatments that may be profitable for the provider but not the best option for the patient. The risk that this is happening is clear, but the Committee has no evidence that it is or is not happening.

7. The Committee finds that Medicaid clients are making inappropriate use of emergency room services. Consideration should be given to co-payments, co-insurance, or even denial of reimbursement unless triage has determined the existence of an actual emergency. The Department should also explore additional means of educating patients about appropriate uses of emergency room visits.

8. The Committee endorses the Department's proposal for a pilot program of primary care case management. The pilot should be focused on clients who utilize large numbers of expensive services or who are, based on statistical evidence, likely to do so. A further focus should be on those with chronic conditions for which 'best practice' protocols and treatment guidelines are available. The objectives are twofold: 1) making sure the clients actually receive needed services, particularly those designed to prevent future problems; and 2) making sure

clients do not receive unneeded services. It is recommended that the Department expand this program to other segments of the Medicaid population should the pilot program prove cost effective. Any benefit redesign should consider first, making the pilot project permanent, and second, to what degree the program should be expanded.

9. The Committee endorses the Department's preferred drug list and prior authorization programs for prescription drugs. The programs use evidence-based reports from the Center for Evidence Based Policy at the Oregon Health & Sciences University, which the Department has contracted to use. This has been effective and the contract should be continued. The annualized savings from these programs for six classes of drugs is reported to be $1.3 million, less administrative costs. These savings can be expected to grow as the programs are expanded to cover additional drug classes. Expansion of such systems to other Medicaid services may produce additional cost savings and should be implemented by the Department. The Committee recognizes, however, that some of the drug cost savings will be lost after January 1, 2006, when the federal government replaces approximately one-half of Wyoming's Medicaid prescription drug program with the Medicare Part D program.

10. Incentives for long term care insurance. To reduce nursing home expenses, there should be incentives in Medicaid to reward the purchase of long term care insurance. Although federal law currently forbids such incentives, testimony before the Committee indicated a likelihood that the prohibition will be repealed.

11. Create a Cash and Counseling program in the adult DD program. The experimental Cash and Counseling program was launched in 1995 to give Medicaid beneficiaries choice and control over their personal care needs. It provides a self-directed, individualized budget to recipients of Medicaid personal care services. Participants use the money to hire their own caregivers or purchase items – such as chair lifts or touch lamps – that help them live independently. Each person's budget is comparable to the value of services that he or she would have received from an agency. Consulting and bookkeeping services are available to help participants weigh their options and keep up with required paperwork. Grantee states need to secure 1915(c) or 1115 waivers from the Centers for Medicare and Medicaid Services (CMS) in order to implement a participant-directed individual budget model for Medicaid.

12. Consider creation of Cash and Counseling or other partial benefit opportunities, in the home and community based waiver program for potential nursing home clients, in order to prevent or delay admission to a nursing home. The program should include, but not limited to, assisted living services.

13. The Department should study ways to prevent medical cost shifting. The Committee finds low provider reimbursement in the Medicaid program is one of the causes, though not the largest cause, of high private health insurance costs. Costs unreimbursed by Medicaid are shifted to other payers, especially private health insurers.[7] The Committee cautions that controlling

[7] A study of cost shifting within the trauma and catastrophic care areas by the Wyoming Healthcare Commission showed that Medicare paid 71%, Medicaid 68% and private pay 172% of the Medicare cost standard. When weighted by market share, cost shifting was attributable 65.6% to Medicare, 17.4% to Wyoming Medicaid, 13.0% to bad debt and charity care, 2.9% to other government programs and 1.3% to worker's compensation. The Commission's preliminary results on the full range of hospital charges shows a larger share of the problem caused by

Medicaid costs by cutting hospital or physician reimbursements will cause additional cost shifting and create an additional hidden tax on the private healthcare sector.

Private sector employers and insurance companies reducing or eliminating healthcare benefits may also cause cost shifting and significant growth in Medicaid enrollment. The burden of providing care eventually falls on Medicaid. The State Health Access Profile by the U.S. Census Bureau shows that only 44% of Wyoming private sector employers offer health insurance to their employees, while the national average is 58.3%. The Committee recommends further study of this cost shifting phenomenon and incentives for private sector employers to offer full health coverage to their employees, including possible pooling of public and private funds.

