

# MEDICAID OPTIONS STUDY REPORT TWO

AUGUST 29, 2012

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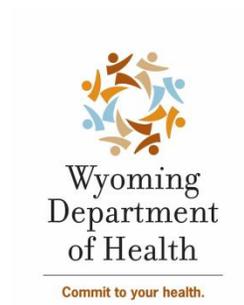
**Wyoming Department of Health**

# MEDICAID OPTIONS STUDY REPORT TWO

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**August 29, 2012**

Prepared by  
Medicaid Options Study Internal Work Group



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**Director**

**Wyoming Department of Health**

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## FOREWARD

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ON JUNE 28, 2012, the United States Supreme Court issued its opinion in *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et. al.* The Supreme Court’s decision precludes the United States Department of Health and Human Services (HHS) Secretary from penalizing states that choose not to expand their Medicaid programs in compliance with the Affordable Care Act (ACA) expansion by withholding existing Medicaid funds. This decision is being interpreted as making the ACA Medicaid expansion “optional.” While it is unknown how the Federal Government will respond specifically, it is known that the HHS Secretary is precluded from eliminating existing Medicaid funding to states that do not comply with the ACA expansion. The State of Wyoming now has the choice to expand or not to expand its Medicaid program.

The report that follows will not discuss whether or not the State should expand its Medicaid program. Instead, this report will focus on options for improvements, including modifications, design, or redesign, to the current Wyoming Medicaid system.

## SUMMARY OF OPTIONS

Report Two of the Medicaid Options Study focused on the identification of options for Wyoming Medicaid, and used a variety of expert sources to locate and research these options. For the benefit of the reader, options are presented here in tables. A complete description of each option can be found in Sections V through XI in the pages that follow.

Overall Wyoming Medicaid System   Options	
<b>System Design</b>	Option 1   Accountable Care Organization, p.14 Option 2   Block grant, p. 15 Option 3   Bundled payments, p.15 Option 4   Capitated payments, p. 16 Option 5   Co-payments, p. 16 Option 6   Global payments, p. 16 Option 7   Global waiver, p. 17 Option 8   Managed care, p. 17 Option 9   Medical homes, p. 18 Option 10   Patient incentives, p. 19 Option 11   Reduce unnecessary emergency room visits, p. 19 Option 12   Vouchers, p. 20 Option 13   Waiver 1115, p. 21
<b>Internal Management</b>	Option 1   Increased use of Medicaid data, p. 21 Option 2   Move recipient fraud program to WDH, p. 22
<b>Eligibility</b>	Option 1   Make referrals to job service and training programs, p. 23 Option 2   More frequent eligibility determinations , p. 23 Option 3   More stringent consideration of significant other’s income, p. 23 Option 4   Limit of the length of time an adult can receive Medicaid, p. 23
<b>Benefit and/or Services</b>	Option 1   Evaluate optional services, p. 23
<b>Rate and/or Payment</b>	Option 1   Periodic review of provider reimbursement rates, p. 25
<b>Healthcare Quality</b>	Option 1   Expand case management for high-cost recipients, p. 25 Option 2   Expand chronic care and disease management, p. 25

Elderly and Physically Disabled Recipients   Options	
<b>Program Design</b>	Option 1   Increase use of community resources and natural supports, p. 30 Option 2   Pay partial room and board at assisted living facilities, p. 31 Option 3   Encourage use of adult daycare, p. 31 Option 4   Explore managed care for SSI clients, p. 31 Option 5   Increase low cost and suitable housing for seniors and SSI, p. 31

	Option 6   Patient Centered Medical Home, p. 32 Option 7   Evaluate creative placement and diversion programs, p. 32
<b>Internal Management</b>	Option 1   Encourage PACE programs, p. 32 Option 2   Improve pharmacy management of dual-eligible individuals, p. 33 Option 3   Align plan of care and services received, p. 33
<b>Eligibility</b>	Option 1   Higher quality nursing home eligibility determinations, p. 33 Option 2   Eliminate caps on slots for the LTC Waiver and ALF Waiver, p. 33 Option 3   Medicaid version of Community Based In-Home Services program, p. 34 Option 4   Evaluate income eligibility for nursing homes and LTC waivers, p. 35 Option 5   Use waivers to divert or relocate from nursing home placement, p. 35
<b>Benefit and/or Services</b>	Option 1   Different benefit package for Medicare-Medicaid dual-eligibles, p. 36 Option 2   Tennessee 1115 waiver, p. 37
<b>Rate and/or Payment</b>	Option 1   Services, rates, and budget as determined by LT 101 assessment, p. 38 Option 2   Reduce conflict of interest in case management/client assessments, p. 39 Option 3   Tie nursing facility rate cost to percentage of clients on Medicaid, p. 39 Option 4   Maximum cost for durable medical equipment (DME), p. 40 Option 5   Reward high-quality providers that achieve good client outcomes, p. 40 Option 6   Add a Memory Care Unit rate tier to ALF waiver, p. 40
<b>Healthcare Quality</b>	Option 1   Enrollment immediate medical assessment and case management, p. 40 Option 2   Improve transitions of care –Provider processes, p. 40 Option 3   Medication reviews for Medicaid clients, p. 41

<b>Adults with Developmental Disabilities   Options</b>	
<b>Program Design</b>	Option 1   Create a support waiver with a max dollar per person amount, p. 45 Option 2   Change to Support Intensity Scale, p. 46 Option 3   Health Home or Coordinated Care, p. 46 Option 4   Create a new Adult DD waiver, p. 46 Option 5   State Plan amendments 1915(k) and 1915(i), p. 46
<b>Internal Management</b>	Option 1   Retool the ICF-ID, p. 47 Option 2   Downsize the ICF-ID from current resident level, p. 47 Option 3   Repurpose the ICF-ID campus to serve a different population, p. 47 Option 4   Close the ICF-ID, p. 48 Option 5   Focus on efficiency and revenue reforms at the ICF-ID facility, p. 48
<b>Eligibility</b>	Option 1   Tighten financial eligibility for ICF-ID and Adult DD waivers, p. 48 Option 2   Change eligibility for the ABI Waiver, p. 48
<b>Benefit and/or Services</b>	Option 1   Promote residential habitation service models, p. 49
<b>Rate and/or Payment</b>	Option 1   Change Individual Cost Limitations on Adult DD Waiver, p. 49 Option 2   Revise current Funding Model, p. 50 Option 3   Cost-sharing, co-pays, and premiums for this group, p. 50 Option 4   15 minute increments for Case Management, p. 50
<b>Healthcare Quality</b>	Option 1   Implement independent case management through RFP, p. 50 Option 2   Increase provider qualifications, p. 50

	<p>Option 3   Increase provider certification standards for group home facilities, p. 51</p> <p>Option 4   Implement Statewide Electronic Provider Documentation System, p. 51</p> <p>Option 5   Moratorium on certain types or sizes of providers, p. 51</p> <p>Option 6   Independent case management as a policy, p. 52</p> <p>Option 7   Apply for the Balancing Incentive Payment program, p. 52</p>
<b>Children with Developmental Disabilities   Options</b>	
<b>Program Design</b>	<p>Option 1   Create capped supports waiver(s), p. 56</p> <p>Option 2   Do not renew Children’s DD waiver, p. 56</p> <p>Option 3   Transition all participants to a capped supports waiver, p. 57</p> <p>Option 4   Short-term waiver to help the family begin supporting the child, p. 57</p> <p>Option 5   Self-direction required within capped support waiver, p. 57</p>
<b>Internal Management</b>	<p>Option 1   Encourage reuse and sharing of durable medical equipment, p. 57</p> <p>Option 2   Review authorization practice for skilled nursing ordered, p. 57</p>
<b>Eligibility</b>	<p>Option 1   Consider parental income for child’s eligibility, p. 58</p> <p>Option 2   Co-payments for waiver services, p. 58</p> <p>Option 3   Alter age range, or place age limits on some services, p. 58</p> <p>Option 4   Change eligibility of care to nursing facility standard, p. 59</p>
<b>Benefit and/or Services</b>	<p>Option 1   Reduce individual budgets without limiting services, p. 59</p> <p>Option 2   Restrict services by using targeting criteria, service caps, etc., p. 59</p> <p>Option 3   Restrict waiver to offer a smaller amount of respite care, p. 59</p> <p>Option 4   Provide only "training" type services, no respite on waiver, p. 60</p> <p>Option 5   Restructure Residential Habilitation Training service, p. 60</p> <p>Option 5   Overall weekly cap on the hours of similar services received, p. 60</p>
<b>Rate and/or Payment</b>	<p>Option 1   Revise current funding model, p. 61</p>
<b>Healthcare Quality</b>	<p>Option 1   Independent case management, p. 61</p> <p>Option 2   Implement statewide electronic provider documentation system, p. 61</p> <p>Option 3   Increase provider qualifications, p. 61</p>

<b>Pregnant Women and Newborns   Options</b>	
<b>Program Design</b>	<p>Option 1   Maternity Medical Homes, p. 65</p> <p>Option 2   High risk clinics in Wyoming, p. 66</p> <p>Option 3   Expand use of Telehealth technology, p. 66</p>
<b>Internal Management</b>	<p>Option 1   Require participation in pregnancy case management, p. 66</p> <p>Option 2   Require paternity confirmation, p. 66</p> <p>Option 3   Require nutrition counseling and referral to SNAP, p. 67</p>
<b>Eligibility</b>	<p>Option 1   Extend “Pregnant by Choice” Waiver, p. 67</p> <p>Option 2   Provide pre-natal services for non-citizens, p. 68</p>
<b>Benefit and/or Services</b>	<p>Option 1   Expand home visiting programming post-delivery, p. 68</p>
<b>Rate and/or Payment</b>	<p>Option 1   Reduce Wyoming OB/GYN reimbursement rates, p. 68</p> <p>Option 2   Implement bundled payments for prenatal care through birth, p. 69</p>

	Option 3   Incentivize prenatal visits, p. 69 Option 4   NICU hospital reimbursement rate reduction, p. 69 Option 5   Incentivize physicians for good outcomes, p. 70
<b>Healthcare Quality</b>	Option 1   Require physicians to refer into case management, p. 70 Option 2   Require Screening, Brief Intervention, and Referral to Treatment, p. 70

<b>Family Care Adults   Options</b>	
<b>Program Design</b>	Option 1   More integrated/coordinated care, p. 73
<b>Internal Management</b>	No options for changes were identified
<b>Eligibility</b>	No options for changes were identified
<b>Benefit and/or Services</b>	Option 2   Encourage clients to use available family planning services, p. 73
<b>Rate and/or Payment</b>	No options for changes were identified
<b>Healthcare Quality</b>	No options for changes were identified

<b>Children and Foster Care Children   Options</b>	
<b>Program Design</b>	Option 1   Preclude court ordered placements at PRTF, p. 78 Option 2   Enforce assessment requirement <u>before</u> PRTF placement orders, p. 79 Option 3   Manage PRTF admissions and reduce readmissions, p. 79 Option 4   Use CME for children with emotional disturbances or disorders, p. 79 Option 5   Focus case management at clinical level outcomes, p. 80 Option 6   Focus on youth transitioning out of the foster care system, p. 80
<b>Internal Management</b>	Option 1   3rd party case management and review children in foster care, p. 80
<b>Eligibility</b>	No options for changes were identified
<b>Benefit and/or Services</b>	Option 1   Wrap-around services, p. 81
<b>Rate and/or Payment</b>	Option 1   Proper screening and support from schools, p. 81
<b>Healthcare Quality</b>	Option 1   Refer all children in foster care for health management, p. 81

## SECTION I: INTRODUCTION AND OVERVIEW

### A Review: Medicaid Options Study

During the Sixty-First Legislature of the State of Wyoming 2012 Budget Session, the Wyoming Legislature passed Original Senate File No. 0034, Enrolled Act No. 58, Senate (hereinafter SEA0058 or the Medicaid Options Study legislation) requiring the WDH to conduct a study into the Medicaid system. This legislation required the WDH to:

analyze the cost drivers and identify other areas within the Medicaid program that may benefit from redesign, to evaluate potential redesign of current Medicaid programs and to evaluate the design of Medicaid programs mandated by the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, hereinafter referred to collectively as ‘the health care reform acts.’ *See SEA0058.*

SEA0058 required the WDH to present preliminary reports to the Joint Labor, Health and Social Services Interim Committee on June 1, 2012 and October 1, 2012<sup>1</sup>. The study must be complete, and a final report is due, by December 1, 2012. The Legislature appropriated \$200,000 to the WDH to complete this study.

In order to meet the requirements set out by SEA0058, the WDH created an in-house team made up of Medicaid staff, fiscal staff, policy staff and Senior Administrators, to work with stakeholders, subject matter experts and consultants to conduct this study. This team determined that the best strategy to completing a quality study would be to dissect the study into three phases, each resulting in a report.

#### Overview of Reports



<b>Report One:</b> Observation	<ul style="list-style-type: none"><li>• Overview</li><li>• Data Reconciliation</li><li>• Identification of High Growth/High Cost Areas</li></ul>
<b>Report Two:</b> Analysis and Options	<ul style="list-style-type: none"><li>• Identification of Wyoming Medicaid Cost Drivers</li><li>• Presentation of Options</li></ul>
<b>Report Three:</b> Recommendations	<ul style="list-style-type: none"><li>• Completed Evaluation</li><li>• Recommendations</li><li>• Proposed Action Plan</li></ul>

<sup>1</sup> The original deadlines were moved up, so that this report could be presented at the Joint Labor, Health and Social Services Interim Committee meeting held in Lovell, WY on September 4, 5, and 6<sup>th</sup>, 2012.

Report One, dated June 1, 2012, detailed the findings of the Medicaid Options Study initial phase: Observation. This report discussed overall Medicaid system costs, as well as potential contributing factors to cost increases. The report included results from significant research into specific Wyoming Medicaid data, compared Wyoming Medicaid to national and regional Medicaid systems, and summarized current cost containment efforts implemented by Wyoming Medicaid.

Report Two is the culmination of the second portion of the Medicaid Options Study: Analysis and Options. Report Two explores the “high-level interest areas” identified in Report One, along with overall Medicaid system costs, to identify specific cost drivers within Wyoming Medicaid. Additionally, this report goes beyond identification of cost drivers to present numerous options that can be taken by the State to improve Wyoming Medicaid. During this second portion of the study, robust outside stakeholder input was gathered and summarized.

The work done thus far on the Medicaid Options Study has focused on identifying and analyzing/evaluating data and options. In the final report, Report Three, due December 1, 2012, the WDH will present its recommendations for modification or redesign of the Wyoming Medicaid system. The WDH will also propose a plan of action for its recommendations.

It is the goal of the WDH to utilize this study to identify the best possible approaches to operating the Wyoming Medicaid system.

## Report Two Roadmap

- Section I:** Introduction and Overview
- Section II:** Report One | A Review
- Section III:** Analysis
- Section IV:** Identification of Options
- Section V:** Options | Overall Wyoming Medicaid System
- Section VI:** Options | Elderly and Physically Disabled
- Section VII:** Options | Adults with Developmental Disabilities
- Section VIII:** Options | Children with Developmental Disabilities
- Section IX:** Options | Pregnant Women and Newborns
- Section X:** Options | Family Care Adults
- Section XI:** Options | Children and Foster Care Children
- Section XII:** Conclusion

Following the Introduction, Section II will provide a summary of the Medicaid Options Study, Report One, dated June 1, 2012.

Section III will recount the steps taken to prepare the presentation of options in this report. In order to identify high-cost areas of interest and the options for improving these areas of the Medicaid system, a variety of resources were used. The methodology and analysis used to identify these high-cost sub-groups will be discussed in this section and the accompanying Appendix A.

Section IV will discuss the process by which options were identified. This section will include the WDH definition of an “option”, as well an explanation of process for categorizing, selecting and presenting options.

In Section V, the presentation of options will begin. This section will discuss changes that could be made across multiple Medicaid programs or throughout the entire Wyoming Medicaid system.

In Sections VI through XI, the identified high-cost sub-groups (discussed in Section III) are described and specific data on each sub-group is presented. After the brief description of the sub-groups, options for improvement to the programs that serve these groups are offered.

Section XII concludes Report Two, and will summarize its contents. The final report in this three-part study (Report Three: Recommendations) will be introduced.

Throughout this report, options for improvements to Wyoming Medicaid are presented. It is important to remember that these options are not being presented as recommendations. Recommendations will be given in the final report, due December 1, 2012.

## SECTION II: REPORT ONE | A REVIEW

Report One detailed the initial findings of the 2012 Medicaid Options Study. This included a discussion of the national Medicaid system, as well as the Wyoming Medicaid system more specifically. The purpose of Report One was to examine Medicaid data and provide a background for the investigation of options, which will be presented in Report Two.

Report One examined the current Wyoming Medicaid plan and determined the annual cost of benefits for each program (e.g., Children, Pregnant Women, etc.), as well as defined how much of these costs were paid by the State, by the federal match, by client co-pays, and how much administration of Wyoming Medicaid costs. Report One also presented data on the highest cost programs and the highest areas for potential growth. For illustration, Table 1 from Report One has been reproduced below.

**TABLE 1: Medicaid Programs in SFY11 by State and Federal Share**

Medicaid Programs	Total Expenditures <sup>4</sup>	State Share %	Federal Share %	# of Recipients <sup>1</sup>	Cost Per Recipient	% of Total Expenditures
Aged, Blind, & Disabled <sup>2</sup>	\$ 304,200,528	49.4%	50.6%	12,970	\$ 23,454	58.6%
<i>AB&amp;D - HCBS</i>	154,929,180	49.9%	50.1%	4,722	32,810	29.9%
<i>AB&amp;D - Institution</i>	97,492,649	49.0%	51.0%	2,843	34,292	18.8%
<i>AB&amp;D - SSI &amp; SSI Related</i>	51,778,699	48.3%	51.7%	6,099	8,490	10.0%
Children	138,125,451	48.5%	51.5%	49,966	2,764	26.6%
Pregnant Women	36,079,605	47.9%	52.1%	6,122	5,893	7.0%
Family Care Adults	29,097,326	46.3%	53.7%	6,942	4,191	5.6%
Other <sup>3</sup>	11,365,176	44.7%	55.3%	3,676	3,092	2.2%
<b>Grand Total</b>	<b>\$ 518,868,086</b>	<b>48.8%</b>	<b>51.2%</b>	<b>77,207</b>	<b>\$ 6,720</b>	<b>100.0%</b>

<sup>1</sup>Recipients are presented as unduplicated counts for each program. A client may be in more than one program in a given year; therefore, the subtotals should not be added together by hand. They will not equal the Grand Total.

<sup>2</sup>The Aged, Blind, & Disabled total expenditures is the sum of the AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

<sup>3</sup>The Other Subtotal line is the sum of the Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens groups.

<sup>4</sup>The Expenditures in this table will not match those in the Service Area tables, due to the fact that only Chart A Programs were used. The non-eligibility categories not represented here accounted for \$238,591 in SFY11.

As noted in this previous report, the top 5% of Medicaid Recipients in SFY11 used over half (52%) of the dollars. This is a very common pattern of cost consumption across a variety of insurance plans both private and public. Thus, a focus on the top 5% (and the next most costly 15%) of recipients was determined to be beneficial to discussions about options for cost savings in Wyoming Medicaid.

Report One concluded with the presentation of five high-level interest areas for future examination, including: the Top 5% and 15% of Recipients; the Aged, Blind, or Disabled Programs; the Pregnant Women's Programs; the Children's Programs; and Service Areas (e.g., physical health, mental health, etc.). It is these interest areas that were explored further in this report in order to provide a framework for the examination of viable options for the Wyoming Medicaid system. These options are presented in Sections V through XI.

## SECTION III: ANALYSIS

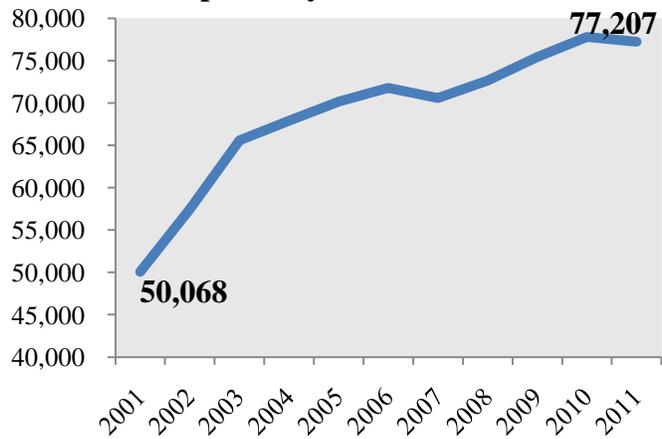
In this report<sup>2</sup>, the analysis focused on determining cost drivers for Wyoming Medicaid. This was achieved by examining the Wyoming Medicaid cost and utilization patterns over the past decade. Through this process, two general cost drivers were identified: growth in number of Medicaid recipients (see Figure 1), and growth in cost per recipient (see Figure 2)<sup>3,4</sup>. These two trends show clear growth from 2001 through 2011 (though it should be noted that this growth has slowed considerably over time).

The source of the growth in number of Medicaid recipients is most likely related to the economic downturn that occurred across the country and in Wyoming. This particular pattern will not be examined in-depth in this study. However, the rise in annual cost per recipient will be investigated fully, as this pattern can be impacted by the system options presented in this report. These general cost drivers are similar to those found by other states as they have examined their Medicaid systems.

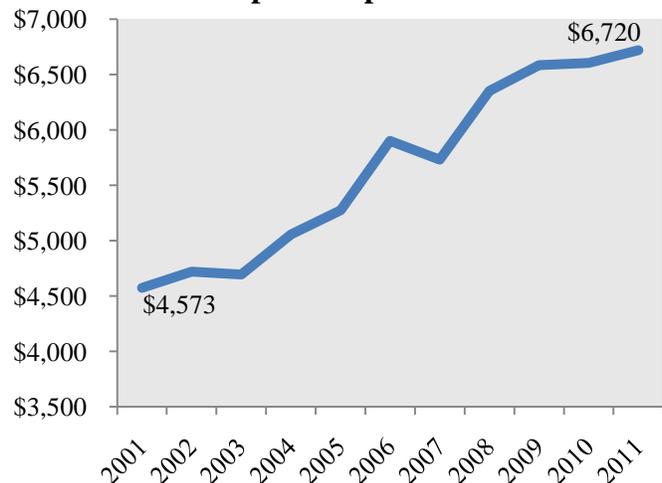
### Detailed Cost Driver Analysis

While there appear to be two larger patterns of system growth that drive cost in Wyoming Medicaid, it was clear that defining options would be harder without some additional detail about Medicaid recipients. Report One focused on describing the larger ten (10) Medicaid Programs in

**Figure 1. Wyoming Medicaid Recipients by SFY: 2001-2011**



**Figure 2. Wyoming Medicaid Average Annual Cost per Recipient: 2001-2011**



<sup>2</sup> Report Two was informed by the most current and complete data available to the Wyoming Department of Health. The Medicaid Management Information System (MMIS) database (maintained by Xerox, a Medicaid program contractor) was queried to provide all claims data through SFY 2011 (the most recently available data; providers have up to one year following service delivery to bill for that service in the MMIS, which means that aggregate figures may change over time). The WOLFS financial management system was queried to provide financial data through SFY 2011.

<sup>3</sup> A third factor which only impacted General Fund expenditures was a reduction in the federal match rate that Wyoming receives from the federal government. This is discussed in depth in the FMAP white paper, attached.

<sup>4</sup> Internal data used for SFY 1998-SFY 2007 from internal records. SFY 2008 through SFY 2011 using data from Medicaid Option Study Report One.

Wyoming using data, and provided an initial look at the 27 sub-groups that make up these 10 larger programs. In order to supply a deeper understanding of the cost and use patterns, and thus, to provide better definition for the options presented in Sections V-XI, the 27 sub-groups were examined in-depth. Each sub-group was ranked on the basis of three factors: overall cost, cost per recipient, and the gap between the top 5% and the bottom 80% recipients in terms of cost. The sub-groups scoring highest on these three factors were chosen as cost drivers (see list below). A detailed description of how the subgroup selection occurred can be found in Appendix A.

- 1) AB& D – Adult DD Waiver
- 2) AB& D – Nursing Home
- 3) Low Income Children
- 4) AB& D – SSI
- 5) Pregnant Women
- 6) Newborn
- 7) AB&D – Long Term Care (LTC) Waiver
- 8) Family Care Adults
- 9) Foster Care Children
- 10) AB& D – Child DD Waiver
- 11) Children (Top 5% and 15%)
- 12) ICF – ID (Wyoming Life Resource Center; Federal Share)
- 13) AB& D – Hospital Care

These sub-groups are indeed representative of the five interest areas presented in Report One. Additionally, these 13 sub-groups comprise the majority (95%) of the overall Medicaid expenditures in SFY11 (see Figure 3).

**Figure 3. Expenditures by Medicaid Program Sub-Groups of Interest | SFY11**

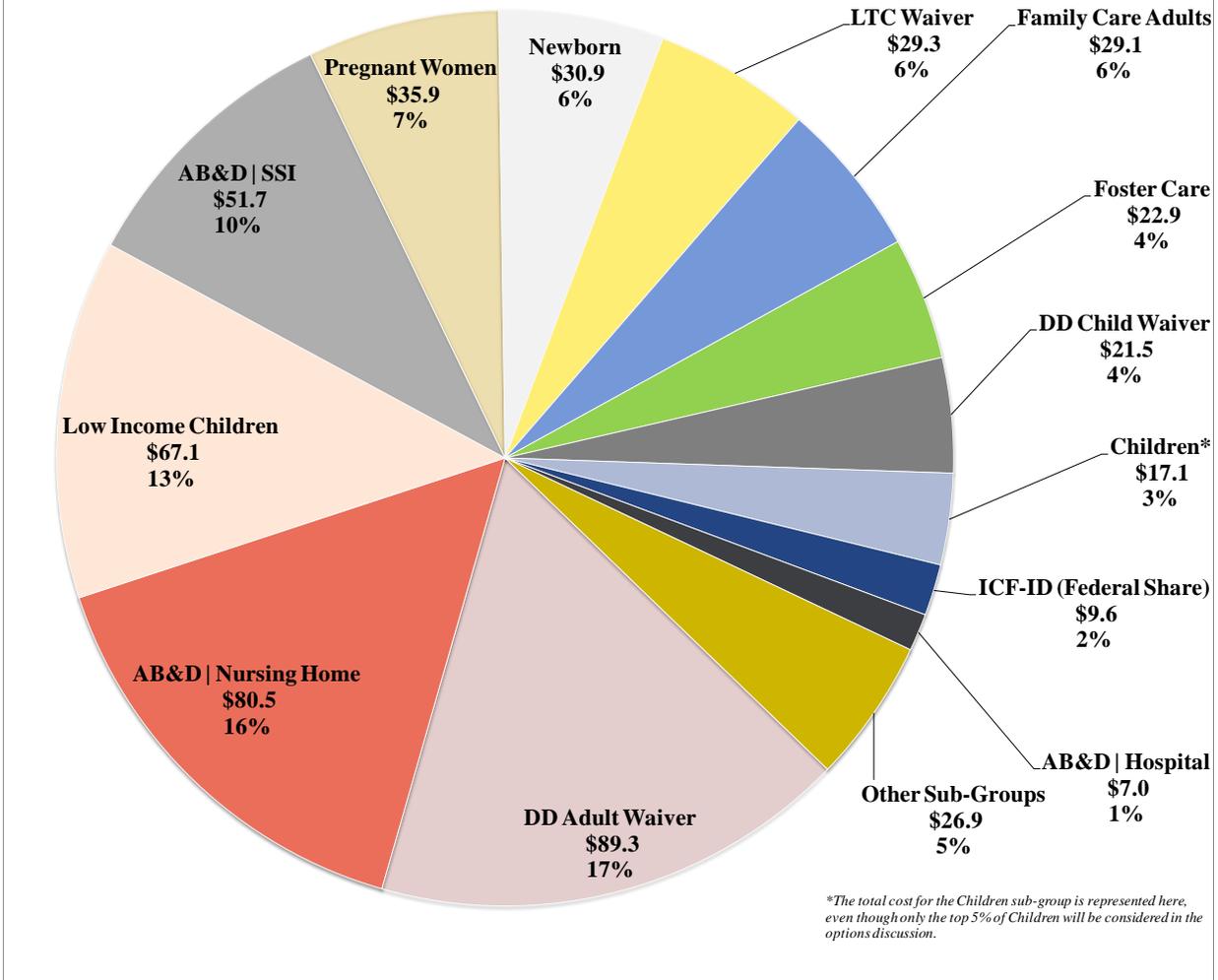


Table A (on the next page) contains a description of the 13 sub-groups of interest. Additional data and details about the sub-groups (utilization of services, overall cost, etc.) can be found in Sections V-XI, before each sub-groups’ options are presented.

