Aging and Long-Term Care Review

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Department
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Agenda

- Summary
- Problem
  - Demographic projections
    - Age
    - Long-term care need
  - Cost of long-term care
  - Preparedness for retirement
  - Long-term care insurance market
- Public payers
  - Wyoming Medicaid
  - Aging Division

Summary

As the largest payer for long-term care services, the State will face increased costs from an aging population.

With current trends, cost to Wyoming Medicaid for long-term care is projected to increase from **$130 million** per year in 2017 to **~$250 - $300 million** in 2030.

Summary

Five major factors driving the problem:

- An aging population that is increasingly burdened with chronic disease;
- A decreasing ratio of working-age adults per older individual;
- The high and increasing cost of long-term care;
- A population that is increasingly unprepared to pay for long-term care costs out-of-pocket; and,
- A small and weakening long-term care insurance market.

Summary

The State should continue to develop policies that encourage healthy aging at home and delay or prevent institutionalization.

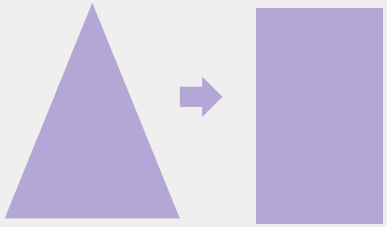
- → Older people often prefer to remain at home, rather than go into a nursing home.

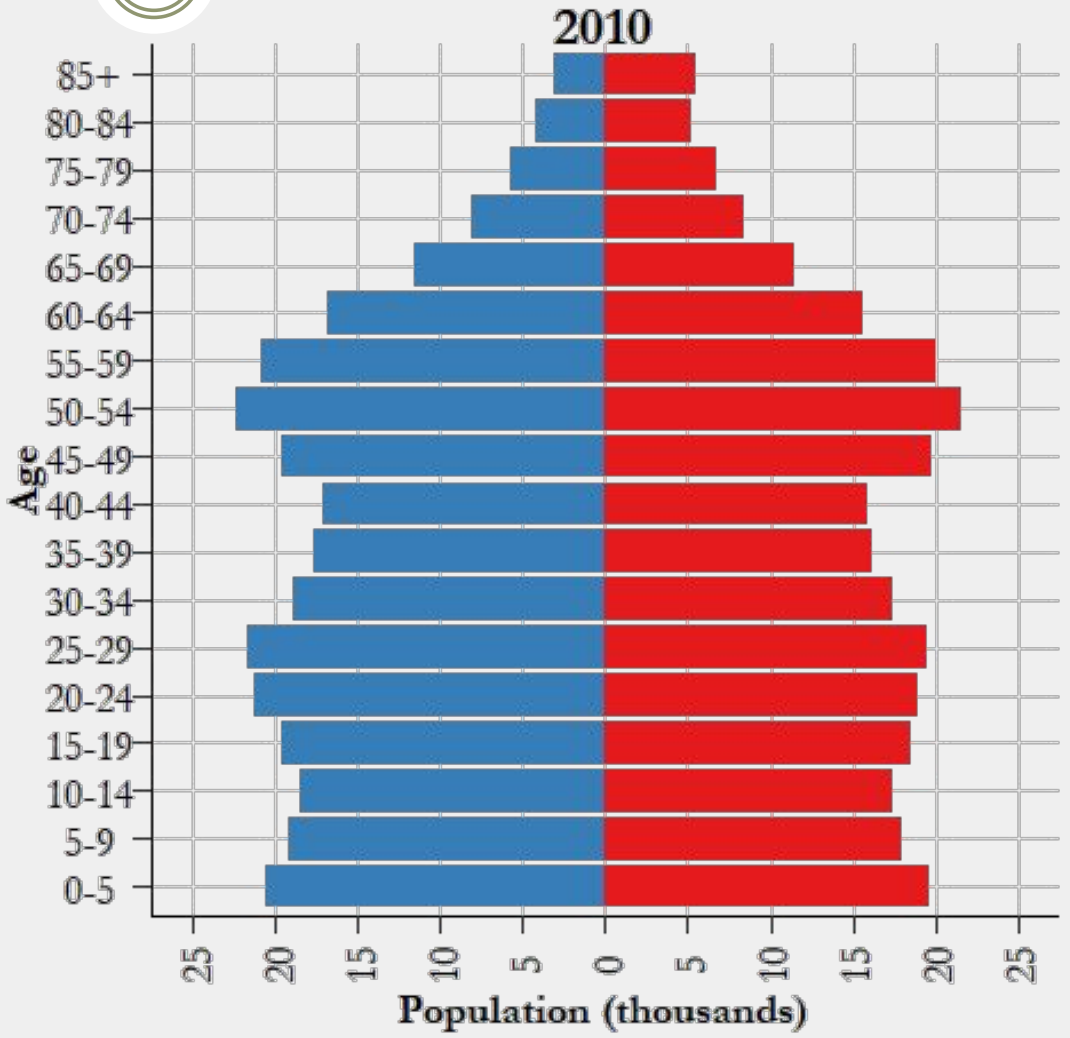
- → Home-based care is cheaper to the State:

Medicaid Setting	PMPM
Nursing facility	$4,293
Community Choices Waiver	$1,635

Wyoming's population pyramid

As a society ages, its population pyramid begins to look more like a rectangle



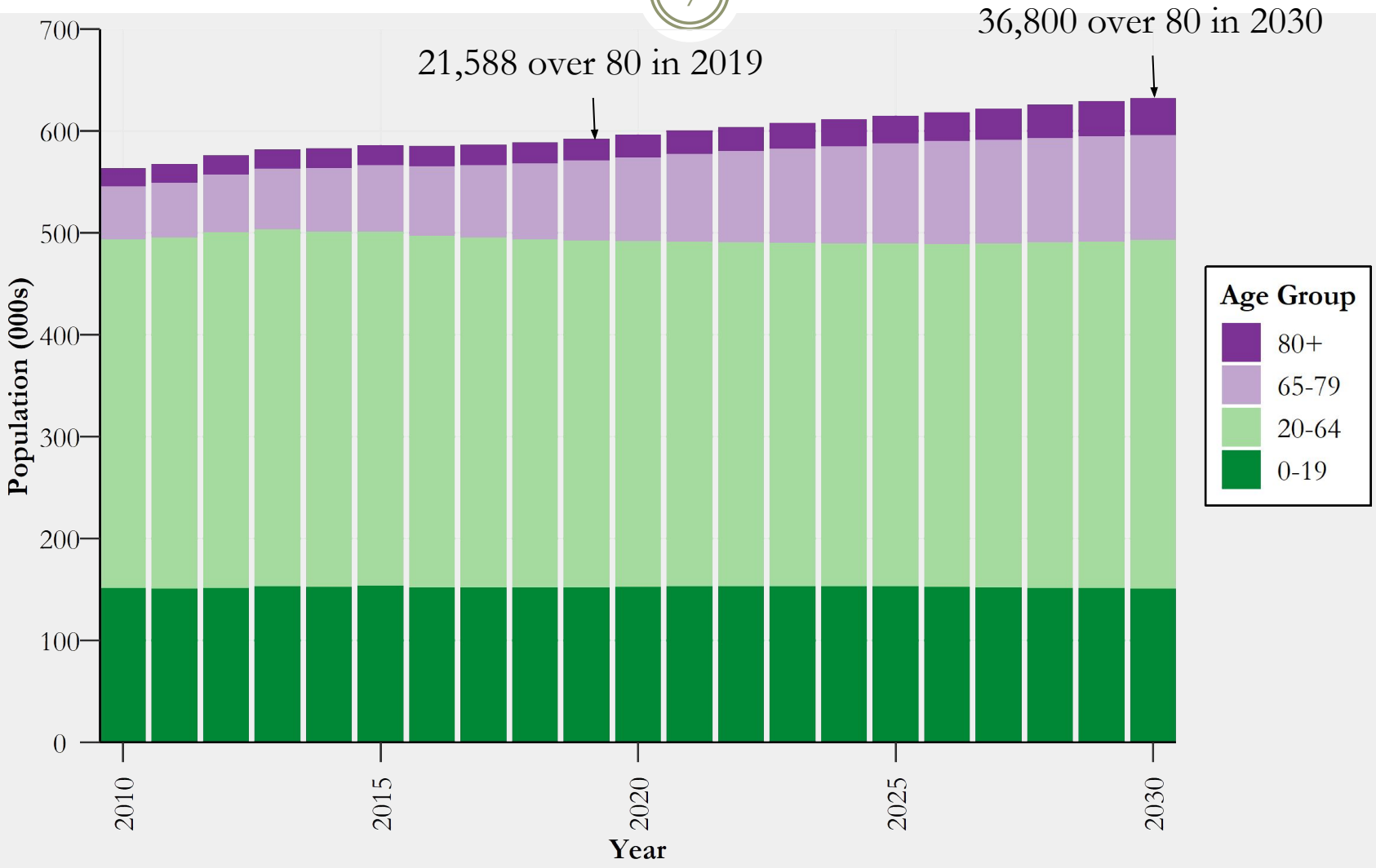


Men

Women

data: A&I Economic Analysis population projections (Census)

Demographic projections



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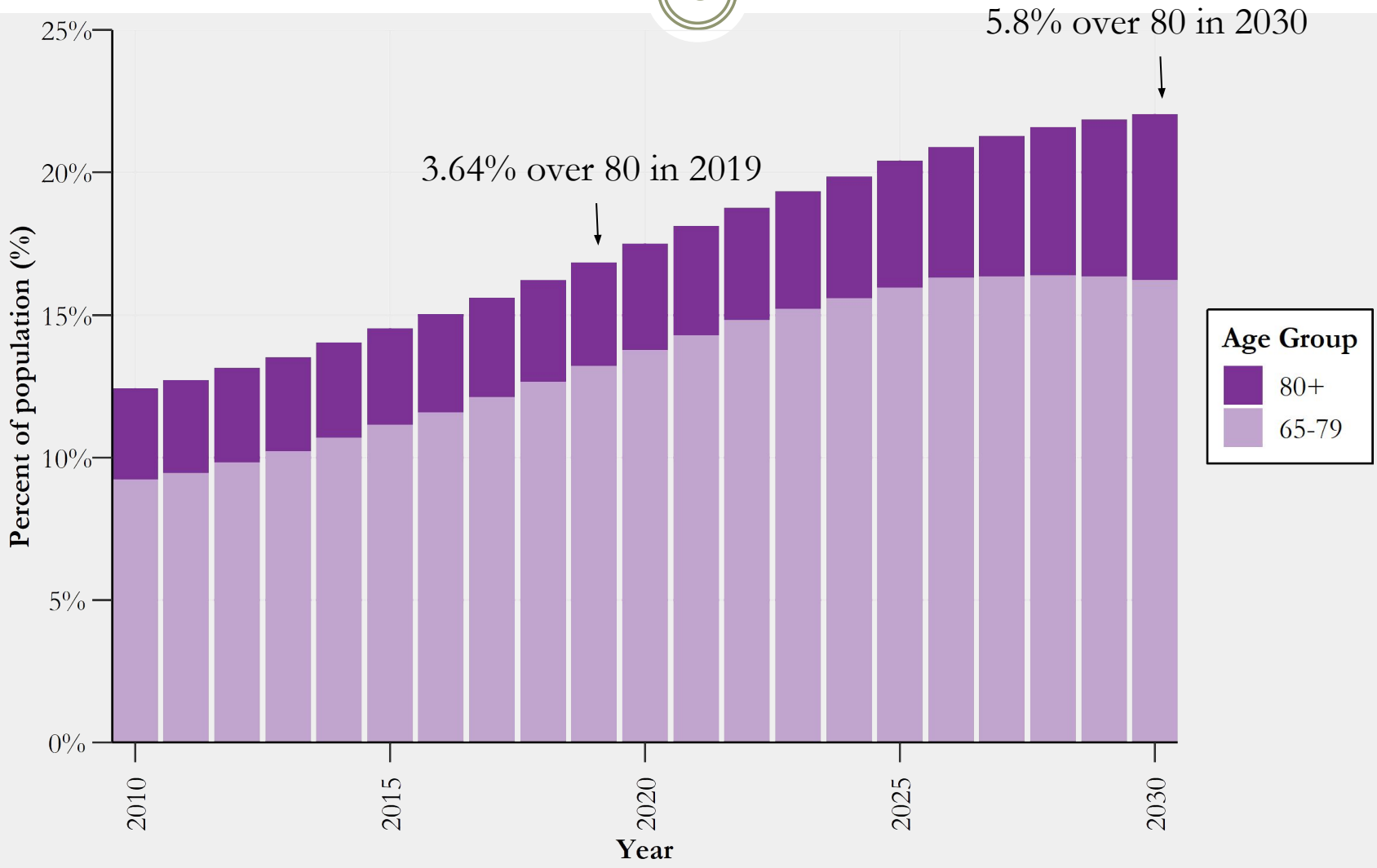

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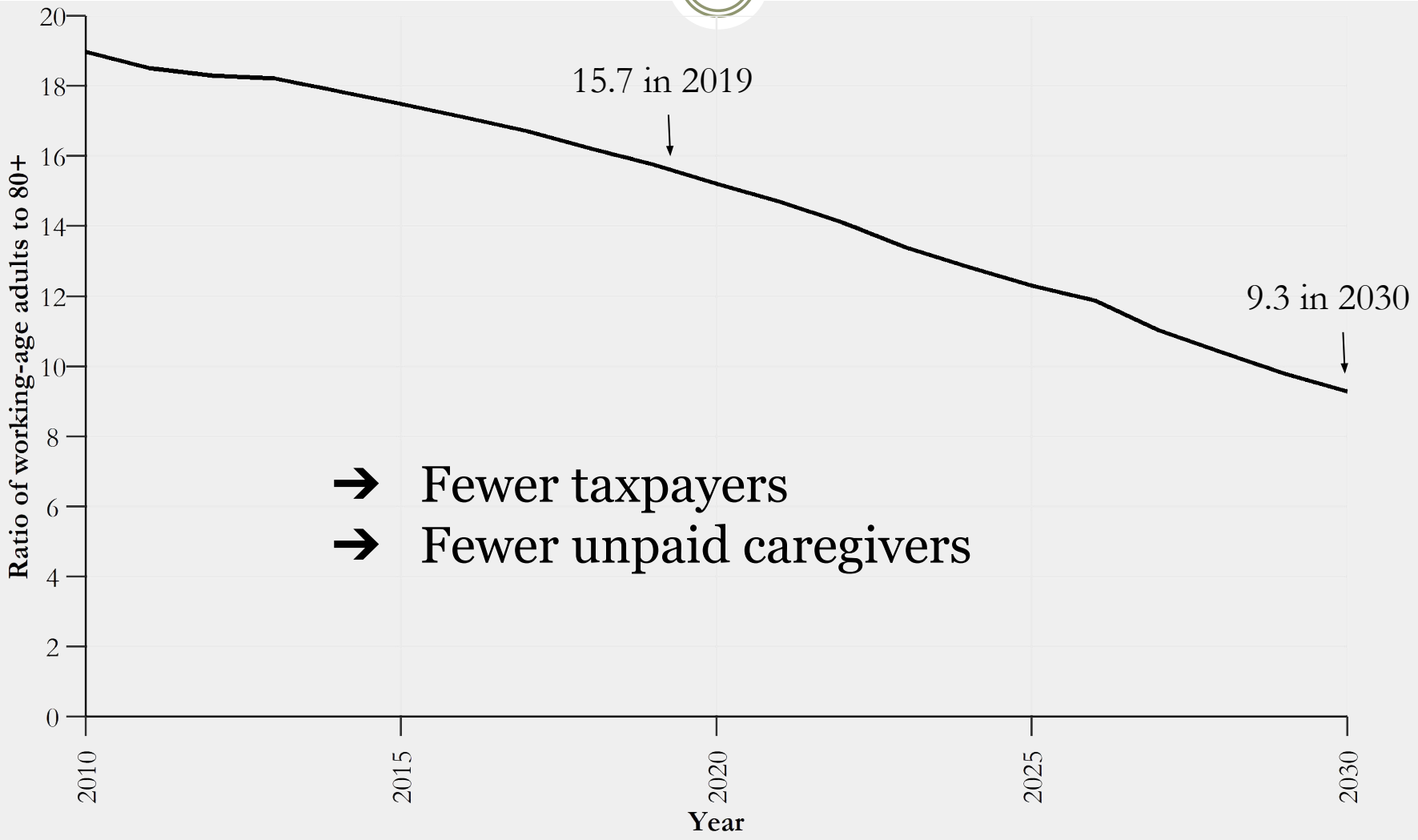


➔ Fewer taxpayers

➔ Fewer unpaid caregivers

data: A&I Economic Analysis population projections (Census)

Need for long-term care

Of Americans turning 65 today, 48% can expect to require some amount of paid long-term care:

- ➔ 23% projected to require less than a year
- ➔ 9% between 1-2 years
- ➔ 10% between 2-5 years
- ➔ 6% more than 5 years

On average, those who will require services face total expected costs of **$266,000** in 2015 dollars.

data: HHS ASPE brief - "Long term services and supports for older Americans."

