LONG TERM CARE IN WYOMING

ISSUES AND POLICY OPTIONS

Wyoming Department of Health

October 15, 2017

TABLE OF CONTENTS

EXECUTIVE SUMMARY

As a safety-net payer and provider of long-term care services, the State will face increasing costs from Wyoming's aging population. This problem is the product of five major factors:

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

Depending on the policies that the State pursues, the cost to Wyoming Medicaid for long-term care could increase from $130 million in 2017 to between $184 and $312 million in 2030.

The primary lever that the State has in influencing these future costs lies in encouraging healthy aging at home, by supporting long-term care in home- and community-based settings instead of institutions. Staying at home is not only often preferable to older people, but it also represents a significant cost savings to the State.

The policy options identified in this report are aimed at this common purpose. The options include:

- Merging the administration of the Wyoming Home Services program into the Medicaid Community Choices waiver.

- Allowing buy-in to home-based services for higher-income older people.

- Developing outcomes-based payments for long-term care case managers.

- Exploring federal shared-savings opportunities.

While none of these options require new money or involve cuts to institutional providers, they do disrupt the status quo and therefore may need a Legislative mandate before they are pursued.

PROBLEM

Faced with a rapidly-aging population that is increasingly unprepared for the cost of long-term care, the State of Wyoming will necessarily shoulder a larger safety-net burden.

Wyoming's population is growing older

Figure 1, below, shows the projected growth in Wyoming's population between 2010 and 2030.[1] The figure breaks the population into four major age groups: 0 to 19-year olds ("children"), 20 to 64-year olds ("working age adults"), adults between the ages of 65-79 ("the young-old") and individuals who are over 80 ("the old-old"). Figure 2, below Figure 1, illustrates how the oldest age groups will increase as a percent of the total population over the same time period.

Figure 1: Demographic projections for Wyoming, 2010 - 2030

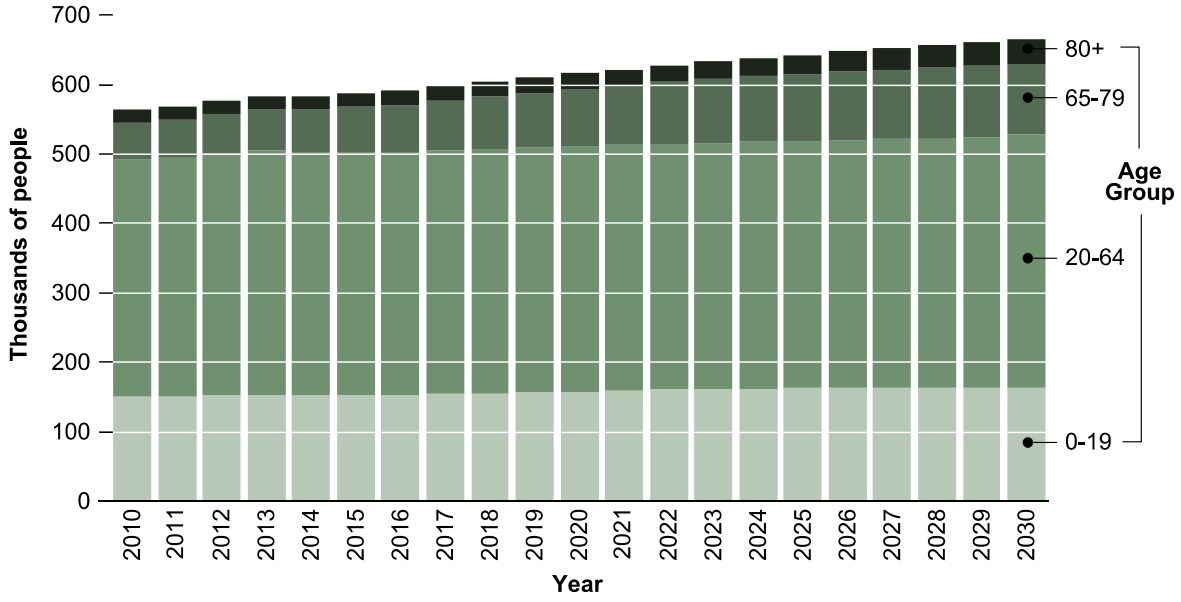
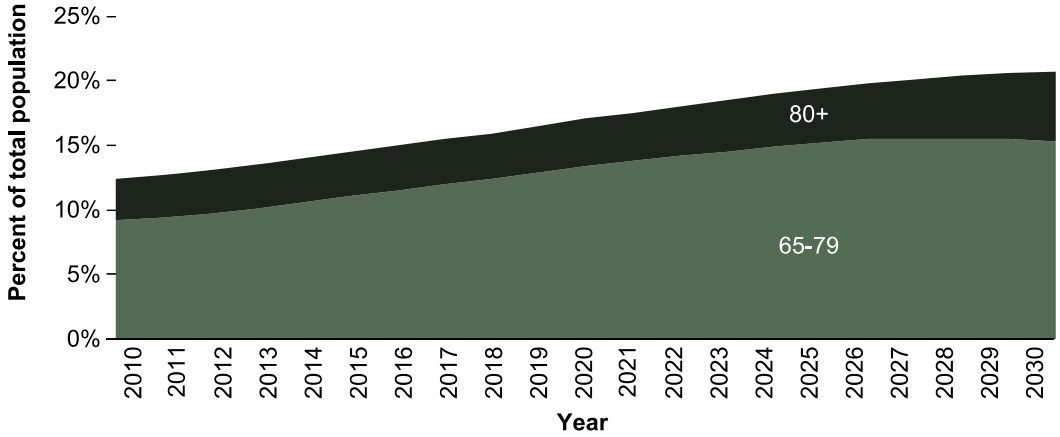