The sub-groups were combined into six groupings for the discussion of Medicaid options due to sub-groups sharing similar service use patterns, or because the sub-groups formed natural combinations (e.g., Pregnant Women and Newborns were combined, etc.). These groupings are reflected in the first column in Table A. Each of the larger groupings represents a section of the report (Sections VI-XI).

**TABLE A. WYOMING MEDICAID | CHOSEN SUB-GROUPS**

<b>Elderly and Physically Disabled</b>	<b>NURSING HOME</b>	The Nursing Home eligibility sub-group consists of persons who are living in a nursing home, and whose income is less than or equal to 300% of the SSI standard. Resources are also taken into consideration.
	<b>SSI</b>	The SSI eligibility sub-group consists of persons already receiving SSI (these people are automatically qualified for Medicaid).
	<b>LONG TERM CARE (LTC) WAIVER</b>	The LTC Waiver eligibility sub-group consists of persons aged 19 years and older, who are eligible for a nursing home level of care, yet receive services in their homes.
	<b>AB&amp;D   HOSPITAL CARE</b>	The AB&D - Hospital Care sub-group consists of people living in institutions who receive hospital care outside of the institution. These recipients are eligible if their personal income is less than or equal to 300 percent of the SSI standard.
<b>Adults with Developmental Disabilities</b>	<b>ADULT DD WAIVER</b>	The Developmentally Disabled (DD) Adult Waiver eligibility sub-group consists of developmentally disabled adults (ages 21 and up) that receive training and support services which allow them to remain in their home communities and avoid institutionalization.
	<b>AB&amp;D   WYOMING LIFE RESOURCE CENTER</b>	The AB&D - Wyoming Life Resource Center sub-group consists of people that qualify for an intermediate care facility for intellectual disabilities (ICF-ID) facility level of care. These recipients are eligible if their personal income is less than or equal to 300 percent of the SSI standard.
<b>Children with Developmental Disabilities</b>	<b>CHILD DD WAIVER</b>	The Developmental Disabilities (DD) Child Waiver eligibility sub-group consists of children with developmental disabilities children (birth to age 21) that receive training and support services which allow them to remain in their home communities and avoid institutionalization.
<b>Pregnant Women and Newborns</b>	<b>PREGNANT WOMEN</b>	The Pregnant Women eligibility sub-group consists of women that are pregnant, whose family income is less than or equal to 133% FPL. Presumptive eligibility allows for Medicaid to cover outpatient services for up to 60 days while Medicaid eligibility is determined.
	<b>NEWBORN</b>	The Newborn eligibility sub-group consists of newborns up to age one, born to Medicaid-eligible mothers whose family income is less than or equal to 133% FPL.
<b>Family Care</b>	<b>FAMILY CARE ADULTS (Top 5%)</b>	The Family Care Adults eligibility sub-group consists of adults that provide care and control at least one eligible child (less than 19 years of age) living in the household. Adults must have income less than or equal to the family care income standard. There are no resource limits.
<b>Children</b>	<b>LOW INCOME CHILDREN (0-18; Top 5%)</b>	The Low-Income Children eligibility sub-group consists of children between the ages of 0 and 5 whose countable family income is less than or equal to 133% FPL, or children between the ages of 6 and 18 whose countable family income is less than or equal to 100% FPL.
	<b>FOSTER CARE</b>	The Foster Care eligibility sub-group consists of children in the custody of the Wyoming Department of Family Services, up to the age of 19. Children who turn 18 while in foster care may continue to receive coverage until 21. In 2014 due to the ACA, children in foster care can continue coverage until they turn 26.
<b>Special Group (Not Part of Options)</b>	<b>BREAST AND CERVICAL</b>	The Breast and Cervical Cancer Treatment Program is a special eligibility sub-group that consists of uninsured women diagnosed with breast or cervical cancer, who are eligible for Medicaid if their income is less than or equal to 250% FPL.

## SECTION IV: IDENTIFICATION OF OPTIONS

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### Report Two: Steps Taken

The focus of Report Two is the analysis of Medicaid data and the development of options for cost containment and improvement of Wyoming Medicaid. During the development of this report, WDH focused its efforts on identifying overall Medicaid system options, as well as options for the specific 13 high-cost Medicaid sub-groups identified in Section III of this report. Sections V-XI present numerous options for modification of Wyoming Medicaid. The process for identifying these options is explained in the following paragraphs.

#### ***WDH Research***

The WDH created an in-house team of Medicaid staff, fiscal staff, policy staff and Senior Administrators to conduct this study. During this phase of the study, WDH staff conducted extensive research. Research included: State-level publications, other state Medicaid studies, webinars, federal publications, federal agency reports (e.g., the Centers for Medicare and Medicaid Services), and academic research publications. Additionally, Medicaid program content experts were consulted throughout phase two to ensure accuracy and understanding of information.

#### ***Internal Discussions and Brainstorming Workshops***

Internal meetings/discussions and brainstorming workshops were conducted throughout the summer with WDH staff who have expertise, experience and knowledge about the programs for which WDH sought options. All participants contributed ideas about the redesign of Wyoming Medicaid as it related to Wyoming Medicaid and each sub-group of interest.

Due to the complexity of the waiver programs, a committee was formed to specifically address options for waivers. This committee met regularly throughout the summer and will continue to meet throughout the study process. This committee was also able to obtain technical assistance from a national consultant.

The options gathered through research, brainstorming workshops, technical assistance and substantive discussion were discussed and rank-ordered by member preference by the Medicaid Options Study Executive Team.<sup>5</sup> The results of this process are presented in detail in Sections V-XI.

#### ***Stakeholder Input: Focus Groups, Web Survey, Public Forums***

In addition to the internal work completed by the WDH, Report Two incorporates the work of three contractors. Two contractors were selected to facilitate widespread stakeholder

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<sup>5</sup> Members of the Medicaid Options Study Executive Team include: the Wyoming Department of Health Director, Deputy Director, Senior Administrator for Healthcare Financing, Chief Financial Officer, Senior Administrator for the Behavioral Health Division, and members of the Director's Unit for Policy, Research and Evaluation.

input. The third contractor was selected to perform specific and in depth analysis of Medicaid data.

Public Knowledge, LLC (PK) was contracted to facilitate an online survey and stakeholder interviews. The online “Survey Monkey” questionnaire was available to Medicaid clients, Medicaid providers, and general citizens from July 5<sup>th</sup> to August 6<sup>th</sup>. The survey was also distributed and available to all 90 Wyoming Legislators. The online survey received 390 responses from a variety of respondent types. Of those that responded, almost 44% were Medicaid providers, 28% were interested citizens, 13% were Medicaid clients, almost 15% were other types of responders, and less than one percent were legislators.

In addition to facilitating the online survey, PK conducted stakeholder interviews during the months of June, July and August. Medicaid stakeholders interviewed included: Medicaid providers, health care associations, client advocates, Department of Family Services (DFS) staff, and Medicaid and Behavioral Health staff. Overall, 136 stakeholders participated in over 30 interviews. A report detailing the findings of the online survey and stakeholder interviews can be found at <http://www.health.wyo.gov/director/dupre.html> (the Executive Summary is attached as Appendix B).

Stakeholder input also included public forums. Six public forums were held across the State (in Cheyenne, Casper, Gillette, Riverton, Rock Springs, and Jackson) during the month of July. Community Builders, Inc. (CBI), a Douglas based consulting firm, conducted these forums, synthesized the feedback from each forum, and produced a comprehensive report (see Appendix C for the Executive Summary; the full report can be found at <http://www.health.wyo.gov/director/dupre.html>).

### ***Data Analytics Contractor***

The efforts behind Report Two also included contracted work completed by Human Capital Management Services, Inc. (HCMS) over the course of several months. This work included the profiling of risk of the whole Medicaid recipient population and the sub-groups chosen in this study. These groups were then compared to private Wyoming insurance and national private insurance databases (held by HCMS) where it made reasonable sense to compare similar categories of recipients.<sup>6</sup> The results of these analyses continue to be used internally by the WDH as it uses data to inform decision-making.

## **Definition and Identification of Options**

Hundreds of options for improving Wyoming Medicaid have been offered and discussed. These options vary in feasibility, cost, effort, tolerability, and return on investment. Some options for improvement would require the entire Wyoming Medicaid system to change, while others would have a concentrated impact on programs serving specific populations.

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<sup>6</sup> For example, WDH did not request that Adult DD Waiver clients be compared to private insurance clients, as the waiver services for these clients that are paid by Wyoming Medicaid would not typically be covered by an average insurance plan.

### *Identification of Options*

After the 13 high-cost sub-groups were identified through analysis of Wyoming Medicaid data, certain sub-groups were combined due to the similarity in service use or natural fit. From the 13 sub-groups, six groupings emerged as areas that could benefit from modification or redesign. Once these six groupings were identified, options to improve these areas were identified through research, brainstorming sessions, technical assistance and substantive discussion.

### *Describing the Six Buckets*

For the sake of discussion and presentation, options were categorized using six buckets. These buckets are descriptive of the type of change necessary and the likely affect on the program or system. The buckets are described in the table below.

Bucket	Description
System/Program Design	System design options include broad or sweeping changes that could be made across multiple Medicaid programs. They could include overall health care delivery system redesigns, alterations or redesign of payment structure, and increased requirements for recipient involvement.  Program design options are similar to system design options, but would only apply to one Medicaid program or eligibility group.
Eligibility	Eligibility options include modifications to eligibility criteria, process, or rules and regulations.
Benefit and/or Services	Benefit and Services options include modifications to the services or benefits offered, service levels, or process by which services are obtained.
Rate and/or Payment	Rate and Payment options include modifications to rate reimbursement methodology, amount, or payment process. This also includes payment incentives or disincentives.
Internal Management	Internal Management options include modifications to administrative processes, program management, and cost containment. These changes would be implemented by Medicaid staff or contractors.
Healthcare Quality	Health Care Quality options include modifications that improve health outcomes.

### *Preface to the Presentation of Options*

Sections V-XI present the majority of the work completed in the development of Report Two. While Section V discusses options that could impact multiple Medicaid programs or the entire State system, Sections VI-XI focus on options that could impact specific populations in the identified high-cost sub-groups.

It is important to realize that not all the options presented are feasible for Wyoming Medicaid. While some options may not be feasible due to federal law or regulation, others may not be feasible because of lack of resources in the State or for other reasons. Options that are not feasible will obviously not appear as recommendations in the next report.

## SECTION V: OPTIONS | OVERALL WYOMING MEDICAID SYSTEM

### WYOMING MEDICAID SYSTEM RECIPIENTS SFY11

**SFY11 MEDICAID BUDGET | \$518.9 million [100%]\***

**NUMBER of RECIPIENTS in SFY11 | 77,207 [100%]\***

**WHO**

The Medicaid System provides services to people that qualify for the Medicaid program in broad categories: Children, Pregnant Women, Family Care Adults, and Aged, Blind, or Disabled persons. These categories include optional services, such as waivers, vision, and dental services.

#### COMPARISONS of COST CATEGORIES\*

Highest Cost Recipients   Top 5%	Moderate Cost Recipients   Middle 15%	Lowest Cost Recipients   Lowest 80%
Annual Cost Per Recipient = \$69,659	Annual Cost Per Recipient = \$13,949	Annual Cost Per Recipient = \$1,431

#### TOP 5 SERVICES BY EXPENDITURES\*\*

Inpatient Hospital Services   15%	
Skilled Nursing Facility Services   14%	
Physician Services   11%	
Residential Habilitation (Waiver)   11%	
Prescribed Drugs   8%	

*\*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.*

*\*\*The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for all Medicaid clients is presented next to the service type name.*

### **Group Overview**

In SFY 2011, approximately 77,000 Wyoming residents received health care services through Wyoming Medicaid. While there are four primary categories of Medicaid eligibility in Wyoming: Children, Pregnant Women, Family Care Adults, and individuals who are Aged, Blind or Disabled, the majority of those enrolled in Wyoming Medicaid are children.

In addition to the four major categories, Wyoming extends Medicaid eligibility to “other groups” for individuals in the Medicare Savings Program, individuals with breast or cervical cancer,

individuals with tuberculosis, employed individuals with disabilities, and non-citizens with medical emergencies. Wyoming also has six Home and Community-Based Services Waivers that were implemented at the option of the State.

Medicaid is financed by the Federal Government, as well as the State. The Federal Medical Assistance Percentage (FMAP) for Wyoming is near 50%, which basically means that the Federal Government reimburses the State approximately 50 cents for every dollar the State spends on a Medicaid recipient. Total expenditures for Wyoming Medicaid totaled nearly 520 million dollars in SFY 2011. For more information on the FMAP, see the FMAP White Paper prepared by Wyoming Medicaid staff and attached as a supplement to this report.

When attempting to identify options for the redesign of the overall Wyoming Medicaid System, it is important to recognize two points. First, there is wide discrepancy among recipient service utilization and cost. In fact, in SFY 2011, the top 5% most expensive recipients accounted for 52% of Wyoming Medicaid's cost.

Second, on average it is more expensive to serve recipients in certain categories than in others. Therefore, a Medicaid system's recipient mix (number of recipients in each eligibility category) has a great impact on its overall cost. In SFY 2011 the cost per recipient in each of the four major categories were, from highest to lowest: individuals who are Aged, Blind or Disabled (\$23,454 per recipient); Pregnant Women (\$5,893 per recipient); Family Care Adults (\$4,191 per recipient); and Children (\$2,764 per recipient). The average cost per recipient for all Wyoming Medicaid recipients was \$6,720.

Focusing on lower cost recipients or categories will limit the State's return on investment. For example, while children made up 64.7% of the Wyoming Medicaid population in SFY 2011, children only represented 26.6% of expenditures. Redesigns focused only on the general child population will produce limited savings. Alternatively, focusing on the higher cost populations could generate greater savings.

The following section, *Options / Overall Wyoming Medicaid System*, will discuss broad changes that can be made to the entire Wyoming Medicaid system or across multiple Medicaid programs. These more expansive alterations include health care delivery system redesign, payment structure redesign, funding structure redesign, and changes to recipient involvement.

## Overall Medicaid System Design Options

### Option 1 | Accountable Care Organization

*Description:* Accountable Care Organizations (ACO) are made up of doctors, hospitals and other health care providers that come together to provide a full continuum of integrated and coordinated care. The organizations are held accountable for the quality and cost of the care given to their patients.<sup>7</sup> Providers that form or join an ACO have the potential to share

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<sup>7</sup> Focus on Health Reform, Glossary of Key Health Reform Terms at <http://www.kff.org/healthreform/upload/7909.pdf>.

documentable savings from exceeding benchmarks on outcomes, while eventually assuming a risk of penalties for poor performance against established benchmarks.

For this option, Medicaid would partner with an Accountable Care Organization to provide care to the Medicaid population or parts of the Medicaid population. Feasibility of this option may be an issue, as there are currently no functional ACOs in Wyoming. In fact, there are few operating or successful ACOs in the country.

## **Option 2 | Block Grant**

*Description:* A block grant is a lump sum of money given to an entity for a specific purpose. Commonly, fewer restrictions are placed on block grant funds than are placed on other types of funding arrangements. A block grant arrangement could mean less federal involvement with Wyoming Medicaid which would allow the State more flexibility and control over its Medicaid System. Under a block grant, the State would receive a set amount of money from the Federal Government for a certain time period. Currently, there is no set amount of federal reimbursement the State receives. The State is reimbursed at a FMAP of 50% for the Medicaid services it pays for as long as Medicaid rules and regulations are followed.

Traditional block grants are currently not offered for state Medicaid programs by the Federal Government. Instead, states wanting more flexibility in administration of their Medicaid programs need to apply for 1115 waivers. Rhode Island, for example, administers its entire Medicaid program through an 1115 waiver. 1115 waivers are explained more fully later in this section.

## **Option 3 | Bundled Payments**

*Description:* A bundled payment is a pre-determined payment to providers for care provided during a pre-defined time period or for all services involved in a procedure or diagnosis.<sup>8</sup> A bundled payment would reimburse providers a pre-set amount of money based on the expected costs for defined episodes of care, rather than reimburse providers for each service provided as is done in the current fee-for-service model. For example, providers receive one payment for an episode of care, such as a hip replacement. In a fee-for-service arrangement, the hospital, anesthesiologist, and surgeon are all paid separately. Using a bundled payment approach, only one payment is made to the group of providers and disbursed to everyone involved in the hip replacement.

The concept of bundled payments is that the provider group works together to reduce the cost; reduced cost would result in reduced payment, and thus, savings to the payer. The payer can then share its savings with the provider group. This can incentivize care coordination among providers, which can lead to higher quality care at a lower cost.

Wyoming Medicaid pays the vast majority of providers through a fee-for-service arrangement. Some believe that fee-for-service arrangements incentivize increased provision of services, as

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<sup>8</sup> *Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms*, Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation.

providers are paid per service. With a bundled payment arrangement, providers are paid a set amount for a certain time period or episode of care.

#### **Option 4 | Capitated Payments**

*Description:* A capitated payment is a set payment per month or year, per person. Under this payment method, providers are paid a set amount per client instead of per service provided.

This option would allow Wyoming Medicaid to modify the way it pays providers moving away from the traditional fee-for-service model to a capitated payment model. A capitated payment arrangement would allow the State to forecast costs more accurately, as the cost of care for clients or the capitated payment would be set in advance.

#### **Option 5 | Co-Payments**

*Description:* A co-payment is a type of patient cost sharing. It is a fixed amount of money paid by the client to the provider for the medical care the client receives. A Medicaid provider cannot deny services to a Medicaid recipient because of that recipient's inability to make the co-payment, unless the recipient regularly refuses to pay the co-payments. Currently, Wyoming Medicaid reduces the final payment to a provider by the amount of the required co-payment for claims that require co-payments.

Too often recipients are insulated from health care costs, and thus have little appreciation for the cost of services. Requiring a co-payment exposes the recipient to the cost of their own health care.

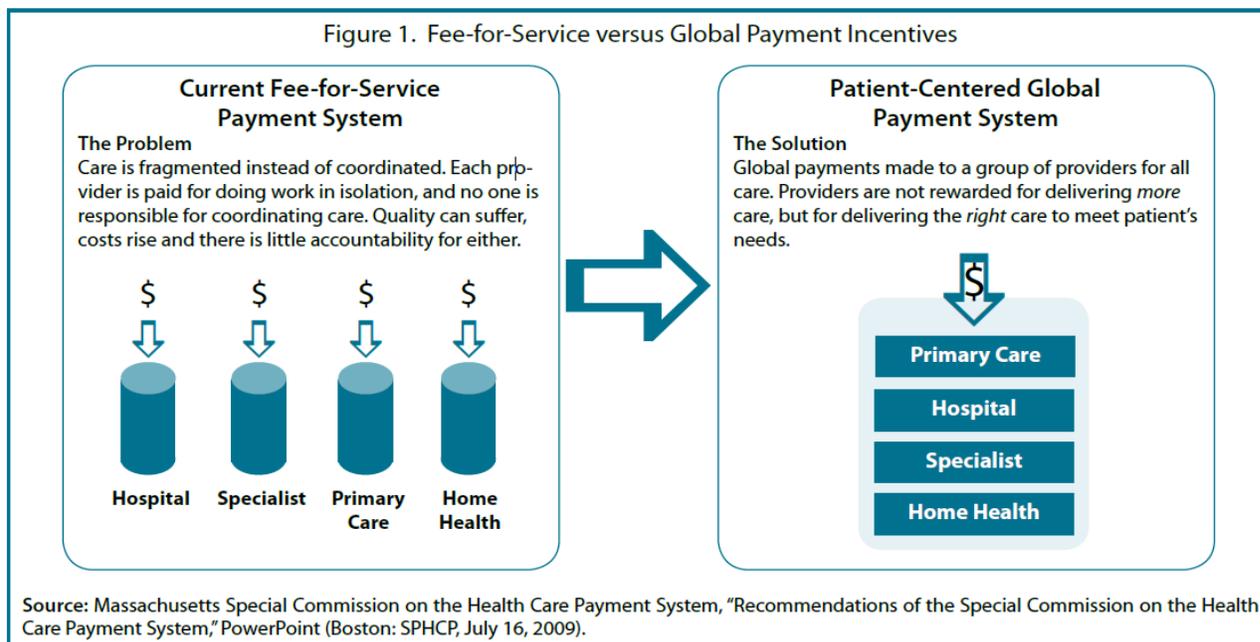
Wyoming Medicaid already charges the maximum allowable co-payments on several services, however, it could add co-payment requirements to additional services. Co-payments and other cost sharing required by Wyoming Medicaid are more fully discussed in a White Paper drafted by Medicaid staff and attached to this report as Supplement One.

#### **Option 6 | Global Payments (Global Bundling)**

*Description:* A global payment is a per person payment made to providers to cover care for a set period of time. A global payment is a form of bundling but is not tailored to specific episodes of care. Instead, all services for one particular person are bundled into one payment. The figure on the following page illustrates the global payment concept.<sup>9</sup>

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<sup>9</sup> National Conference of State Legislators. (2010). Health Cost Containment and Efficiencies, NCSL Briefs for State Legislators.



 National Conference of State Legislatures

## Option 7 | Global Waiver

*Description:* Global waivers are a type of 1115 waiver (discussed later in this section).

## Option 8 | Managed Care

*Description:* Managed Care is a type of health care delivery. While there are different types of managed care models, under a common model, a managed care organization is paid a capitated rate (discussed above) per participant. The managed care organization contracts with providers to create a network. Clients who are enrolled in the managed care plan seek care through that provider network. Some risk is shifted from the payer to the managed care organization through the capitated payment structure. Since the managed care organization is only getting a certain amount of money per person, there is incentive for the managed care organization to “manage” the population’s health. Managed care should produce increased efficiency and increased quality, as care is coordinated.

Managed care can be implemented for the entire State Medicaid population or parts of the population. It is not uncommon for the most complex populations or services to be excluded or “carved out” from managed care plans. However, if complex populations and services are excluded from the managed care plans, most costs of the Medicaid system remain outside of the managed care system.

Wyoming is one of only a few states in the nation that has no Medicaid clients enrolled in a managed care plan. In fact, managed care does not really exist at this time in Wyoming. However, recently at least one managed care organization has approached the executive branch and the WDH offering its services to Wyoming Medicaid.

## Option 9 | Medical Homes<sup>10</sup>

*Description:* A medical home is a model of health care service delivery which emphasizes integrated and coordinated care focused on the patient. The Medical Home concept is one that has evolved over the past several years.<sup>11</sup> There are now different “types” of Medical Homes, including: Patient-centered medical homes, enhanced medical homes, and health homes. Commonly, a patient who has a medical home can expect to receive comprehensive primary care, less fragmented care, and enhanced access to non-emergent care. Additionally, medical homes offer access to a health care provider to assist the patient and their family in coordinating the patient’s care.

The Affordable Care Act (ACA) establishes health homes as a model of integrated care for certain Medicaid recipients with chronic conditions. Under the ACA, states that choose to implement health homes will benefit from increased federal assistance for certain health home services for a limited time. Individuals that qualify for the ACA health home are those who: are eligible for the State Medicaid plan, have two chronic conditions, have one chronic condition and are also at risk for a second chronic condition, or have one serious mental health condition.

Additionally, the ACA specifies which services must be offered by a health home. These services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, referral to community and social support services, and the use of health information technology to link services.

Behavioral Health Homes (BHH) can also be developed by Medicaid programs and can benefit from the enhanced federal funding provided through the ACA. BHH are very similar to health homes. A BHH is an integrated delivery system that encompasses the “whole health” philosophy of treatment and is managed within a behavioral health environment such as a community mental health center. Whole health treatment that addresses both the mental illness and the chronic disease results in better treatment outcomes, and reduces emergency room visits and/or hospitalizations.

As Wyoming considers options for implementing medical homes, it is beneficial to understand potential resources within the State. One potential resource is the Wyoming Integrated Care Network (WYICN). The WYICN was created in late 2010. Powered by a \$14 million Innovation Award administered by Cheyenne Regional Medical Center’s Wyoming Institute of Population Health, the 23 hospital members, along with the University of Wyoming College of health sciences and six Wyoming healthcare professional organizations, are committed to ensuring that physicians and hospitals have the care coordination infrastructure, fully developed continuums of care, and access to technology and health information necessary to transform their role from volume-based providers, to “population health managers” working to improve health, improve quality, and contain the cost of healthcare.

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<sup>10</sup> Defined at <http://www.kff.org/healthreform/upload/7909.pdf>.

<sup>11</sup> See *Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms*, Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, May 2012.

Primary Care Medical Homes are a key component to the work being done by the WYICN; Wyoming Medicaid staff meeting regularly with WYICN staff to explore **furtherance** of mutual goals.

**Option 10 | Patient Incentives**

*Description:* A patient incentive is a financial or non-financial enticement for the patient to perform or avoid certain behaviors. Incentives are directed at changing behavior resulting in healthier lifestyles.

Examples of incentives include direct cash incentives, supplemental preventive and support services not otherwise available under Medicaid, or other incentives. Incentive payments can be directly given to the beneficiary or indirectly through family members, friends, or community agencies that provide supports to facilitate a participant’s progress toward health goals.

Incentives support changes in behavior. When a Medicaid client changes their behavior to become healthier (loses weight, quits smoking, etc.), not only is that person’s quality of life improved, but a healthier lifestyle can lead to decreased medical costs.