Long term care is expensive

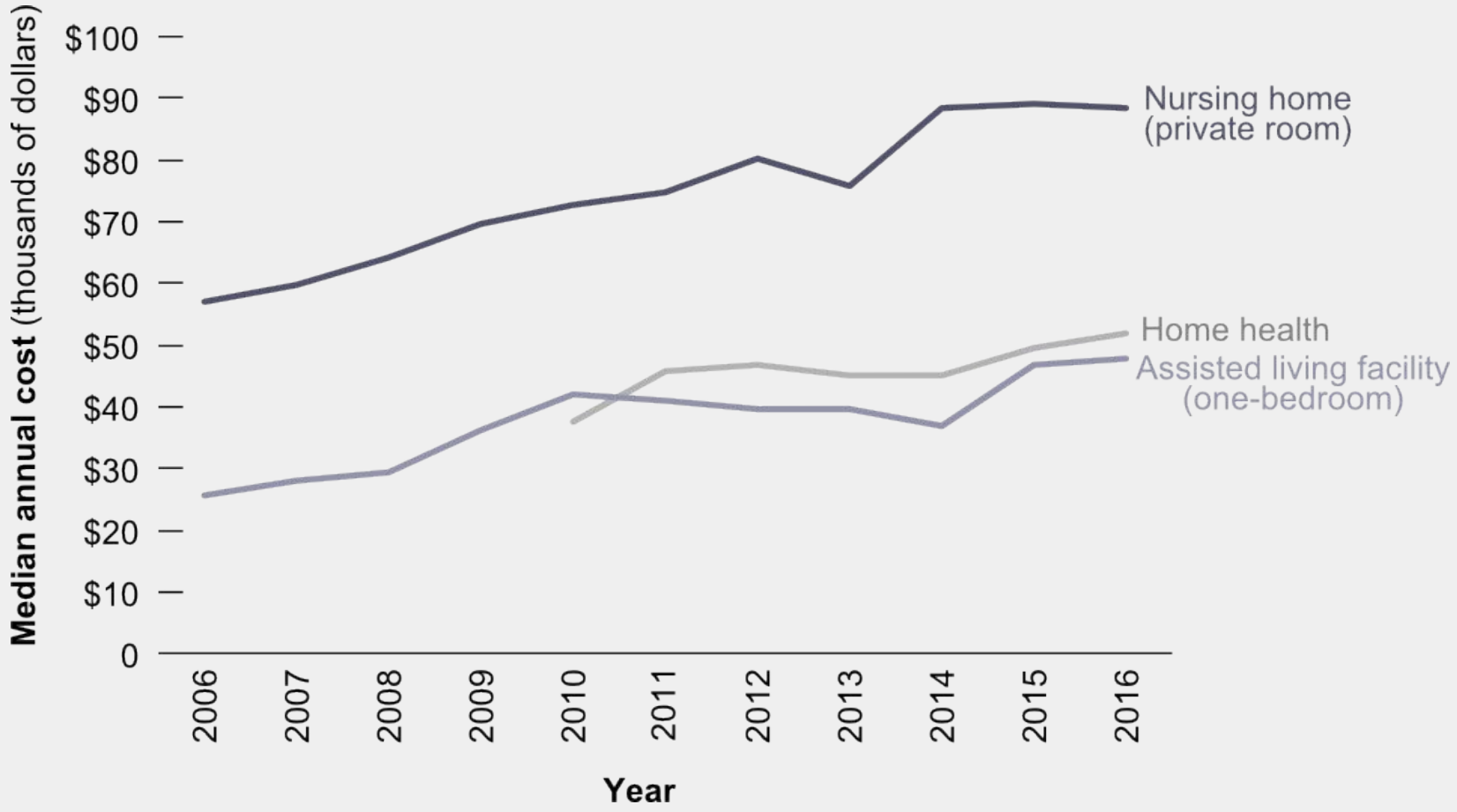
Private-pay median annual prices

State	In-home	Assisted living	Nursing home
Wyoming	$52,052	$47,940	$88,505
Montana	$52,624	$42,150	$83,220
Idaho	$45,760	$38,400	$88,878
Utah	$48,048	$35,400	$76,650
Colorado	$54,912	$48,750	$97,546
Nebraska	$53,768	$42,120	$76,833
US Median	$46,332	$43,539	$92,378

data: 2016 Genworth Cost of Care Survey. Cost for ALF and SNF are for private, single-occupancy rooms

Long term care is expensive

Private-pay median annual prices, Wyoming



data: 2016 Genworth Cost of Care Survey. Cost for ALF and SNF are for private, single-occupancy rooms

People are increasingly unprepared for this cost

How is long-term care financed privately?

- → Income (or principal) from savings/retirement accounts
- → Defined-benefit/pension plan payments
- → Long-term care insurance
- → Home equity

People aren't saving enough

For households between the ages of 55 and 64:

- → 41% have no retirement savings
- → Overall median net worth of $9,000 and median home equity of $53,000
- → For those with any savings, median total was $104,000

data: Government Accountability Office. GAO-15-419. May, 2015

Defined benefit plans are decreasing

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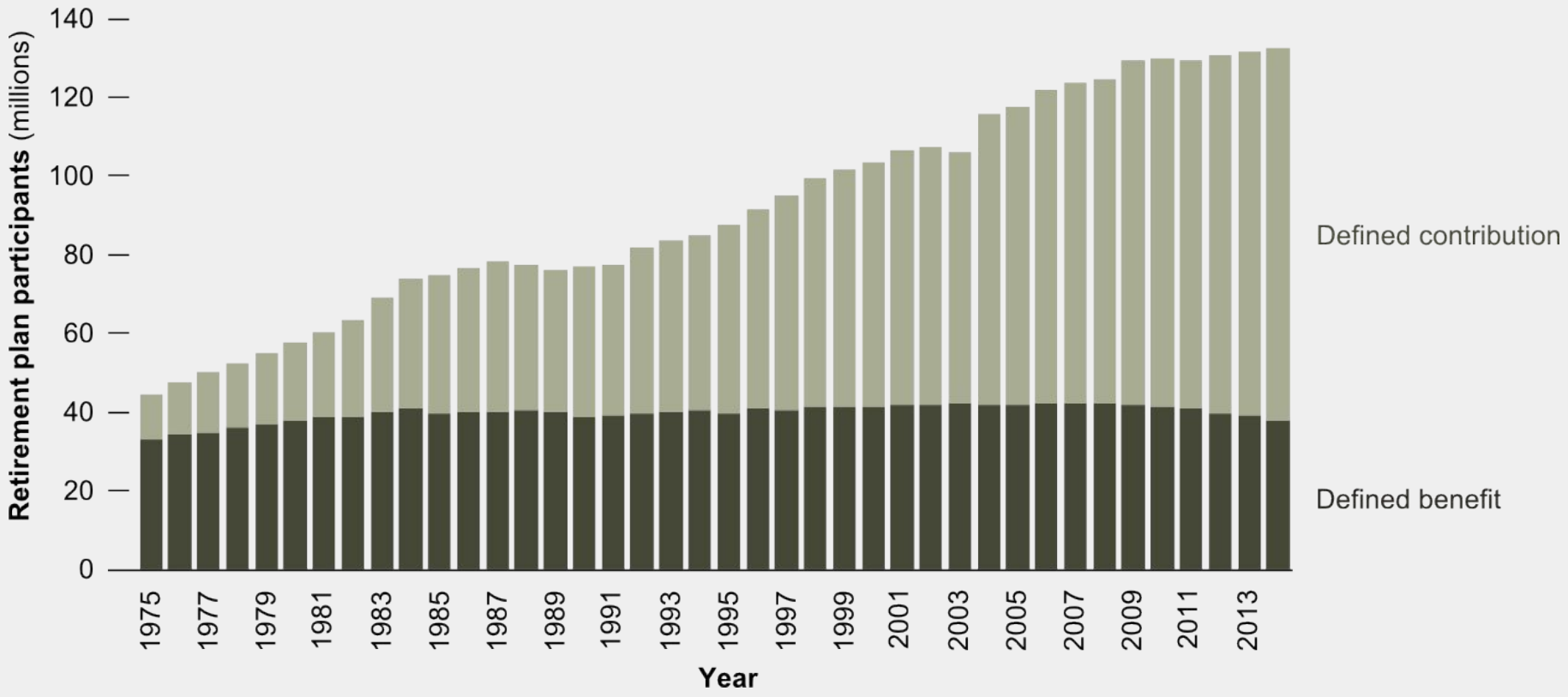
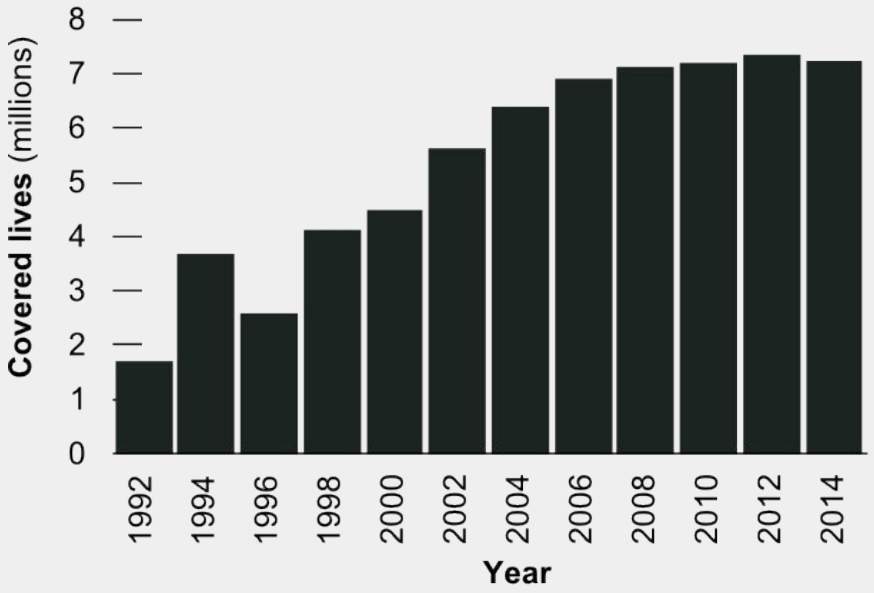


data: US DOL EBSA Private Pension Plan Bulletin Historical Tables and Graphs, 1975 - 2014

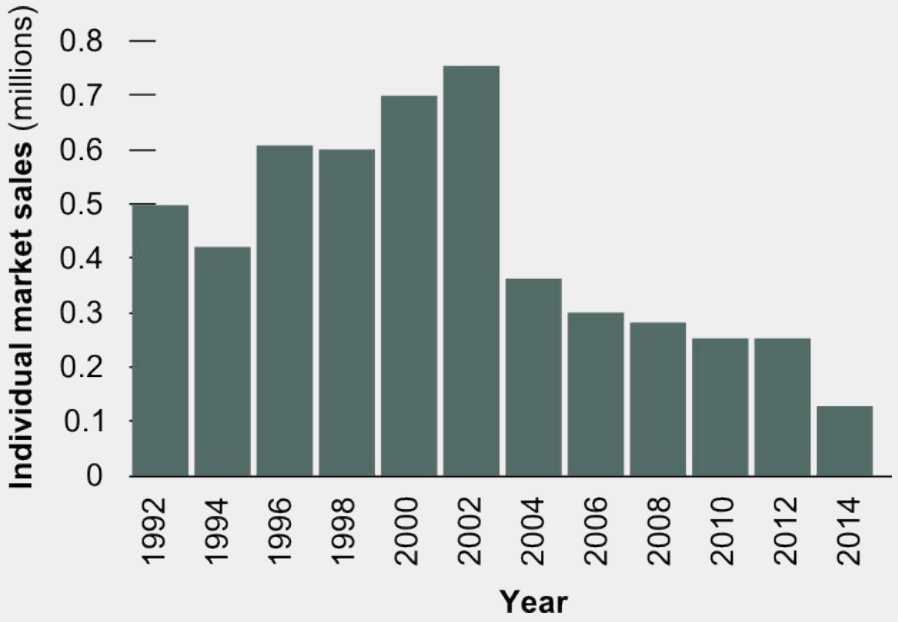
The outlook for long-term care insurance is poor

(page 9 of report)

Total covered lives

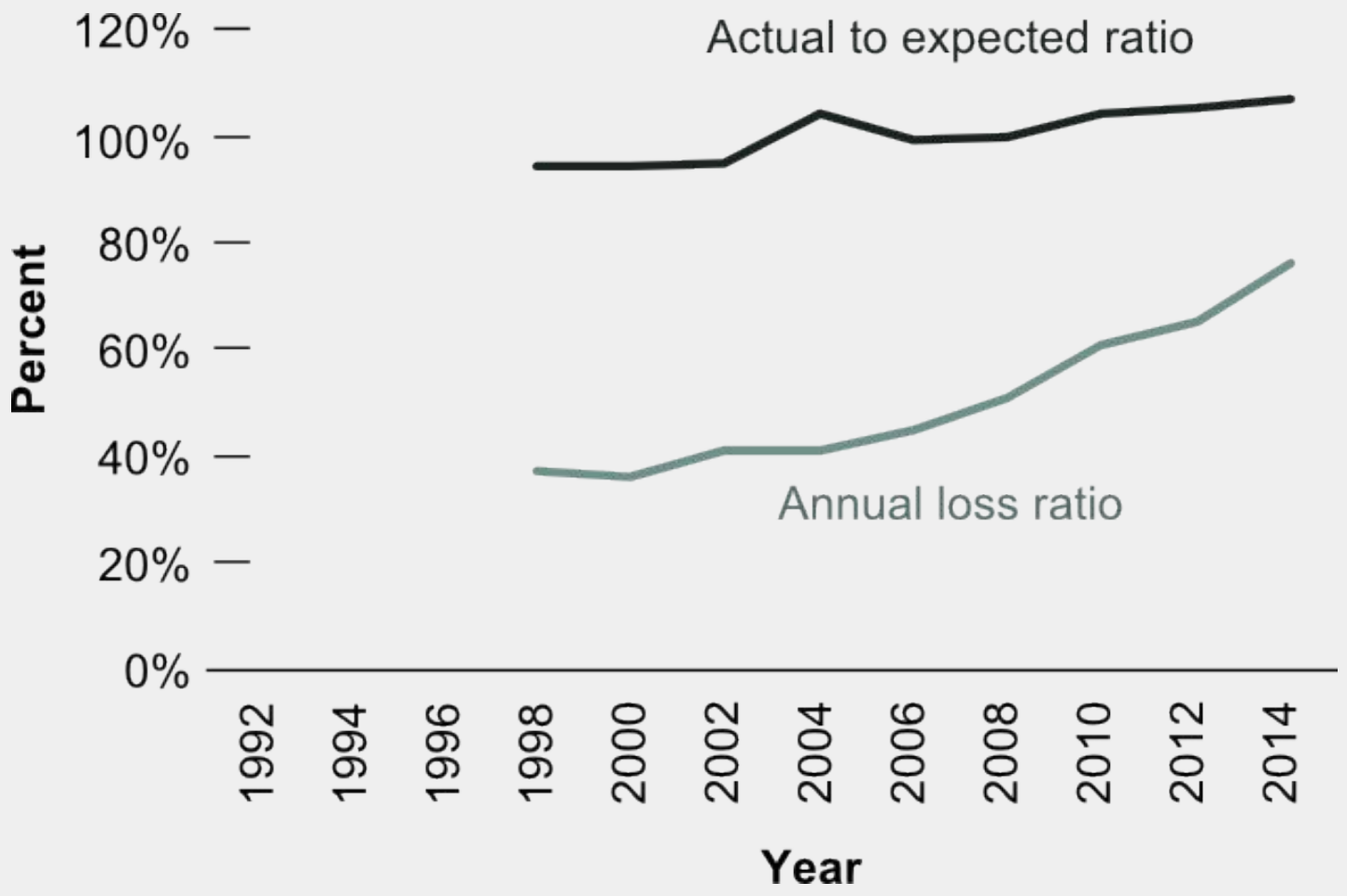


Individual market sales



data: NAIC Center for Insurance Policy and Research - The State of Long Term Care Insurance. 2016.

The outlook for long-term care insurance is poor



data: NAIC Center for Insurance Policy and Research - The State of Long Term Care Insurance. 2016.

Wyoming Medicaid - Long Term Care

Medicaid provides long-term care through three programs:

- → Skilled Nursing Facility (SNF) settings
- → Program of All-Inclusive Care for the Elderly (PACE)
  - ◆ Serves catchment area around Cheyenne (CRMC)
- → Community Choices Waiver
  - ◆ Long Term Care and Assisted Living Facility Waivers merged in SFY 2017.

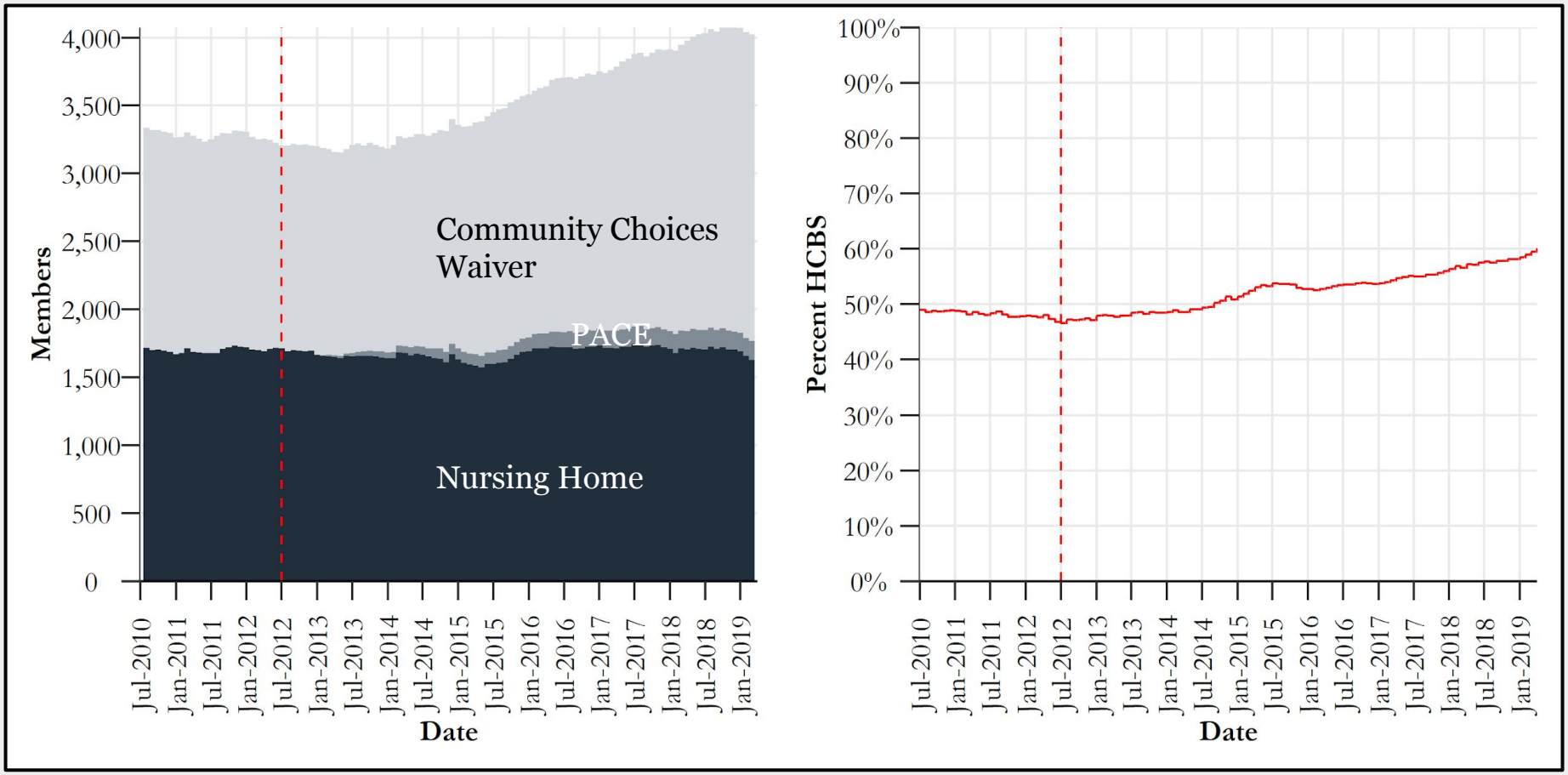
Skilled Nursing Facility: costs and enrollment

