Aging and Long-Term Care Review

Franz Fuchs
Policy Analyst
Director’s Unit for Policy, Research and Evaluation

Wyoming Department of Health
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
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**.
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:

<table>
<thead>
<tr>
<th>Medicaid Setting</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing facility</td>
<td>$4,293</td>
</tr>
<tr>
<td>Community Choices Waiver</td>
<td>$1,635</td>
</tr>
</tbody>
</table>
Wyoming’s population pyramid

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

Data: A&I Economic Analysis population projections (Census)
Demographic projections

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

- 21,588 over 80 in 2019
- 36,800 over 80 in 2030
Demographic projections

3.64% over 80 in 2019

5.8% over 80 in 2030

Percent of population (%)

Year

2010
2015
2020
2025
2030

Age Group

80+
65-79

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

Fewer taxpayers
Fewer unpaid caregivers

15.7 in 2019
9.3 in 2030

Ratio of working-age adults to 80+

Year

2010
2015
2020
2025
2030

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**

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

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

Defined benefit plans are decreasing
(page 8 of report)

data: US DOL EBSA Private Pension Plan Bulletin Historical Tables and Graphs, 1975 - 2014
The outlook for long-term care insurance is poor

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

Actual to expected ratio

Annual loss ratio

Year


Percent

0% 20% 40% 60% 80% 100% 120%
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

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

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

Setting
SNF
HCBS

 Avg. monthly enrollment

Year
2010 2015 2020 2025 2030
Projections - Medicaid cost

- Expected cost (millions)
- Year

<table>
<thead>
<tr>
<th>Setting</th>
<th>SNF</th>
<th>HCBS</th>
</tr>
</thead>
</table>

2010: $0
2012: $25
2014: $25
2016: $75
2018: $75
2020: $100
2022: $125
2024: $150
2026: $150
2028: $200
2030: $200
Nursing Home Market Trends

**Occupancy**

**Medicaid Percent (%)**

**Medicare Percent (%)**

**Private Percent (%)**

The graphs show trends in occupancy and insurance coverage for nursing homes over fiscal years 2011 to 2017. The data is compared to the national average (US) and specific states (e.g., WY for Wyoming).
Nursing Home Cost Coverage

Cost coverage before UPL

Cost coverage after UPL

Medicaid Cost Coverage
Generally speaking, nursing homes that are more dependent on Medicaid tend to tailor their cost structure accordingly.
## Labor force issues - VA SNF study

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

Lisa Osvold
Senior Administrator
Aging Division

Wyoming Department of Health
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

Carol Day
Mental Health and Substance Abuse Services Administrator
Behavioral Health Division

Wyoming Department of Health
Behavioral Health Programs Overview

Chris Newman
Senior Administrator
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