**Option 11 | Reduce Unnecessary Emergency Room Visits**

*Description:* A common concern among stakeholders with regard to the Medicaid population is the perceived high rate of recipient ER utilization. To determine whether this should in fact an issue, the WDH requested analysis from one of its consultants, HCMS, Inc., on Wyoming Medicaid recipient ER utilization. The HCMS analysis found significantly higher ER usage among the Medicaid population, with 33.7% of Medicaid recipients using the ER at least once during the year (SFY 2011), as compared to 11.9% for Wyoming residents with private insurance. The comparison is in the table below.

**Emergency Room (ER) Visits | July 2010 – June 2011**

<b>Insurance Recipient Type</b>	<b>% of population</b>
Medicaid Recipients with at least 1 visit	33.7%
Wyoming Private Insurance Recipients with at least 1 visit	11.9%
National Private Insurance Recipients with at least 1 visit	11.7%

While certainly not all ER visits by the Medicaid recipients were non-emergent, such differences in utilization rates suggests there is room for reduction in non-emergent visits.

There are a variety of ways that Wyoming Medicaid might approach this issue. Some states have begun to attempt to limit Medicaid recipients’ non-emergent use of the emergency room. For example, the State of Washington created a rule that Medicaid will cover the full cost of up to three non-emergent emergency room visits for recipients in a one-year period. This rule did not

take effect but the State proposed a new more stringent rule that banned payment for a list of 500 non-emergent conditions that was to go into effect on April 1, 2012.

The Governor of Washington suspended this rule on March 31, 2012 to allow budget negotiations to continue on a plan proposed by doctors and hospitals limiting emergency room utilization. On April 11, the Washington State Legislature adopted a budget proviso giving hospitals the opportunity to implement seven best practices by June 15, 2012 and reduce Medicaid emergency department visits by January 15, 2013. If a sufficient number of hospitals adopt all seven best practices (electronic health information system implemented, patient education process, patient review and coordination process, provider education, prescription monitoring), and reduce emergency room visits the original plan rate cuts will not take effect.<sup>12</sup>

The Washington example highlights the controversy that can surround defining some services or conditions as not constituting emergencies (the range of discussion of what diagnoses were non-emergent ranged between 200 and 500 diagnoses). The Washington example does show that the threat of significant cuts spurred significant commitments to improve the emergency system by private providers.

Several of the options listed in this section may help to reduce non-emergent ER utilization, including: managed care, medical homes, and co-payments. For instance, if a Medicaid recipient has a medical home, it is more likely that medical conditions could be dealt with early on, as opposed to requiring emergent care after the condition has worsened (without primary care treatment).

Another potential option is the development of a Navigator Program.<sup>13</sup> These types of programs are implemented in a hospital's emergency department. Each patient that comes to the ER would receive a medical screening exam, and those that have non-emergent issues would be offered treatment in the most appropriate clinical setting. This process is facilitated by "Navigators" (these may be nurses, or other trained medical personnel) who help the patient to make an appointment, and to establish a primary care physician if one is not already identified.

## **Option 12 | Vouchers**

*Description:* A voucher program would allow recipients to purchase private insurance coverage with the financial assistance of the government. WDH did not identify any states with voucher programs for their mandatory Medicaid populations. Additionally, it is questionable whether a health insurance plan purchased through vouchers would offer the same services or required level of services currently offered by Medicaid, as Medicaid currently covers some services not traditionally offered by private health insurance plans (i.e. dentistry, travel, vision etc.).

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<sup>12</sup> ER is for Emergencies, Washington State Hospital Association, <http://www.wsha.org/0443.cfm>

<sup>13</sup> An example of this type of program can be found at Presbyterian Hospital in Albuquerque, N.M..

<http://www.hfma.org/Publications/Leadership-Publication/Archives/E-Bulletins/2010/October/ER-Navigator-Program-Triages-Nonurgent-Cases-to-Primary-Care/>

## Option 13 | Waiver 1115

*Description:* Section 1115 Demonstration Waivers are approved to give states flexibility to design and improve their Medicaid programs.<sup>14</sup> Section 1115 of the Social Security Act allows the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid regulations in order for states to implement and evaluate approaches to Medicaid that expand Medicaid or CHIP coverage; expand or increase services, and/or implement innovative service delivery systems that improve care, increase efficiency, and reduce costs.<sup>15</sup> Developing an 1115 demonstration waiver would be a lengthy and complex process, requiring the redesign of the current Medicaid health care delivery system.

An 1115 waiver would allow the State some flexibility and independence in administering its Medicaid program. Any demonstration under this waiver must be budget neutral (or better); the demonstration project could not cost the Federal Government more than would be spent absent the waiver.<sup>16</sup>

Possibly the most well-known 1115 waiver is the Rhode Island Global Consumer Choice Compact. Rhode Island operates its entire Medicaid program under this one 1115 waiver demonstration.<sup>17</sup> Rhode Island legislation passed in 2008 directed the State to apply for an 1115 waiver “to restructure the State’s program to establish a ‘sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options’ and ‘a results-oriented system of coordinated care.’ ”<sup>18</sup>

## Overall Medicaid System: Internal Management Options

### Option 1 | Increased Use of Medicaid Data

*Description:* The enormous task of gathering, storing, analyzing, and then using Medicaid data to make informed policy decisions is of great importance, particularly in times of budget cuts. This option suggests the creation of a more formalized internal mechanism within the WDH to ensure that data are used to continuously improve the performance of Wyoming Medicaid.

*Medicaid Informatics Unit.* The Wyoming Medicaid program does not currently have adequate staff and resources dedicated solely to interpretation and use of its large quantities of data. Complicating things further is the fact that Medicaid claims data are gathered and maintained by an external contractor that, at present, uses a data management and storage software that is out of step with the most current information technology solutions for processing massive quantities of

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<sup>14</sup> Information about Section 1115 Demonstration waivers can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>.

<sup>15</sup> See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

<sup>16</sup> See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

<sup>17</sup> More information on Rhode Island’s 1115 waiver can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-fs.pdf>

<sup>18</sup> See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-fs.pdf>

data in a way that is accessible to the average decision maker (discussions are ongoing regarding a new Medicaid Management Information System, (MMIS)). The increased interest in data from both the legislature and WDH Senior Management has led to discussions of creating a unit dedicated to analysis and conceptual processing of Medicaid data.

In a review of other states' Medicaid programs, the states of Louisiana<sup>19</sup> and Kansas<sup>20</sup> stood out as having well-developed units related to providing both economic and service data processing support. Often, these units are referred to as "Medicaid Informatics" units. These units typically house data and content-related experts that can support the work of the existing Medicaid program staff, and respond to ad-hoc requests from stakeholders. These staff could literally be a bridge between the more technical database experts and the more content-knowledgeable program staff in such a way that data turns into information, and is more likely to be used to policymakers.

*Increased Internal Data Use.* WDH Senior Management, Medicaid fiscal support staff, and Medicaid program staff have already increased their interactions surrounding the use of data over the last few years. In order to ensure the consistent use of data that is available, timely, and meaningful, dedicated data processing meetings are necessary. Attendance by program content experts, as well as decision-makers in the agency, is essential to ensuring that accurate interpretation occurs. It is the intention of the WDH to continue Medicaid data processing meetings well beyond the reach of the Medicaid Options Study to focus on continuous program performance improvement.

## **Option 2 | Transfer Recipient Fraud Program to WDH**

*Description:* This option would transfer the responsibility of investigating recipient fraud from the Department of Family Services to the Department of Health. Currently, recipient fraud is investigated by the Department of Family Services, Prosecution Recovery Investigation Collection and Enforcement (PRICE) Unit. Provider fraud is investigated by Medicaid's Quality Assurance Unit in the Department of Health. The Attorney General's Office houses the Medicaid Fraud Control Unit (MFCU) which investigates and prosecutes Medicaid provider fraud and patient abuse and neglect in Medicaid funded facilities. So, there are three different state agencies involved in investigating Medicaid fraud.

Along with Medicaid recipient fraud, the PRICE unit also investigates recipient fraud for non-Medicaid programs in the Department of Family Services.

Moving the responsibilities involved with investigating recipient fraud to the WDH would allow recipient and provider fraud to be handled by one agency. Wyoming Medicaid has a vested interest in reducing and eliminating all types of fraud, as it is responsible to the Federal Government for any reimbursement of fraudulent payments. While the PRICE Unit recovers and reimburses Wyoming Medicaid for the Federal Government's share of fraudulent payments, it does not reimburse Wyoming Medicaid for Medicaid's share. Instead, the state share reverts to the General Fund.

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<sup>19</sup> See <http://new.dhh.louisiana.gov/index.cfm/page/26>

<sup>20</sup> See <http://www.kdheks.gov/phi/index.htm>

## Overall Medicaid System: Eligibility Changes

### Option 1 | Make Referrals to Job Service and Training Programs

*Description:* This option would integrate referrals to job service or training programs into the eligibility/enrollment/re-enrollment process for Wyoming Medicaid. While a *requirement* to pursue these services would not be allowed, Wyoming Medicaid could make efforts to incorporate these referrals into its eligibility/enrollment/re-enrollment processes for job-mobile recipients. This option would allow another avenue for interested Medicaid recipients to find appropriate services that may lead them to self-sufficiency.

### Option 2 | More Frequent Eligibility Determinations

*Description:* Federal regulations, along with a current Maintenance of Effort (MOE), limit Wyoming Medicaid's ability to conduct more frequent eligibility determinations at this time. In addition, the new Eligibility Rule under the ACA indicates that redeterminations of eligibility cannot occur more frequently than every 12 months. Currently, recipients are required to report changes in circumstances that would affect their eligibility. Recipients must, within ten days of the change, report changes in resources, living circumstances, earned income, unearned income, and health insurance coverage.

Wyoming Medicaid is currently implementing a new eligibility system that will bring additional sophistication to the process of determining eligibility (the new system is expected to be in place by January 2014). While eligibility is currently determined manually by caseworkers, this system will determine eligibility electronically. Additionally, this system will be able to interface with other state and federal data systems (including wage and tax information) and provide a level of tracking and analysis not available with the current system.

### Option 3 | More Stringent Consideration of Significant Other's Income for Eligibility

*Description:* This option is limited by federal law and regulation.

### Option 4 | Limit of the Length of Time an Adult Can Receive Medicaid

*Description:* This option is limited by federal law and regulation.

## Overall Medicaid System: Benefits or Services Offered

### Option 1 | Evaluate Optional Services

*Description:* The Federal Government mandates that states participating in Medicaid provide coverage for certain services (mandated services). Other services can be provided at the option of the State (optional services). This option would require the evaluation of all optional services

currently offered by Wyoming Medicaid. Once evaluated, the State could choose to accept, expand, limit or eliminate certain optional services. The elimination or limitation of certain optional benefits could potentially save the State money that would have been expended covering those services. Additionally, expansion or continuance of certain optional services may lead to a better quality health care program.

The following table details the services that are Mandatory vs. Optional in Wyoming.

Federally Mandated Covered Services	Optional Services <sup>21</sup> as Selected by Wyoming Legislature
<ul style="list-style-type: none"> <li>• Administrative transportation</li> <li>• Durable medical equipment (DME)</li> <li>• Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</li> <li>• Emergency transportation</li> <li>• Family planning services</li> <li>• Federally Qualified Health Center (FQHC)</li> <li>• Home health care</li> <li>• Indian Health Service Clinic (IHS)</li> <li>• Inpatient hospital</li> <li>• Laboratory and Radiology</li> <li>• Nursing facility services</li> <li>• Nurse practitioner services, includes nurse midwife and Certified Registered Nurse Anesthetist (CRNA)</li> <li>• Outpatient hospital</li> <li>• Physician services</li> <li>• Rural Health Clinic (RHC)</li> </ul>	<ul style="list-style-type: none"> <li>• Ambulatory Surgical Center</li> <li>• Audiologist and hearing aids</li> <li>• Comprehensive Outpatient Rehab Facility</li> <li>• Dental</li> <li>• End Stage Renal Disease Clinic (ESRD)</li> <li>• Hospice</li> <li>• Independent psychologist</li> <li>• Institution for Mental Diseases (IMD) &gt;65</li> <li>• Intermediate Care Facility for Intellectually Disabled - ICF-ID (Wyoming Life Resource Center)</li> <li>• Mental Health and Substance Abuse Rehabilitative Services</li> <li>• Nursing facility services under age 21</li> <li>• Occupational therapist</li> <li>• Optometrist services</li> <li>• Physical therapy (independent)</li> <li>• Prescription drugs</li> <li>• Prosthetics and orthotics</li> <li>• Targeted case management</li> <li>• Transplants (kidney, liver and bone marrow)</li> <li>• Waiver Services<sup>22</sup></li> </ul>

<sup>21</sup> Optional Services are at the discretion of each state. Wyoming has legislated coverage of the above optional services for adults. All states cover prescription drugs. Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers for children.

<sup>22</sup> Wyoming Legislature has authorized six Medicaid Waivers to selectively “waive” one or more federal requirements and allow for greater flexibility in the Medicaid system. These waiver programs can be used to fund services not authorized by federal Medicaid statute such as respite care, home modifications and non-medical transportation and can be used to provide optional Medicaid services such as case-management and personal assistance services. These are 1915 (c) home and community-based services waivers: DD Adult, DD Child, Acquired Brain Injury (ABI), Elderly and Physically Disabled (LTC), Assisted Living Facility (ALF), and Children’s Mental Health Waiver (CMHW).

## Overall Medicaid System: Rate or Payment Changes

### Option 1 | Periodic Review of Provider Reimbursement Rates

*Description:* Establishing provider reimbursement rates is a balancing act. While cost containment is certainly a priority, so too in a rural state, is maintaining access for Medicaid recipients to health care providers. It is important to maintain competitive rates. For more information on how Wyoming Medicaid sets rates, see the Medicaid Provider Reimbursement Methodology White Paper, written by Medicaid staff, attached as a supplement to this report.

## Overall Medicaid System: Healthcare Quality

### Option 1 | Expand Case Management for High-Cost Recipients

*Description:* Case management is a “process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.”<sup>23</sup> Case Management has been found to greatly impact clinical outcomes and thus, result in cost-savings.

The most expensive 20% of Medicaid recipients make up 83% of Wyoming Medicaid costs. The top 5% make up 52% of the cost, and the next most costly 15% of recipients add 31%. While Wyoming Medicaid already provides case management to its recipients, an exploration of additional levels of case management could be beneficial. For example, Wyoming Medicaid could look into providing more intensive case management than what it currently offers to certain recipients with complex needs. Additionally, designs for case management of dual-eligible Medicare and Medicaid recipients or for clients with significant co-occurring behavioral and medical conditions could be explored.

### Option 2 | Create Additional Tiers of Service for Chronic Care/Disease Management

*Description:* Chronic Care Management identifies high-cost clients with chronic diseases (e.g., asthma, diabetes, etc) and develops a plan to coordinate health care and support services.<sup>24</sup> The goal is to provide clients with knowledge, skills, and support so that they can learn to better manage their own health. This plan reiterates information given to the client by their healthcare providers and establishes a support system to facilitate making healthy behavior changes. This is done by making one-on-one health coaching, educational materials and a nurse line available to recipients.

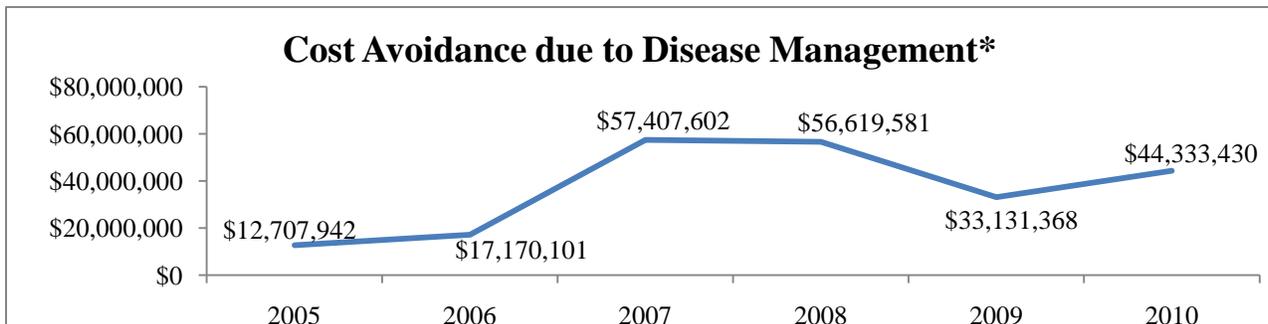
Wyoming Medicaid already has a disease management program. In 2010 the per member per month cost with disease management was \$390 less than would be expected without disease management based on comparison to a baseline per member per month trend established before

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<sup>23</sup> Definition taken from *Focus on Health Reform, Glossary of Key Health Reform Terms*, by the Henry J. Kaiser Family Foundation, found at <http://www.kff.org/healthreform/upload/7909.pdf>, visited August 14, 2012.

<sup>24</sup> Definition taken from *Focus on Health Reform, Glossary of Key Health Reform Terms*, by the Henry J. Kaiser Family Foundation, found at <http://www.kff.org/healthreform/upload/7909.pdf>, visited August 14, 2012.

the beginning of the program. This savings per month multiplied times 113,440 member months equals total savings in calendar year 2010 of \$44,333,430. The chart below shows the increase of savings since the program started in 2005. Savings for calendar year 2011 were not yet available and were estimated for this use based on the average of 2008-2010 actual savings.



### 2011 Estimated Savings

Disease Management*	\$ 44,694,793
<u>Inpatient Cost Avoidance (2011 Actual)</u>	<u>\$ 3,927,352</u>
Total Savings Calculated for 2011	\$ 48,622,145

*\*3 year actual average 2008-2010, used for 2011 estimate.*

Medicaid currently has a significant chronic care/disease management program with demonstrated savings, but this type of program could be expanded to focus on additional recipients by creating tiers of service. Options for chronic care and disease management are to create an additional higher tier of services to more intensively serve the highest-cost clients through regular in-person contact or direct treatment, or lower tiers to serve clients at-risk of chronic diseases that are not yet high-cost recipients. However, it must be noted that most “low-hanging fruit” have most likely been captured by the current disease management program design so returns will likely be less significant for these additional efforts.

## SECTION VI: OPTIONS | ELDERLY AND PHYSICALLY DISABLED RECIPIENTS

NURSING HOME		
<b>SHARE of SFY11 MEDICAID BUDGET   \$80.5 million [16%]*</b>		
<b>NUMBER of RECIPIENTS in SFY11   2,611 [3%]*</b>		
<b>WHO</b>	The Nursing Home eligibility sub-group consists of persons who are living in a nursing home, and whose income is less than or equal to 300% of the SSI standard. Financial resources are also taken into consideration when considering eligibility.	
<b>WHY</b>	The Nursing Home sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and high cost per recipient in the 5%, 15%, and 80% categories.	
COMPARISONS of COST CATEGORIES*		
Highest Cost Nursing Home   Top 5%	Moderate Cost Nursing Home   Middle 15%	Lowest Cost Nursing Home   Lowest 80%
Annual Cost Per Recipient = \$84,371	Annual Cost Per Recipient = \$55,992	Annual Cost Per Recipient = \$22,768
TOP 5 SERVICES BY EXPENDITURES**		
Skilled Nursing Facility Services   87% ICF-ID   2% Inpatient Hospital Services   2% Skilled Nursing Facility Crossover   1% Outpatient Hospital Services   1%		
<i>*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.</i>		
<i>**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.</i>		

## LONG TERM CARE (LTC) WAIVER

**SHARE of SFY11 MEDICAID BUDGET | \$29.3 million [6%]\***

**NUMBER of RECIPIENTS in SFY11 | 1,993 [2.6%]\***

**WHO** The LTC Waiver eligibility sub-group consists of persons aged 19 years and older, who are eligible for a nursing home level of care, yet receive services in their homes.

**WHY** The LTC Waiver sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and high cost per recipient in the 5%, 15%, and 80% categories.

### COMPARISONS of COST CATEGORIES\*

Highest Cost LTC Waiver   Top 5%	Moderate Cost LTC Waiver   Middle 15%	Lowest Cost LTC Waiver   Lowest 80%
Annual Cost Per Recipient = \$74,981	Annual Cost Per Recipient = \$28,110	Annual Cost Per Recipient = \$8,397

### TOP 5 SERVICES BY EXPENDITURES\*\*

Certified Self-Help Assistance   14%
Inpatient Hospital Services   12%
Case Management   11%
Prescribed Drugs   9%
Home Delivered Meals   7%

*\*SFY11 data were used for these analyses. Budget share, # recipients, annual cost per recipient and top five services are based on internal analyses.*

*\*\*The top 5 services were selected based on ranking services types from most to least costly within the 5%, 15%, and 80% categories. The percent of the cost for just that category of people is presented next to the service type name.*

<b>SSI</b>		
<b>SHARE of SFY11 MEDICAID BUDGET   \$51.7 million [10%]*</b>		
<b>NUMBER of RECIPIENTS in SFY11   6,052 [8%]*</b>		
<b>WHO</b>	The SSI eligibility sub-group consists of persons already receiving SSI (these people are automatically qualified for Medicaid).	
<b>WHY</b>	The SSI sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and high cost per recipient in the 5% and 15% categories.	
<b>COMPARISONS of COST CATEGORIES*</b>		
<b>Highest Cost SSI   Top 5%</b>	<b>Moderate Cost SSI   Middle 15%</b>	<b>Lowest Cost SSI   Lowest 80%</b>
Annual Cost Per Recipient = \$73,977	Annual Cost Per Recipient = \$18,871	Annual Cost Per Recipient = \$2,508
<b>TOP 5 SERVICES BY EXPENDITURES**</b>		
Inpatient Hospital   27% Prescribed Drugs   22% Physician Services   13% Outpatient Hospital   10% Mental Health Clinic Services   5%		
*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.		
**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.		

**Group Overview**

Elderly and physically disabled sub-groups were combined for options due to the similarity of services used, which primarily revolve around the long-term care needs of this population. This grouping includes options dealing with the following sub-groups: SSI, Nursing Homes, Long-Term Care Waiver, Assisted Living Facility Waiver, In-Patient Hospital, and Hospice.

Combined, expenditures for elderly and physically disabled sub-groups in FY 2011 equaled \$172,291,711 for 11,124 recipients.

The sub-groups identified as having the largest costs per recipient, representing significant expenditures overall, and/or having a large amount of variability between the top 5% and the bottom 80% were: Nursing Homes, Long-Term Care Waiver, SSI, and LTC-Hospital.

Eligibility of the nursing home, long-term waiver, and assisted living facility waiver population is determined primarily by a health and needs assessment and by other eligibility criteria.<sup>25</sup> SSI patients are eligible based on receiving SSI benefits, or having a disability that would qualify for SSI benefits.

These groups had higher use of long-term placements, support services and healthcare services than other groups.<sup>26</sup>

### *Common Concerns*

The primary concern was to identify ways to keep people in their homes or at a lower intensity of service, as well as minimizing negative outcomes that often lead to poor health outcomes and a need for expensive acute care in a hospital. Generally, costs increase as the length of stay and intensity of services provided increase. Seniors and persons with physical disabilities would often prefer to stay at home or in a less restrictive environment, however these options may not be available in their communities or these persons may be unaware of the other options available to them.

Wyoming Medicaid has a number of program design features that help keep people in their homes (or less restrictive environments) and therefore, limit costs. Key features are the assisted-living facility waiver and the long-term care waiver, which help limit costs by shifting placements from nursing home level of care to less intensive care.

Additionally, Wyoming Medicaid is currently administering a number of internal management activities to manage costs to ensure that Medicare, or other payers are the primary payers. Current activities include maximizing payments by Medicare, buying SSI eligible patients into Medicare, ensuring that veterans eligible for Veterans Administration (VA) benefits are receiving VA benefits, paying private health insurance co-pays if a person is privately insured, and paying Medicare Part A & B premiums for recipients eligible for Medicaid and Medicare. These types of activities reduce or offset costs when other payers are available.

## **Elderly and Physically Disabled: Program Design Options**

### **Option 1 | Utilize community resources and natural supports more extensively.**

*Description:* By utilizing existing community resources and natural supports, this strategy can lower costs while increasing involvement and socialization of the recipient.

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<sup>25</sup> Benefit specialists verify income, resources, citizenship, residency and other criteria to determine eligibility.

<sup>26</sup> Supplemental Security Income (SSI) is a Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income by providing cash to meet basic needs for food, clothing, and shelter. Clients receiving SSI payments automatically qualify for Medicaid. Wyoming is a 1634 agreement state and accepts SSI determinations from the Social Security Administration for Medicaid eligibility. More information available at <https://secure.ssa.gov/poms.nsf/lnx/0501715010>

## **Option 2 | Pay partial room and board at assisted living facilities**

*Description:* The assisted living facility waiver currently cannot cover room and board, and recipients must pay these costs out of pocket. In comparison, room and board is included in the rate that Medicaid pays skilled nursing facilities. This creates a situation where the design of the system is encouraging higher use of more expensive nursing home care, rather than less expensive assisted living facility care.

The current average cost per recipient of the assisted living facility waiver is \$13,715 per year, while the average yearly cost per recipient of the skilled nursing facility is \$30,832. This difference in cost allows for significant savings for recipients that move from nursing homes to assisted living facilities, even with a room and board allotment. Flexibility would be needed to shift funding from nursing homes to the assisted living facility waiver or to a general revenue supplemental program to follow the recipient.

For other recipients not currently placed in a nursing home, this change may increase short-term costs to the system if those recipients move from a lower-cost home placement to a higher cost assisted living facility placement.

## **Option 3 | Encourage use of adult daycare**

*Description:* Adult daycare centers are designed to provide care for seniors who need assistance or supervision during the day. Such programs may delay or prevent institutionalization by providing alternative care that enhances a primary caregiver's ability to continue providing care by allowing the caregiver to work. There are two types of adult daycare: adult social daycare and adult health daycare. Adult social daycare provides social activities, meals, recreation and some health-related services. Adult health daycare offers more intensive health, therapeutic and social services for individuals with severe medical problems including those at risk of requiring nursing home care.

Adult daycare is a covered service under the LTC Waiver but not under regular Medicaid. The service is paid at \$8.40 per hour, or \$2.10 per 15 minute unit.

## **Option 4 | Explore managed care for SSI recipients**

*Description:* Under this option, a contractor would take primary responsibility for the non-institutionalized SSI population in exchange for a capitated monthly fee per recipient. This is a limited form of managed care targeted at one subgroup or population.

## **Option 5 | Increase low cost and suitable housing for seniors and SSI**

*Description:* Lack of affordable housing can sometimes lead to institutionalization due to the person's inability to afford a home or an apartment. Unsuitable housing that is not adapted to the individual's needs for access and safety can also cause premature institutionalization. Targeting this population with housing supports may help save money by avoiding more expensive levels of care.

## **Option 6 | Patient Centered Medical Home**

*Description:* Require a patient centered medical home for every participant. Medical homes were previously addressed in more detail in Part Five of this report.