Figure 2: Persons 65+ and older, as a percent of the total Wyoming population, 2010 – 2030



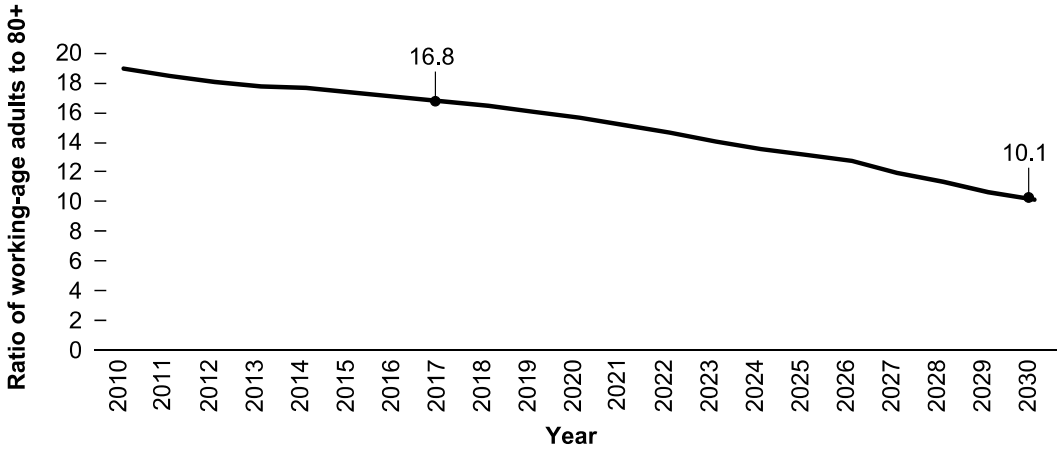
[1] Projections from Wyoming Department of Administration and Information, Economic Analysis Division. Retrieved in March, 2017. http://eadiv.state.wy.us/pop/pop.html

Note from the figures that, while Wyoming's population is expected to grow to a total of 665,672 persons in 2030, most of this population growth will be in the two older demographics (65+).

More precisely, in 2017 the State had an estimated 71,410 people between the ages of 65 and 79, and 20,830 persons over age 80. By 2030, these numbers are projected to grow to 102,180 and 35,963, respectively. As a percentage of the total population, the two oldest demographics are projected to increase from approximately 12% and 3.5% of Wyoming's population in 2017 to 15.3% and 5.4%, respectively, by 2030.

A third way of looking at this change is in the decreasing "aged dependency ratio" -- the number of working-age adults for every individual over 80 years old. Figure 3, below, illustrates how this ratio will shrink in Wyoming from 16.8 adults for every person over 80 today to 10.1 adults by 2030. Not only does this decreasing ratio indicate that there will be fewer working-age adults paying taxes to support safety net programs, but there will also be fewer adults available to provide informal, unpaid caregiving to the elderly population.

Figure 3: Ratio of working-age adults to persons over 80 years old, 2010 – 2030



Of those Americans turning 65 today, an estimated 48% will ultimately require some form of paid long-term care services. 23% are projected to require less than a year of services, 9% between 1-2 years, 10% between 2-5 years, and approximately 6% requiring more than five years of paid long-term care.[2]

Increasing chronic disease complicates long-term care

Older Americans today are increasingly burdened with chronic disease. The proportion of adults over age 65 reporting at least four chronic diseases has increased from 11.7% to 17.4% between 1998 and 2008.[3] Similarly, the proportion of new nursing home entrants who are moderately to severely obese has increased from 14.7% in 2000 to 25% in 2010.[4]

Increasing morbidity complicates the delivery -- and adds to the cost -- of long-term care. A nursing home that serves severely obese nursing home patients, for example, requires investments that range from larger

[2] "Long-term services and supports for older Americans." HHS Assistant Secretary for Planning and Evaluation (ASPE) https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief (Table 2)

[3] Hung, et al. BMC Geriatrics 2011, 11:47 "Recent trends in chronic disease, impairment and disability among older adults in the United States." http://www.biomedcentral.com/1471-2318/11/47

[4] "Rising Obesity Rates Put Strain on Nursing Homes." New York Times. Dec 14th, 2015. https://www.nytimes.com/2015/12/15/health/rising-obesity-rates-put-strain-on-nursing-homes.html

wheelchairs and sturdier toilets to bariatric lifts and wider door frames. Additional staffing and the increased potential for workers' compensation claims also add to costs. Since few nursing homes are willing to make these investments, severely obese patients are often unable to be quickly discharged from hospitals, resulting in longer stays in a more expensive setting.[5]

Geriatric-psychiatric clients and behavioral challenges

In addition to chronic disease, mental illness and the legacy of de-institutionalization have further stressed the long-term care safety net. Nursing homes are often reluctant to take older people with both physical disabilities and mental illness – particularly those with behavior issues – due to liability concerns and the risk of being labeled an "Institute for Mental Disease" (IMD) by the Centers for Medicare and Medicaid, which would limit Medicaid revenue.