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	$79,967,179	20,307	1,692	$3,938
2012	$79,243,110	20,569	1,714	$3,853
2013	$77,134,902	20,232	1,686	$3,813
2014	$75,382,096	20,092	1,674	$3,752
2015	$74,242,244	19,667	1,639	$3,775
2016	$88,192,883	20,250	1,688	$4,355
2017	$89,955,370	20,592	1,716	$4,368
2018	**$89,642,788**	**20,878**	**1,739**	**$4,293**

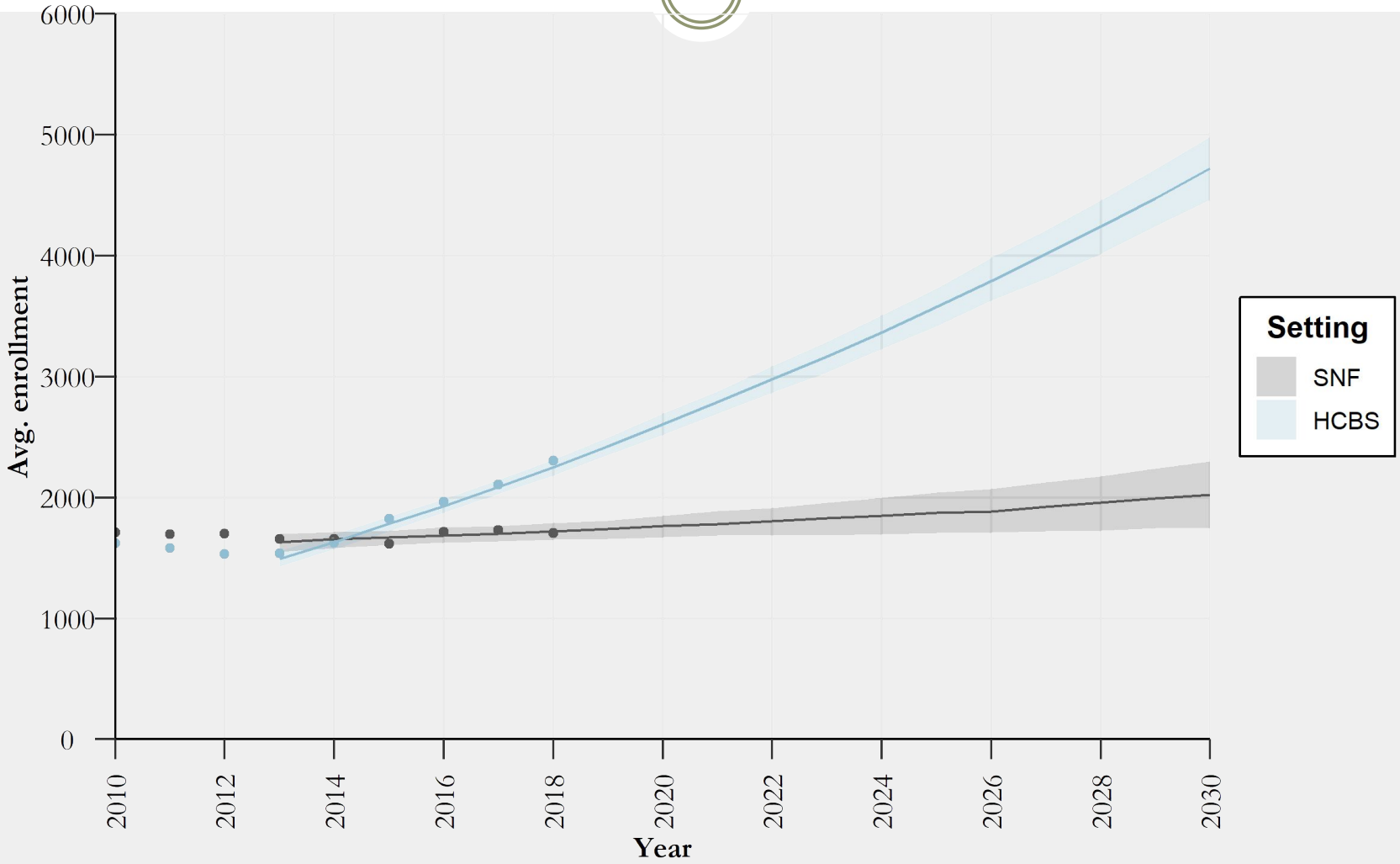
Community Choices Waiver

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	$31,663,825	19,203	1,600	$1,649
2012	$33,821,599	18,812	1,568	$1,798
2013	$30,383,671	18,152	1,513	$1,674
2014	$30,236,004	18,369	1,531	$1,646
2015	$32,719,341	19,776	1,648	$1,654
2016	$37,126,339	21,642	1,804	$1,715
2017	$38,522,589	22,865	1,905	$1,685
2018	**$40,758,131**	**24,916**	**2,076**	**$1,635**

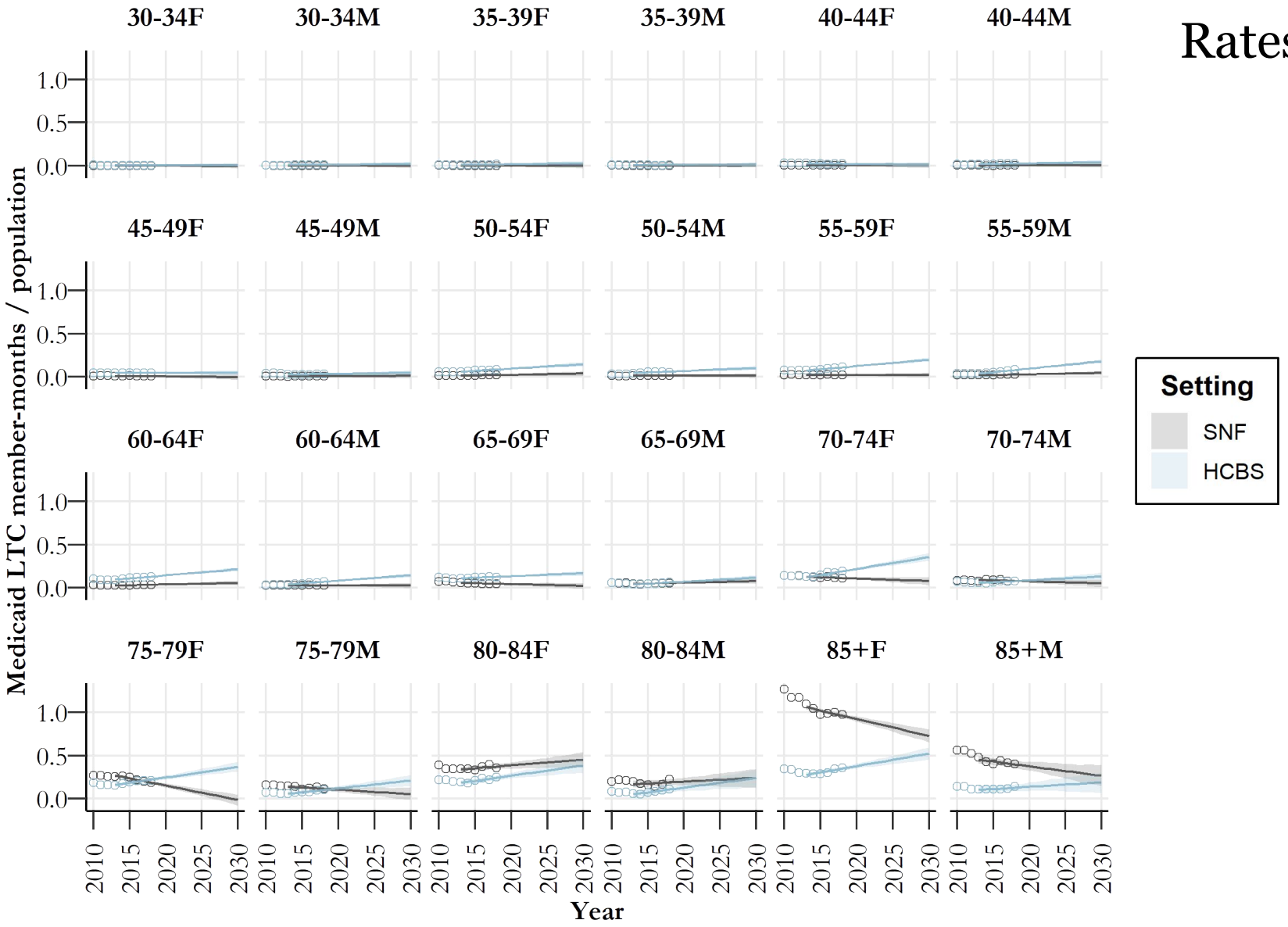
Medicaid Long-Term Care Trends



Projections - Medicaid enrollment



Rates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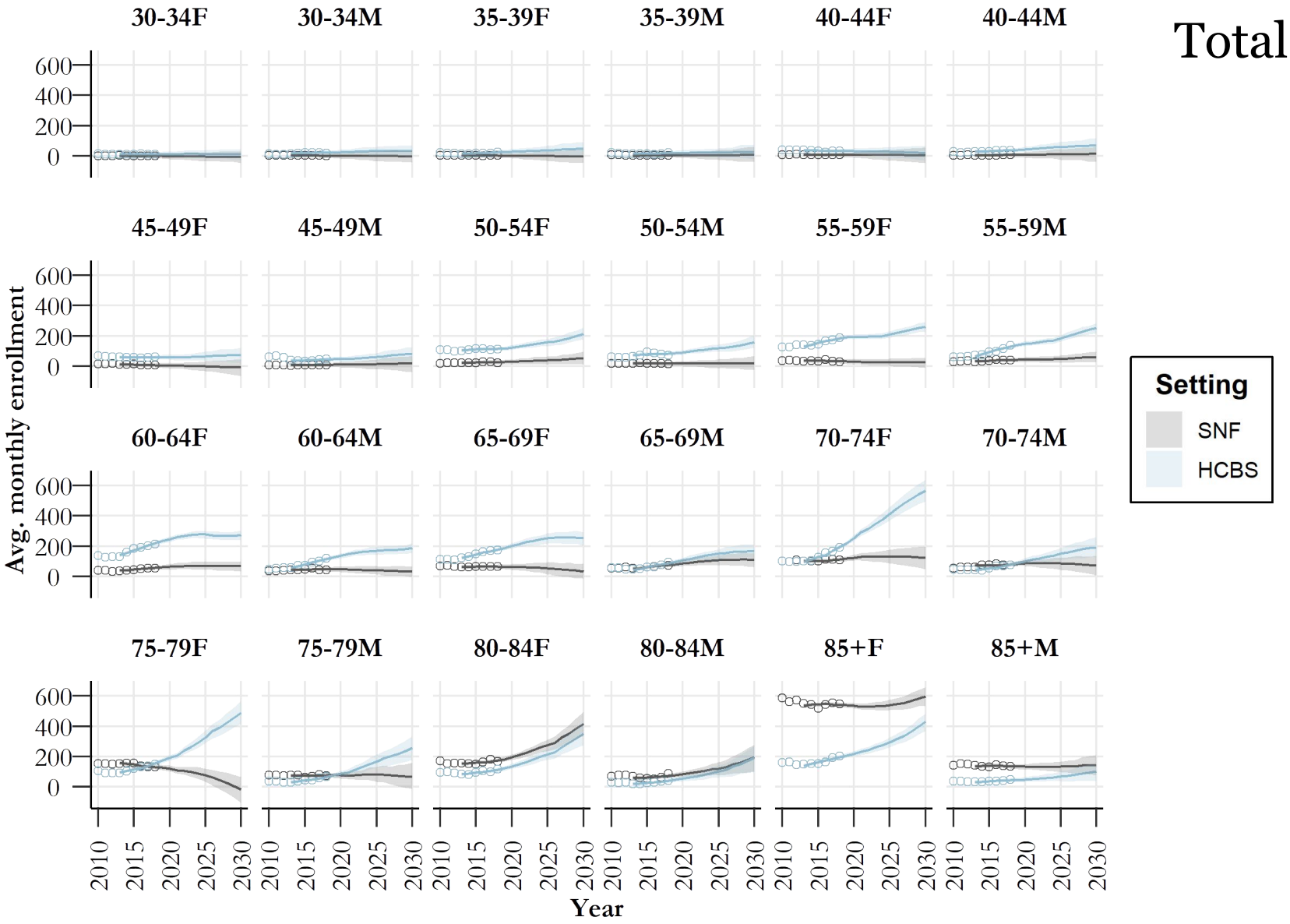
65-69M
70-74F
70-74M
75-79F
75-79M
80-84F
80-84M
85+F
85+M
Medicaid LTC member-months / population
1.0
0.5
0.0
2010
2015
2020
2025
2030
Year
Setting
SNF
HCBS

Totals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80-84F
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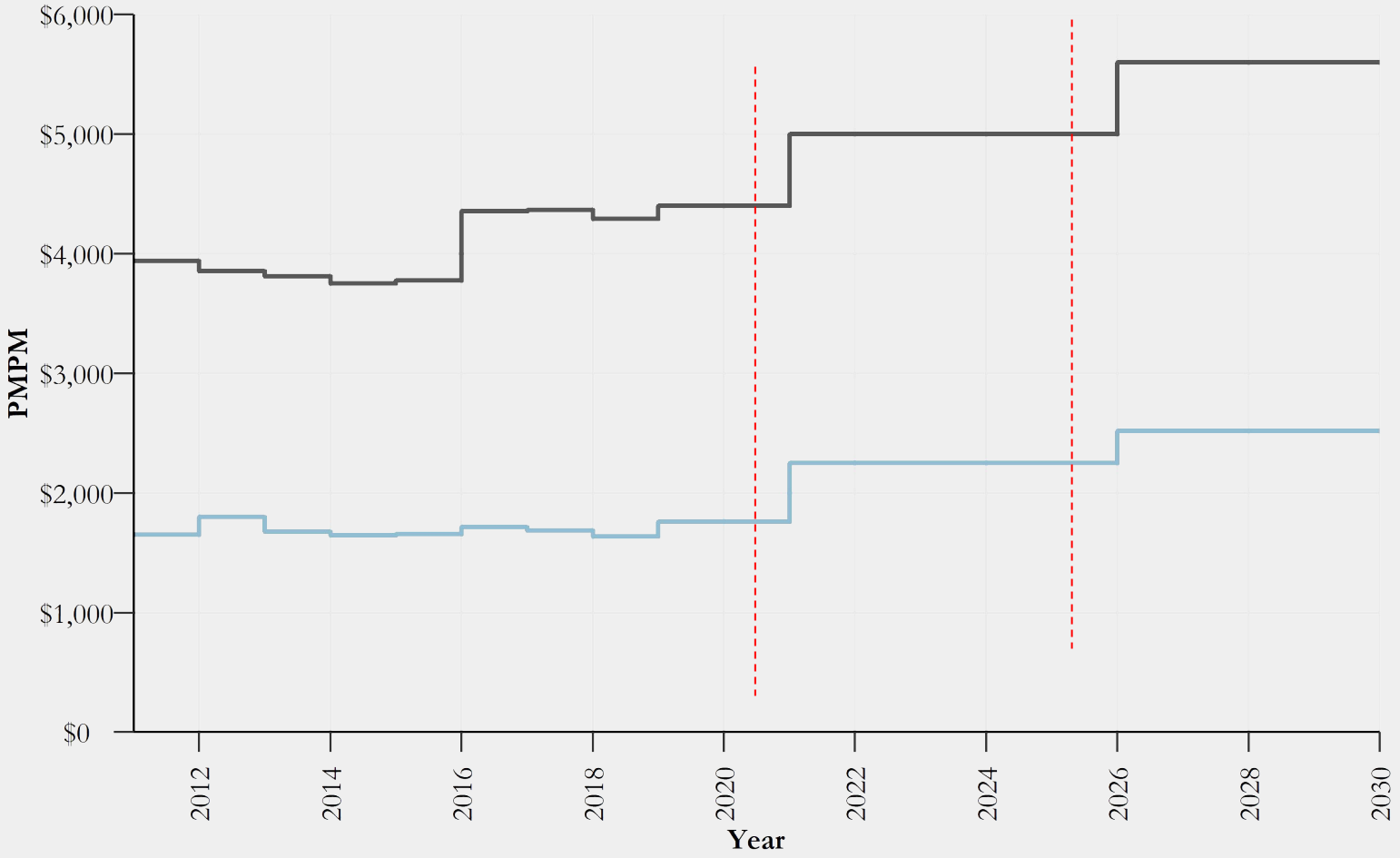
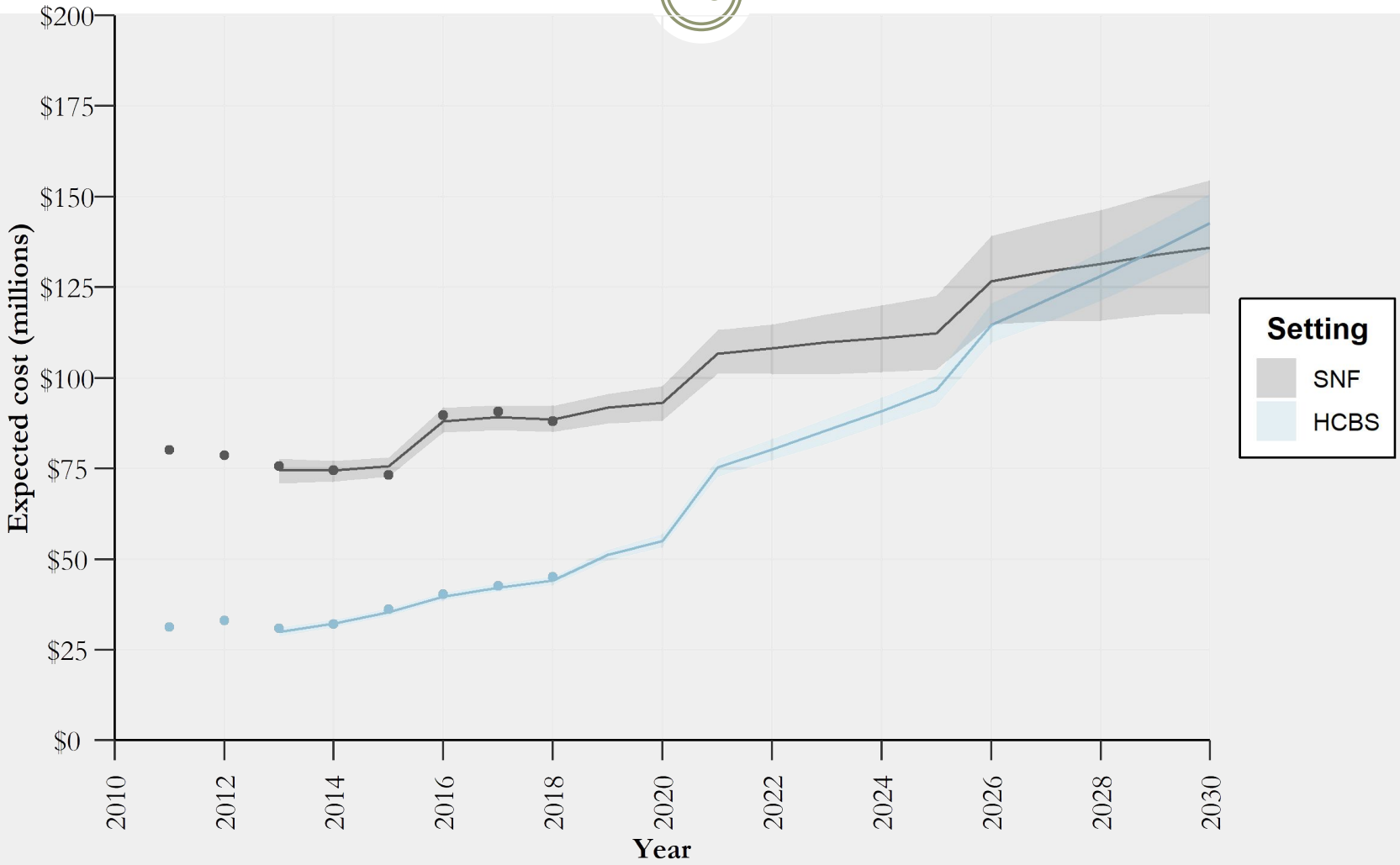
Avg. monthly enrollment
600
400
200
0
2010
2015
2020
2025
2030
Year
Setting
SNF
HCBS