## **Option 7 | Evaluate creative placement and diversion programs**

*Description:* Wyoming is currently exploring long term care options through projects with contractors. These programs will explore the effectiveness of placement or diversion options for individuals that want to return to independent living in the community from skilled nursing facilities, or for individuals at imminent danger of going into a nursing facility.

For instance, the Project Out<sup>27</sup> program assists individuals with housing assistance which may include: first and last month's rent, accessibility, adaptive equipment, and other types of assistance.

## **Elderly and Physically Disabled: Internal Management Options**

### **Option 1 | Encourage PACE programs (Program of All Inclusive Care for the Elderly)**

*Description:* The Program of All-Inclusive Care for the Elderly (PACE) program is a provider model where all services are received through the PACE organization, and the PACE organization can pay for services or items that may not be reimbursable by traditional Medicare or Medicaid programs. This allows the PACE organization to place the focus on less expensive preventive care in order to avoid expensive acute care.

PACE programs are paid a capitated monthly amount which is used to cover all of a recipient's preventive, primary, acute and long term care needs. As each PACE program is "owned" by a group of providers, PACE is a community based form of managed care. The PACE model of care is established as a provider type in the Medicare program and also enables states to provide PACE services to Medicaid beneficiaries as a state option.

PACE programs provide a community based system of care that includes comprehensive long term services and supports to Medicaid and Medicare recipients. Services include but are not limited to long-term care, health care, transportation, and nutrition. The focus is on the total needs of the individual rather than only one type of service. An interdisciplinary team of health professionals collaborate to provide individuals with coordinated care that often enables recipients to receive care at home rather than at a nursing home.

Individuals can join PACE if they are age 55 or older, live in the service area of a PACE organization, are eligible for nursing home care, and are able to live safely in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible recipients who choose this program, but individuals can leave the program at any time.

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<sup>27</sup> Project Out. Wyoming Independent Living Rehabilitation. <http://www.wilr.org/out.html>  
Wyoming Medicaid Options Study | Report Two

Cheyenne Regional Medical Center has a PACE program that will begin in early 2013.

### **Option 2 | Improve pharmacy management of dual-eligible individuals**

*Description:* Use drug information from the federal Minimum Data Set (MDS) for case management of individuals eligible for both Medicaid and Medicare. The MDS is part of the process for clinical assessment of all residents in Medicare or Medicaid certified nursing facilities. This data should always be used when conducting medication regimen reviews for insight into the patient's prior history of medication-related problems and effects.<sup>28</sup>

### **Option 3 | Align plan of care and services received**

*Description:* Better service oversight for long-term care to ensure that all services received are required by the plan of care and that expected positive outcomes for each service are being achieved. Medicaid staff or a contractor would need to establish a secondary review process to ensure that services billed by providers comply with the plan of care. For instance, if the plan of care did not mention nutrition as an issue then Medicaid would not pay for home-delivered meals. This process would help ensure that only the services needed are paid for by Medicaid.

## **Elderly and Physically Disabled: Eligibility Changes**

### **Option 1 | Higher quality nursing home eligibility determinations**

*Description:* Wyoming currently determines eligibility for nursing home level of care based on a health and needs assessment called the LT 101. As eligibility determinations are the basis for extending Medicaid eligibility, more stringent quality control of eligibility determinations and periodic outside reviews of assessments would cause some individuals that do not need nursing facility level of care to not receive this care. This would likely reduce eligibility and reduce costs.

### **Option 2 | Eliminate caps on slots for the LTC Waiver and ALF Waiver**

*Description:* Skilled nursing facilities are a mandatory service under Medicaid. This means that anyone who requests a skilled nursing placement and is eligible must be placed in a skilled nursing facility. There are no slots or waitlists for skilled nursing facilities. Skilled nursing facilities are one of the most expensive placements with an average cost per recipient in SFY 2011 of \$30,832.

Lower cost optional services such as the long-term care (LTC) waiver and the Assisted Living Facility (ALF) waiver can result in cost savings by serving as an alternative to skilled nursing facilities.

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<sup>28</sup> See <https://www.ascp.com/articles/minimum-data-set-mds-resources>

At the end of FY 2011, there were 181 people on the LTC waiver waitlist and 29 people on the ALF waiver waitlist that were at-risk of placement in a skilled nursing facility. This option would eliminate the cap on the number of slots for the long-term care waiver and the assisted living facility waiver. This would extend eligibility for LTC or ALF waiver services to all individuals that qualify based on income and needing skilled nursing facility level of care. Additionally, it would serve as a diversionary program away from more expensive skilled nursing facility placements.

This option may save significant funds if recipients are relocated or diverted from an actual nursing home placement. As shown in the table below, for every recipient that can be diverted from a skilled nursing facility placement to the LTC waiver or ALF waiver could result in savings up to \$15,000 annually (based on SFY 2011 average annual expenditure per recipient).

Assisted Living Facility Waiver	Long Term Care Waiver	Skilled Nursing Facility
255 Recipients	1,993 Recipients	2,611 Recipients
Avg. Annual Cost \$13,715	Avg. Annual Cost \$14,684	Avg. Annual Cost \$30,832
Slots Capped	Slots Capped	Cannot Cap Slots

**Option 3 | Create a Medicaid equivalent of the Community Based In-Home Services program**

*Description:* The Community Based In-Home Services (CBIHS) program is a 100% state-funded program created by State Statute §9-2-1208. This program is provided through 23 county providers that provide community based in-home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older. Priority is given to persons at risk of placement in nursing homes, assisted living or other institutional care settings. In FY 2010, the CBIHS served 2,243 at-risk recipients for the cost of \$2,246 per year per recipient.<sup>29</sup> The selection of services offered by the program includes case management, homemaking, home modifications, personal care, adult daycare (at licensed facilities only), chores, medication set-ups, respite, and hospice. The program has client cost sharing based on a sliding fee scale.

This option would create a maximum per year capped waiver with tighter income eligibility with per person funding similar to the current CBIHS program. This would allow the program to leverage federal matching funds. This may require a new 1915(c) waiver or an 1115 waiver. It may be possible to design this new waiver so that recipients may only receive waiver services without extending full Medicaid eligibility for other services to these recipients.<sup>30</sup>

<sup>29</sup> General Fund cost only. The actual cost of service provision varies by provider and is supplemented by other funds.

<sup>30</sup> Wyoming Medicaid has received conflicting information on this issue, and additional technical assistance is necessary to determine the extent to which waiver services can be extended without extending full Medicaid eligibility.

#### **Option 4 | Evaluate optional income eligibility for nursing homes and LTC waivers**

*Description:* Wyoming’s policy of 300% SSI income eligibility and Miller Trust spend-down policies significantly extend skilled nursing facility Medicaid income eligibility beyond the federal minimum of 100% SSI. As the skilled nursing facility income eligibility standard is also used by the long-term care and assisted living facility waivers, eligibility is also extended for those waivers.

Currently, eligibility for nursing homes and LTC waivers are based on the optional 300% SSI income standard (\$25,128 for a single person, \$37,728 for a couple). Wyoming also allows “Miller Trusts” which allow an individual to place any income above the 300% SSI standard into a trust account in order to lower their income to the 300% income standard and become eligible for the waiver or nursing home. The funds in the trust account revert to the State upon the death of the recipient. The recipient retains all income below the 300% SSI standard for their own personal use.

38 states use the “special income limit” or “institutional pathway” income standard of 300% SSI as the income eligibility standard for nursing home care.<sup>31</sup> The “special income limit” standard is not required by the federal government and can be set at lower levels of SSI.<sup>32</sup> For instance, Florida uses 250% of SSI as its standard while Delaware uses \$1,113 per month (approximately 150% of SSI).

If a State does not offer a “medically needy” spend down option which allows medical expenses to be deducted from income, federal law requires states to provide a Miller Trust option. Twenty-three states offer Miller Trusts, and six of these states impose limits or special provisions on the amount of income that can be transferred into the trust to lower eligible income.<sup>33</sup>

Due to the combination of the optional 300% SSI income standard and unlimited Miller Trust contributions, Wyoming currently has significantly expanded income eligibility for this population.

Wyoming may choose a number of options to limit income eligibility including: lowering the Special Income Standard for nursing homes and waivers, limiting the income that can be placed in a Miller Trust, abandoning the Miller Trust in favor of the medically needy eligibility option, or some combination of adjustments. Any of these options would limit eligibility and thereby significantly limit expenditures.

#### **Option 5 | Use waivers solely as a last-step diversion from nursing home placement or to relocate current nursing home recipients.**

*Description:* This option would only enroll Medicaid recipients in a long-term care waiver if an applicant requests nursing home placement or is currently placed in a nursing home. This helps avoid the potential problem of community long-term care waiver services or assisted living

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<sup>31</sup> See <http://www.statehealthfacts.org/comparemaptable.jsp?ind=817&cat=4#notes-1>

<sup>32</sup> 100% SSI is the income limit required by Federal law.

<sup>33</sup> See pages 8 and 9: [http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss\\_revised.pdf](http://assets.aarp.org/rgcenter/ppi/ltc/i44-access-ltss_revised.pdf)

facility waiver services being more attractive to recipients with less severe needs, which could increase utilization beyond the population that would otherwise be placed in a nursing home.

## Elderly and Physically Disabled: Benefits or Services Offered

### Option 1 | Different benefit package for Medicare-Medicaid dual-eligibles

*Description:* Dual-eligibles are Medicaid beneficiaries that qualify both for Medicare and Medicaid.<sup>34</sup> Medicare covers primary health services, while Medicaid pays Medicare premiums, cost sharing, and for services Medicare does not cover. Services covered by Medicaid but not by Medicare include long-term care, dental, and vision care. Medicare covers pharmacy costs, but also requires states to make “clawback” payments that offset any potential savings.

As dual-eligibles are part of two separate programs, services are often uncoordinated, which contributes (along with poor health and poverty) to this population being the most expensive Medicaid and Medicare population nationally. Based on a 2007 state Medicaid-Medicare profile<sup>35</sup>, Wyoming dual-eligibles had significantly higher number of chronic conditions, emergency room visits, prescription drug usage, and other health care utilization than the rest of the Medicare population.

As a potential solution to this problem, the Center for Medicare and Medicaid Innovation (CMMI) encourages states to integrate physical, behavioral, and long-term care services into a seamless and comprehensive care experience for Medicare-Medicaid recipients through the Financial Alignment Initiative.<sup>36</sup> CMMI is working with States to test two models that may better align the service delivery and finances of the Medicare and Medicaid programs.

The two models are:

- **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment from Medicaid and Medicare to coordinate or provide comprehensive care to the dual-eligible individual.
- **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State may share in any savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

Another option is a Medicare Special Needs Plan (SNP) for Dual-Eligibles, where Medicaid and Medicare contract with a single managed care organization for administration. There are currently two models in use.<sup>37</sup> In both models, a participant’s Medicare enrollment is voluntary due to federal law but Medicaid enrollment can either be mandatory or voluntary.

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<sup>34</sup> See [http://www.kff.org/medicaid/upload/4091-04%20final\(v2\).pdf](http://www.kff.org/medicaid/upload/4091-04%20final(v2).pdf)

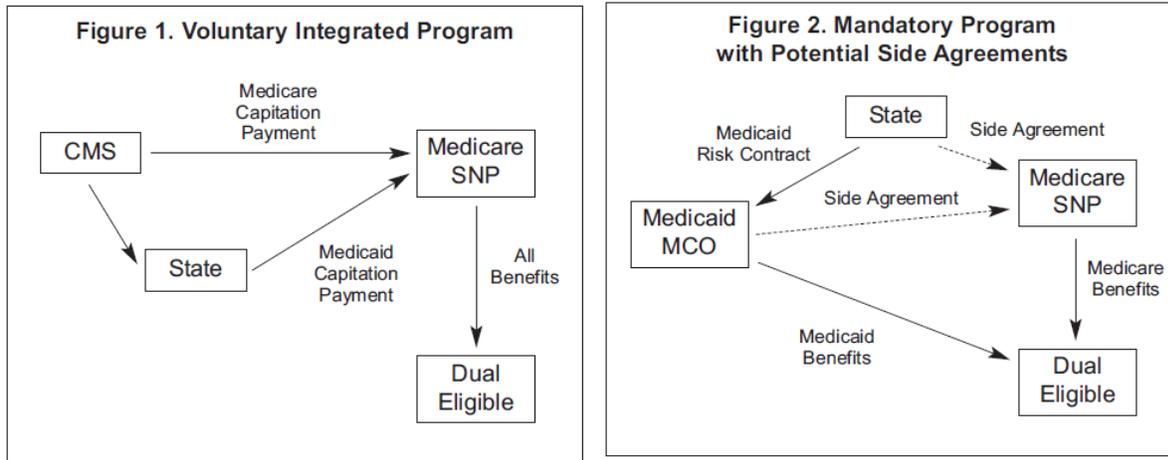
<sup>35</sup> See <http://www.integratedcareresourcecenter.com/PDFs/StateProfileWY.pdf>

<sup>36</sup> See <http://innovations.cms.gov/initiatives/Financial-Alignment/index.html>

<sup>37</sup> Commonwealth Fund. Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans. Issue Brief February 2008.

[http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Feb/Coordinating%20Care%20Wyoming Medicaid Options Study | Report Two](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Feb/Coordinating%20Care%20Wyoming%20Medicaid%20Options%20Study%20Report%20Two)

This first model has been used in Minnesota since 1997 and Massachusetts since 2004. It is a voluntary enrollment model for Medicaid participants. The second model has been implemented in Arizona and in Texas, and requires mandatory enrollment by dual-eligible Medicaid participants.



Aligning Medicaid and Medicare spending could result in significant savings for both programs.

Medicaid could contract with a managed care organization for management of its dual-eligible recipients, and require formation of a Medicare SNP as part of that agreement. Wyoming could also contract with a Medicare SNP for management of its Medicaid recipients. Currently, there are no Medicare SNP health plans operating in Wyoming.<sup>38</sup>

**Option 2 | Tennessee 1115 waiver- Tighter nursing homes admission standards and broader eligibility for a \$15,000 maximum supports waiver**

*Description:* In 2009, Tennessee created a home and community based waiver for long-term care that has caused a significant shift away from nursing home level of care to home and community based care.

2010 Tennessee	2012 Tennessee
83% of recipients in nursing homes	66% of recipients in nursing homes
17% of recipients in home and community based care	34% of recipients in home and community based care

for%20Dual%20Eligibles%20Options%20for%20Linking%20State%20Medicaid%20Programs%20with%20Medicare%20Adva/Milligan\_coordcaredualeligibles\_1109\_ib%20pdf.pdf

<sup>38</sup> See <http://www.statehealthfacts.org/profileind.jsp?rgn=52&cat=6&ind=333>

In 2012, Tennessee created a Section 1115 waiver to further encourage home and community based care. Admission criteria in Tennessee for nursing homes have been tightened and a focus has been placed on serving recipients in their homes or with their families. Tennessee created less stringent eligibility standards for a home and community based care program with a maximum budget of \$15,000 per year that is not tied to nursing home admission standards, and made more stringent its admission standards for nursing facilities.<sup>39</sup> Tennessee also created a second home and community based waiver option for people who meet the more stringent nursing facility admission standard to receive an option for a maximum \$55,000 home and community based waiver rather than enter a nursing home.

The plan is expected to save \$47 million for Tennessee in 2012. Tennessee did all of these changes under a Section 1115 demonstration waiver<sup>40</sup>.

In Wyoming, this option would generate an estimated \$15,000 average savings for each individual shifted from nursing facility care to the current long-term care or assisted living facility waivers. In FY 2011, Wyoming had 4,859 individuals receiving long-term care through a nursing home or a waiver (LTC and assisted living facility waivers). In FY 2011, 53.7% of long-term recipients were served in a nursing home and 46.3% were served on a waiver for long-term care or an assisted living facility. A potential savings of \$3.5 million-\$4 million per year results for each 5% of recipients<sup>41</sup> that shift from nursing homes to the current long-term care waiver.

## Elderly and Physically Disabled: Rate or Payment Changes

### **Option 1 | Tie the services received, skilled nursing facility rates, and maximum budget amount to the level of care required by the LT 101 assessment.**

*Description:* This option seeks to align services and payment with the needs and severity of the recipient. Medicaid would only pay for services identified as necessary in the LT 101 assessment.

For in-home services, this would limit the selection of services available to recipients to those needs identified on the LT 101 assessment. For example, if the LT 101 assessment does not mention nutrition as an issue, then Medicaid would not pay for in-home meals.

For nursing facilities, this option would base nursing facility payments on a recipient needs and severity score. The rate would acknowledge specialty care considerations and would reimburse skilled nursing facilities on recipient needs, rather than on the current cost coverage basis. Recipient needs could incorporate behavior in addition to health needs. This would encourage acceptance of difficult recipients that are currently hard to place by paying more for these

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<sup>39</sup> See <http://www.kaiserhealthnews.org/Stories/2012/July/29/tennessee-medicaid-long-term-care.aspx>

<sup>40</sup> See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tennicare-ii-ca.pdf>

<sup>41</sup> A 5% shift equals approximately 243 recipients with an average estimated savings of \$15,000 per year.

recipients, and encourage skilled nursing facilities to place lower need/lower rate recipients in home based services.

In addition, low severity recipients could be more easily identified and targeted for transition to home and community based services.

This payment method would more closely tie payment to the resources needed to service recipients, rather than rewarding nursing facilities with high cost structures. This method would create incentives to take hard to place recipients by aligning payment rates with severity, and may encourage specialization among nursing homes (low, moderate, high intensity, behavioral).

This would require a rate redesign<sup>42</sup> for skilled nursing facility care. In addition, plans of care would need to be closely monitored to ensure that services are in compliance with the plan. A new eligibility system with a modern enterprise payment system would ease administration of this change.

## **Option 2 | Eliminate conflicts of interest in case management and recipient assessments**

*Description:* Examine conflicts of interest between certain types of services/providers. Examples of potential conflicts of interest include case management vs. providing direct services, and LT-101 assessments vs. waiver service providers. For instance, in the current system case managers can provide direct services and case management<sup>43</sup> to the same client. In those instances, case managers are asked to provide quality oversight over their own work, or in situations where they have a personal financial self-interest in the recipient receiving as many services as possible. A lack of independence could potentially be harming the quality of care and increasing costs.

Eliminating conflicts of interest would help eliminate or limit unnecessary services, and would create a true independent monitoring system to ensure high quality care and desired outcomes are met. CMS has issued a guidance statement on conflicts of interest, and supports states adopting a model policy on conflict free case management.

## **Option 3 | Tie skilled nursing facility rate cost coverage to percentage of recipients on Medicaid.**

*Description:* This option would pay a higher cost coverage ratio for nursing homes with a high percentage of Medicaid nursing home beds. This would tie reimbursement levels to accepting a greater percentage of Medicaid recipients, and would help with hard to place or high-acuity Medicaid recipients<sup>44</sup>. The formal name for this type of rate setting methodology is case-mix payments.

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<sup>42</sup>One example of an alternative rate design is Resource Utilization Groups (RUGs).  
[http://medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_07\\_SNF.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_07_SNF.pdf)

<sup>43</sup> Case management conflicts can also occur when a case manager works for the same company as the service provider.

<sup>44</sup> See <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797088/>

#### **Option 4 | Maximum cost for durable medical equipment (DME) in nursing home rate.**

*Description:* Create a maximum allowable cost for durable medical equipment that will be considered in the nursing home rate, so that Medicaid does not pay for wide variation in purchasing practices among skilled nursing facilities.

#### **Option 5 | Reward high-quality providers that achieve good client outcomes.**

*Description:* Create provider incentives based on outcomes, bundled services, and value-based purchasing.

#### **Option 6 | Add a Memory Care Unit rate tier to Assisted Living Facilities waiver**

*Description:* When Assisted Living Facility recipients are diagnosed with Alzheimer's and other memory conditions, these recipients often must move to Skilled Nursing Facilities. By creating a higher rate tier for Memory Care Units, assisted living facilities would be encouraged to add Memory Care Units for recipients above base level assisted living care but below nursing facility level of care. This option would present some savings by paying a lower rate for the Memory Care Unit rate tier than the recipient would cost if placed in a skilled nursing facility.

### **Elderly and Physically Disabled: Healthcare Quality**

#### **Option 1 | Immediate medical assessment and case management at enrollment**

*Description:* Often, patients wait until an acute episode before seeking care. Requiring an immediate medical assessment as part of the enrollment process would help avoid the increased costs from unidentified conditions becoming more severe. This strategy would focus on preventive care which would help patients manage their chronic conditions and would likely reduce emergency room visits.

This strategy would identify potential high cost patients earlier in the process and allows health interventions such as case management and chronic disease management to begin immediately upon enrollment.

#### **Option 2 | Improve transitions of care –Provider processes**

*Description:* Comprehensive use of electronic health records could improve case management and transitions of care, especially among a Medicaid population that uses many providers. If providers properly and regularly used an Electronic Health Record system for pharmacy, medical, and behavioral care then services could be provided more seamlessly.

This change could result in fewer cases requiring hospitalization or acute care during transitions between levels of care. This objective could be achieved through incentives or through policy and legislation.

### **Option 3 | Medication reviews for Medicaid recipients with multiple medications**

*Description:* Increase the use of a second opinion process when multiple medications, excessive dosages, and potential side effects may be present.

**SECTION VII: OPTIONS | ADULTS WITH DEVELOPMENTAL DISABILITIES**

<b>ADULT DD WAIVER</b>		
<b>SHARE of SFY11 MEDICAID BUDGET   \$89.3 million [17%]*</b>		
<b>NUMBER of RECIPIENTS in SFY11   1,392 [2%]*</b>		
<b>WHO</b>	The Adults with Developmental Disabilities (DD) Waiver eligibility sub-group consists of developmentally disabled adults (ages 21 and up) that receive training and support services which allow them to remain in their home communities and avoid institutionalization.	
<b>WHY</b>	The Adult DD Waiver sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and high cost per recipient in the 5%, 15%, and 80% categories.	
<b>COMPARISONS of COST CATEGORIES*</b>		
<b>Highest Cost DD Adult Waiver   Top 5%</b>	<b>Moderate Cost DD Adult Waiver   Middle 15%</b>	<b>Lowest Cost DD Adult Waiver   Lowest 80%</b>
Annual Cost Per Recipient = \$191,639	Annual Cost Per Recipient = \$112,836	Annual Cost Per Recipient = \$47,012
<b>TOP 5 SERVICES BY EXPENDITURES**</b>		
Residential Habilitation   58%		
Day Habilitation   21%		
Case Management   5%		
Special Therapy/Skilled Nursing   3%		
Prescribed Drugs   2%		
*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.		
**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.		

This section discusses options for adults with developmental disabilities served through the Adult DD waiver and Intermediate Care Facility for Intellectual Disabilities (ICF-ID) facility at the Wyoming Life Resource Center. Adults with developmental disabilities that are not on a waiver, also receive services through Medicaid if they qualify based on SSI eligibility. This section also discusses options for adults with acquired brain injury because this program uses the same eligibility standard as the Adult DD waiver and the ICF-ID facility. All costs shown in this section include medical costs and waiver or facility costs (unless otherwise noted).

## *Group Overview*

Adults with developmental disabilities are served in two primary programs, which are the Adult DD waiver and the Intermediate Care Facility for Intellectual Disabilities (ICF-ID). In Wyoming, ICF-ID services are provided at the Wyoming Life Resource Center. All Medicaid recipients receive the same mandatory and optional services, which include medical care. Waiver recipients and ICF-ID recipients receive services in addition to core Medicaid services. Clients that are already eligible for Medicaid without a waiver (such as SSI recipients) receive core Medicaid services, even while they may be on a waitlist for extended home and community based services through a waiver.

Eligibility for the Adult DD waiver and the ICF-ID facility (the Wyoming Life Resource Center) is determined using the ICF-ID standard that Wyoming has adopted. The Adult DD waiver expires on June 30, 2014 and can be renewed, amended, or ended at that time. If desired, a new waiver(s) can take the place of or supplement the current waiver.

Adults with acquired brain injury (ABI) group were not identified as a group requiring additional analysis in report one, or in the secondary sub-group analysis. However, as the Acquired Brain Injury waiver (ABI Waiver) uses the ICF-ID standard to determine eligibility, this group has been included in this section, as any changes to the eligibility standards for the Adult DD waiver or ICF-ID facility will impact this group's eligibility standards. In addition, the use of the ICF-ID standard for the ABI waiver entitles ABI clients to choose between community-based waiver services and placement at the ICF-ID facility. The ABI Waiver expires on June 30, 2014 and can be renewed, amended, or ended at that time. If desired, a new waiver(s) can take the place of or supplement the current waiver.

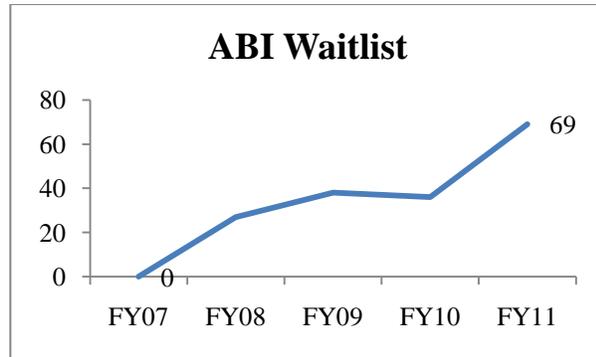
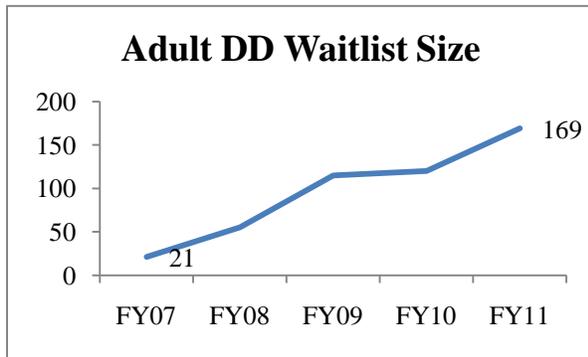
## *Common Concerns*

A concern is whether services and placements are encouraging positive client outcomes and integration into the community. The most expensive services are residential habilitation and day habilitation<sup>45</sup>, while other types of services and placements may be better at encouraging positive client outcomes. Desired outcomes include increased independence, life skills, supported employment, increased integration into the community, and smaller or more diverse residential settings.