<table>
<thead>
<tr>
<th>Division</th>
<th>Source</th>
<th>Purpose</th>
<th>Est. Annual Expenditures*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHD</td>
<td>Mental Health/Substance Abuse</td>
<td>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</td>
<td>$51.8M</td>
</tr>
<tr>
<td></td>
<td>Court Supervised Treatment</td>
<td>Sentencing alternatives through “Drug Courts”</td>
<td>$3.4M</td>
</tr>
<tr>
<td></td>
<td>State Hospital</td>
<td>Inpatient psychiatric hospital for civil commitment and forensic evaluation, including Title 25 costs at designated hospitals and Title 7 costs for outpatient evaluations</td>
<td>$35.5M</td>
</tr>
<tr>
<td>PHD</td>
<td>SA/Suicide Prevention</td>
<td>Implement state-level prevention strategies and provide funding for community-level prevention programs for tobacco, substance abuse, and suicide.</td>
<td>$8.6M</td>
</tr>
<tr>
<td></td>
<td>Medicaid</td>
<td>Payments for MHSA-related claims (all providers)</td>
<td>$41.2M</td>
</tr>
<tr>
<td></td>
<td>Care Management Entity</td>
<td>Wrap-around services for Medicaid children with mental health needs</td>
<td>$7.1M</td>
</tr>
<tr>
<td></td>
<td>Psych. Residential Treatment</td>
<td>Residential treatment for youth</td>
<td>$12.1M</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Statute</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>§ 7-11-301 through 307</td>
<td>Mental illness or competency in criminal proceedings</td>
</tr>
<tr>
<td>§ 9-2-102</td>
<td>Foundation for the inclusion or performance and outcome measures in contracts for “human services” programs. Establishment of statewide suicide prevention program.</td>
</tr>
<tr>
<td>§ 9-2-2701</td>
<td>Outlines the Substance Abuse Control Plan, in which community mental health and substance abuse centers play a key role.</td>
</tr>
<tr>
<td>§ 9-2-2708</td>
<td>Authority for the Behavioral Health Division to award methamphetamine and other substance abuse treatment grants.</td>
</tr>
<tr>
<td>§ 35-1-611 et. seq.</td>
<td>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.”</td>
</tr>
<tr>
<td>§ 25-10-101 et. seq.</td>
<td>Legal system for emergency detention and involuntary hospitalization. Touches all aspects of the mental health continuum of care.</td>
</tr>
</tbody>
</table>
# Community MHSA Treatment Funding, by Source

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

[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.
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 activities

- Training & Education
- Workgroups & Councils
- Tools & Resources
- Wyoming Tobacco Quitline
- Compliance
- Community Prevention Grant
- Research & Technical Assistance
- Media

Substance Abuse, Tobacco, and Suicide Prevention
# Prevention funding breakdown

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent</th>
<th>Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workgroups &amp; councils</td>
<td>2.4%</td>
<td>$400,000</td>
</tr>
<tr>
<td>Wyoming Tobacco Quitline</td>
<td>9.9%</td>
<td>$1,666,546</td>
</tr>
<tr>
<td>Research &amp; technical assistance</td>
<td>14.9%</td>
<td>$2,513,400</td>
</tr>
<tr>
<td>Community prevention grants</td>
<td>52.2%</td>
<td>$8,800,000</td>
</tr>
<tr>
<td>Media</td>
<td>8.1%</td>
<td>$1,362,260</td>
</tr>
<tr>
<td>Alcohol &amp; tobacco compliance checks</td>
<td>5.9%</td>
<td>$995,000</td>
</tr>
<tr>
<td>Tools &amp; resources</td>
<td>4.4%</td>
<td>$739,950</td>
</tr>
<tr>
<td>Training &amp; education</td>
<td>2.3%</td>
<td>$380,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$16,857,156</strong></td>
</tr>
</tbody>
</table>
## County prevention funding

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

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

**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

Franz Fuchs
Policy Analyst
Director’s Unit for Policy, Research and Evaluation

Wyoming Department of Health
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

High Country News, Feb 6th, 1984
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

<table>
<thead>
<tr>
<th>Transport Type</th>
<th>Mode</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-1 Scene Response</td>
<td>Helicopter</td>
<td>342</td>
<td>8.5%</td>
</tr>
<tr>
<td>Interfacility (hospital to hospital)</td>
<td>Helicopter</td>
<td>1,625</td>
<td>40.1%</td>
</tr>
<tr>
<td></td>
<td>Plane</td>
<td>2,079</td>
<td>51.4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4,046</td>
<td>100%</td>
</tr>
</tbody>
</table>

Most air ambulance trips are hospital to hospital transfers.
### Stylized facts - air ambulance in Wyoming