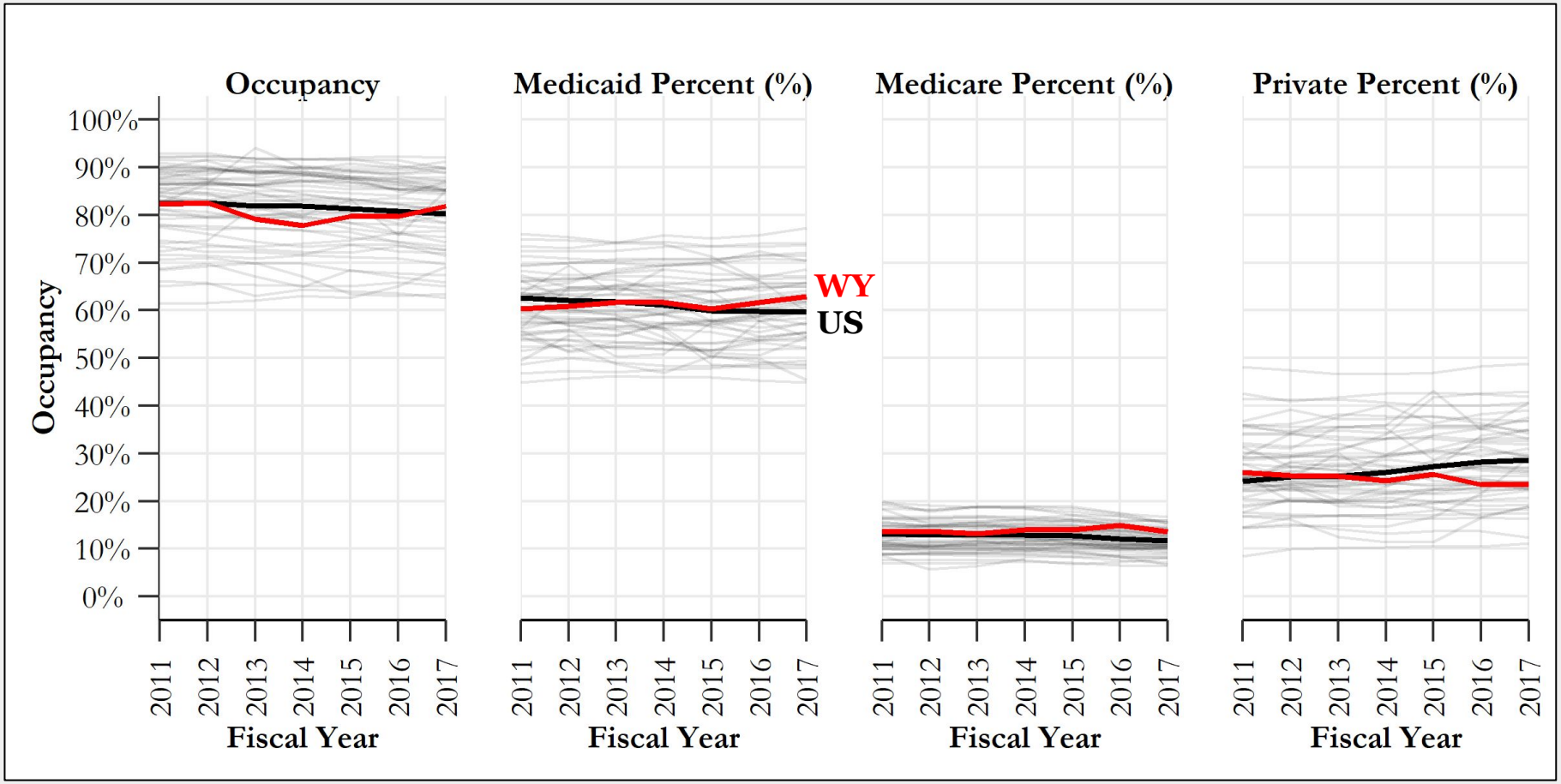
Projections - Medicaid PMPM



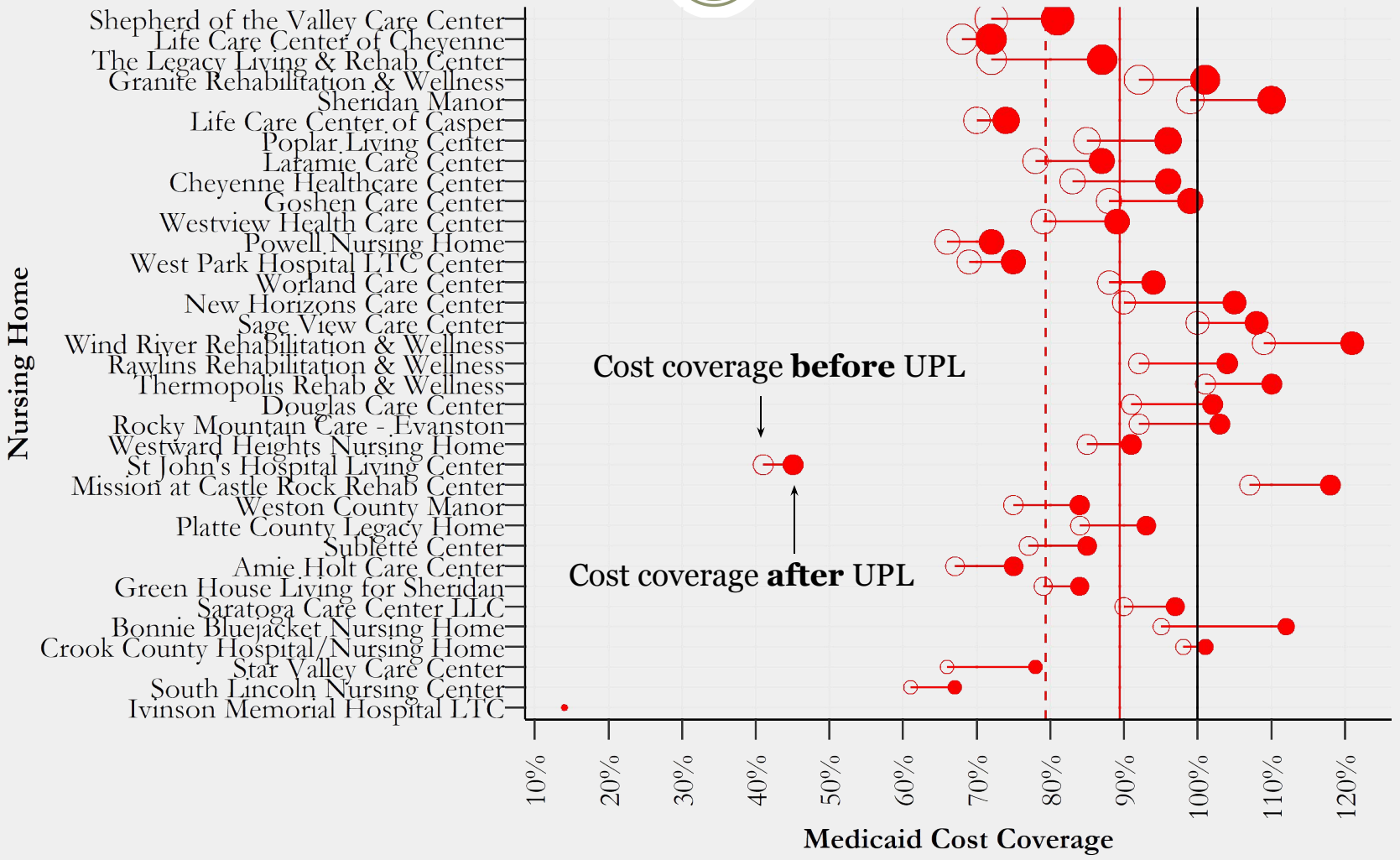
Projections - Medicaid cost



Nursing Home Market Trends



Nursing Home Cost Coverage



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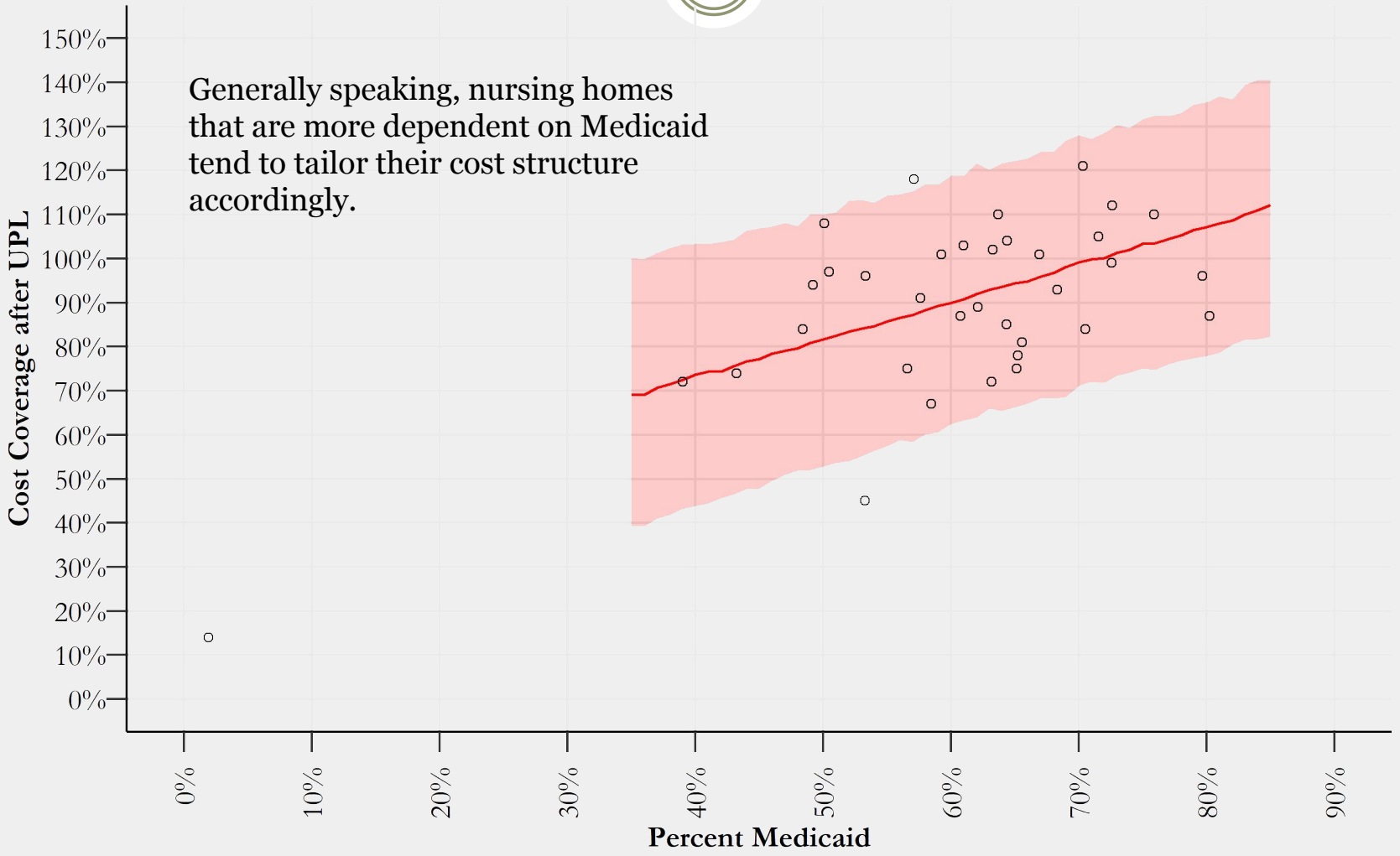

Labor force issues - VA SNF study

City	SNF workforce	Access to CNA graduates	CNA graduate quality	Median CNA wage	Median RN wage
Buffalo	104.4	79	72.64	$12.16	$28.62
Casper	860.9	138.02	66.26	$13.80	$28.73
Cheyenne	692.3	129.77	75.22	$13.87	$31.98
Sheridan	527.2	81.85	72.16	$12.77	$32.01
Gillette	320.6	67.54	75.95	$14.34	$30.71
Lander	119.0	41.21	63.68	$14.45	$29.85
Riverton	158.7	58.02	64.43	$14.45	$29.85
Laramie	169.2	106.87	77.55	$11.72	$27.57
Thermopolis	77.1	44.95	69.49	$14.15	$30.88
Rock Springs	124.5	80.27	85.22	$13.98	$28.12
Newcastle	143.3	22.49	78.93	$14.34	$30.71
Basin	178.8	33.86	75.35	$14.36	$30.04

CNA Apprenticeship Program

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Senior Administrator
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Department
of Health

CNA Apprenticeship Program

- In 2018, to address issues potentially related to CNA labor shortage in WY, a multi-agency workgroup was formed, including:
  - WDH
  - Board of Nursing
  - Workforce Services
  - Dept. of Labor
  - Industry partners
- Workgroup met to develop program framework and identify best practices and potential barriers.
- 34 week program consists of onsite classroom work, skills lab, and clinical experience. CNA earns $12/hr while working toward certification.
- WDH piloting the program at Wyoming Retirement Center.

WICHE Study Update

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Mental Health and Substance Abuse Services Administrator
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Behavioral Health Programs Overview

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Behavioral Health Division

Lindsey Schilling
Provider Operations Administrator
Wyoming Medicaid

Stefan Johansson
Policy Administrator

Wyoming Department of Health

WDH: Mental Health Continuum of Care

Prevention and community treatment. Examples:

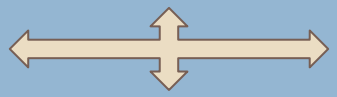
- Public Health Prevention
- Medicaid coverage
- CME (for children)
- Community mental health centers
  - Treatment
  - Gatekeepers
- Court Supervised Treatment (Drug Courts)

Hospital / Institutional Care. Examples:

- Wyoming State Hospital
  - Civil commitments (Title 25)
  - Forensic evaluations (Title 7)
- Other inpatient psychiatric stays
  - Designated hospitals (Title 25)
  - Medicaid
- Psychiatric Residential Treatment Facilities (PRTF) for youth
- Department of Corrections

Community step-down and aftercare. Examples:

- Community mental health centers
  - Outpatient & residential treatment
  - Gatekeepers
- State Hospital follow-up and monitoring
- Medicaid coverage (for those who qualify)



Legal System

Whether through Title 25, Title 7, sentencing alternatives through Court Supervised Treatment, Department of Corrections, or court-ordered PRTF placements, the legal system has a role in governing much of the mental health treatment continuum in Wyoming.

WDH Behavioral Health Programs

Division	Source	Purpose	Est. Annual Expenditures*
BHD	Mental Health/Substance Abuse	General access funding for community mental health and substance abuse treatment, Title 25 gatekeeper grants, and other programs delivered by community mental health and substance abuse centers	$51.8M
	Court Supervised Treatment	Sentencing alternatives through "Drug Courts"	$3.4M
	State Hospital	Inpatient psychiatric hospital for civil commitment and forensic evaluation, including Title 25 costs at designated hospitals and Title 7 costs for outpatient evaluations	$35.5M
PHD	SA/Suicide Prevention	Implement state-level prevention strategies and provide funding for community-level prevention programs for tobacco, substance abuse, and suicide.	$8.6M
HCF	Medicaid	Payments for MHSA-related claims (all providers)	$41.2M
	Care Management Entity	Wrap-around services for Medicaid children with mental health needs	$7.1M
	Psych. Residential Treatment	Residential treatment for youth	$12.1M
Total Funding (General Funds + Federal Funds + Other Funds)			**$159.7M**

*These figures come from estimated expenditures (e.g., contracts) for SFY 2019, historical claims data, or the 2019-2020 state budget.

Community Mental Health and Substance Abuse System

- → Operated by **Behavioral Health Division**
- → **18 contracted providers** statewide.
- → Funding includes **base payments and "per hour" reimbursements**.
- → Centers offer a **mix of outpatient and residential** services.
  - ◆ Outpatient services reimbursed at $87/hour for general population, $120/hour for priority populations (e.g., serious mental illness (SMI)).
  - ◆ Residential services funded separately, generally on a "per bed" basis.