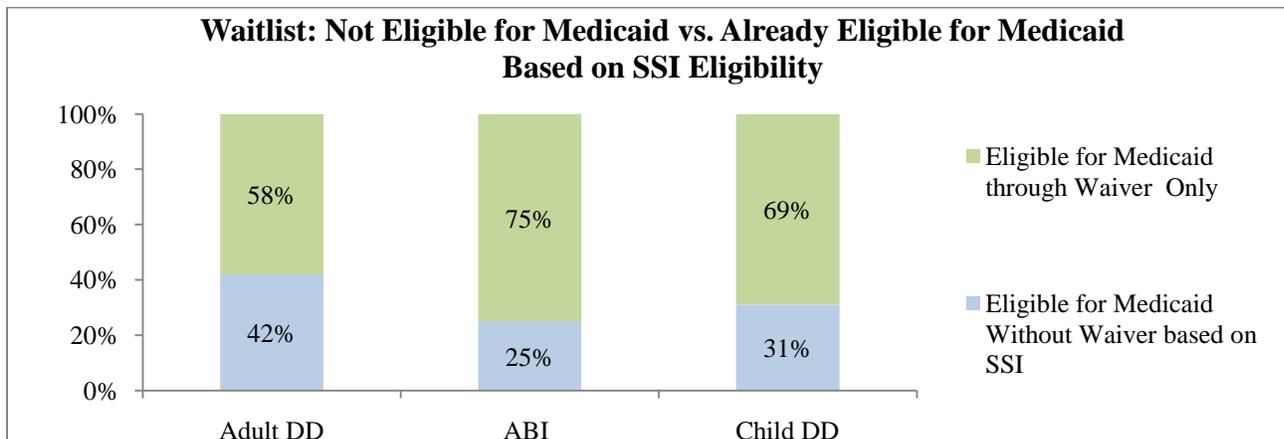
The waitlist size and length of time on the waitlist are concerns with the Adult DD and ABI waiver programs. The waitlists for the Adult DD program and the ABI program continue to grow over time.

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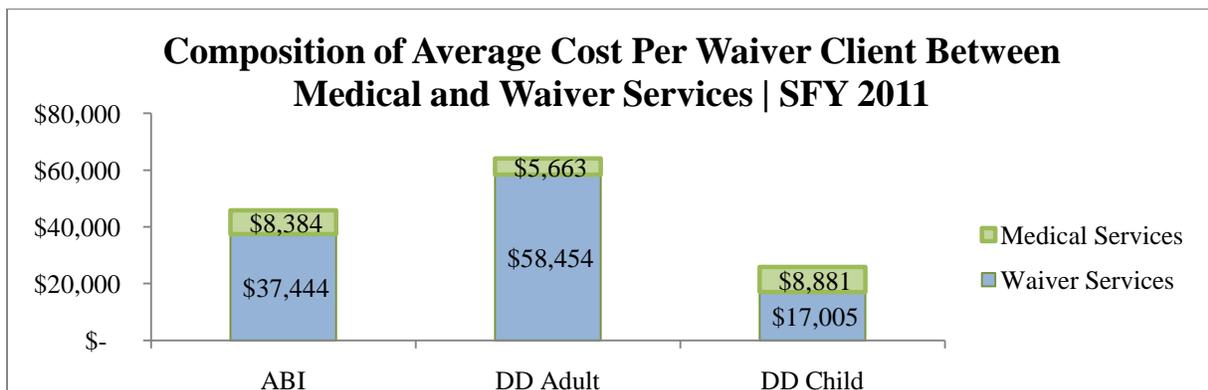
<sup>45</sup> Residential habilitation includes residential care, skills training, and supervision, assistance with daily living skills (personal grooming, etc.), as well as with social and adaptive skills. Day habilitation involves daily assistance with acquisition, retention, or improvement of self-help socialization and adaptive skills.



Some clients on the waitlist for waiver services may already be eligible and receiving Medicaid services based on their income and SSI disability eligibility. As non-waiver eligibility criteria (SSI) consider family income, rather than individual income, this likely lowers the number of ABI and Child DD clients that qualify based solely on SSI status for Medicaid without a waiver.



Waiver recipients use both medical services (through regular Medicaid) and supplemental waiver services such as residential habilitation or supported employment. Only waiver services can be capped or budgeted, medical services may not be limited but must be medically necessary.



Waivers allow a great deal of flexibility in design. The reader must consider what the desired outcome should be, as this will help lead to which options should be pursued. The potential outcomes of a waiver redesign are:

- To maintain overall costs and maintain current design with few changes
  - Serve fewer people with more comprehensive waiver services, including quality of life and optional services
  - Other people are on a waitlist and may not be receiving essential services
- To maintain overall costs and change the design of the system
  - Serve more or all people with a less comprehensive or a minimum set of essential waiver services first, with the objective of reducing or eliminating the waitlist
  - Then address additional needs for comprehensive and quality of life waiver services
- To reduce overall costs

## Adults with Developmental Disabilities: Program Design Options

### **Option 1 | Create a new support waiver with a max dollar per person amount**

*Description:* This option would use new legislative funding for waivers to create and fund a capped per person amount on a supports waiver rather than expand the current comprehensive waivers. The capped amount would allow access to home and community services for the current waitlist. The capped amount would only apply to home and community based support and would not limit access to needed non-waiver Medicaid health services. This waiver could start small and then ramp-up with funding coming from the transition of slots from other waivers or from future legislative funding.

Unless this option is used as a transition for the comprehensive waiver, this option would increase costs by expanding waiver slots, and thereby eligibility. One strategy to make this option cost-neutral is to fund the supports waiver as current participants transition off the current Adult DD waiver (slowly reducing the number of Adult DD waiver slots).

This option would permit available funding to make the largest impact on the waitlist and would allow access to a base level of community supports for more participants.

For instance, given the current average waiver cost of the Adult DD waiver in SFY 2011 of \$58,454 (excluding medical costs), a capped per person support waiver of \$15,000 could serve approximately four individuals, or a capped per person support waiver of \$10,000 could serve approximately six individuals.

The SFY 2011 Adult DD waitlist of 169 people times \$10,000 would be \$1,690,000 waiver cost per year plus health care costs of newly eligible Medicaid recipients. The average medical cost per Adult DD recipient was \$5,663 in SFY 2011 for new Medicaid recipients would also need to be budgeted. Recipients already eligible and participating in Medicaid (such as SSI eligible clients) would not increase overall healthcare costs if they shifted to the waiver from another non-waiver Medicaid eligibility group such as SSI. An estimate done in January 2012 estimated that 42% of waitlist clients were already eligible and receiving services based on SSI eligibility. Given this estimate, health care costs would add an additional \$460,000 to the cost of extending eligibility.<sup>46</sup>

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<sup>46</sup> 169 clients times 48% not currently receiving services equals 81 clients. Each client medical cost is estimated to be equal to the current average of \$5,663 per year. Some estimates are rounded.

As of the end of SFY 2011, the ABI waitlist of 69 people (SFY 2011), multiplied by \$10,000 per person, would amount to \$690,000 in waiver costs per year (this does not include health care costs). Average medical costs for ABI waiver recipients were \$8,384 in SFY 2011, and medical costs would likely add \$440,000 per year to the waiver costs.<sup>47</sup>

### **Option 2 | Change to Support Intensity Scale, instead of using the current ICAP methodology**

*Description:* The support intensity scale measures the support needs of clients, rather than their deficits. The support intensity scale is widely accepted in the nation as a competent tool for service planning. The cost of implementing the new tool, training, and reassessing all participants could be large. This methodology is much more intensive than the ICAP method, and takes approximately twice as long to complete which would increase assessment costs. However, creating better alignment between services clients need and the services actually provided to clients could have long-term savings that far outweigh these initial costs. Assessments would need to be provided by independent assessment contractors.

This scale would allow services to be more closely matched to the actual support needs of participants, rather than what a person would theoretically need at a certain ICAP score. This option may present significant long-term savings if services are better matched to client needs and unneeded services are avoided. This change would require modification of all waivers that use the ICAP score methodology.

### **Option 3 | Health Home or Coordinated Care**

*Description:* Serve the highest cost clients with chronic needs, co-occurring conditions through a health home or some other type of coordinated care that would coordinate all primary, acute, behavioral, and long-term services. The extra layer of services related to health homes qualify for an enhanced FMAP of 90% for the first eight quarters of health home services per recipient. This enhanced FMAP program is targeted by CMS for Medicaid recipients that have two or more chronic conditions, or one chronic condition and are at-risk for second, or have one serious and persistent mental health condition. Additional information on health homes and medical homes is available in Section V of this report.

### **Option 4| Create a new Adult DD waiver when the current waiver expires**

*Description:* If extensive changes to the Adult DD waiver are desired, creating a new waiver is a preferable alternative to making extensive adjustments to the existing waiver.

### **Option 5 | State Plan amendments 1915(k) and 1915(i)**

*Description:* State Plan amendments through the 1915(k) authority and the 1915(i) authority add home and community based support services directly to the State plan, rather than offering these services through a waiver. These new State plan amendment options are not yet widely used throughout the nation and require further research through technical assistance.

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<sup>47</sup> 69 clients times 75% not currently receiving services equals 52 clients. Each client medical cost is estimated to be equal to the current average of \$8,384. Some estimates are rounded.

## Adults with Developmental Disabilities: Internal Management Options

The Wyoming Life Resource Center is Wyoming's sole Intermediate Care Facility for Intellectual Disabilities (ICF-ID). Operating an ICF-ID is a Medicaid optional service, and some states such as Alaska do not operate an ICF-ID.

The ICF-ID facility has highest average per person cost compared to all other Medicaid groups. The average billed cost at the ICF-ID facility in SFY 2011 was approximately \$275,000 per Medicaid recipient.

However, the amount billed to Medicaid does not capture the full cost per recipient because it does not consider ABI recipients, Horizons Healthcare clinic recipients, and other programs that cannot be billed to Medicaid. For SFY 2013-2014 biennium, the facility's budget is \$61,605,987, or \$30,802,993 per year. Based on the SFY 2011 average occupancy of 93.75 residents for all programs<sup>48</sup>, the average budgeted cost per resident at the facility is \$328,565.

### **Option 1 | Retool the ICF/ID to care for people with co-occurring conditions and people in crisis**

*Description:* A key problem at the ICF-ID is the declining number of residents at the facility, which was built for a much larger residential population. As the number of residents shrinks, fixed costs are spread over fewer individuals increasing per recipient costs.

This strategy would pursue an additional group of clients to be served at the ICF-ID, such as individuals with co-occurring conditions or people in crisis. Clients with co-occurring conditions have both a serious medical and behavioral condition. Clients in crisis are experiencing severe behavioral episodes that could result in institutionalization in the State Hospital without some form of intervention.

Increasing service provision to capacity would bring the average cost per recipient served at the facility down to more acceptable levels, if done without increasing staffing. Additional research would need to be conducted on whether sufficient demand exists to make retooling the facility a feasible option.

### **Option 2 | Downsize the ICF from current resident level and repurpose the existing facility to other agencies or privatize**

*Description:* This option would shrink the facility to fewer buildings and lower the number of staff, and maintain the current use of the facility. Additional buildings could be used for other State or private purposes and generate income to help offset costs at the facility.

### **Option 3 | Repurpose the campus to serve a different population than the current residents, current residents move to community providers**

*Description:* This option would refocus the facility on a non-DD population. It is unclear which alternate population would be suitable for the facility.

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<sup>48</sup> Average occupancy based on FY 2012 WDH Operational Facilities Reports.  
Wyoming Medicaid Options Study | Report Two

#### **Option 4 | Close the ICF/ID**

*Description:* This option would close the facility and would need significant research and planning into the impact on clients, transition planning, and the impact to the community.

#### **Option 5 | Focus on efficiency and revenue reforms at the facility but leave current focus intact.**

*Description:* This option would continue the current studies of the ICF-ID facility and focus on adjusting staffing levels and increasing efficiency before making a dramatic change. Another consideration is tightening eligibility standards for ICF-ID. The facility could also seek revenue solutions such as re-evaluating “free” programs and programs that are not reimbursed by Medicaid, such as the Horizons health care program and the ABI program.

### **Adults with Developmental Disabilities: Eligibility Changes**

#### **Option 1 | Tighten financial eligibility for ICF-ID and Adult DD waivers**

*Description:* Evaluate tightening financial eligibility for waivers and the institution to a lower level of SSI. Currently, eligibility for the ICF-ID, the Adult DD waiver, and the ABI waiver are based on the optional 300% SSI income standard<sup>49</sup> (\$25,128 for a single person, \$37,728 for a couple). Wyoming also allows “Miller Trusts” which allow an individual to place any income above the 300% SSI standard into a trust account in order to lower their income to the 300% income standard and become eligible for the waiver. The funds in the trust account revert to the State upon the death of the client. The client retains all income below the 300% SSI standard for their own personal use. In Wyoming, an unlimited Miller Trust contribution may be used to lower an individual’s income to the eligibility level.

The optional 300% SSI income standard and unlimited Miller Trust contributions are two expansions of income eligibility that Wyoming currently has available for this population.<sup>50</sup>

A lower income limit, combined with a Miller Trust account, would require that clients with resources commit some of those resources to their care before Medicaid assumes full responsibility for costs. If clients are impacted by the change to a lower income eligibility threshold, clients could place additional resources in a Miller Trust to maintain eligibility.

#### **Option 2 | Change eligibility for the ABI Waiver to nursing home level of care**

*Description:* By changing eligibility for the ABI waiver to the nursing home standard level of care rather than ICF/ID standard, Wyoming would increase Medicaid reimbursement for ABI clients.

Currently, ABI clients placed at the Wyoming Life Resource Center ICF-ID facility do not qualify for Medicaid reimbursement and are paid with 100% General Funds. This is the result of using the ICF-ID standard for ABI clients, because Medicaid will only reimburse for persons with developmental intellectual disabilities at ICF-ID facilities. Wyoming Medicaid is currently seeking the ability to be reimbursed for ABI clients at the ICF-ID facility.

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<sup>49</sup> The mandatory standard is 100% SSI income standard.

<sup>50</sup> See: <http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm>

This change would no longer require or allow ABI clients to choose to be placed at the ICF-ID. The twelve clients at the Wyoming Life Resource Center cost an estimated \$250,000 per person each per year for a total cost of \$3,000,000 and are paid 100% from General Funds. Participants placed in the ABI waiver cost on average \$42,158, and are paid 50% from General Funds. Overall, this shift could save approximately \$2,500,000.

## **Adults with Developmental Disabilities: Benefits or Services Offered**

### **Option 1 | Promote new residential habilitation service models that offer more community integration**

*Description:* Residential habilitation in a group home is one of the most expensive residential options in the Adult DD waiver program. By shifting reliance from large group homes to lower cost residential options, this option should begin to generate average per person cost savings.

If living at home is no longer possible or a preferred option, there are some new residential models that include host families, shared living arrangements, and other alternatives to living at home that are less costly than residential habilitation in a group home. Over the long-term building additional choices for participants would shift reliance from large group homes to lower cost residential options.

An additional option is to create financial incentives for group home providers to provide supported living or more independent living arrangements, so that clients can “step-down” into more independent living arrangements.

If done in a gradual way, growth in the population would provide sufficient clientele for current provision levels and would not threaten the viability of the current provider base if combined with a moratorium on new/expansion of large providers.

## **Adults with Developmental Disabilities: Rate or Payment Changes**

### **Option 1 | Change Individual Cost Limitations on Adult DD Waiver to Mirror ABI Waiver**

*Description:* The ABI waiver is currently capped at the ICF-ID cost. This cap only includes waiver services, and does not include medical costs which cannot legally be capped. No ABI participants are currently impacted by the Individual Cost Limitation.

Currently, the Adult DD waiver does not have an individual cost limit but the average cost per person must be lower than average institutional cost (federal regulation). Very few (two recipients in SFY 2011) Adult DD recipients’ waiver expenditures exceed the average annual cost per person at the ICF-ID (approximately \$275,000 for SFY 2011).

An Individual Cost Limit would impact a small number of Adult Waiver participants (2 recipients in SFY 2011) and could save approximately \$50,000 per participant (savings in SFY 2011 would have been \$106,199). These recipients may be grandfathered in so that this new rule does not negatively impact these current recipients. A larger benefit is creating a theoretical limit to the waiver to create a cap on future expenditure growth per recipient.

## **Option 2 | Revise current Funding Model**

*Description:* Reevaluate the current funding model, including Individual Budget Amounts (IBA) budgets. Per the regional CMS office and national data, Wyoming's payments for service are high compared to regional and national rates, especially for certain rates such as residential habilitation. Several areas of concern include:

- Current practice of allowing 1:1 staffing ratios that may exceed need of client and corresponding funding impact.
- Current practice of basing average costs on average overhead amount rather than a maximum allowable amount as is done in nursing homes.
- Services that encourage client dependence rather than encouraging life-skills and independence.
- Reconsider rebasing rates for high-cost driver services.

## **Option 3 | Cost-sharing, co-pays, and premiums for this group**

*Description:* This option would maximize cost-sharing, co-pays and premiums for this group.

## **Option 4 | 15 minute increments for Case Management**

*Description:* The option would pay case management in 15 minute increments, rather than a monthly flat fee. The current case management rate is \$271.58 per month and is not based on actual service provision levels. In public forums, some clients reported seeing their case managers for less than an hour each month, often on the last days of the month. For these types of clients, this equates to a \$271.58 hourly rate which is excessive. For a small group of clients, case management is a primary expense. A 15 minute increment rate could help identify clients that are receiving too little case management based on their ICAP score or intensity of services.

## **Adults with Developmental Disabilities: Healthcare Quality**

### **Option 1 | Implement independent and conflict-free case management through RFP**

*Description:* Wyoming currently spends approximately \$6.9 million on case management for the Adult DD, ABI, and Child DD waiver population. Currently case managers can also provide other waiver services or their employers can provide waiver services to the same clients. Issuing a case management Request for Proposals (RFP) and having one provider for all independent case management would streamline the function, and would create a single independent point of accountability. A private entity could specialize in independent case management and also manage case managers throughout the State, and would only provide case management services.

Life and safety issues and cost increases are significant issues that can result from a lack of independent case managers in the current system.

### **Option 2 | Increase provider qualifications required to provide certain services**

*Description:* Some providers are not qualified to provide certain services and may have no training or education in the field. This has partially arisen due to Wyoming legislation requiring Wyoming Medicaid to consider family members as equivalent to trained providers for most

services, which is not always the case. This can potentially lead to poor outcomes for clients if skilled assistance is needed.

Family members and paid staff not meeting qualification standards could still provide some services, but would be paid a rate that reflects their skill, training, and certifications.

### **Option 3 | Increasing provider certification standards for larger group home facilities**

*Description:* Increasing provider certification standards for larger group home facilities is a way to promote and steer new growth towards models/sizes preferred by CMS, as well help the State of Wyoming to avoid Olmstead<sup>51</sup> issues regarding involuntary institutionalization. Increasing certification standards would impact current and future providers, with the most drastic step being requiring very large facilities (between 8 and 16 residents) to be certified as ICF/IDs.

This would help align Wyoming with new rules proposed by CMS<sup>52</sup>, as facilities would either meet more stringent standards or would reduce the number of residents at each facility in order to avoid regulation. Either of these outcomes would promote true home and community based placements rather than growth of quasi-institutions.

### **Option 4 | Implement Statewide Electronic Provider Documentation System**

*Description:* Providers would log-in and use one system to document services provided. State monitoring of appropriateness of services, proper usage, and fraudulent activity could happen remotely rather than on-site. This would improve the consistency and quality of documentation allowing for review that could help manage usage and reduce fraud, thereby reducing costs to the State.

### **Option 5 | Moratorium on certain types or sizes of providers**

*Description:* A moratorium on certain types or sizes of providers would provide a clear signal to the industry about preferred models. Of greatest concern are residential habilitation group homes above four persons in size, which are now strongly discouraged by CMS but not yet banned. However, CMS considers facilities larger than four persons to be “institutions.” Therefore, facilities with more than four residents are in conflict with the underlying concept behind home and community based waivers, which is to reduce institutionalization. Through a moratorium, Wyoming could avoid growth in a service model size that is likely to be severely limited or banned in the future.

Also considered is the location of providers. CMS is considering whether facilities placed in industrial or remote areas are truly “community” settings, or whether these settings are more reflective of institutional settings.

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<sup>51</sup> Olmstead v L.C., No. 98—536., U.S. Supreme Court. Argued April 21, 1999—Decided June 22, 1999. This decision held that a state’s failure to discharge qualified institutional clients that request discharge to a community-based setting was a form of discrimination prohibited by the Americans with Disabilities Act. See <http://www.law.cornell.edu/supct/html/98-536.ZS.html>

<sup>52</sup> See: <http://www.regulations.gov/#!documentDetail;D=CMS-2009-0071-0302>

## **Option 6 | Independent case management as a policy**

*Description:* An alternative option to Option 1 is to implement independent case management as a standard through the current delivery model. This could be slower to implement and Wyoming Medicaid would have to manage and monitor private sector employees to ensure their independence. This additional oversight would require the State of Wyoming to expend additional resources on oversight staff.

## **Option 7 | Apply for the Balancing Incentive Payment program**

*Description:* The Balancing Incentive Payment program is a voluntary program created as part of the Affordable Care Act that rewards states for implementing best practices for home and community based services and generating savings from the shift from institutional models to home and community based models. The primary goal of the program is to assist states in shifting to effective and modern home and community based models of service delivery. States can apply for the Balancing Incentive Program to access a share of the \$3 billion allocated in the Balancing Incentive Payment program.

In order to qualify for the Balancing Incentive Payment program, Wyoming would need to research ways to reduce institutional placements, formally apply to the program and commit to reducing institutional placements in the State. In addition, Wyoming would need to adopt a number of best-practice policies. For instance, one condition of the program is to institute administrative changes which include conflict-free case management service.

## SECTION VIII: OPTIONS | CHILDREN WITH DEVELOPMENTAL DISABILITIES

### CHILD DD WAIVER

**SHARE of SFY11 MEDICAID BUDGET | \$21.5 million [4%]\***

**NUMBER of RECIPIENTS in SFY11 | 831 [1%]\***

**WHO** The Developmental Disabilities (DD) Child Waiver eligibility sub-group consists children with developmental disabilities children (birth to age 21) that receive training and support services which allow them to remain in their home communities and avoid institutionalization.

**WHY** The DD Child Waiver sub-group was chosen due to high total expenditures across the 15% and 80% categories, and high cost per recipient in the 5%, 15%, and 80% categories.

#### COMPARISONS of COST CATEGORIES\*

Highest Cost DD Child Waiver   Top 5%	Moderate Cost DD Child Waiver   Middle 15%	Lowest Cost DD Child Waiver   Lowest 80%
Annual Cost Per Recipient = \$112,905	Annual Cost Per Recipient = \$53,357	Annual Cost Per Recipient = \$15,297

#### TOP 5 SERVICES BY EXPENDITURES\*\*

Kids Respite Care   22%
Kids Special Family Habilitation Homes with Trainers   10%
Kids Case Management   10%
Prescribed Drugs   9%
Kids Residential Habilitation Trainer without Transportation   7%

*\*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.*

*\*\*The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.*

### **Group Overview**

Children with developmental disabilities are served through a waiver for home and community based supports (referred to as Child DD waiver) and through regular Medicaid for health care services. The Child DD waiver expires on June 30, 2015. The waiver can be amended, renewed, or ended at that time.

New waivers to serve the same population can be started at any time and can have a different design or focus.

Children differ from the rest of the Medicaid population in that they also receive additional services through their school districts, and through the Early Intervention and Education program provided free of charge at developmental preschools. Those outside programs are not accounted for in this analysis.

Although children are rarely served at the Wyoming Life Resource Center, the Child DD waiver uses the Intermediate Care Facility for Intellectual Disabilities (ICF-ID) eligibility standard to determine eligibility. For children, eligibility is based on clinical eligibility as well as the *child's income* based on the 300% SSI standard (\$25,128 in 2012). Generally any child that meets the medical criteria is placed on the waitlist for the Child DD waiver, as most children have minimal or no income. Parental income cannot be considered under Wyoming's current eligibility standard.<sup>53</sup>

If Wyoming chooses to amend or renew the waiver<sup>54</sup>, it cannot make the eligibility criteria for any child group (under age 19) more restrictive through September 30, 2019 due to maintenance of effort (MOE) requirements in the Affordable Care Act.<sup>55</sup> If Wyoming does decide to change the income standards when the MOE expires, it would require a State Plan Amendment in addition to the Waiver change.

Some options that apply to both the adult and child waivers are explained in detail in the Adult DD section of the report and are reiterated in this section.

### *Common Concerns*

The waitlist for this program was 145 children at the end of FY 2011. Some individuals on the waitlist are already eligible and enrolled in Medicaid based on their disability status and income (SSI), and receive medical, dental, vision and other non-waiver Medicaid services while they are on the waitlist. An estimate done in January 2012 estimated that 31% of children with developmental disabilities on the waitlist were already eligible and receiving Medicaid services based on their SSI eligibility<sup>56</sup>.

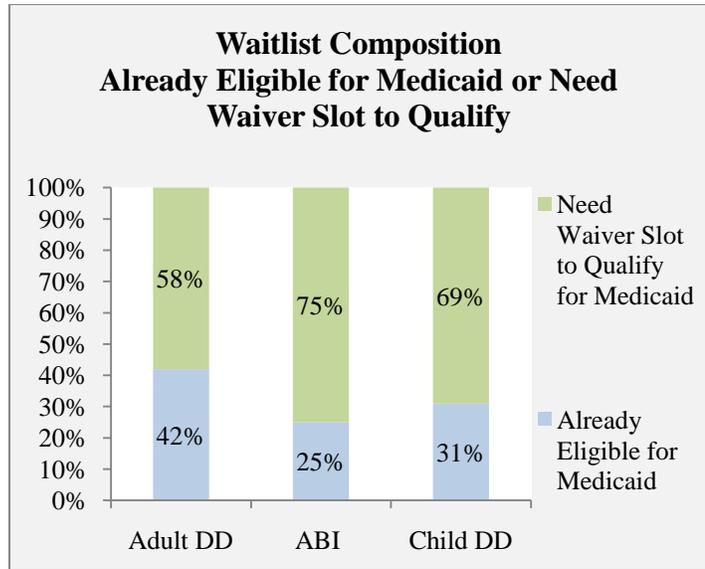
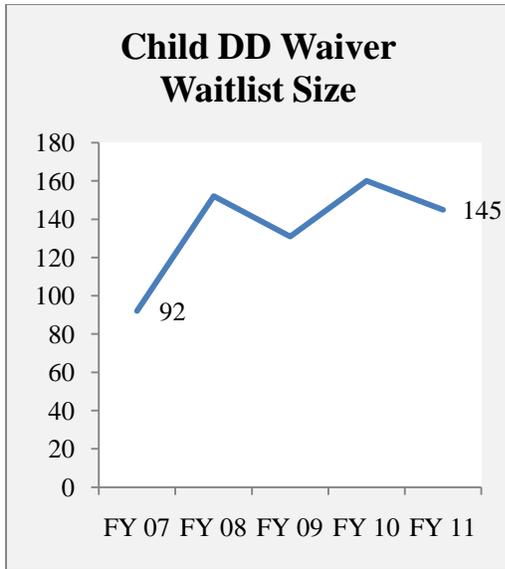
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<sup>53</sup> States can choose to “deem” or “not deem” the income/resources of parents available to persons eligible under an HCBS waiver program. Other states use different eligibility standards and some do consider parental income for eligibility, premiums, and co-payments for children, including those served by waivers. Generally, these are states that operate under 209(b) authority which allows more restrictive eligibility than SSI and these states make their own eligibility determinations. These states have also “deemed” that parental incomes are available to persons eligible under an HCBS waiver program. See <http://aspe.hhs.gov/daltcp/reports/primer.htm>.