#### Largest volume from private plans and Medicare

<table>
<thead>
<tr>
<th>Payer</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>~500</td>
<td>12.5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>~1,500</td>
<td>37.5%</td>
</tr>
<tr>
<td>Workforce Services</td>
<td>~100</td>
<td>2.5%</td>
</tr>
<tr>
<td>Self-pay</td>
<td>~400</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other government</td>
<td>~200</td>
<td>5.0%</td>
</tr>
<tr>
<td>Private plans + EGI</td>
<td>~1,300</td>
<td>32.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>~4,000</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Largest volume from private plans and Medicare.
Stylized facts - air ambulance in Wyoming

Peak times for most flights are in the afternoon
9-1-1 scene response volume varies by county and season

Stylized facts - air ambulance in Wyoming

58
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.
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

Market characteristics

- Emergency situations
- Prices not transparent to consumer
- Inelastic demand
- Increasing private-pay prices
- Increasing average cost
- Decreasing productivity
- Growth in high fixed-cost supply
- Industry profitability
- Flat Medicare/Medicaid rates

Outcomes

- Network negotiations fail
- Health insurance premiums
- Balance billing
- Claim denials/utilization review

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, specialty 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

State of Wyoming Medicaid

Requests for proposals

Air ambulance company

Air ambulance company

Air ambulance company

Air ambulance company
“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
  - If situation emergent or medically-necessary
- Balance billing significantly reduced, if not eliminated.
"Utility model" - funding

- Individuals
- Medicare
- Private insurers
- Self-insured employers
- EGI
  Workers’ Comp
- State of Wyoming
  Medicaid

Billing contractor

Established fee-for-service and cost sharing

Monthly revenue

Opt-in

Capitated payments

Wyoming Ambulance Trip Reporting System

Air ambulance account

Quarterly fixed payments
Advantage: simplified administration

- Individuals
- Medicare
- Private insurers
- Self-insured employers
- EGI Workers’ Comp
- State of Wyoming Medicaid

Uniform fees

Billable contractor

- Only one biller (vs. many)
- Fewer FFS bills

Wyoming Ambulance Trip Reporting System

Air ambulance account

- Companies focus on safety and service (vs. billing / chasing)

Goal 2

Private insurers

Self-insured employers

Medicare

EGI Workers’ Comp

State of Wyoming Medicaid

Air ambulance company

Dispatcher

Air ambulance company

Only one biller (vs. many)

Fewer FFS bills
Advantage: price transparency

- Individuals
- Medicare
- Private insurers
- Self-insured employers
- EGI Workers’ Comp
- State of Wyoming Medicaid

Billing contractor

- Clear prices for consumer decisions
- Budget stability for payers who opt-in

Wyoming Ambulance Trip Reporting System

Air ambulance account

Goal 3

Air ambulance company

Dispatcher

Air ambulance company

Goal 3
Advantage: utilization control

Individuals

Medicare

Private insurers

Self-insured employers

EGI Workers’ Comp

State of Wyoming Medicaid

Billing contractor

Air ambulance company

Dispatcher

Air ambulance company

Wyoming Ambulance Trip Reporting System

Air ambulance account

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.
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**
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2019</td>
<td>Governor’s decision - 4/1/19</td>
</tr>
<tr>
<td></td>
<td>Informal discussions with CMS on waiver feasibility and process</td>
</tr>
<tr>
<td>April - June 2019</td>
<td>Working group / public meetings (including tribal consultation)</td>
</tr>
<tr>
<td>July 2019</td>
<td>Waiver application development</td>
</tr>
<tr>
<td>August 2019</td>
<td>Submit waiver application to CMS</td>
</tr>
<tr>
<td></td>
<td>Submit report to Joint Labor and JAC</td>
</tr>
<tr>
<td>October 2019</td>
<td>Preliminary review complete (45 days)</td>
</tr>
<tr>
<td>November - December 2019</td>
<td>Public comment period</td>
</tr>
</tbody>
</table>
Questions?

Wyoming Department of Health
Medicaid Updates
Physician UPL and SBS

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)

Franz Fuchs
Policy Analyst
Director’s Unit for Policy, Research and Evaluation

Wyoming Department of Health