Community Mental Health and Substance Abuse System

Statute	Purpose
§ 7-11-301 through 307	Mental illness or competency in criminal proceedings
§ 9-2-102	Foundation for the inclusion or performance and outcome measures in contracts for "human services" programs. Establishment of statewide suicide prevention program.
§ 9-2-2701	**Outlines the Substance Abuse Control Plan, in which community mental health and substance abuse centers play a key role.**
§ 9-2-2708	Authority for the Behavioral Health Division to award methamphetamine and other substance abuse treatment grants.
§ 35-1-611 et. seq.	**Established the Community Human Services Act to "maintain and promote…services in communities…to provide prevention or, and treatment for individuals affected by mental illness, substance abuse, or developmental disabilities, and to provide shelter and crisis services."**
§ 25-10-101 et. seq.	Legal system for emergency detention and involuntary hospitalization. Touches all aspects of the mental health continuum of care.

Community MHSA Treatment Funding, by Source

SFY	SGF	FF	TSF	Total		...of which, primary	...and secondary contracts[1]
2011	$42,881,232	$2,105,723	$4,411,953	$49,398,908			
2012	$42,403,609	$2,105,721	$4,411,951	$48,921,281			
2013	$46,759,185	$2,702,806	$4,411,951	$53,873,942		$51,322,831	$2,551,111
2014	$46,204,424	$2,562,260	$4,797,502	$53,564,186		$51,192,361	$2,371,825
2015	$46,405,494	$2,572,886	$4,791,602	$53,769,982		$51,407,774	$2,362,208
2016	$46,339,640	$3,094,544	$4,791,602	$54,225,786		$51,437,518	$2,788,268
2017	$40,774,041	$3,464,382	$4,791,602	$49,030,025		$47,871,844	$1,158,181
2018	$42,745,371	$5,883,987	$4,781,380	$53,410,738		$48,971,025	$3,239,727

[1] Secondary contracts include those for peer specialists, continuous funding received through House Enrolled Act 136 from the 2005 General Session, quality of life funds, and special projects.

Wyoming Medicaid: Behavioral Health Services

- Medicaid covers MH/SA services for individuals **who qualify for Wyoming Medicaid:**
  - Elderly
  - Disabled
  - Children
  - Extremely low-income caretakers.
- Service examples:
  - Outpatient (e.g., therapy, case management, peers)
  - Hospital services
  - PRTF
  - Care management entity for youth

Wyoming Medicaid: Behavioral Health Services

- → **~2,500 enrolled providers** (both in-state and out-of-state).
- → **~12,500 unique recipients** of MH/SA services each year.
- → Most services are reimbursed on a **fee-for-service** basis.

Prevention Funding Overview

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Commit to your health.

Prevention activities

Prevention funding breakdown

Activity	Percent	Funds
Workgroups & councils	2.4%	$400,000
Wyoming Tobacco Quitline	9.9%	$1,666,546
Research & technical assistance	14.9%	$2,513,400
Community prevention grants	52.2%	$8,800,000
Media	8.1%	$1,362,260
Alcohol & tobacco compliance checks	5.9%	$995,000
Tools & resources	4.4%	$739,950
Training & education	2.3%	$380,000
Total		$16,857,156

County prevention funding

County	Total
Albany	$447,150
Big Horn	$247,466
Campbell	$506,920
Carbon	$273,135
Converse	$261,845
Crook	$213,492
Fremont	$458,265
Goshen	$258,589
Hot Springs	$192,985
Johnson	$221,548
Laramie	$900,492
Lincoln	$303,073

County	Total
Natrona	$758,584
Niobrara	$175,613
Park	$380,926
Platte**	$222,197
Sheridan	$385,777
Sublette	$231,545
Sweetwater	$486,458
Teton	$333,298
Uinta	$312,367
Washakie	$218,434
Weston	$209,843

***Platte County has not requested funding.*

Prevention priorities

- Counties have been asked to allocate funding within the following program areas:
  - 4%-14% - Opioid/prescription drug and other drug
  - 14%-24% - Tobacco prevention
  - 16%-26% - Adult binge drinking
  - 18%-28% - Underage alcohol use
  - 23%-33% - Suicide prevention

Air Ambulance Waiver

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Wyoming
Department
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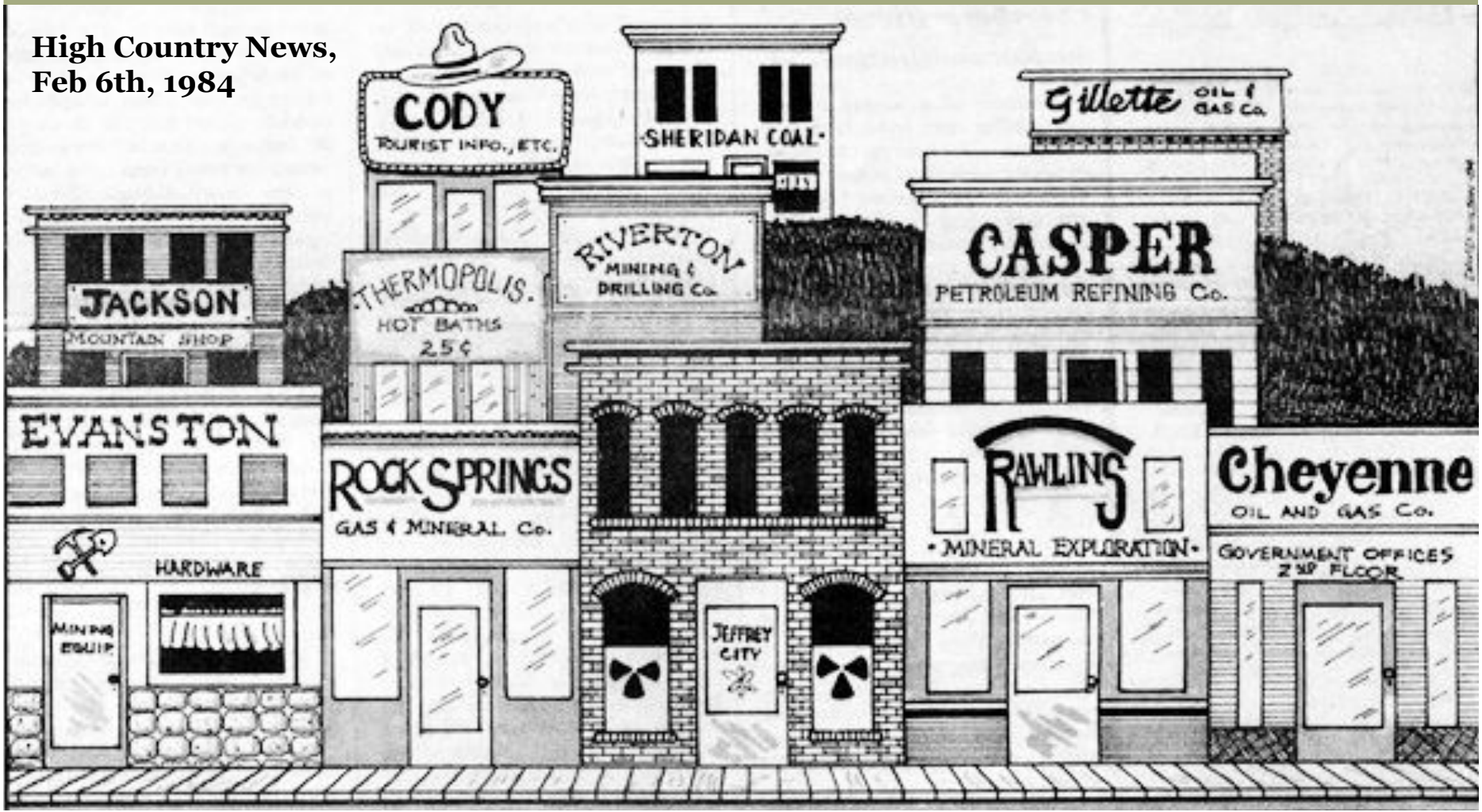
Agenda

- Executive summary
- Legislative requirements
- Background - air ambulance in Wyoming
- What is the problem we're trying to solve?
- Policy proposal
  - Goals and criteria
  - Primary and secondary models
- Waiver process
  - Timeline
  - Public input

Executive Summary



Executive summary

- ➔ **What's the problem?**
  - **Average cost** of an air ambulance flight is too high; increases prices paid and drives "surprise billing."
  - Largely caused by a growing number of air ambulance providers serving a set amount of calls.
- ➔ **What's the proposed solution?**
  - Increase the productivity of expensive air ambulance assets by treating them like a **public utility**.
  - This is similar to how a "small town with really long streets"* might approach local fire or police coverage.
- ➔ **Why Medicaid?**
  - State-only policy generally overruled by federal law when it comes to air ambulance sector. Need **federal partner**.

Legislative requirements

Legislative requirements

- **House Enrolled Act 112** (2019 General Session), if fully implemented, would cover most (non-Medicare) air ambulance flights in Wyoming through Medicaid.
- Though specific policies are spelled out in the bill, there remains **significant uncertainty** as to what exactly will be approved by the federal government.
  - In order to maximize chance of waiver approval, this plan departs in places from the statute.
  - If approved by CMS, we therefore anticipate that **statute changes** will be required in the Budget Session.
  - This represents another opportunity for the Legislature to consider this issue in light of federal feedback and make a final decision.

Short-term Legislative requirements

- **House Enrolled Act 112** (2019 General Session) requires the Department, effective immediately, to:
  - Seek approval from the Governor on whether to proceed with waiver application, no later than April 1st, 2019 [Section 5(a)];
  - If approval is granted, convene working group of stakeholders to provide feedback on waiver application [Section 5(c)];
  - Submit all waiver and state plan applications necessary to implement Sections 1 - 3 of the Act; report to Joint Labor as to details of application.
  - Request support for the application from the congressional delegation [Section 5(b)].

Background

Stylized facts - air ambulance in Wyoming

Most air ambulance trips are hospital to hospital transfers

Transport Type	Mode	Count	Percent
9-1-1 Scene Response	Helicopter	342	8.5%
Interfacility (hospital to hospital)	Helicopter	1,625	40.1%
	Plane	2,079	51.4%
Total		**4,046**	**100%**

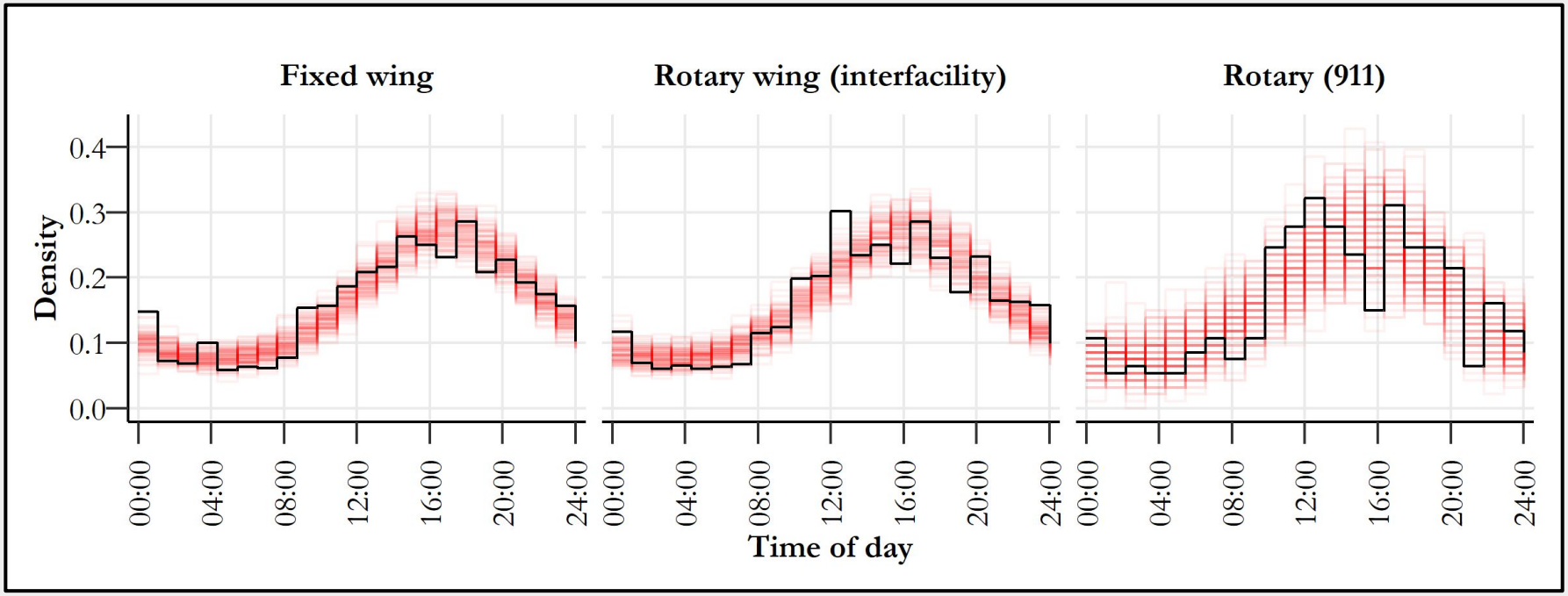
Stylized facts - air ambulance in Wyoming

Largest volume from private plans and Medicare

Payer	Count	Percent
Medicaid	~500	12.5%
Medicare	~1,500	37.5%
Workforce Services	~100	2.5%
Self-pay	~400	10.0%
Other government	~200	5.0%
Private plans + EGI	~1,300	32.5%
Total	**~4,000**	**100.0%**

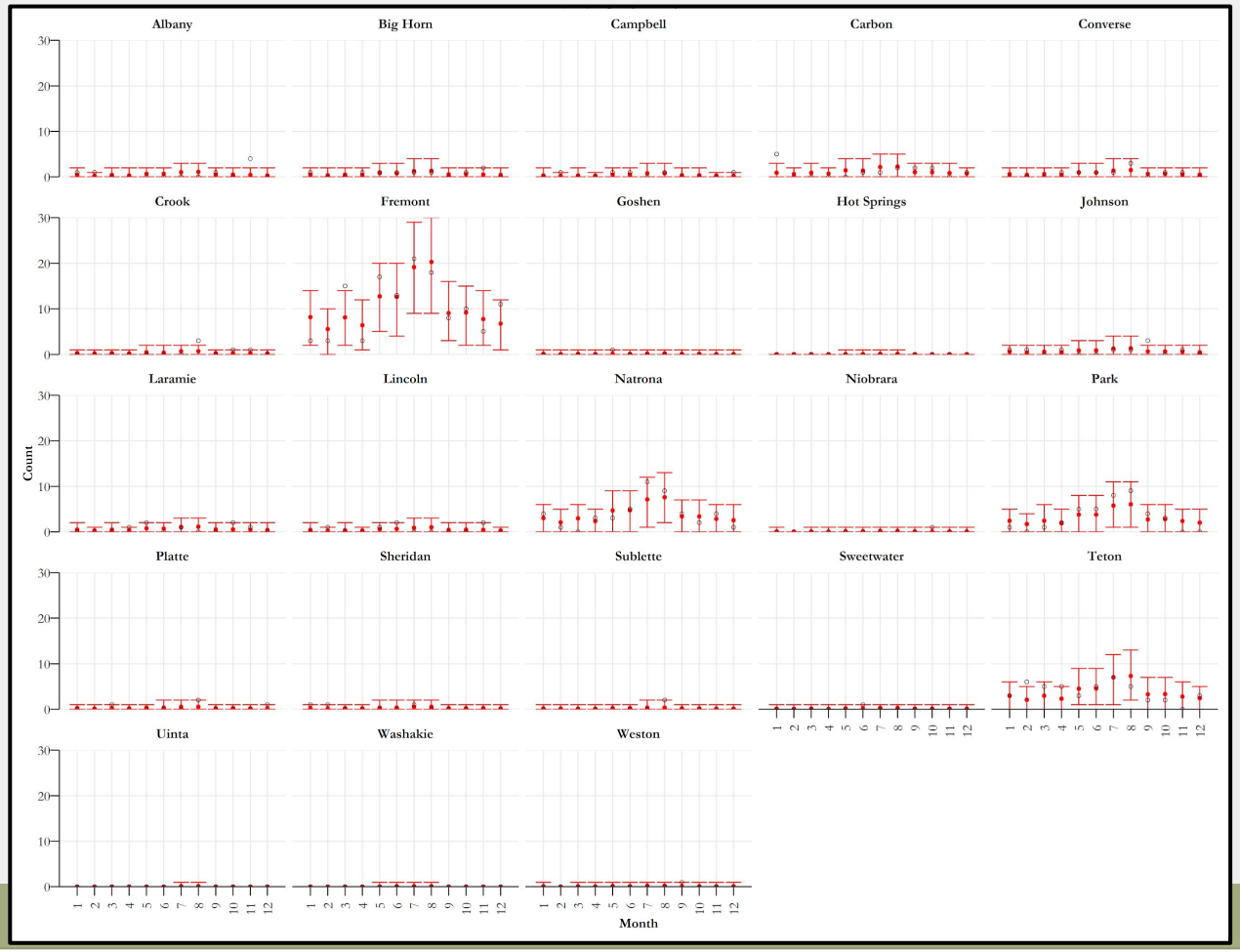
Stylized facts - air ambulance in Wyoming