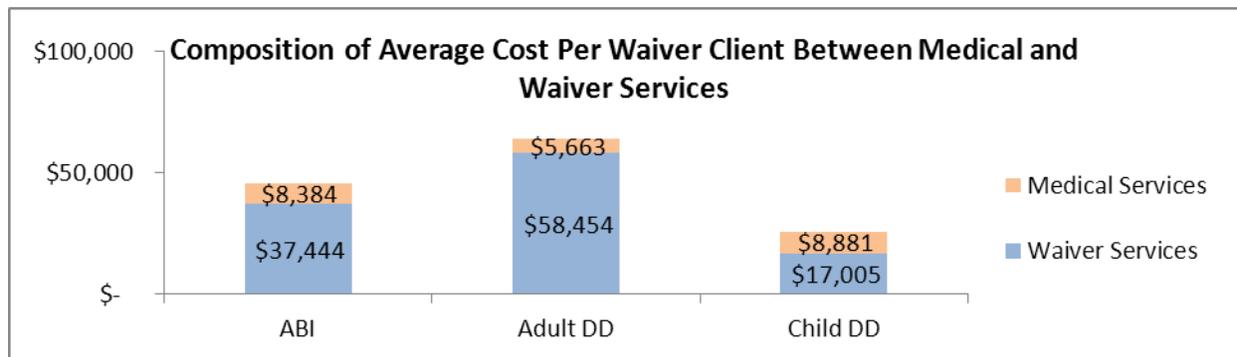
<sup>54</sup> State Medicaid Director letter from Center for Medicare and Medicaid Services, SMDL#11-001, ACA #14, see <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf>

<sup>55</sup> See <http://www.healthcare.gov/law/resources/authorities/title/ii-role-of-public-programs.pdf>

<sup>56</sup> Estimate 1/31/2012, WDH, Percent Eligible for Medicaid (SSI) also on DD waiting lists. This information is being updated with more recent data through a formal process and will be included in Report 3.



This population uses a higher proportion of cost in medical services relative to waiver services, when compared to the Adult DD and ABI waiver programs.



Some other general concerns include a high number of hours of use for certain services by a small percentage of the population. Each of these services will be addressed individually with options.

The use of out of home residential placements called “Special Family Habilitation Home” is being phased out for new clients, since children who are not living in the family home should be involved with the Department of Family Services (DFS) and the foster care system. The process is being redesigned so that DFS must be formally involved through the legal process in all placements outside of the home. Placements outside of the home without DFS as the legal guardian are not consistent with the intent of this waiver, and can result in a confusion of who has legal custody of the child.

Medicaid currently does not consider the number of hours of services received through school district or the developmental preschool program when determining waiver services. The State may be providing duplicative services through multiple programs or paying twice for similar services.

## Children with Developmental Disabilities: Program Design Options

### **Option 1 | Create new supports waiver(s) with a capped budget maximum per person amount**

*Description:* This option would use any new legislative funding for waivers to create and fund a new supports waiver with a capped budget per person amount. The capped amount would allow access to home and community services for persons on the current waitlist, and would not limit access to any needed non-waiver Medicaid health services. This waiver could start small and then ramp-up with funding coming from transition of slots from other waivers or from additional future legislative funding.

Unless this option is used as a partial replacement for the children's waiver, this option would increase costs by expanding waiver slots further. One strategy to make this option cost-neutral is to fund the support waiver as current participants transition off the current Child DD waiver (slowly reducing the number of Child DD waiver slots).

Multiple tiers of waivers are used in Colorado, where a lesser tier of waiver is called the Home and Community Based Services (HCBS) waiver and a higher tier is a Children's Extensive Support waiver.

If the waiver allowed services up to \$10,000, the estimated cost to cover the 145 children currently on the waitlist would be \$1,450,000 plus healthcare costs. Clients already eligible and participating in Medicaid (such as SSI eligible children and children already eligible due to parental income) would not increase overall healthcare costs if they shifted to the waiver from another non-waiver eligibility group.

An internal analysis in January 2012 estimates that 31% of the children on the Child DD waitlist already receive medical services on the Medicaid program. Approximately 100 children on the waitlist do not already receive Medicaid medical services.<sup>57</sup> Children on the Child DD waiver averaged \$8,881 in medical costs in SFY 2011. Using this estimate and average medical costs as a guide, the estimated costs of medical care would add approximately \$900,000 to the cost of this option.

Using this option to provide capped waiver services to the children on the waitlist would cost an additional \$2,350,000 per year including total estimated waiver (\$1,450,000) and medical costs (\$900,000). This program would be funded similar to the rest of Medicaid with 50% General Funds and 50% federal funds.

### **Option 2 | End the Children's DD waiver when it expires**

*Description:* This option would end the Child DD waiver when it expires, without a replacement. Wyoming Medicaid is required to provide a transition plan for all clients served under the current Child DD waiver if the waiver is allowed to expire without a replacement.

The largest impact would be for children who have been receiving services that would no longer qualify for Medicaid medical services due to parental income. This option would also

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<sup>57</sup> A more recent internal process is in place to verify the number of waitlist children already on Medicaid but was not complete in time for Report 2.

significantly impact families who, because of the waiver services, have been able to continue to meet their child's needs at home. Without these services, it is likely that some children currently served on the Child DD waiver would need to be placed in a nursing home or the Wyoming Life Resource Center.

**Option 3| Transition all participants on the children's waiver to a new supports waiver with capped funding amount per person.**

*Description:* This would resemble Option 1 described in this section, with the difference that rather than the supports waiver becoming a first tier supplementing the current children's waiver, the supports waiver would replace the children's waiver.

**Option 4| Short-term waiver that focuses on helping the family get ready to support the child**

*Description:* This type of waiver would be short-term and would focus on the entire family to help build additional natural support capacity for the child. Services could include training of family members, group activities, and adaptations to the child's residence.

**Option 5| Self-direction required within capped support waiver**

*Description:* This would preserve the budget for the child for other services if families choose to self-direct their services, rather than using paid case management and paid advocates. This would also help build responsibility and knowledge of family members. An example is New Mexico "Mia Via" or "my way" self-directed waiver<sup>58</sup>.

**Children with Developmental Disabilities: Internal Management Options**

**Option 1 | Encourage reuse and sharing of durable medical equipment**

*Description:* Children's equipment in particular is outgrown quickly. If functional equipment is not re-used, it is a wasted resource that diverts funding from other services. Medicaid cannot require the return of equipment but could set up a mechanism (posting board, like Craigslist) for sharing between participants. The Wyoming Life Resource Center also has a lending library program.

**Option 2 | Review authorization practice for amount of skilled nursing ordered**

*Description:* Doctors often defer to provider requests as to the extent of skilled nursing needed, rather than using a standard based on severity or need. This leads to inconsistent provision for clients with the same needs throughout the State.

This change would increase consistency between clients of the same need by establishing recommended guidelines and a standard authorization process. This option may generate potential savings by requiring additional justification and documentation for higher levels of service, which would deter unnecessary requests.

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<sup>58</sup> See: <http://mivianm.org/>

## Children with Developmental Disabilities: Eligibility Changes

### Option 1 | Change income eligibility to a standard that considers parental income

*Description:* This option could link income eligibility to parental income at a higher level, such as 500% of FPL (2012 FPL \$115,250 for a family of four). This has been attempted by Illinois but not yet approved by CMS for its medically fragile and technology-dependent waiver program. Illinois has proceeded without CMS approval as of the writing of this report.

This would likely only impact a small proportion of children on the program. Illinois estimates the change affecting 5% of its current waiver recipients. It is unclear whether these children in Illinois will now receive no services, or whether the family must contribute significantly to the cost of care before becoming eligible.

There are rare cases where the children of wealthy individuals qualify for Medicaid and waiver services because only the children's income is considered. This change would shift at least partial financial responsibility for care to these parents.

It is unclear from the Illinois example whether this is legal, and whether these changes will be approved as part of the new waiver. Wyoming is seeking additional technical assistance on what steps and changes would be necessary in order to consider parental income for waiver eligibility.

### Option 2 | Co-payments for Waiver Services –Requires ability to consider parental income

*Description:* Establish co-payments for waiver services (not including medical care) for all families at or above 150% of the federal poverty level. The maximum co-payments could be set at the maximum level allowed by federal law, which is expected to be five % of family income.

Instituting co-payments and cost sharing would increase client contributions and reduce State and Federal contributions. Sharing in part of the cost can help increase parental awareness of the cost difference between different options.

Amendment of the waiver or beginning a new waiver with this standard would be needed to implement co-pays for waiver services. This option would only be possible in conjunction with changes to the eligibility standard for the Child DD waiver, as co-payments can only be charged for children when the eligibility standard considers parental income and is above 150% of FPL. Currently, Wyoming's eligibility standard does not consider parental income. This is a result of using the ICF-ID standard which allows a child to qualify under the child's income.

### Option 3 | Alter age range, or place age limits on some services

*Description:* Some states have child waivers but do not begin eligibility until a child reaches school age. Other states take the approach that school districts are responsible once a child reaches school age, and limits service offerings to those not offered by school districts. Others do not allow waiver services until a child reaches three years of age.

This would avoid duplication of training and education type services within the school district and the early childhood education preschool program.

#### **Option 4 | Change eligibility from ICF-ID standard of care to nursing facility standard of care**

*Description:* Child DD waiver recipients are currently rarely placed at the Wyoming Life Resource Center, but this standard has been retained for use in the waiver. This allows costs to be set relative to ICF-ID average costs (average \$275,000) rather than a skilled nursing facility level of care (approximately \$68,000), and increases maximum costs of the waivers.

Some children may not qualify for the waiver under the nursing facility standard of care because their medical needs are not severe enough to impact activities of daily living.

### **Children with Developmental Disabilities: Benefits or Services Offered**

#### **Option 1 | Reduce individual budgets, but don't limit services**

*Description:* This option would give greater flexibility for parents and recipients to select which services they prefer or find most valuable, but would reduce the overall budget for each recipient.

#### **Option 2 | Restrict certain services by using targeting criteria, service caps, etc.**

*Description:* This option would tie services available to the plan of care recommended for the child, and also institute caps on the number of units of each service that could be used. Many services, such as respite, already have caps on the number of hours allowed per month, but this option would explore creating caps for all service types. Targeting criteria and caps could ensure that services match the needs of the child and that resources are used effectively so that more children can be served on this program.

#### **Option 3 | Restrict waiver to offer a smaller amount of respite care**

*Description:* Respite care is a service that provides a short-term break for families and other unpaid care givers by providing care to the child. Generally, respite care does not provide a training or education for the child and is limited to supervision to ensure the health and safety of the child.

Wyoming's current limit is 35 hours per week of respite care and SFY 2011 respite care expenditures in the Child DD waiver were \$4.7 million. Respite care represents approximately 22% of total expenditures spent on all services including health care for recipients served in the Child DD waiver. Other states have much lower caps on services such as respite. For instance, New Mexico provides a maximum of \$950 of respite per family per year, which would be approximately 1.5 hours per week.

Respite is currently available in addition to other sources of care such as developmental preschool or services provided by the school district, and the 35 hour per week respite cap does not consider whether these other sources of care are used.

Respite cannot be used when a parent is working. Instead families can use the child habilitation service, where the family pays for the child care and Medicaid pays for the extra "needs" a child has.

In some cases, the current 35 hour limit per week may allow the respite service to be overused when combined with a set of other services, such as child habilitation and non-Medicaid services. Evaluating service coverage provided through other programs such as the school district and the developmental preschool program, including other in-home services, could help address this potential overuse.

#### **Option 4 | Provide only "training" type services, no respite on waiver**

*Description:* This redesign would no longer provide respite, and would only provide training services on a more limited basis.

#### **Option 5 | Restructure Residential Habilitation Training Service**

*Description:* Residential habilitation training is a high-cost one-on-one hourly service that should include a “training component” for each unit of service provided, but the actual service delivered and documented often appears to be similar to lower cost respite. Options for this restructure include: capping the service at a lower level, eliminating the service and promoting the “child habilitation” service which is already on the waiver, increasing provider qualifications, or redefining the service to a more comprehensive training for participant and family.

#### **Option 6 | Overall weekly cap on the hours of similar services received without receiving an exception review**

*Description:* When taking a comprehensive look at all hours of services combined, it is clear that some families are using extraordinarily high numbers of hours of total service. Similar services include personal care (max 35 hours a week), respite care (max 35 hours a week), residential habilitation training, and child habilitation. While a week has 168 total hours, including waking and non-waking hours, some children have almost all waking hours covered by paid waiver services. This does not include or consider the hours of service provided by developmental preschools and the school districts.<sup>59</sup>

By creating an overall weekly cap on the number of hours of waiver services that can be received, and considering hours of service received through the developmental preschool and school districts in this cap, appropriate service levels can be provided to recipients.

Some recipients’ high hours represent a true medical need, rather than a change that may inconvenience family members. Cases of true need could still proceed through an exception request process that would protect these children if they need services in excess of an overall hours per week of paid waiver services cap.

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<sup>59</sup> Per the Center for Medicare and Medicaid Services Home and Community Based Waiver Application Instructions “Waiver funding may not be used to pay for special education and related services that are included in a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies.”

## **Children with Developmental Disabilities: Rate or Payment Changes**

### **Option 1 | Revise current funding model**

*Description:* These options are discussed in the Adult DD section and would potentially impact this population.

## **Children with Developmental Disabilities: Healthcare Quality**

### **Option 1 | Independent case management**

*Description:* Independent case management options discussed in the Adult DD section would also impact this population.

### **Option 2 | Implement statewide electronic provider documentation system**

*Description:* This option is discussed in the Adult DD section and would also impact this population.

### **Option 3 | Increase provider qualifications required to provide certain services**

*Description:* This option is discussed in the Adult DD section and would also impact this population.

## SECTION IX: OPTIONS | PREGNANT WOMEN AND NEWBORNS

PREGNANT WOMEN		
<b>SHARE of SFY11 MEDICAID BUDGET   \$35.8 million [7%]*</b>		
<b>NUMBER of RECIPIENTS in SFY11   6,011 [8%]*</b>		
<b>WHO</b>	The Pregnant Women eligibility sub-group consists of women that are pregnant, whose family income is less than or equal to 133% FPL. Presumptive eligibility allows for Medicaid to cover outpatient services for up to 60 days while Medicaid eligibility is determined.	
<b>WHY</b>	The Pregnant Women sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and a high cost per recipient in the bottom 80% of recipients.	
COMPARISONS of COST CATEGORIES*		
<b>Highest Cost Pregnant Women   Top 5%</b>	<b>Moderate Cost Pregnant Women   Middle 15%</b>	<b>Lowest Cost Pregnant Women   Lowest 80%</b>
Annual Cost Per Recipient = \$22,384	Annual Cost Per Recipient = \$12,796	Annual Cost Per Recipient = \$3,661
TOP 5 SERVICES BY EXPENDITURES**		
Inpatient Hospital Services   38% Physician Services   35% Outpatient Hospital Services   8% Radiology   5% Nurse Practitioner   3%		
<i>*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.</i>		
<i>**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.</i>		

## NEWBORNS

**SHARE of SFY11 MEDICAID BUDGET | \$30.9 million [6%]\***

**NUMBER of RECIPIENTS in SFY11 | 7,082 [9%]\***

**WHO** The Newborn eligibility sub-group consists of newborns up to age one, born to Medicaid-eligible mothers whose family income is less than or equal to 133% FPL.

**WHY** The Newborn sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories, and a high cost per recipient in the top 5% of recipients.

### COMPARISONS of COST CATEGORIES\*

Highest Cost Newborn   Top 5%	Moderate Cost Newborn   Middle 15%	Lowest Cost Newborn   Lowest 80%
Annual Cost Per Recipient = \$48,255	Annual Cost Per Recipient = \$5,649	Annual Cost Per Recipient = \$1,392

### TOP 5 SERVICES BY EXPENDITURES\*\*

Inpatient Hospital Services   66%
Physician Services   16%
Prescribed Drugs   4%
EPSDT Screening   4%
Outpatient Hospital Services   4%

*\*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.*

*\*\*The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.*

### **Group Overview**

The Pregnant Women and Newborns sub-groups were combined for the purposes of discussing options. This decision was made due to the similarity of services used, and the obvious link between a pregnant women and her newborn's health. The services used by these groups primarily revolve around prenatal care, delivery, hospitalization, and healthcare for the newborn (through 12 months of age). In SFY 2011, Wyoming Medicaid served 6,122 pregnant women and 7,082 newborns. According to the Wyoming Medicaid Birth Report for 2011 (calendar year), Medicaid paid for 3,166 (43%) of the 7,339 total births in Wyoming.

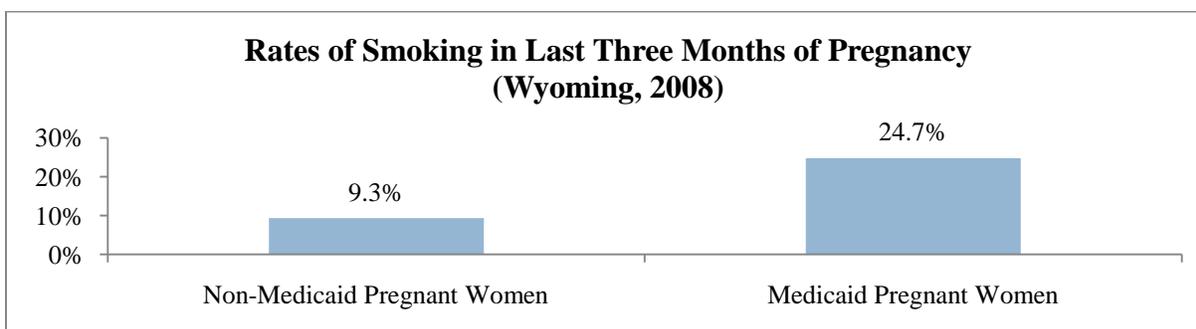
Depending on the health of the baby, newborn costs traditionally show a wide range. In 2011, approximately 105 babies required a Neonatal Intensive Care Unit (NICU) level of care that is not available in Wyoming. These NICU hospital stays cost Wyoming Medicaid over \$13.2 million in 2011 or approximately \$126,000 per NICU stay.

### Common Concerns

The general philosophy in discussing options for these two sub-groups involves identification of ways to keep mothers and infants healthy. This may include attempts to minimize negative behaviors that lead to poor health outcomes for the baby (i.e., decreasing smoking by pregnant women), thus decreasing the need for NICU and inpatient hospital care. This also would include improving maternal attendance at prenatal care services, and improved maternity care management. For instance, the average cost of routine prenatal care, delivery, and postpartum care for pregnant women is estimated to be \$5,860 per person. This cost is minimal when compared with the NICU costs for just 105 babies mentioned above, which highlights the importance of finding ways to encourage Medicaid pregnant women to attend prenatal and postnatal care appointments. While Wyoming Medicaid already offers a maternity management program that provides a variety of telephonic services for prenatal care, there is always more that could be done to increase the identification of risk factors for pregnancy complications early so that the negative impacts are minimal.

It is essential to begin to address unhealthy behavior patterns by pregnant women in Wyoming Medicaid. One concern raised in a variety of forums during the course of this study was the smoking rate among pregnant women in Medicaid. Smoking cigarettes during pregnancy increases the likelihood of pregnancy complications (e.g., restricted fetal growth, preterm delivery) and after delivery, the occurrence of sudden infant death syndrome (SIDS)<sup>60</sup>.

According to the most recently available data<sup>61</sup>, 9.3% of Wyoming non-Medicaid mothers reported smoking behavior in the last 3 months of pregnancy, as compared to 24.7% of Wyoming Medicaid mothers.

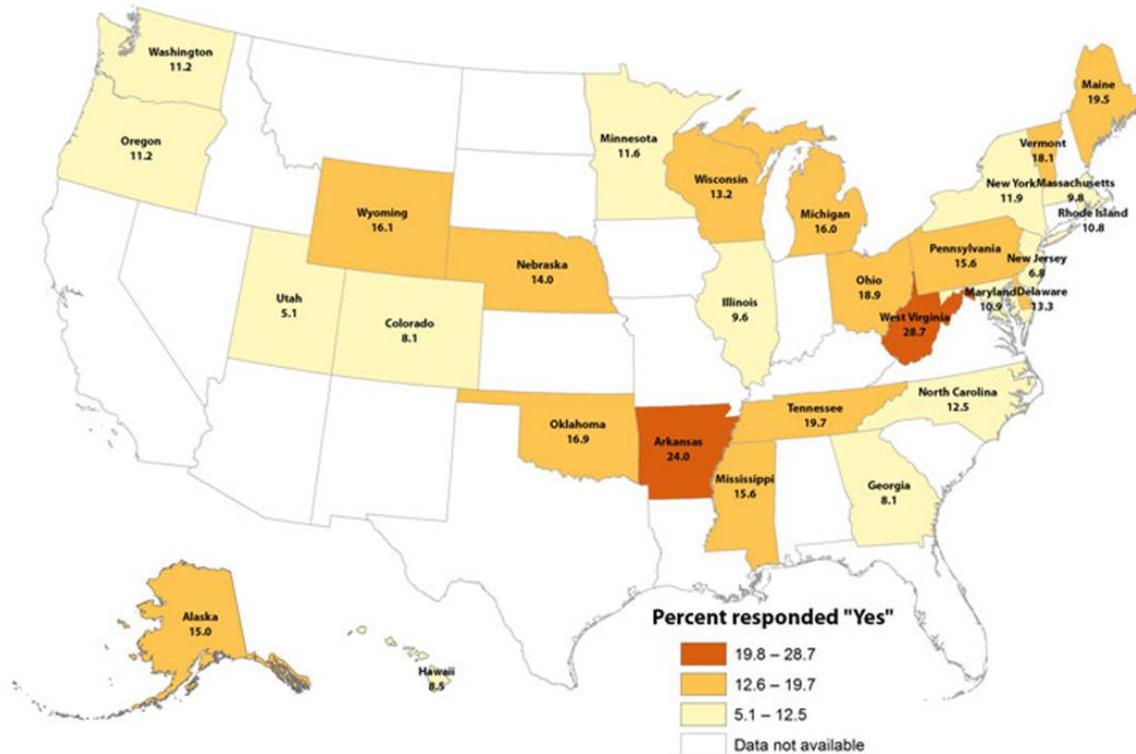


In 2008, only 8 other states show a higher smoking rate among all pregnant women (Medicaid and non-Medicaid) in the last 3 months of pregnancy than Wyoming (see Figure 4).

<sup>60</sup> Centers for Disease Control and Prevention. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services; 2004.

<sup>61</sup> Pregnancy Risk Assessment Monitoring System (PRAMS). Wyoming. 2008. See: <http://apps.nccd.cdc.gov/cPONDER/>

**Figure 4. State by State Comparison: Percentage of All Mothers who Smoked during the last 3 Months of Pregnancy (PRAMS | 2008)<sup>62</sup>**



Another issue raised is the use of elective pre-term Cesarean sections. Wyoming Medicaid does not pay for elective cesarean procedures; it only pays for this type of delivery when it is deemed to be medically necessary. The provider reimbursement rate for a cesarean delivery is \$3,649.01 and the rate for a vaginal delivery is \$2,984.72. Cesarean deliveries represented 29.6%<sup>63</sup> of total Wyoming Medicaid deliveries. Nationally for all births, the rate is 32.8%<sup>64</sup>.

## Pregnant Women and Newborns: Program Design Options

### Option 1 | Maternity Medical Home

*Description:* Wyoming Medicaid already provides case management for identified high-risk pregnancies. However, Maternity Medical Homes would help identify high-risk pregnancies earlier and would help coordinate care for the entire pregnant women population.

<sup>62</sup> See: <http://www.cdc.gov/prams/DATA-TobaccoMaps.htm>

<sup>63</sup> The total number of births on Wyoming Medicaid for SFY10 was 3,506 with 1,038 being cesarean and 2,468 vaginal births, the cesarean rate was 29.6%. The total number of births on Wyoming Medicaid for SFY11 was 3685 with 1097 being cesarean and 2,588 vaginal births, the cesarean rate was 29.6%.

<sup>64</sup> See: <http://www.cesareanrates.com/us-cesarean-rate-1970-2010/>

Maternity Medical Homes allow a pregnant woman to receive coordinated services that are proportional to her identified needs. Case management (and care management) through a medical home would ensure that a woman's pregnancy is monitored via regular contact with her physician. The outcomes that could be expected from pregnancy medical homes include decreased birth-related complications and increased gestational ages for newborns. All of these outcomes are related to improved health for newborns.

The work that Wyoming Medicaid (and others, including the Wyoming Integrated Care Network, etc.) is already doing in moving the medical home concept forward lays the foundation for pregnancy medical homes. Additional collaboration between private care providers (general/family practice, OB/GYN practices, multi-specialty practices, Federally Qualified Health Clinics, Rural Health Clinics, Local Health Departments, nurse practitioners, certified nurse midwives, etc.) would be required for this option to be fully realized in Wyoming.

### **Option 2 | High risk clinics in Wyoming**

*Description:* High risk clinics in the population centers of Wyoming (e.g., Cheyenne and Casper) would allow for better ongoing management of pregnancies, and decrease the chances that women need to leave the State for access to specialist care.

### **Option 3 | Expand use of Telehealth technology**

*Description:* Rural areas of Wyoming struggle with access to specialized care, which may hinder pregnant women from seeking prenatal care (e.g., if the nearest specialist OB/GYN is a 3-hour drive away). An increase in the use of telehealth technology in Wyoming's rural communities would provide greater access to specialist care for these women.

## **Pregnant Women and Newborns: Internal Management Options**

### **Option 1 | Require participation in pregnancy case management**

*Description:* Similar to the ideas presented in the section surrounding medical homes, increased case management of pregnancies for Wyoming Medicaid women may improve outcomes for both the mothers and their newborns. Pregnancy Case Management is directed, condition-specific case management, including telephone calls, home visits (if necessary), and incentives for attendance at prenatal appointments. Case Management would be provided by personnel that have relevant medical knowledge to increase the value of care given to the pregnant woman. The case manager would also possess knowledge of the resources available in the local community that could address any of the risks associated with a particular patient.

Requiring participation in case management could result in more positive health outcomes for pregnant women and newborns. It may also decrease the frequency of utilization of the most expensive inpatient hospital costs for these mothers, and their children (especially in the first year of life).

### **Option 2 | Require paternity confirmation**

*Description:* At this time, Wyoming Medicaid requires any woman under 36% FPL to establish biological paternity upon her enrollment via the eligibility process, which has historically been

completed by the Department of Family Services (DFS). This allows the system to account for any contributions from the other parent of the child.

However, currently those that qualify for Medicaid at a higher level of income than 36% of FPL are not required to prove paternity. Wyoming Medicaid could examine federal laws, state laws, and other sources to determine whether payment for services for Medicaid-eligible pregnant women may be tied to the determination of paternity.