14. The Committee supports the poly-pharmacy pilot project undertaken by the Department of Health. This project addresses Medicaid clients using two or more state service benefits and multiple medications. The pilot project provides face-to-face intervention with a pharmacist and nurse team, and attempts to address broader issues contributing to high medical and prescription utilization.

15. The Committee endorses the following approaches in the re-design process:

- Add Medicaid eligibility data, including income data from the Department of Family Services, to the WHIN//HCMS Integrated Database for analysis;

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bad debt and charity care with a corresponding decrease in the part of the problem caused by the government programs.

- Expand the collection of household income data for all entitlement program recipients;
- Develop a plan for demand-side, age-sensitive, income-indexed cost share policies for preventive, cognitive, technical and institutional services. The plan should include forecasts of utilization and cost outcomes, including synergistic impact from current cost containment and quality improvement initiatives.
- Develop supply-side performance incentives to reward prevention services, primary care access and cognitive coordinated services, continuing medical education with focus on best practices, health economics and health policy;
- Coordinate this information-driven Medicaid redesign with reform efforts of the State health plan, the workers' compensation system and WyoCare for the uninsured.

Appendix "A"

JOINT LEGISLATIVE/EXECUTIVE DEPARTMENT

OF HEALTH REVIEW COMMITTEE

Senator Charles K. Scott, Cochairman

Representative Doug Osborn, Cochairman

Senator Cale Case

Senator Kathryn Sessions

Representative Roy Cohee

Representative Pete Jorgensen

John Masterson, replaced by Nichole Anderson, Governor's Office

Max Maxfield, State Auditor

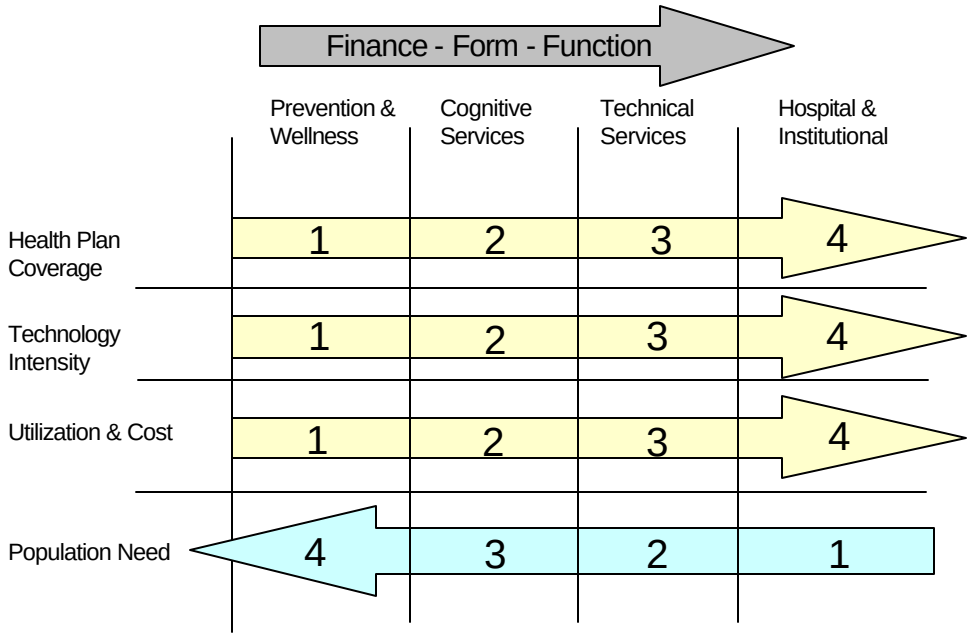
Michael McVay, Department of Administration and Information, Budget Division

Harold (Hank) H. Gardner, M.D., Private Sector, Governor's appointee

Stephen H. Pecha, Private Sector, Governor's Appointee

Appendix "B"

Health Insurance Coverage – Healthcare Services Utilization and Cost Model



Healthcare services can be considered on a continuum. Insurance coverage, technological intensity and relative cost increase correspondingly across the continuum. Conversely, the volume of need for services among the patient population is progressively less across the continuum. Of total payments to providers by Wyoming Medicaid and the state employees health plan, 1.6 % was for prevention services, 8.6% for cognitive services and almost 90% for technical diagnostic, therapeutic and institutional services (Human Capital Management Services). This reflects the economic principal of "what gets paid for gets done."

Source: Harold H. Gardner, M.D.