Peak times for most flights are in the afternoon



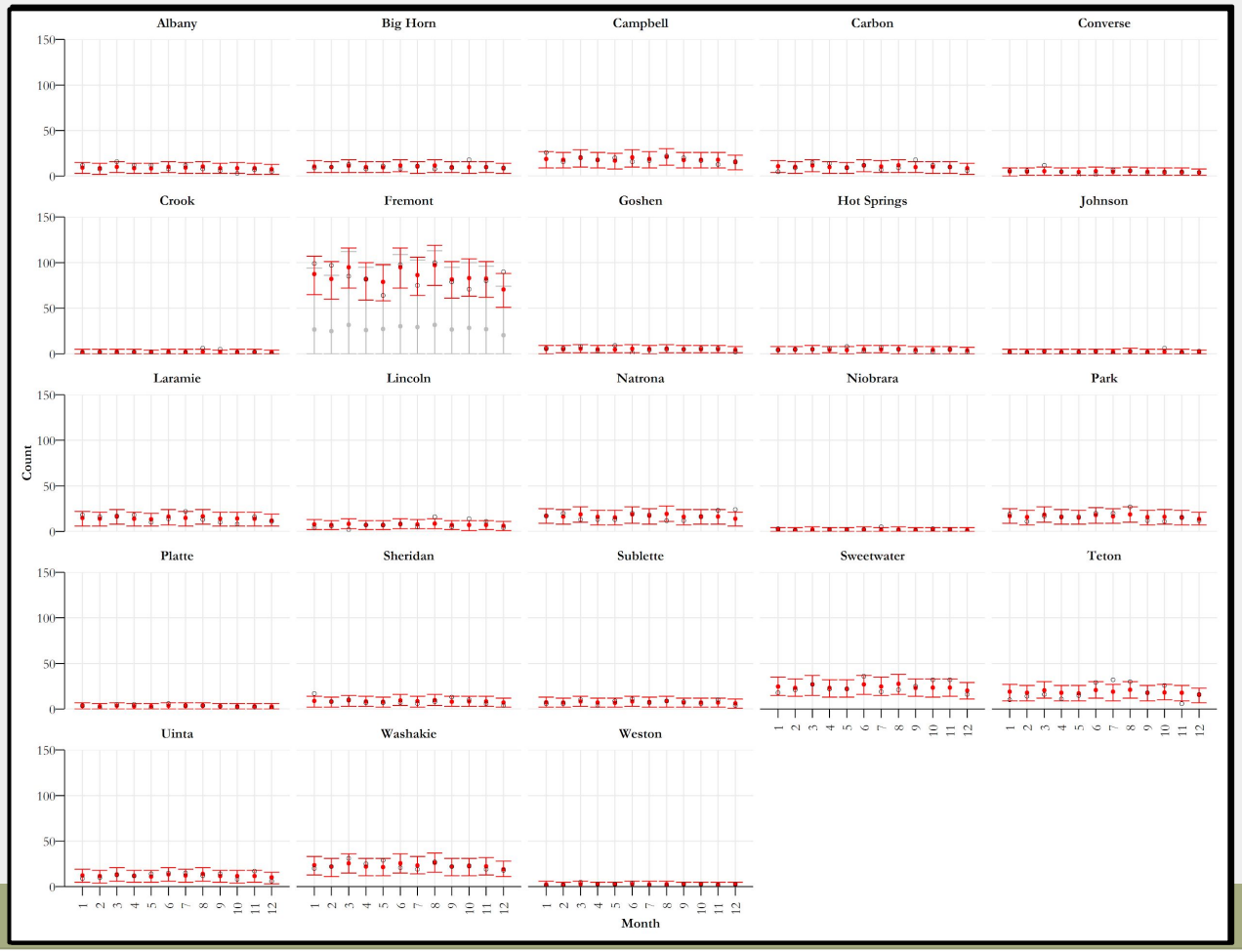
Stylized facts - air ambulance in Wyoming

9-1-1 scene response volume varies by county and season



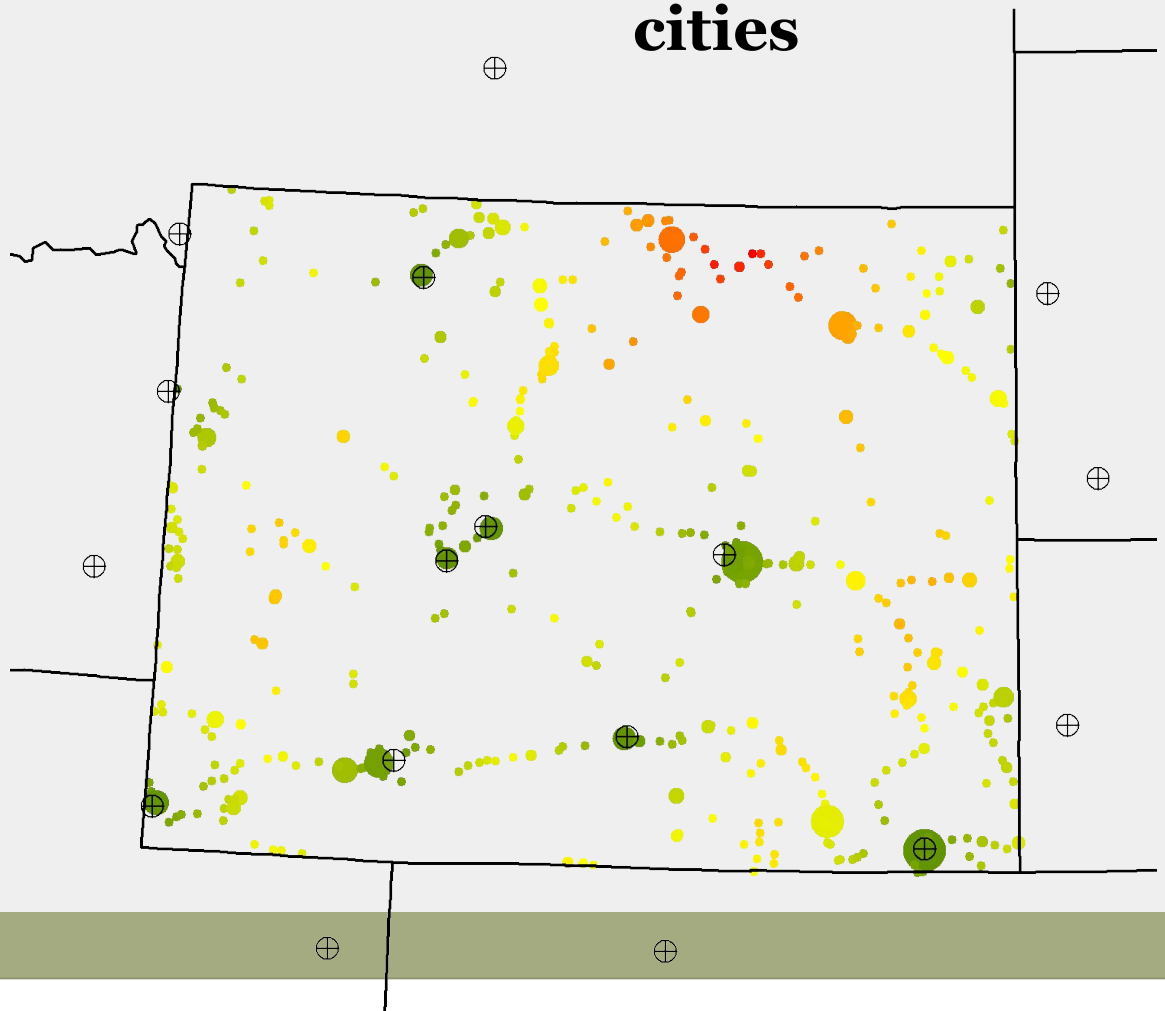
Stylized facts - air ambulance in Wyoming

Interfacility response volume varies by county



Stylized facts - air ambulance in Wyoming

Rotary-wing base locations and distance to Wyoming cities



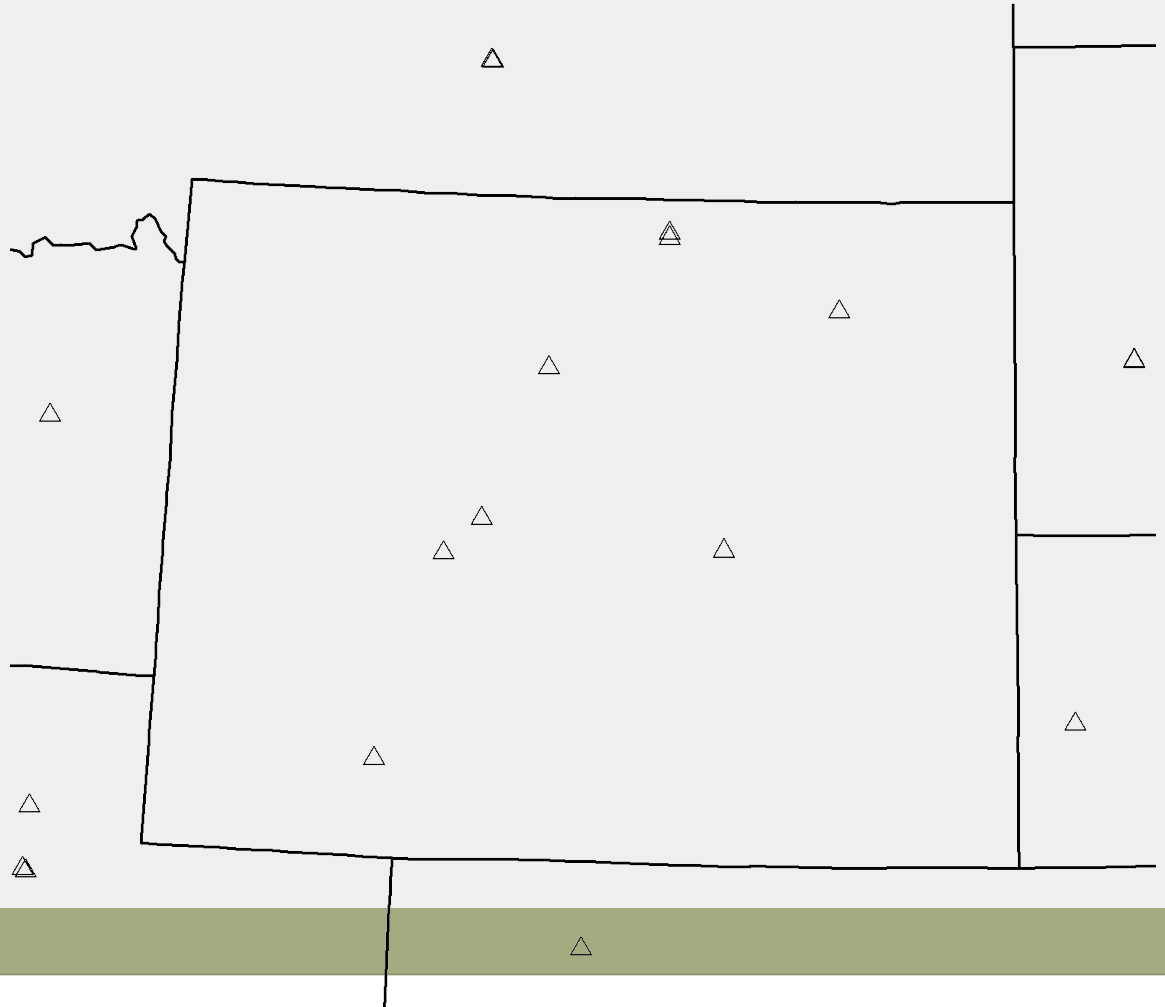
Color represents distance from closest base

- Green - < 10 miles
- Yellow - 50 miles
- Red - 120 miles

Size of point proportional to population of city/town

Stylized facts - air ambulance in Wyoming

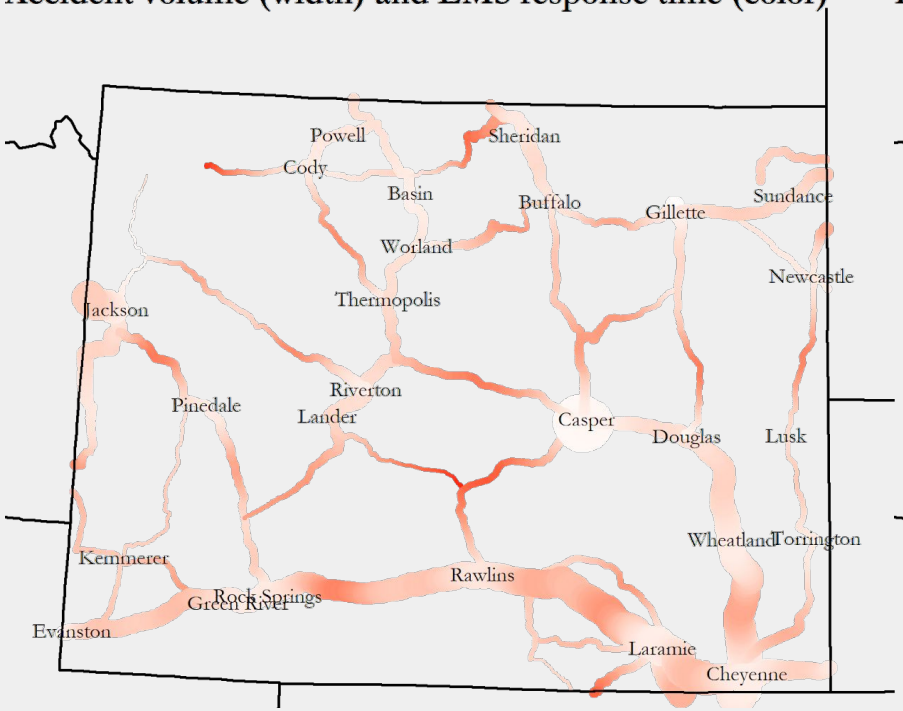
Fixed-wing (planes) base locations



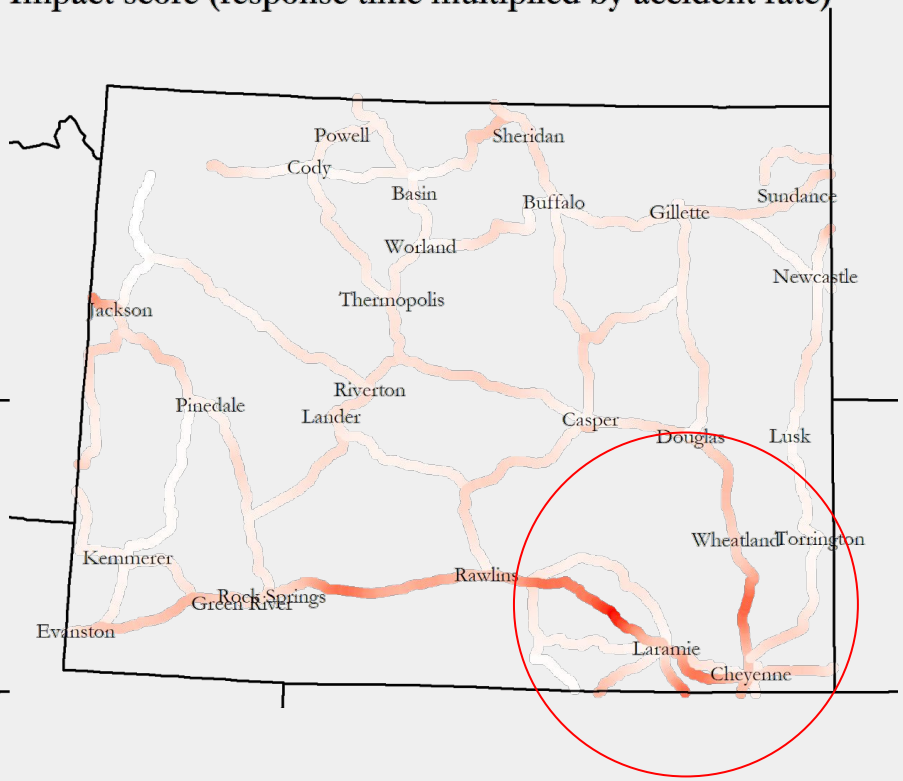
Stylized facts - air ambulance in Wyoming

Highway accident volume and EMS response time

Accident volume (width) and EMS response time (color)



Impact score (response time multiplied by accident rate)



Potential gap

Problems

Perceived problems ("symptoms")

- **Workers' Compensation case**
  - WFS court-ordered to pay billed charges (previously had fee schedule set in rule).
  - Perceived affront to State sovereignty.
  - May increase premiums on employers.

- **Balance billing**
  - We know few air ambulance companies are in-network, due to difficulties with insurer negotiations.
  - Anecdotes of high ($30 - $70K) balance-billing practices on individuals.
    - However, little available data on amounts actually paid; frequency or impact of medical bankruptcies.

Deeper issues - State policy pre-empted

➔ **Most attempts by states to regulate air ambulance industry have been preempted by federal law.**

- 1978 Airline Deregulation Act prohibits state from enacting regulation "related to a price, route or service of an air carrier."
- This preemption clause has been broadly interpreted to include *any* regulation having *direct or indirect* impact on rates, routes or services
- Only laws directly related to assuring appropriate medical care are not preempted.

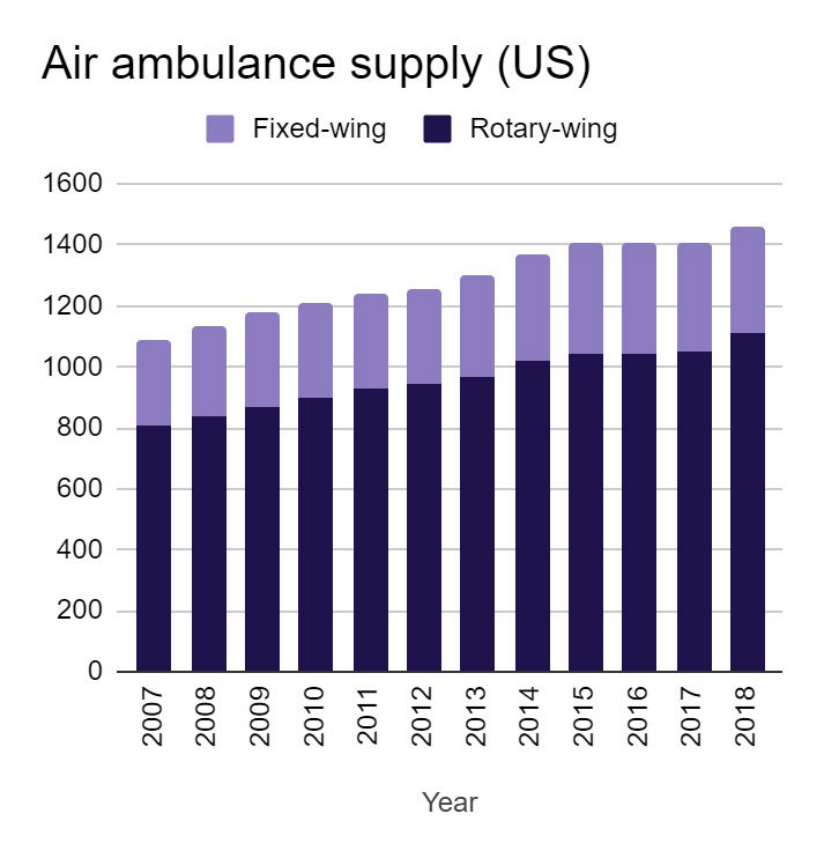
Deeper issues - economics

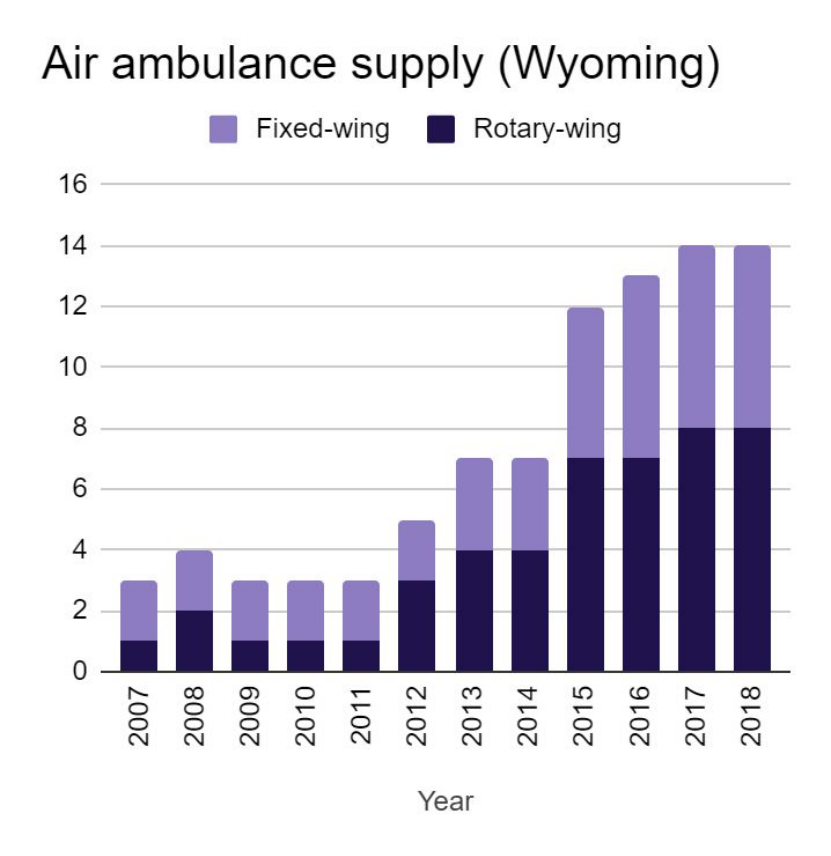
- **The free market does not work effectively to balance cost against access.**
  - Consumers often cannot make informed decisions or 'vote' with their dollars based on price or quality;
  - Prices do not appear to be limited by demand;
  - Supply has grown over last decade;
  - Productivity has fallen and average costs have increased, further increasing prices.