It is possible that some Medicaid costs to the State and federal government for pregnant women and/or newborns may decrease if biological fathers' income is part of the calculation for Medicaid eligibility. Significant legal research would be required to implement this change.

Medicaid has prepared a White Paper on the pregnant women recipient group that deals more at length with this issue. The White Paper is included in Supplement One.

### **Option 3 | Require nutrition counseling and referral to SNAP**

*Description:* At this time, when Medicaid eligibility is determined by DFS, women have the opportunity to seek nutrition counseling and referral to the food stamp program, SNAP. The goal should be 100% participation in nutrition counseling/SNAP for Medicaid eligible pregnant women.

### **Option 4 | Increase visibility and use of Nursing Health Line**

*Description:* The Nursing Health Line has seen increased use and visibility in the past months. Additional capabilities should be added, and increased advertising would help to ensure that more Medicaid pregnant women know about this resource and use it. This may decrease the number of women that need to see a physician or visit an emergency room for concerns that could be answered by a registered nurse via phone.

## **Pregnant Women and Newborns: Eligibility Changes**

### **Option 1 | Extend “Pregnant by Choice” Waiver**

*Description:* The Medicaid Pregnant by Choice Waiver is currently a five-year demonstration waiver that ends September 30, 2013. The purpose of the program is to provide family planning and birth control options to women in Medicaid's pregnant women program that would otherwise lose Medicaid eligibility 60 days after giving birth. The goal of this program is to minimize unintended closely-spaced pregnancies, and decrease the number of unintended pregnancies. A variety of services are available under this waiver, including: physical exams, annual follow-up exams for reproductive health and family planning, contraceptive management (including prescriptions, devices, etc.), sterilization services, and medically necessary family planning health laboratory procedures, tests, and medications.

Currently, only women that have had at least one pregnancy while on Medicaid are eligible for the “Pregnant by Choice” waiver. This option would expand the Pregnant by Choice waiver to other low-income women in order to encourage participation and a real preventative step (i.e.,

before even a first pregnancy occurs). Many of these services are required to be covered under private insurance with no cost-sharing in plan years starting on or after August 1, 2012.<sup>65</sup>

Extending the eligibility group for the Pregnant by Choice waiver may result in cost savings to the State of Wyoming over time, particularly if unwanted pregnancies are reduced, and higher risk closely-spaced pregnancies are reduced.

## **Option 2 | Provide pre-natal services for non-citizens**

*Description:* At this time, Wyoming Medicaid only pays for emergency care for non-citizens. Medicaid benefits are provided only for services that are tied to the emergency condition, and are no longer provided once that condition is no longer considered an emergency. Newborns born to pregnant female non-citizens who have not received the benefit of prenatal care may be at higher risk for complications, either during delivery or post delivery. These complications bring high cost to Wyoming Medicaid, and could potentially be prevented by providing care to pregnant female non-citizens as soon as a pregnancy is detected, if they were eligible for Medicaid services. It should be noted that a baby born to a non-citizen immediately becomes a Medicaid recipient.

Extending eligibility to pregnant female non-citizens may result in cost savings to the State of Wyoming over time, by reducing costly complications due to lack of prenatal care. This option and potential savings are examined more in-depth in the Pregnant Women White Paper written by Medicaid staff (found in Supplement One).

## **Pregnant Women and Newborns: Benefits or Services Offered**

### **Option 1 | Expand home visiting programming post-delivery**

Wyoming Public Health Nursing provides home visiting programs to certain mothers following delivery. This option would expand these programs in order to ensure good nutrition, provide safety consultation, and training that the women may not have received in prenatal visits or at the hospital.

## **Pregnant Women and Newborns: Rate or Payment Changes**

### **Option 1 | Reduce Wyoming OB/GYN reimbursement rates**

*Description:* Currently, Wyoming Medicaid reimbursement for OB/GYN providers is 90% of billed charges. This reimbursement structure has been in place since the 2004 legislative session, when the legislature mandated Medicaid to reimburse for certain services at 90% of the previous year's statewide average of the providers usual and customary charges. Over time the fees have risen dramatically and are in every instance higher than other Medicaid programs in the region. For example, procedure code 59618 (routine obstetric care – global payment) pays \$3,866 in Wyoming Medicaid, whereas the same code pays much less in surrounding states (e.g., \$1,315 in Colorado; \$2,324 in Montana). Across 22 obstetric procedure codes, Wyoming pays 235% of the regional average as compared to Colorado, Montana, Idaho, South Dakota, Nebraska, and Utah.

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<sup>65</sup> See <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforWomenIncludingPregnantWomen>  
Wyoming Medicaid Options Study | Report Two

Proc Code	Proc Code Description	WY	CO	MT	ID	SD	NE	UT
59618	Routine Obstetric Care, Global Payment	\$3,867	\$1,316	\$2,325	\$1,783	\$1,559	\$2,182	\$1,489

Additional details are included in a Pregnant Women White Paper included as a supplement to this report.

Medicaid costs for services to pregnant women would decline as the rates decrease. An unintended consequence of decreasing rates may be that some providers stop providing services to Medicaid recipients, if reimbursement rates are not competitive with rates paid by other insurance plans. It would be important to evaluate this comparison as decisions are made.

### **Option 2 | Implement bundled payments for prenatal care through birth**

*Description:* All of the services that are needed for a healthy transition from conception through post natal care of a new born are currently paid on a service-by-service basis. A bundled, risk-adjusted payment system would combine payment for an essential package of maternity care services for pregnant women and newborns. This package could focus on prevention and wellness (and additional services for high-risk pregnancies to minimize the likelihood for pre-term births and delivery complications). Private insurance companies offer packages similar to this for pregnant women. Bundled payments have been shown to limit overuse, deliver effective preventative services, and improve outcomes and value.

Implementation of bundled payments could decrease costs to Wyoming Medicaid in the coming years, as service overuse and unhealthy outcomes for pregnant women and newborns are reduced.

### **Option 3 | Incentivize prenatal visits**

*Description:* Wyoming Medicaid could incentivize prenatal visits to increase mothers' attendance and decrease missed appointments. Studies in other states have shown that incentives are an effective way to improve appointment attendance for expecting mothers. For example, Alabama Medicaid offered a coupon book worth about \$300 if women attended their prenatal appointments on a monthly basis.<sup>66</sup> This increased the motivation of women to attend their appointments.

### **Option 4 | NICU hospital reimbursement rate evaluation**

*Description:* This option would have Wyoming Medicaid evaluate the NICU level 3 reimbursement rates for children's hospitals, which is at this time reimbursed by Wyoming Medicaid at 150% of cost.

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<sup>66</sup> See <http://www.ncbi.nlm.nih.gov/pubmed/10128261>  
Wyoming Medicaid Options Study | Report Two

## **Option 5 | Incentivize physicians for good outcomes**

*Description:* One method for improving care coordination, and thus outcomes, for pregnant women may be incentivizing not only the patients, but also the physicians who provide these services. Incentives have been used by other healthcare service systems in order to pay for desired outcomes rather than solely for quantity of services.

## **Pregnant Women and Newborns: Healthcare Quality**

### **Option 1 | Require physicians to refer into case management**

*Description:* Improved quality of care for pregnant women and their newborns may be achieved if primary physicians shared responsibility for case management with other pregnancy-specialty providers. This concept accompanies the aforementioned option for pregnancy medical homes, and pregnancy case management, but includes a provision that physicians are required or incentivized to refer pregnant women into case management.

Similar to the discussion about medical homes presented in Section V of this report, case management specific to pregnancy would benefit Wyoming such that better care management could occur. This may, for example, improve prenatal service attendance, thus resulting in better health for newborns.

### **Option 2 | Require Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

*Description:* SBIRT<sup>67</sup> is an integrated approach to the delivery of early intervention and treatment services for people with substance use or abuse issues (including those who are at risk for developing problems with substance use). The goal of SBIRT is to provide screening for substance abuse as part of routine medical care. This screening would provide a way to identify pregnant women that may need additional assessment for substance abuse disorders that could be harmful to them and their babies. The screening could be provided in physician's offices, specialty offices (OB/GYN), or in urgent care or emergency room settings.

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<sup>67</sup> See <http://www.samhsa.gov/prevention/SBIRT/index.aspx>  
Wyoming Medicaid Options Study | Report Two

## SECTION X: OPTIONS | FAMILY CARE ADULTS

FAMILY CARE ADULTS		
<b>SHARE of SFY11 MEDICAID BUDGET   \$29.1 million [6%]*</b>		
<b>NUMBER of RECIPIENTS in SFY11   6,942 [9%]*</b>		
<b>WHO</b>	The Family Care Adults eligibility sub-group consists of adults that provide care and control to at least one Medicaid eligible child (less than 19 years of age) living in the household. Adults must have income less than or equal to approximately 36% of the Federal Poverty Level. There are no resource limits.	
<b>WHY</b>	The Family Care Adults sub-group was chosen due to high total expenditures across the 5%, 15% and 80% categories.	
COMPARISONS of COST CATEGORIES*		
Highest Cost Family Care Adults   Top 5%	Moderate Cost Family Care Adults   Middle 15%	Lowest Cost Family Care Adults   Lowest 80%
Annual Cost Per Recipient = \$32,796	Annual Cost Per Recipient = \$9,572	Annual Cost Per Recipient = \$1,395
TOP 5 SERVICES BY EXPENDITURES**		
Inpatient Hospital Services  22% Physician Services  21% Outpatient Hospital Services  19% Prescribed Drugs  16% Dental Services  5%		
<i>*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.</i>		
<i>**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.</i>		

### **Group Overview**

Family care adults are adults that qualify based on income and must also be providing care and control for a child eligible for Medicaid.

This group is a mandatory eligibility group and eligibility is set at the lowest income standard allowed. The income level for this group is the Aid for Families with Dependent Children (AFDC) income standard that was in place prior to welfare reform in 1996. Wyoming added an

optional earned income disregard for employed individuals, which disregards \$200 a month of income for one employed caregiver or \$400 a month for two employed caregivers.

Generally, eligibility is limited to individuals with annual income significantly below the poverty level as shown in the table below. Income limits for family care adults are approximately 36% of the Federal Poverty Level but vary depending on family size and employment status.

<b>Family Care Income Standard- (AFDC/1931)</b>				
Wyoming Income Limit Per Year based on Wyoming's July 1996 AFDC/1931 eligibility levels				
<b>Family Size</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Unemployed	\$ 4,344	\$ 6,144	\$ 7,080	\$ 7,908
Employed w/ \$200 per month disregard	\$ 6,744	\$ 8,544	\$ 9,480	\$ 10,308
Employed w/ \$400 per month disregard	\$ 9,144	\$ 10,944	\$ 11,880	\$ 12,708

The dollar amounts of this income standard have not changed since 1996, except for the earned income disregard. The earned income disregard is based on household composition and marital status.

The average age for this group is 33 and this group is primarily female (77% female).

<b>Metric</b>	<b>Medicaid Family Care Adult Recipients</b>		
	<b>5%</b>	<b>15%</b>	<b>80%</b>
Average Age	37	33	32
% Female	81%	82%	76%

### **Common Concerns**

When discussing family care adults, some common concerns arise such as lack of a primary care physician, use of the emergency room for non-emergent care, presence of chronic conditions, and high use of pharmacy.

The significantly higher use of multiple providers among the 5% and 15% population, shown in the table below, may reflect a lack of a primary care physician or a sign of uncoordinated care. It may also reflect serious health issues requiring numerous specialists or types of care.

<b>Group</b>	<b>Metric</b>	<b>5%</b>	<b>15%</b>	<b>80%</b>
Medicaid Family Care Adult Recipients	Avg. # of Providers	20	11	4
Wyoming Private Insurance Recipients	Avg. # of Providers	8	5	2

### **Family Care Adults: Program Design Options**

Only program design options were generated for the Family Care group.

**Option 1 | More integrated/coordinated care**

*Description:* This group may benefit from options for integrated or coordinated care discussed in Section V, including managed care, primary care, or medical homes.

**Option 2 | Encourage recipients to use available family planning services**

*Description:* This option would encourage the use of family planning services and counseling for the family care population, as this group may have multiple children born on Medicaid over the course of multiple years. Better planning for and spacing of births would help reduce costs, and may result in healthier pregnancies and newborns.

## SECTION XI: OPTIONS | CHILDREN AND FOSTER CARE CHILDREN

LOW-INCOME CHILDREN (0-18)			
<b>SHARE of SFY11 MEDICAID BUDGET   \$67.1 million [13%]*</b>			
<b>NUMBER of RECIPIENTS in SFY11   36,261 [47%]*</b>			
<b>WHO</b>	The Low-Income Children eligibility sub-group consists of children between the ages of 0 and 5 whose countable family income is less than or equal to 133% FPL, or children between the ages of 6 and 18 whose countable family income is less than or equal to 100% FPL.		
<b>WHY</b>	The Low-Income Children sub-group was chosen due to high total expenditures across the 5%, 15%, and 80% categories.		
COMPARISONS of COST CATEGORIES*			
Highest Cost Low-Income Children   Top 5%	Moderate Cost Low-Income Children   Middle 15%	Lowest Cost Low-Income Children   Lowest 80%	
Annual Cost Per Recipient = \$16,327	Annual Cost Per Recipient = \$3,552	Annual Cost Per Recipient = \$628	
TOP 5 SERVICES BY EXPENDITURES**			
Physician Services   19% Prescribed Drugs   14% Dental Services   11% Inpatient Hospital   11% Outpatient Hospital   10%			
<i>*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.</i>			
<i>**The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.</i>			

## FOSTER CARE CHILDREN

**SHARE of SFY11 MEDICAID BUDGET | \$22.9 million [4%]\***

**NUMBER of RECIPIENTS in SFY11 | 3,346 [4%]\***

**WHO**

The Foster Care eligibility sub-group consists of children in the custody of the Wyoming Department of Family Services, up to the age of 19. Children who turn 18 while in foster care may continue to receive coverage until 21. In 2014 due to the ACA, children in foster care can continue coverage until they turn 26.

**WHY**

The Foster Care sub-group was chosen due to high total expenditures across the 5% and 15% categories, and a high cost per recipient in the 5% and 15% categories of recipients.

### COMPARISONS of COST CATEGORIES\*

Highest Cost Foster Care   Top 5%	Moderate Cost Foster Care   Middle 15%	Lowest Cost Foster Care   Lowest 80%
Annual Cost Per Recipient = \$63,186	Annual Cost Per Recipient = \$14,916	Annual Cost Per Recipient = \$1,819

### TOP 5 SERVICES BY EXPENDITURES\*\*

Psychiatric Residential Treatment Facility (PRTF)   34%
Prescribed Drugs   14%
Physician Services   13%
Mental Health Clinic Services   11%
Outpatient Substance Abuse Treatment   4%

*\*SFY11 data were used for these analyses. Budget share, number of recipients, annual cost per recipient and top five services are based on internal analyses.*

*\*\*The top 5 services were selected based on ranking services types from most to least costly. The percent of the cost for that service for this sub-group is presented next to the service type name.*

### **Group Overview**

Children are the largest group covered by Medicaid and represent 64% of the total Medicaid population; however, they have the lowest average cost per recipient of \$2,166 per year.

Children are eligible for Medicaid when:

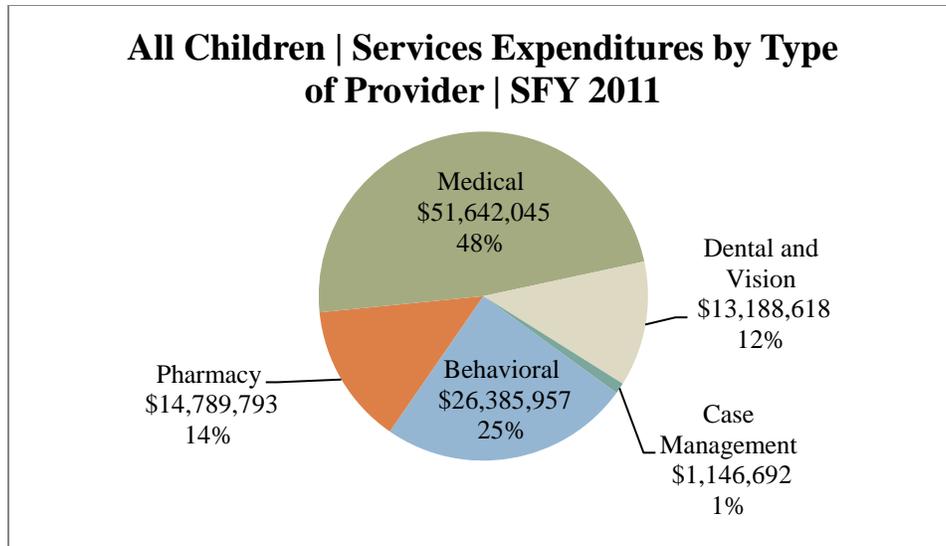
- The child’s mother was eligible for Medicaid at the time of the child’s birth.
- The child is part of a low-income family (133% FPL ages 0-5 yrs., 100% FPL ages 6-18 yrs.).

- Members of the child’s family become eligible for family care coverage.
- The child is part of the foster care system.

While children are the least expensive group per participant, certain portions of the population were identified as high-cost areas of interest. Specifically, foster care children and the top 5% of non-foster care children account for significantly more cost in the children sub-group.

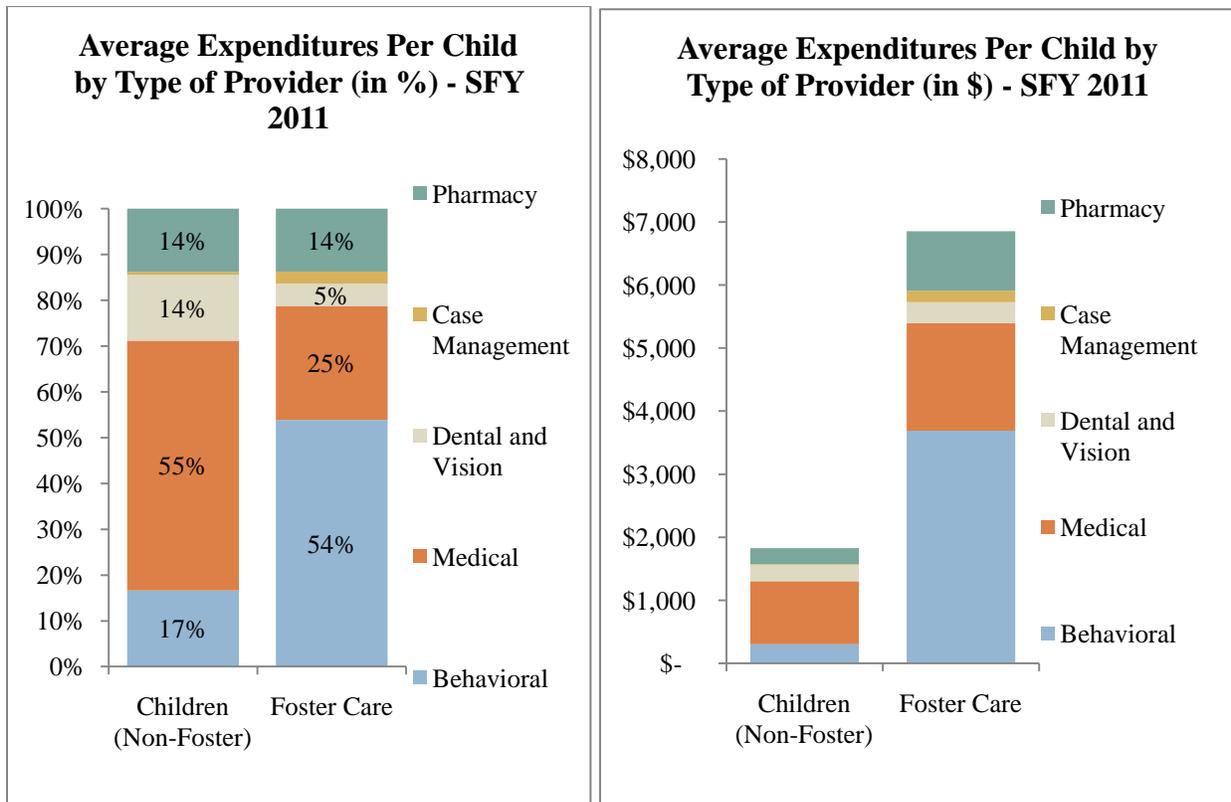
**Common Concerns**

Behavioral health issues and the subsequent treatment (e.g., pharmacy and/or case management) of these issues comprise a significant portion of treatment dollars for all children.<sup>68</sup>



In some groups such as children in foster care, behavioral health treatment requires more resources than physical health services. For children in foster care, 54% of expenditures are spent on behavioral health with approximately half of behavioral health expenditures going to psychiatric residential treatment facilities (PRTFs). PRTFs provide inpatient care and interventions for children who need 24 hour inpatient care for mental illnesses or substance abuse.

<sup>68</sup> For this analysis, it was not possible to break out the pharmacy costs related to medical and behavioral issues.



PRTFs placements are more commonly used for foster care children and the top 5% of non-foster care children than other children. Medicaid staff members have identified problems in the legal process used to place children into PRTF facilities; specifically, judges ordering PRTF placements that should only be ordered by medical professionals. If a judge orders a child to be placed into a particular PRTF, then per CMS, federal dollars cannot be used to pay for the costs. The State must use 100% general funds instead of receiving its normal 50% federal match.

Foster care children and the top 5% of non-foster care children receive significantly more inpatient and outpatient behavioral health treatment than the other 95% of non-foster care children. PRTF placements account for 34% of total expenditures for foster care children.

One program change that the State has implemented aimed at reducing cost is requiring discharge planning to begin on the day of admission to the PRTF to ensure attainment of goals and monitor changes in the treatment plan. This change to discharge planning has recently been instituted as mandatory and is now written into vendor contracts, which should begin to lower readmission rates to PRTF facilities. Due to the growth and high-cost of PRTF placements, additional possible changes for improving PRTF placements are addressed in the next section.

## Children : Program Design

### **Option 1 | Add provision to State statutes precluding court ordered placements at specific Psychiatric Residential Treatment Facilities (PRTF)**

*Description:* CMS regulations require that all placements of children at PRTF facilities be determined by a medical professional considering the needs of the child. Compliant placement orders must include all of the following:

- Medically necessary and ordered by a physician.
- Long-standing (at least six months) psychiatric diagnosis with symptoms that are persistent and pervasive.
- Documented attempts to treat the child with the maximum intensity of services available at a less intensive level of care.
  - The less intensive level of care must have failed to meet the needs of the child in the last six months.
- Patterns of behavior must be present.
- Without intervention, clear evidence that child will present serious risk of harm to self or others.
- PRTF cannot be entry point for children to receive inpatient psychiatric services.

Certain Wyoming judges are issuing orders for placement at PRTF without regard to standards for medical necessity and other CMS rules. Judges are not medically qualified to make these types of determinations. When a judge specifies a specific facility, level of care, or a length of time for treatment then that order is non-compliant with CMS rules. Because the non-compliant order creates a placement, the placement is not eligible for federal reimbursement by Medicaid. For these non-compliant placements, 100% of the cost is paid by the General Fund.

In addition to the cost to the State, the child can be harmed by the inappropriate placement. For instance, while the average medical placement in a PRTF facility is four months, judges often order six months or more of treatment. For this type of treatment, too much can be as detrimental as too little.

Additionally, many judges order out-of-state placement even though State law requires that a community based plan of care be exhausted before using PRTFs. All placements must consider proximity to home and family.

In SFY 2011, \$16,977,353 was spent on all PRTF placements with \$1,758,578 occurring due to improper orders. This resulted in the loss of federal reimbursement of 50%, or \$879,289. In SFY 2012, this problem has become significantly more severe.

WDH staff has provided education on this issue to all DFS staff, region and social service supervisors, county and district attorneys, public defenders, guardian ad litem, and judges regarding the approved process and proper court order language for PRTF placements. Medicaid staff has also prepared a White Paper further detailing this issue, which is included as Supplement One.

## **Option 2 | Enforce medical assessment requirement before PRTF placement orders by court**

*Description:* Psychiatric evaluation by a psychiatrist that specializes in child and adolescent psychiatry is required for PRTF admission. This evaluation should take place no more than 30 days prior to PRTF admission. Wyoming uses a Multi Disciplinary Team (MDT) psychiatric evaluation group that consists of child psychiatrists employed by the University of Washington to conduct these evaluations. These assessments provide recommendations on placement, diagnosis, and treatment for children. The process is convened by the juvenile court system. The child's DFS worker or guardian ad litem can submit a referral for a MDT evaluation to the University of Washington.

A problem occurs when courts issue orders for placement before the MDT assessment has taken place, and therefore the placement is not medically based.

Implementation of this option would require all placements in PRTF facilities to be medically based. Medically based placements are the only placements that Medicaid can pay for. This option would require the child's DFS worker or guardian ad litem to request a delay in the scheduled court date if a MDT assessment has not yet been performed and judges to delay ordering placements until the MDT assessment. Additionally the court order should follow the recommendation of the MDT psychiatric evaluation group.

## **Option 3 | Try to prevent PRTF admissions, better manage admissions that do occur and reduce readmissions**

*Description:* Some PRTF admissions are avoidable if community options are used early and often. By evaluating statewide statistics to identify overuse and inappropriate use, those regions can be targeted for improved coordination and case management through the behavioral health system. PRTF admissions can be avoided by more intensive and effective treatment of children at lower levels of care in the community.

Altering the payment structure to reduce per day payment beyond the initial term recommended by the MDT by creating a sliding fee structure could create a financial disincentive for facilities to keep children in a PRTF longer than the recommended plan of care.

Wyoming could also use "voluntary placement agreements" when possible. Under voluntary placements, parents share custody and expenses with the State, versus full foster care where DFS has primary custody. Voluntary placements should only be used when DFS has determined that the parent is a valid long-term placement for the child. This would allow the return of the child to the parent's home after treatment and would increase cost sharing between Medicaid and the parents' private insurance.

## **Option 4 | Contract with a care management entity (CME) to manage children with serious emotional disturbances or disorders**

*Description:* This option proposes the use of a care management entity (CME) to achieve greater coordination of behavioral health services.

The WDH, Division of Healthcare Financing, in collaboration with the Department of Family Services (DFS) has plans for implementation of a Care Management Entity (CME) Pilot for Medicaid children and youth in Southeastern Wyoming with serious behavioral health issues. An RFP was released on June 18, 2012 to procure a Contractor to serve as a CME for the southeast region of Wyoming. CME project planning has been supported through CHIPRA Grant funds. Through this approach, WDH anticipates improving outcomes for children and youth with behavioral health challenges while decreasing healthcare costs.

The CME will be the centralized accountable hub to coordinate care for children and youth, involved in the pilot, with complex behavioral health challenges who are involved in multiple systems, and their families. The CME will provide the following: (1) a youth guided and family-driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; (3) home and community-based services and peer supports as alternatives to costly residential and hospital care for children and youth with severe behavioral health challenges.