- **Amount, distribution and cost of air ambulance services may therefore not be optimal.**

Deeper issues - economics

→ **Supply has grown steadily over past decades.**





Data compiled from Atlas and Database of Air Medical Services (ADAMS) http://www.adamsairmed.org/products.html

Deeper issues - economics

→ **Air ambulance companies have high fixed costs.**

- Fixed costs ~ 80 - 85% of total costs.
- Avg. cost per base est. $3-4M.
- Why?
  - Capital-intensive operation (airplanes, helicopters, night-vision goggles, simulators).
  - Continuous staffing for unpredictable and highly variable demand.

Deeper issues - economics

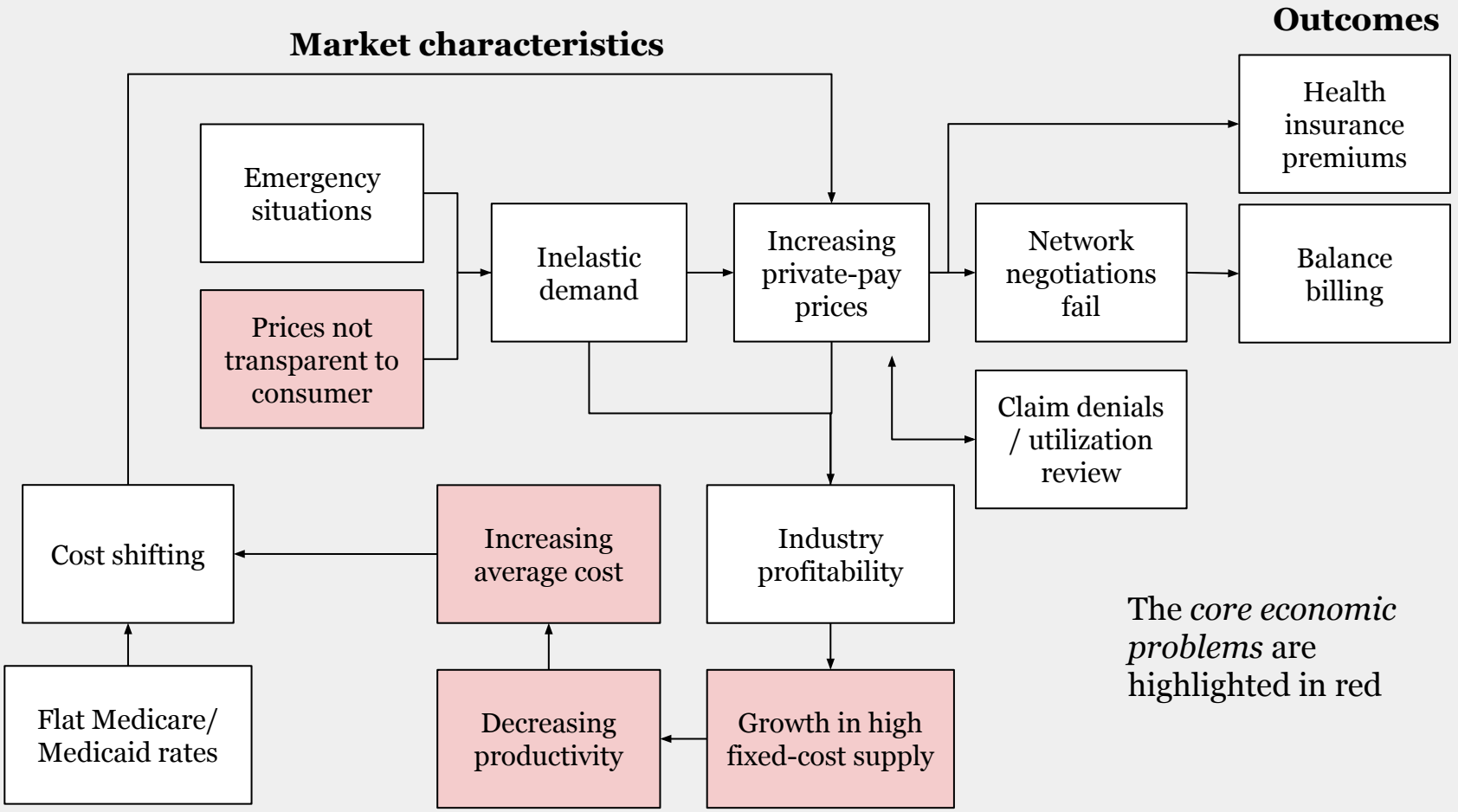
Growth of fixed costs spread over given volume of demand means **increasing average costs.**

- → Nationwide, **productivity** (patients flown per helicopter per year) has fallen from high of 688 in 1990 to 352 in 2016 (Bloomberg, 2018).
- → This often means **better access**.
- → However, **median price charged** increased 76% between 2010 and 2014 (GAO, 2018), from ~$17K to ~ $30K.
- → Today, Wyoming employers pay average of **$36K** per flight.

Deeper issues - economics

- **Prices** paid by insurers and employers reflect increasing average costs, but are compounded by **"cost-shifting" from public payers, claim denials by insurance companies, and uncompensated care.**
  - Medicaid and Medicare rates have not kept pace with increasing average costs.
    - 2017 industry cost study estimates that Medicare paid ~59% of average transport cost in 2015.
  - In order to make up revenue, air ambulance providers increase charges.
- Increasing prices affect health insurance **premiums**.
- Increasing prices lead to **balance billing** on consumers when network negotiations with insurers break down.

Deeper issues - economics



The *core economic problems* are highlighted in red

Policy proposal

Goals of waiver application

Goal 1

Eliminate **balance billing**.

Goal 2

Reduce cost for all payers, while delivering set level of **access**.

Goal 3

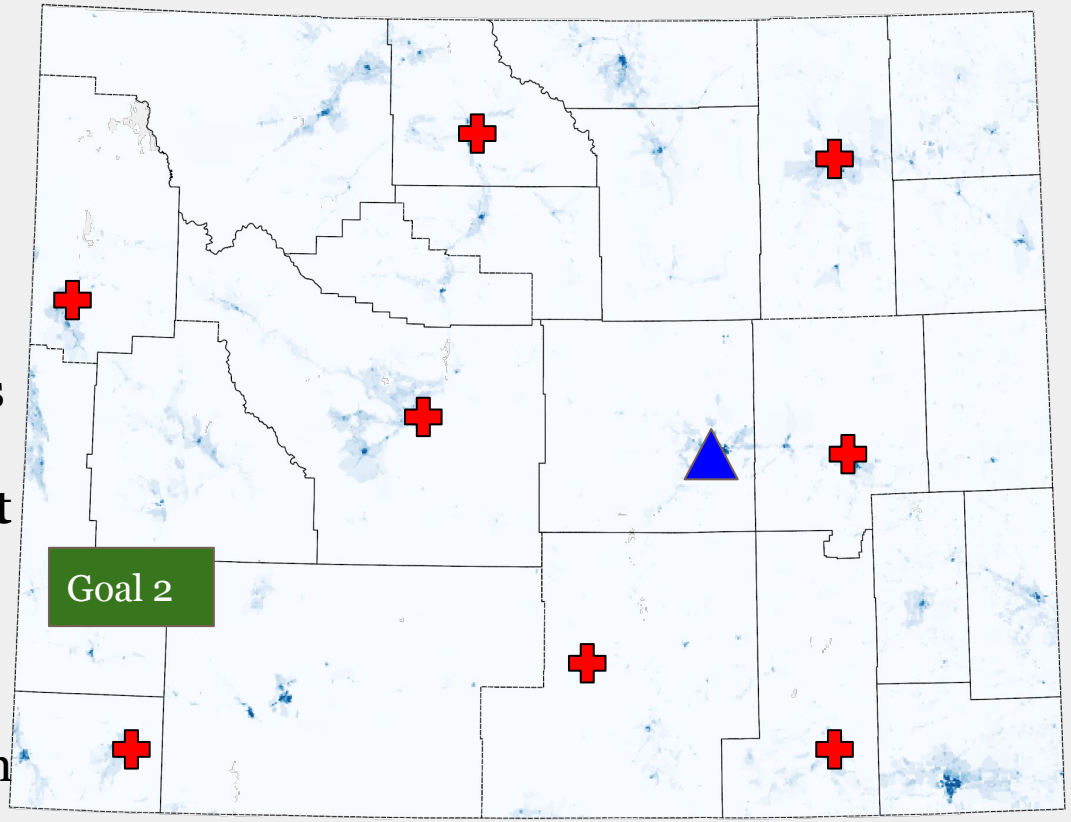
Improve **price transparency**, so consumers can make informed decisions in non-emergent situations.

Proposed plan - “utility” model

- In many cases with high fixed costs, it is more cost-efficient to provide services through a **regulated monopoly**.
  - Water lines, natural gas pipe, electricity transmission, roads.
  - Fire, police and ground EMS services are almost always local monopolies.
- In all of these cases, duplication of infrastructure among multiple providers would increase costs.
- This plan considers air ambulance like **a public utility** with high fixed costs and universal service.
  - Maximizing productivity of assets **lowers average cost.**

Proposed plan - “utility” model

- State evaluates air ambulance **requirements** for State as a whole.
  - Trauma/9-1-1 (RW)
  - Fixed-wing
  - Speciality care
- Potential RW base locations selected to balance **access** (e.g. *response time*) vs. **cost** (e.g. *per-base productivity*)
- These **access vs. cost decisions** could be made periodically by a board, with **public accountability**.



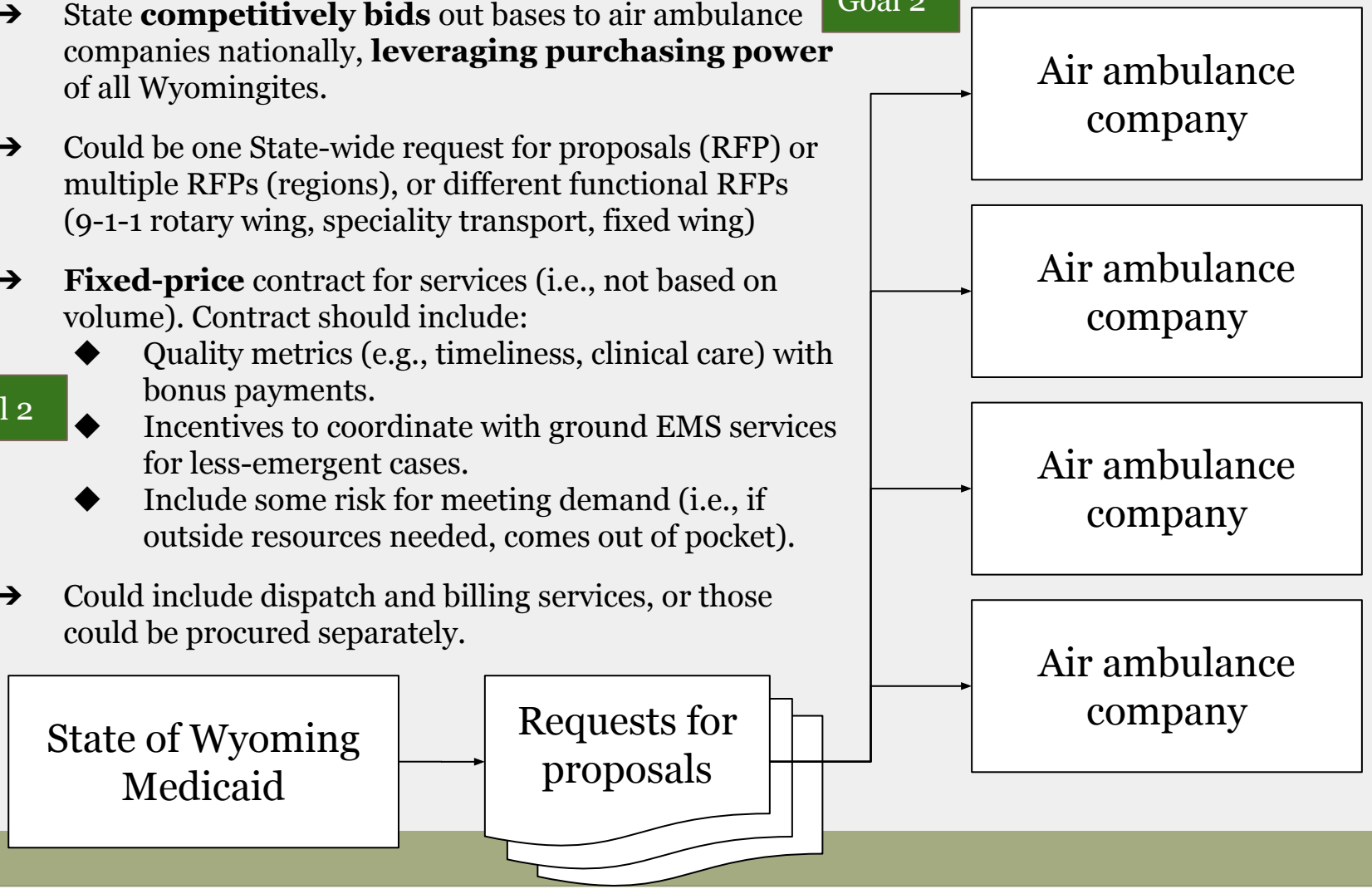
Example base distribution (RW as red crosses, FW as triangle)

“Utility model” - procurement

- ➔ State **competitively bids** out bases to air ambulance companies nationally, **leveraging purchasing power** of all Wyomingites.
- ➔ Could be one State-wide request for proposals (RFP) or multiple RFPs (regions), or different functional RFPs (9-1-1 rotary wing, speciality transport, fixed wing)
- ➔ **Fixed-price** contract for services (i.e., not based on volume). Contract should include:
  - ◆ Quality metrics (e.g., timeliness, clinical care) with bonus payments.
  - ◆ Incentives to coordinate with ground EMS services for less-emergent cases.
  - ◆ Include some risk for meeting demand (i.e., if outside resources needed, comes out of pocket).
- ➔ Could include dispatch and billing services, or those could be procured separately.

Goal 2

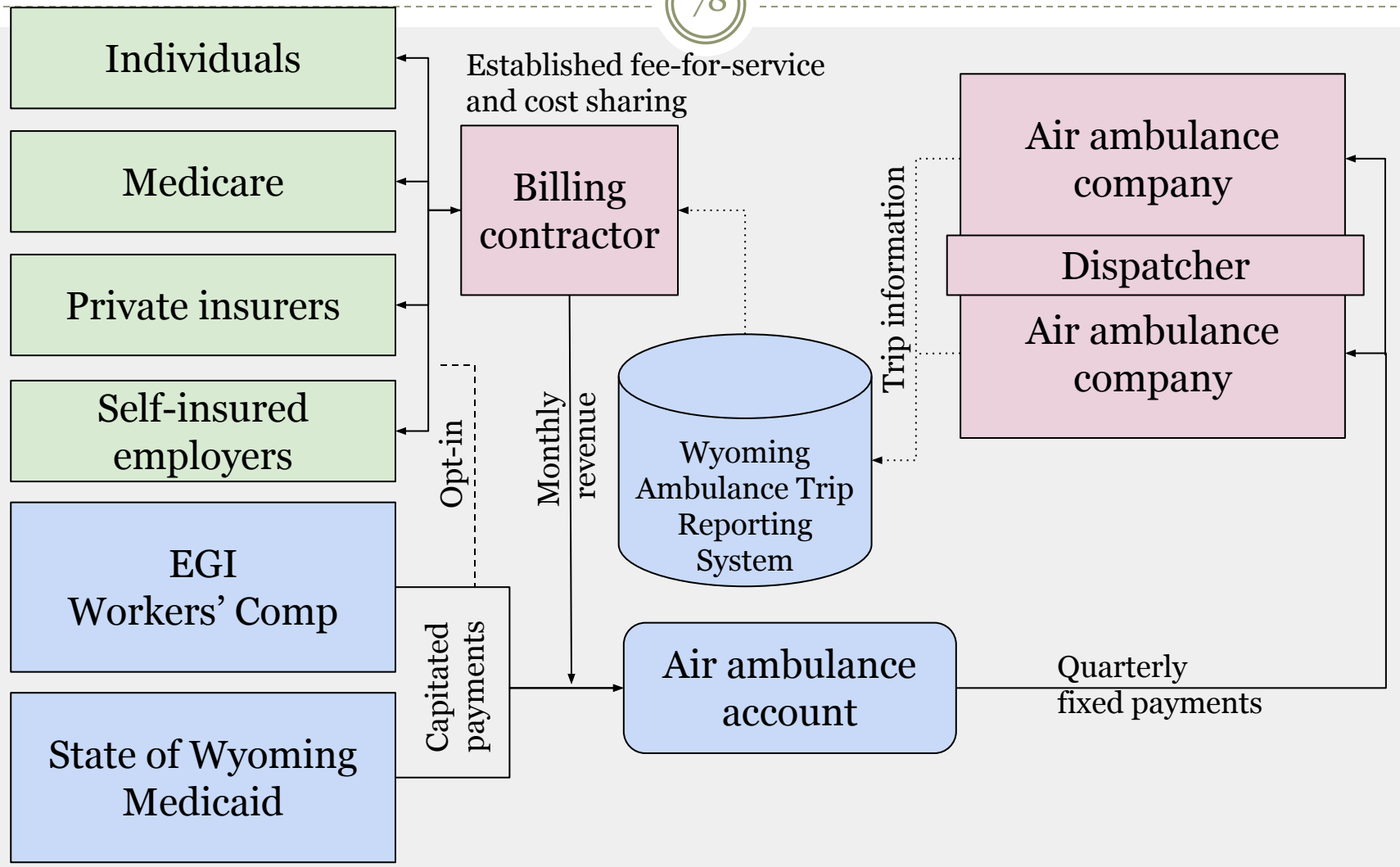
Goal 2



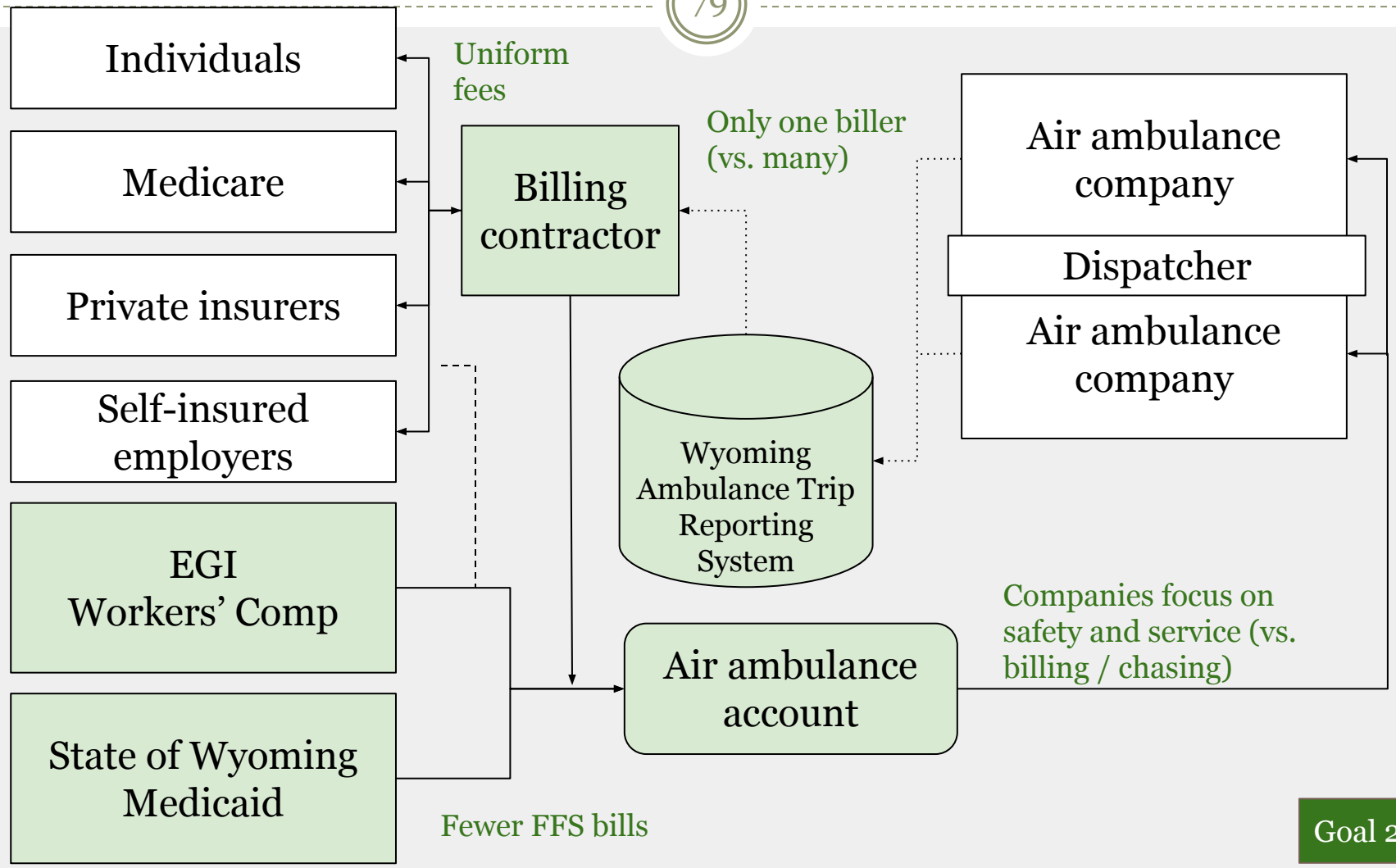
"Utility model" - operations

- ➔ Centralized call center selects most appropriate (closest / shortest queue)
- ➔ Selected air ambulance company(ies) provide services per contract.
- ➔ Trip data reported to State, sent to contracted billing agency.
- ➔ Funded by self-generated revenue already in system:
  - ◆ State payers (Medicaid, Workers' Comp, EGI) provide "up-front" funding for contract on per-member-month basis.
  - ◆ Other payers (insured and self-insured plans, Medicare) billed based on trip data and average cost, unless opt-in to "up-front" system. This would be a form of Third Party Liability for Medicaid.
- ➔ Clear and transparent cost-sharing for patients set by WDH fee schedule, factoring in:
  - ◆ Patient's income Goal 3
  - ◆ If situation emergent or medically-necessary
- ➔ Balance billing significantly reduced, if not eliminated. Goal 1

“Utility model” - funding

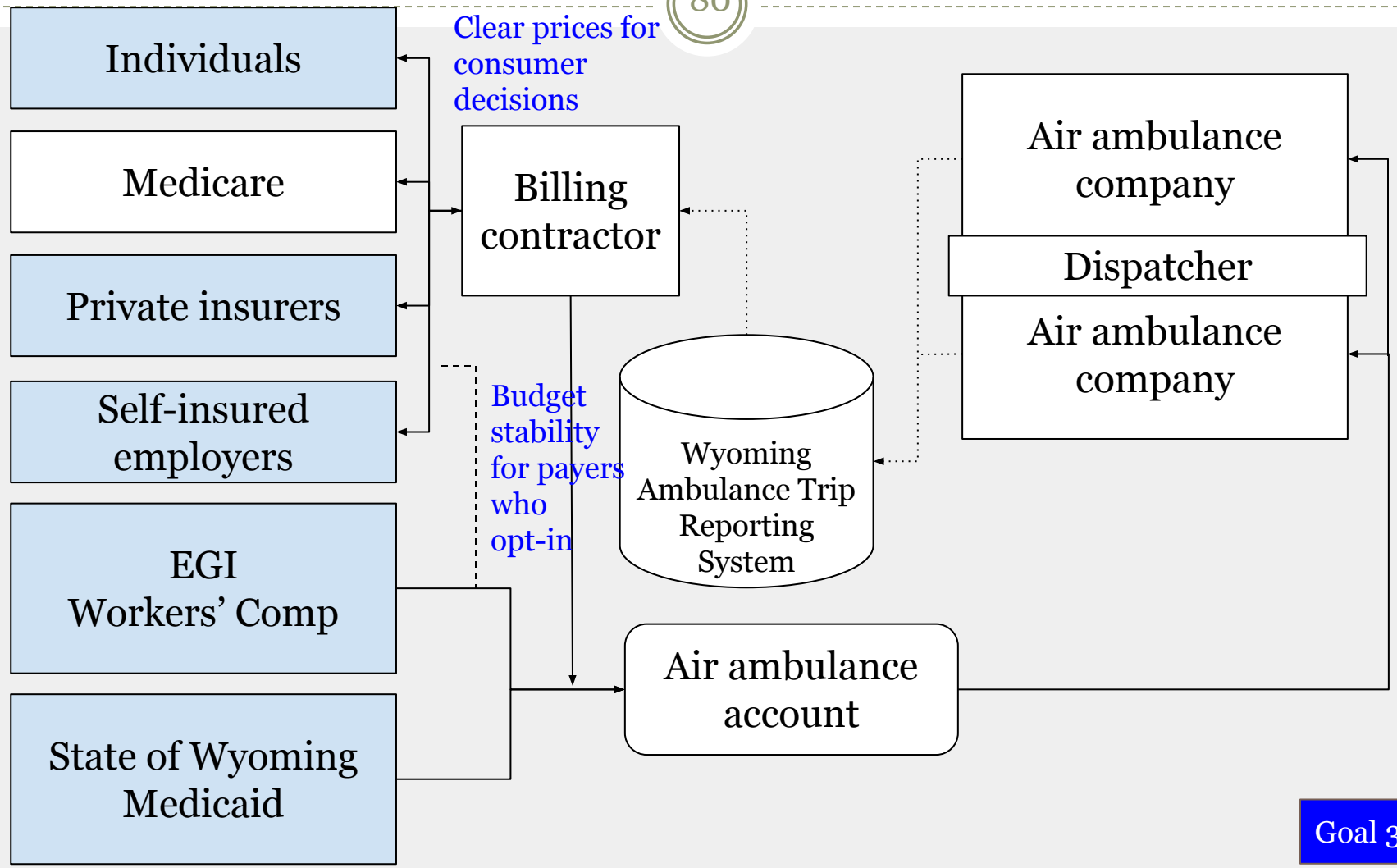


Advantage: simplified administration



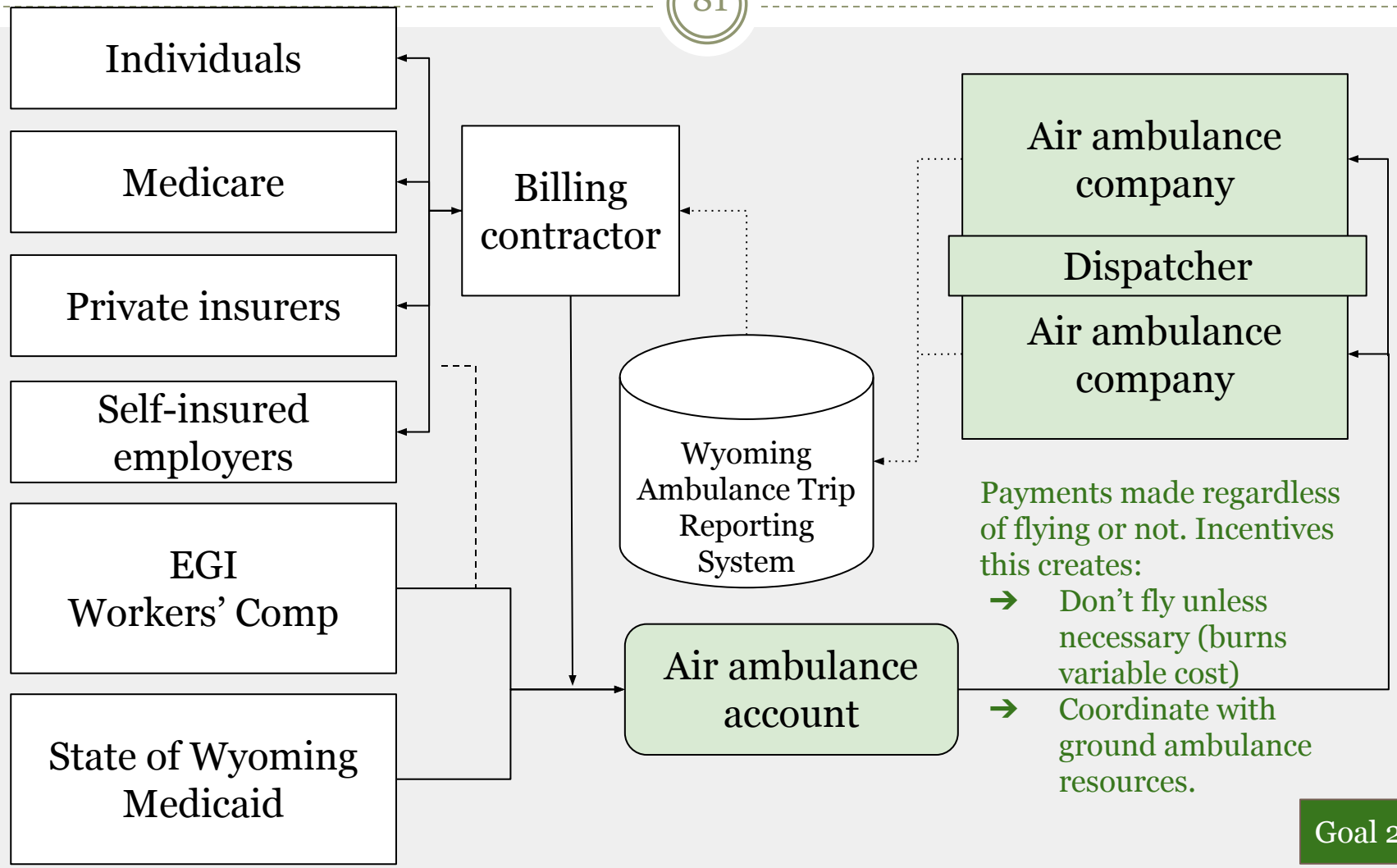
Goal 2

Advantage: price transparency



Goal 3

Advantage: utilization control



Payments made regardless of flying or not. Incentives this creates:

- ➔ Don't fly unless necessary (burns variable cost)
- ➔ Coordinate with ground ambulance resources.

Goal 2

Additional option: Local control

➔ What if a community wants an **air ambulance base locally**, beyond what State has procured?

- Yes, if community provides **annual local subsidy** to offset reduced system-wide productivity losses.
- **This prevents free-riding** on all other payers.
- Required local amount would depend on a lot of factors, but likely between **$1 - $3 million** per year.

Backup plan: “PPO” model

What is the **backup plan** if the State puts out contracts to bid and gets no responses? **“Preferred Provider Organization model”**: Paying **fee-for-service** to a network of enrolled Medicaid providers.

- ➔ **Centralized call center** directs volume to enrolled providers.
- ➔ Rates could factor in **known costs**, expected **productivity**, **quality** bonuses for response time, incentives for underserved areas etc.
- ➔ As condition of enrollment, providers **cannot balance-bill** clients.
- ➔ Flat cost-sharing, revenue/Third Party Liability structure still in place.
- ➔ Cost-sharing and central call center may reduce unnecessary utilization, but model doesn’t directly address central economic problem (average cost).

How is this model "likely to assist in promoting the objectives of [the Medicaid program]"? (42 USC §1315)

(1) Sets up **payment incentives to improve access to care** for current Medicaid beneficiaries.

- Allows State to set minimum quality standards for providers.
- Allows State to ensure access to air transportation meets requirements, with payment incentives to fill coverage gaps or reward prompt response times.
- Ground EMS access is critical, but under strain. Waiver offers potential of coordinating EMS systems based on medical necessity.

(2) Creates incentives to reduce overutilization, and therefore **reduce costs** to Medicaid.

(3) Reduce **second-order effects** of Medicaid reimbursement on other payers due to cost-shifting.

How is this model "likely to assist in promoting the objectives of [the Medicaid program]"? (42 USC §1315)

There is **fundamental interdependence** between Medicaid and rest of payers in the system on this particular issue.

➔ Medicaid does not have the market share to implement payment reforms effectively. Needs other payers to be involved.

➔ Other payers need Medicaid in order to implement any reforms, due to ADA preemption.

How is this model "likely to assist in promoting the objectives of [the Medicaid program]"? (42 USC §1315)

No additional federal dollars will be required or requested. In fact, waiver will likely save federal dollars:

- ➔ Medicare, IHS, TRICARE and VHA may benefit through reductions in unnecessary utilization.
- ➔ If private insurers on the Federal Health Insurance Marketplace see savings due to lower charges and reduced utilization, federal savings on Advance Premium Tax Credits (APTCs).

Waiver application process

Next steps

- ➔ Series of public **working-group** meetings, per bill, in parallel with Joint Labor interim topics.
  - ◆ Working group made up of relevant stakeholders:
    - Air ambulance companies
    - Health care facilities
    - Insurers and employer groups
    - Legislators
  - ◆ Group will provide input on concepts and waiver application.
- ➔ **Waiver application**

Tentative timeline

Date	Event
April 2019	Governor's decision - 4/1/19
	Informal discussions with CMS on waiver feasibility and process
April - June 2019	Working group / public meetings (including tribal consultation)
July 2019	Waiver application development
August 2019	Submit waiver application to CMS Submit report to Joint Labor and JAC
October 2019	Preliminary review complete (45 days)
November - December 2019	Public comment period

Questions?

Wyoming
Department
of Health

Medicaid Updates
Physician UPL and SBS

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Lindsey Schilling
Provider Operations Administrator
Division of Healthcare Financing

Wyoming
Department
of Health

Physician Upper Payment Limit

- Required by Footnote 10 to Section 048 of the Supplemental Budget.
- Would allow hospital-based physicians to draw down additional federal funds using matched local dollars.
- We have received technical assistance from CMS to better understand:
  - Relevant federal regulations re: defining "hospital affiliated providers"
  - Available funding models (e.g., as part of current hospital UPL programs, or stand-alone)
- Working to draft **State Plan Amendment**.
  - Collaborating with WHA; reviewing Louisiana program as model.
  - Will release public notice no later than June 1, 2019.
  - Will submit the SPA to CMS with a requested date of July 1, 2019 (as authorized by statute).
- CMS review may be lengthy, but if approved, should be effective with July 1st date.

School Based Services

- ➔ Required by Section 344 of the Supplemental Budget.
- ➔ Would allow some matching of Special Education SGF with federal funds.
- ➔ WDH and WDE are working with Navigant Consulting on **Oct. 1st report**. Report will:
  - Describe two common reimbursement schemes for SBS nationally;
  - Project additional federal revenue and administrative costs.
- ➔ Informal conversations with CMS re: permissible methodologies; CMS aware of State's intent.
- ➔ WDH and WDE intend to submit required exception requests through normal process.
- ➔ Once final model is selected and State Plan submitted, significant work required on implementation:
  - Provider training
  - System modifications
  - Administrative procedures, etc.

Hospital Viability Study (Sec. 338)

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Wyoming
Department
of Health