#### **Option 5 | Focus the case management body at clinical level outcomes, not just provision of services**

*Description:* Case management currently focuses on managing the type, amount and length of services and ensuring that service levels are appropriate given a child's condition. Adding the additional criterion of monitoring and achieving positive clinical level outcomes for effectiveness to case management contracts would help enhance the system.

#### **Option 6 | Focus on transition-age youth as they are leaving the foster care system**

*Description:* Youth in foster care often lack the support network that helps children as they transition out of the home to become successful, independent adults. A poor transition out of foster care can lead to poor outcomes such as drug use, involvement in the criminal justice system, homelessness, and unemployment. A successful transition plan would include employment, housing, education options, and identification of community supports.

Children who turn 18 while in foster care already continue to receive coverage until age 21. In 2014 due to the ACA, children in foster care can continue coverage until they turn 26.

Some states such as Maryland, Massachusetts, and Mississippi have added a "Medicaid Rehab Option" through a state plan amendment or waiver which allows the state to focus on additional supports for 16-24 year olds transitioning out of the foster care system. This type of program would be more intense during major life stages or times of transition.

### **Children : Internal Management Options**

#### **Option 1| Third party case management and review of all children in foster care**

*Description:* Wyoming Medicaid is already using University of Washington for third-party case management and reviews for PRTF placements and pharmacy reviews. This option would

expand this process to include all children in the foster care sub-group of Medicaid or a sub-set of those with costs and behaviors indicating a serious risk of a future PRTF placement.

“Child psych” consults are currently provided through contract with Seattle Child Psych. The consults are currently used for PRTF placements, but this option would expand the use of these consults to foster children beyond the PRTF population to determine proper courses of care and identify behavioral health issues early.

## **Children : Benefits or Services Offered**

### **Option 1 | Wrap-around services for top five percent of non-foster children and for all or most foster children**

*Description:* Wrap-around services bring together a team to help coordinate a wide array of services for a child including medical care, school services, behavioral services, and other supportive services. Wrap-around services are currently available in the children’s mental health waiver. Extending the children’s mental health waiver to include foster care and the top five percent of children could expand this effective service to the highest cost child population.

If wrap-around services are able to better coordinate care and avoid more intensive treatment, this option could create significant savings for behavioral health services for these children. Behavioral health consumed 54% of expenditures for the foster children sub-population (not including pharmacy). In SFY 11, \$12,349,455 was spent on behavioral health services (not including pharmacy) for the foster care population

## **Children : Rate or Payment Changes**

### **Option 1 | Evaluate whether children in foster care are properly screened as emotionally disturbed to receive additional support from their school districts**

*Description:* Some services currently provided by Medicaid may be services that school districts could provide during school hours if a child is properly screened and identified as “emotionally disturbed.” While this is likely already occurring for most children in foster care, Medicaid does not have a method of verifying receipt of school district services.

## **Children : Healthcare Quality**

### **Option 1 | Identify a primary care doctor to be used continuously as part of foster care process**

*Description:* Children in foster care often lack a continuous figure to provide information to health care professionals about previous instances and locations of medical and behavioral care. This can lead foster children to receive care at multiple locations in an uncoordinated way. By “locking” a foster child into a primary care provider as part of the foster care process, this would help create some continuity in the child’s care. If the child’s Personal and Electronic Health records are properly used, medical professionals and behavioral health professional will have a source to better coordinate care for the child.

## SECTION XII: CONCLUSION

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### *Conclusion*

Report Two focused on analysis of Medicaid data and the development of options for cost containment and improvement to Wyoming Medicaid. WDH staff underwent extensive research to identify areas within Wyoming Medicaid that may be responsible for driving costs in order to focus on those areas when identifying options for cost containment and improvement.

The two main cost drivers in Wyoming Medicaid are growth in number of Medicaid recipients or enrollment and growth in cost per recipient. There is little that can be done by the State to manage growth in the number of Medicaid recipients/enrollment. Thus, WDH focused its efforts on identifying options that could slow or manage the growth in cost per recipient.

Specifically, WDH focused on 13 high-cost sub-groups, which comprised the majority (95%) of overall Medicaid expenditures in SFY11. After these sub-groups were set out as cost drivers, WDH staff conducted research, brainstorming workgroup sessions, focused discussions, and obtained expert technical assistance to identify options for the improvement of the Medicaid programs that serve these sub-groups.

Several options were gathered and presented in the preceding pages of this report.

The options presented in Report Two will undergo further evaluation and discussion in order for the WDH to present its recommendations in the final report, Report Three. Report Three will be completed by December 1, 2012.

Due to the timing of the 2013 General Session of the Wyoming Legislature, the WDH will be prepared to present preliminary recommendations for options that can be implemented in the short-term at the next Joint Labor, Health and Social Services Interim Committee meeting in October of 2012. All other recommendations will be included in the December 1, 2012 report.

## APPENDIX A: METHODOLOGY FOR SUB-GROUP SELECTION

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### A Detailed Description of Sub-Group Selection<sup>69</sup>

1. First, sub-groups were sorted by the highest cost overall and highest cost per recipient. A value of 1 was assigned to each category (5%, 15%, 80%) if the overall cost for that category was in the top 10 most costly sub-groups. A sub-group could receive a total score on overall cost between 0 and 3. For example, looking at the first row of Table A, the sub-group “AB&D | DD Adult Waiver” scored a 3 in the ‘total expended’ column. This means that all three categories of recipients (those in the top 5%, the middle 15%, and the bottom 80%) were in the top 10 highest cost.
2. Second, each category was assigned a value of 1 to indicate whether the 5%, 15%, and/or 80% categories within each sub-group show cost per recipient that is above the category mean. A sub-group could receive a total score on cost per recipient between 0 and 3. To continue with the example of the first row in Table A, “AB&D | DD Adult Waiver” scored a 3 in the ‘>cost per recipient’ column. This means that all three categories of recipients (those in the top 5%, the middle 15%, and the bottom 80%) had higher cost per recipient figures than the other sub-groups.
3. Third, each sub-group was assigned a value of 1 if the top 5% of the sub-group was at least 10 times more costly than the bottom 80% of the sub-group<sup>70</sup>. Sub-groups that did not exceed a multiplier of 10 were given a score of 0. A sub-group could receive a total score on the 5%-80% gap between 0 and 1. In the first row of Table A, “AB&D | DD Adult Waiver” scored a 0 in the ‘5/80 Gap Larger than 10 times’ column. This means that all three categories of recipients (those in the top 5%, the middle 15%, and the bottom 80%) were similar in cost to one another, and that the gap between the top 5% category and the bottom 80% category was very small.

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<sup>69</sup> A brief glossary of the terms that will be used in this discussion include:

- a) Sub-group: the smaller groups within each of the primary 10 Medicaid Programs (see Table B for a complete list).
- b) Category: refers to the 5%, 15%, or 80% cost categories of the sub-group.
- c) Rank score: an assigned number indicating the level of interest in a sub-group based on overall cost, cost per recipient, and the gap between the top 5% and the bottom 80% most expensive recipients in each sub-group.

<sup>70</sup> A small gap indicates that the 5% group is more similar to the 80% group, meaning that we may want to examine the entire sub-group and not limit the drill-downs to just the top 5%. A large gap indicates that the 5% group is ‘much more’ expensive than the 80% group (or, that the 80% group is ‘much less’ expensive than the 5% group). This should lead to a more careful consideration of the 5% group.

<b>Rank Scoring of Medicaid Program Sub-Groups</b>				
<b>Sub-Groups</b>	<b>Total Expended</b>	<b>&gt; Cost Per Recipient</b>	<b>5/80 Gap Larger than 10 times</b>	<b>Total Rank Score</b>
AB&D   DD Adult Waiver	3	3	0	6
AB&D   Long Term Care (LTC) Waiver	3	3	0	6
AB&D   Nursing Home	3	3	0	6
AB&D   SSI	3	2	1	6
AB&D   DD Child Waiver	2	3	0	5
Foster Care	2	2	1	5
Newborn	3	1	1	5
Breast and Cervical Cancer Program <sup>^</sup>	0	3	1	4
Family Care Adults	3	0	1	4
AB&D   Hospital Care	0	3	1	4
Low Income Children (Ages 0-18)	3	0	1	4
Pregnant Women	3	1	0	4
AB&D   Wyoming Life Resource Center	1	3	0	4
AB&D   ABI Waiver	0	3	0	3
AB&D   ALF Waiver	0	3	0	3
AB&D   Children's Mental Health Waiver	0	3	0	3
Employed Individuals with Disabilities	0	2	1	3
Hospice	0	2	1	3
Children	1	0	1	2

<sup>^</sup>This group's options are primarily related to the ACA expansion option; therefore, this group will not be explicitly addressed in Report Two.

- Finally, all of the values were added together to reach a rank score of 0-7. Sub-groups that did not qualify for any of these criteria (i.e., had a rank score of 0) were removed from further consideration.<sup>71</sup> The remaining 19 sub-groups were ordered by overall rank score; scores of 4-7 led to selection of that sub-group as a cost-driver for Wyoming Medicaid, and a sub-group that would be the focus of the options research process. Table A presents all 19 sub-groups and their scores on the three factors, as well as their overall rank scores. The 13 sub-groups that fall above the black line ( with total scores of 4-6) represent those selected as cost drivers.

<sup>71</sup> Eight (8) sub-groups were removed completely from consideration using this methodology, including: Pregnant Women Presumptive Eligibility, Family Planning Waiver, SSI-related, IMD (Wyoming State Hospital), Part B-Partial AMB, Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Non-Citizens.

**TABLE B: WYOMING MEDICAID | ALL PROGRAMS & SUB-GROUPS**

<b>Program Name</b>	<b>Sub-Group Name</b>
<b>Children</b>	Children
	Foster Care
	Low Income Children (Ages 0-18)
	Newborn
<b>Pregnant Women</b>	Pregnant Women
	Presumptive Eligibility
<b>Family Care</b>	Family Care
<b>AB&amp;D   SSI &amp; SSI-Related</b>	SSI Related
	SSI
<b>AB&amp;D   Institution</b>	Hospice
	Hospital Care
	ICF-ID (Wyoming Life Resource Center)
	IMD (Wyoming State Hospital - Age 65+)
	Nursing Home
<b>AB&amp;D   Home and Community Based Waivers</b>	Acquired Brain Injury (ABI)
	Assisted Living Facility (ALF)
	Children's Mental Health
	DD Adult
	DD Child
	Long Term Care (LTC)
<b>AB&amp;D   Employed Individuals with Disabilities</b>	Employed Individuals with Disabilities
<b>Medicare Savings Programs</b>	Qualified Medicare Beneficiary
	Specified Low Income Medicare Beneficiary
	Part B : Partial AMB
<b>Non Citizens with Medical Emergencies</b>	Non Citizens
<b>Special Groups</b>	Breast and Cervical Cancer Treatment
	Tuberculosis
	Family Planning Waiver

STAKEHOLDER OPTIONS & RECOMMENDATIONS

EXECUTIVE SUMMARY

AUGUST 20, 2012

PREPARED FOR:

THE WYOMING DEPARTMENT OF HEALTH

BY:

**Public Knowledge LLC**  
Management Consultants

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## EXECUTIVE SUMMARY

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During the Sixty-First Legislature of the State of Wyoming 2012 Budget Session, the Wyoming Legislature passed Original Senate File No. 0034, Enrolled Act No. 58, Senate requiring the Wyoming Department of Health (WDH) to conduct a study into the Medicaid program. This study would produce three (3) separate reports that would analyze the cost drivers, and identify and evaluate options the State should consider to increase efficiency and cost effectiveness of the Wyoming Medicaid program.

A significant component of the Medicaid Options Study involves a comprehensive stakeholder feedback period to ensure that a broad range of options and opinions are considered. WDH contracted with Public Knowledge, LLC<sup>72</sup> to assist in facilitating stakeholder feedback sessions, gathering and summarizing input and feedback from the stakeholders, and presenting stakeholders' recommended options for the Medicaid program.

Through a combination of in-person interviews and an online Medicaid Options Study Survey (herein referred to as the online survey), Public Knowledge collected a range of options from State staff, Medicaid providers, Legislators, past or current Medicaid recipients (herein referred to as clients) and citizens. This Report uses the term "stakeholders" to represent the array of groups and individuals that participated in both interviews and the online survey throughout the stakeholder feedback period. Public Knowledge conducted over 30 in-person interviews with 136 participants and received over 390 online survey responses. Further detail on the approach is included in Part Two: Summary of Approach. Sample interview and online survey questions are included in Appendices C and D, respectively.

The stakeholder feedback period resulted in a collection of options for the State to consider for the Medicaid program. The options presented in this Report are directly reported from stakeholders and have not been altered or validated for accuracy. Stakeholder responses are based on perceptions of the Medicaid program and many of the suggestions may already be addressed or restricted by State or Federal rules, regulations and policies. Additionally the scope of this Report does not include analysis or evaluation of the presented options as the State's Medicaid Options Study: Report Three will evaluate options and communicate the State's recommendations to increase efficiency and cost effectiveness to the Legislature.

Although stakeholders presented a number of unique ideas and recommendations, common themes emerged-enabling Public Knowledge to group ideas into various options for the State to consider. To best organize options for the State, Public Knowledge summarized options into the following categories:

- *Options to increase efficiency in Medicaid* – Includes options that would increase efficiency in current business and service administration.
- *Options to improve quality in Medicaid* – Includes options that would improve the quality of services and/or care for clients.

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<sup>72</sup> Public Knowledge is a Management Consulting firm with a strong focus on state government and

Medicaid projects. Public Knowledge has staff working in several states, including Wyoming, Colorado, Montana, Idaho, Washington and Oregon. For more information on Public Knowledge, visit: [www.pubknow.com](http://www.pubknow.com)



Figure 1.1: Summary of Options to Increase Efficiency in Medicaid

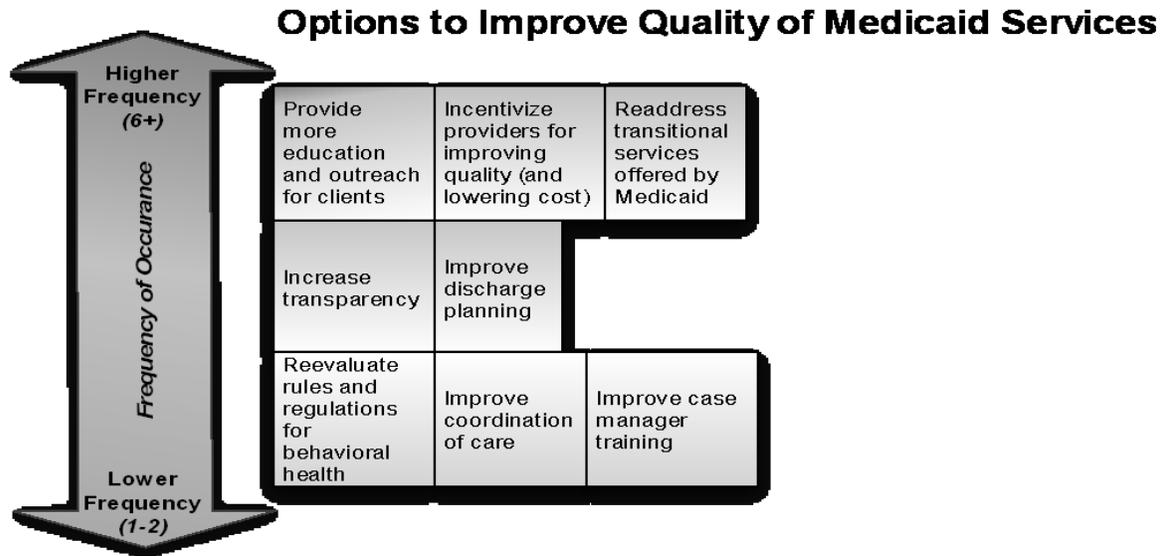


Figure 1.2: Summary of Options to Improve Quality of Medicaid Services

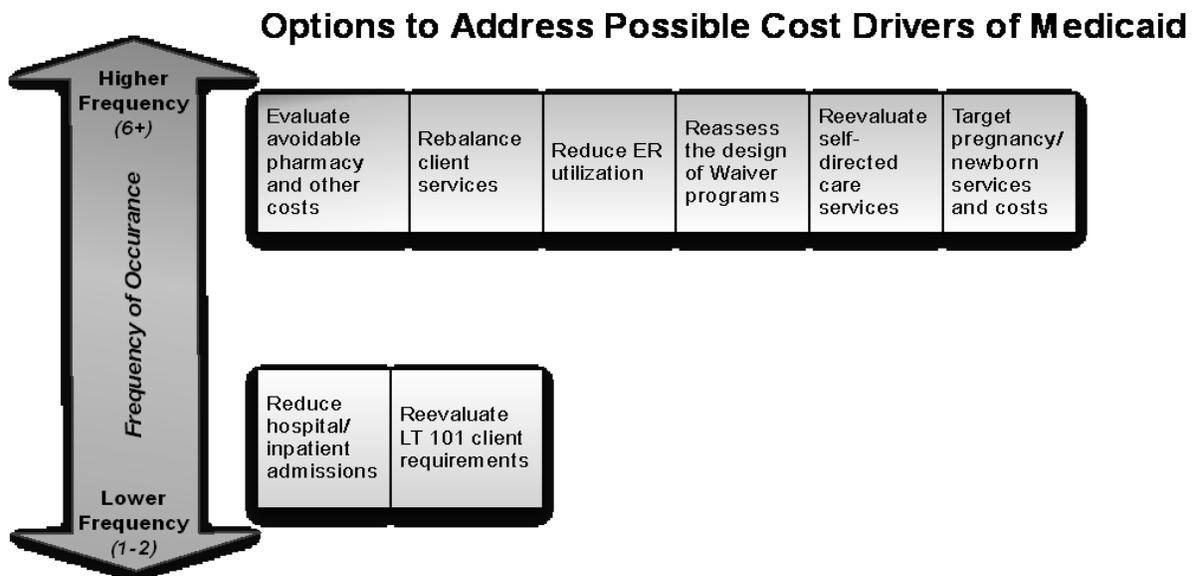


Figure 1.3: Summary of Options to Address Possible Cost Drivers of Medicaid

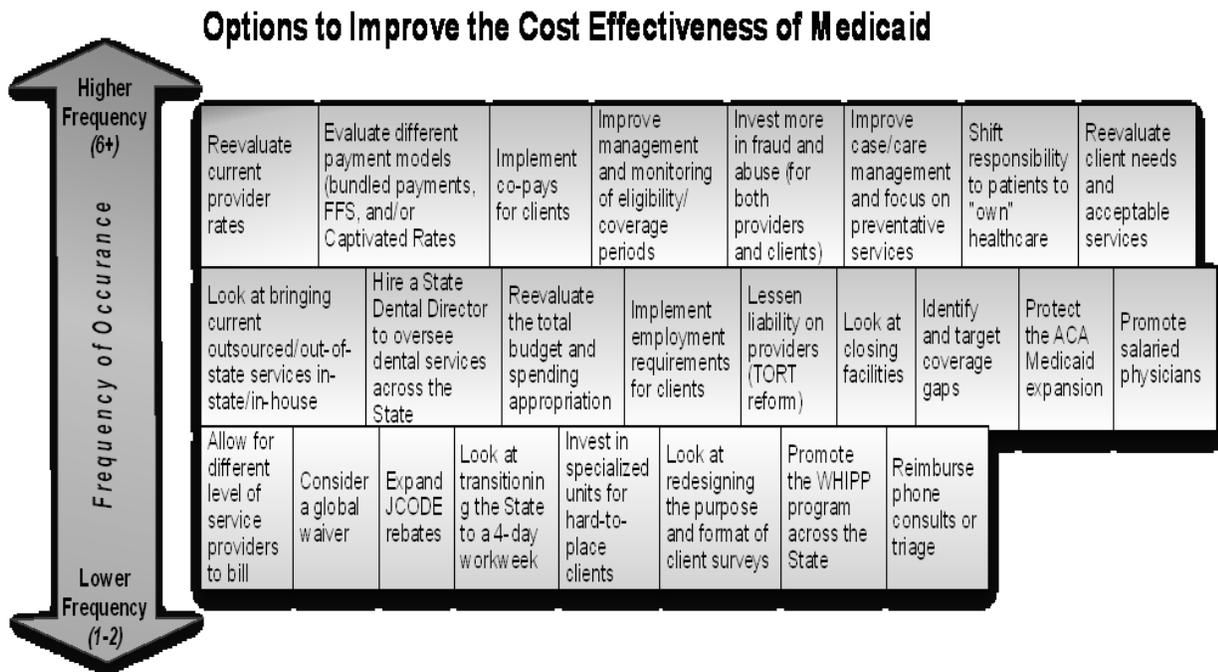


Figure 1.4: Summary of Options to Improve Cost Effectiveness of Medicaid

Part Three: Stakeholder Options and Recommendations of this Report includes a summary of each of the option presented above, as well as challenges and possible mitigation options identified by stakeholders.

WDH will consider options presented by stakeholders in the development of its final Report to the Legislature with its recommendations to increase efficiency, improve quality, and increase cost effectiveness of the Medicaid program. Medicaid Options Study: Report Two will be submitted to the Legislature on October 1, 2012 and will be made available on the WDH’s website at: <http://www.health.wyo.gov/director/dupre.html>.

# Public Forums

**August 7, 2012**

Prepared For:

**The Wyoming Department of Health**

By:

**Community Builders, Inc.**

# MEDICAID OPTIONS STUDY

## PUBLIC FORUMS

### Introduction and Overview

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During the 61st Legislature, the Wyoming Legislature passed the Medicaid Options Study legislation, requiring the Wyoming Department of Health (WDH) to conduct a study of the Medicaid system. An important phase of this mandate is to gather, summarize, and analyze stakeholder input from around the State of Wyoming. The goal of this process is to collect information from the general public about their ideas to reduce costs for Medicaid. A good listening process is critical, as it will lead to a more accurate description and understanding of stakeholder perspectives.

The Wyoming Department of Health contracted with Community Builders, Inc. (CBI), a consulting firm from Douglas, Wyoming, to facilitate a series of public forums in Wyoming. To prepare for this process, CBI reviewed the Medicaid Options Study Report One and background legislation.

CBI worked with WDH staff members to identify key stakeholder groups including Medicaid providers, client sub-groups, government agencies, social service agencies, and other entities.

CBI organized and facilitated six public forums in the State of Wyoming. Forums were conducted in the communities of Casper, Cheyenne, Riverton, Rock Springs, Gillette, and Jackson. The purpose of these focus groups was to seek ideas for making the Medicaid system more cost effective, while retaining or increasing quality.

CBI worked with WDH to set meeting dates and locations. CBI organized logistics and scheduled specific venues. CBI prepared draft press releases promoting the project using WDH website and traditional media outlets (newspaper, TV, and radio). WDH utilized its Public Information Officer to distribute press releases to newspapers around the state. CBI prepared meeting invitations to its email lists of municipalities, counties, and Chambers of Commerce. Written comments were also encouraged and consolidated into the final report.

CBI facilitated six two-hour public forums in the designated communities during the month of July. Attendance varied at each public forum as follows:

**Cheyenne - Tuesday, July 10, 5-7 p.m.**

Laramie County Community College - Conferences and Institutes (CCI) Centennial Room, 1400 East College Drive  
Approximately 40 attendees, including participants from Cheyenne and Laramie

**Casper - Thursday, July 12, 5-7 p.m.**

Casper City Hall Chambers, 200 North David  
Approximately 25 attendees, including participants from Casper and Cheyenne

**Gillette - Monday, July 16, 5-7 p.m.**

Gillette City Hall Community Room, 201 East 5th Street  
Approximately 14 attendees, including participants from Casper, Rozet, Sheridan, Buffalo, and Gillette

**Riverton - Tuesday, July 24, 5-7 p.m.**

Central Wyoming College - RAP Theater (Arts Center Building), 2660 Peck Avenue  
Approximately 50 attendees, with participants coming from Lander, Riverton, Kinnear, Thermopolis, Pavillion, Lovell, Casper

**Rock Springs - Wednesday, July 25, 5-7 p.m.**

Rock Springs City Hall Council Chambers, 212 "D" Street  
Approximately 21 attendees with representation from Evanston, Big Piney, Rock Springs, Green River

**Jackson- Tuesday, July 31, 5-7 p.m.**

Teton County Administrative Building, 200 South Willow Street  
Teton County Commissioners Chambers  
Approximately 90 attendees, including participants from Jackson, Wilson, Big Piney, Kelly, and Lander

Each public forum session involved a presentation by the facilitators (CBI) on the background of the enabling legislation and a brief review of Medicaid and the Medicaid Waiver Program. Key points from Report Number One were presented. A copy of the Power Point presentation used to cover these topics is included in the Appendix.

The majority of the two-hour session focused on input from the public forum attendees. The session was broken into two sections including four questions relating to General Medicaid, and then four similar questions relating to the Medicaid Waiver program. The actual questions are listed below.

### General Health Care Questions:

1. What are your specific suggestions to reduce costs in Wyoming Medicaid while maintaining access to services and quality services?
2. In your experience with Medicaid, are there specific inefficiencies you have identified within the program?
3. What are the options to improve the inefficiencies you have identified?
4. What are some specific Quality Improvements that could help reduce the costs or inefficiencies in Wyoming Medicaid?

### Waiver Questions:

1. What are your specific suggestions to reduce costs in the Wyoming Medicaid Waiver programs while maintaining access to services and quality services?
2. In your experience with Wyoming Medicaid Waivers, are there specific inefficiencies you have identified?
3. What are your recommendations to reduce the inefficiencies you have identified within the Wyoming Medicaid Waiver program?
4. What are some specific Quality Improvements that could help reduce the costs or inefficiencies in the Wyoming Medicaid Waiver programs?

As time permitted, each of these eight questions was asked and comments solicited. The audience at the Jackson forum was very large and focused on the first question, and so not all questions were covered there.

Following public input, the facilitators briefly reviewed the next steps in the process and the general schedule (i.e., WDH will prepare Reports Two and Three, and legislators may be drafting legislation for this next session). Additionally, attendees at the public forums were encouraged to visit the WDH website and to provide additional comments in writing to the facilitators and/or by taking the online survey (the link was provided to attendees).

This report does not attempt to analyze or quantify the responses given at the public forums, other than to identify common themes. The report contains subjective information that was not collected in a scientifically designed random manner. Rather, the process was intended to provide the public with an opportunity to present their views and to have them considered as part of the broader Medicaid Options Study process. To the best of the facilitators' ability, this report accurately reflects the actual comments that were made during the public forums. No effort was made during the public forum, nor in the preparation of this report, to correct the factual accuracy of those public comments, and this report should not be interpreted or used to support the veracity of any comments contained herein. Further, the comments contained in this report do not necessarily reflect the opinions of the facilitators or WDH.

## SUPPLEMENT ONE: MEDICAID WHITE PAPERS

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At the May 31/June 1, 2012 Joint Labor, Health and Social Services Interim Committee meeting, several requests were made by members of the committee for specific information about Wyoming Medicaid. Medicaid Staff prepared the following White Papers in response to these legislative requests.

Medicaid Options Study Report Two references the following white papers as ‘Supplement One.’