Medicaid attempts to incentivize nursing homes to take challenging clients by paying an "Extraordinary Care" rate, which is set based on individual client needs. Wyoming Medicaid currently has 6 ECC cases for clients either on ventilators or with behavioral issues. More individuals, however, end up in State-operated facilities. 60% of the census of the Wyoming Retirement Center, for example, has some indication of mental illness or dementia, compared with an Statewide average of 22%.[6]

Even more challenging behavioral clients end up in the Wyoming State Hospital, which is a far more restrictive and expensive setting (at ~$1,000 per day vs. ~ $200 - $300 per day at a SNF). Worse, since the State Hospital is intended to treat individuals with mental illness on a short-term basis, long-term geriatric-psychiatric clients have spillover effects into the State's system for involuntary hospitalization. Currently, 44% of total civil (not forensic) capacity is taken up by clients who have been there longer than 180 days;[7] these beds are unavailable for short-term stays, meaning the State has to pay private designated hospitals to hold and treat involuntary commitments.

Long-term care is expensive

The current average private-pay rates for various settings of long-term care in selected states is shown in Table 1, below. Note that Wyoming, Colorado and Idaho have slightly higher nursing home rates than the rest of the surrounding region.

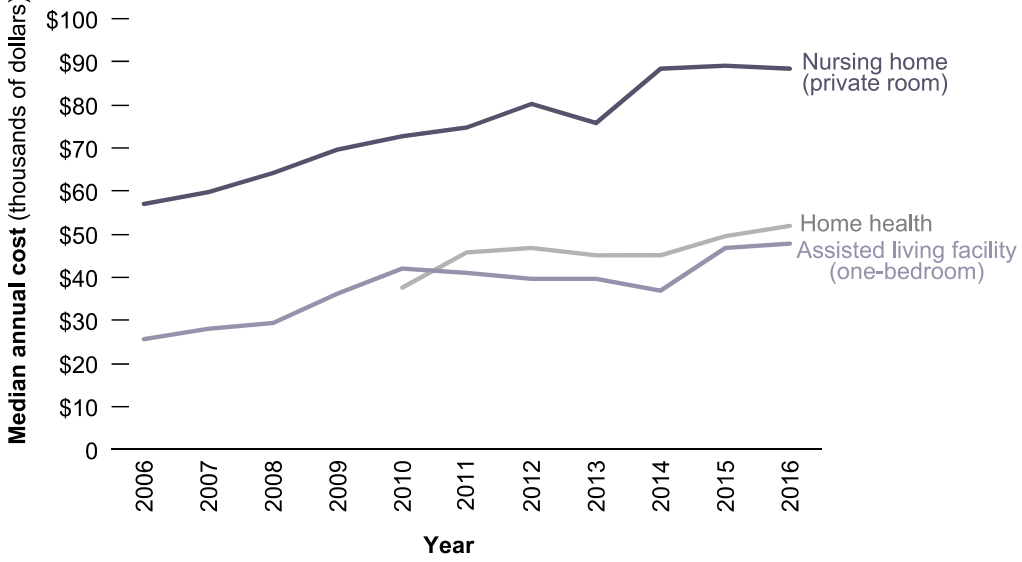
Table 1: 2016 median annual (private pay) rates for long-term care options, selected states[8]

State	Home Health	Assisted Living (Single occupancy)	Nursing Home (Private room)
Wyoming	$52,052	$47,940	$88,505
Montana	$52,624	$42,150	$83,220
Idaho	$45,760	$38,400	$88,878
Utah	$48,048	$35,400	$76,650
Colorado	$54,912	$48,750	$97,546
Nebraska	$53,768	$42,120	$76,833
US Median	$46,332	$43,539	$92,378
5-year annual growth	1.28%	2.16%	3.51%

[5] Ibid.
[6] Based on a PASRR Level I flag from Medicaid claims data.
[7] WDH Operational Reports. Report as of 8/31/17.
[8] 2016 Genworth Cost of Care Survey (https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/179703_CofC_Annual_060316.pdf)

In Wyoming, these rates have trended upwards over time, shown in the figure below, at average annual rate increases between 5% and 8% since 2006.

Figure 4: Private rates for long-term care settings in Wyoming, 2006 - 2016[9]



On average, the 48% of Americans who ultimately require paid long-term care services will face an expected total lifetime cost of $266,000 in 2015 dollars.[10]

People are increasingly unprepared for long-term care costs

Generally speaking, the cost of long-term care can be privately financed through a mix of financial tools:

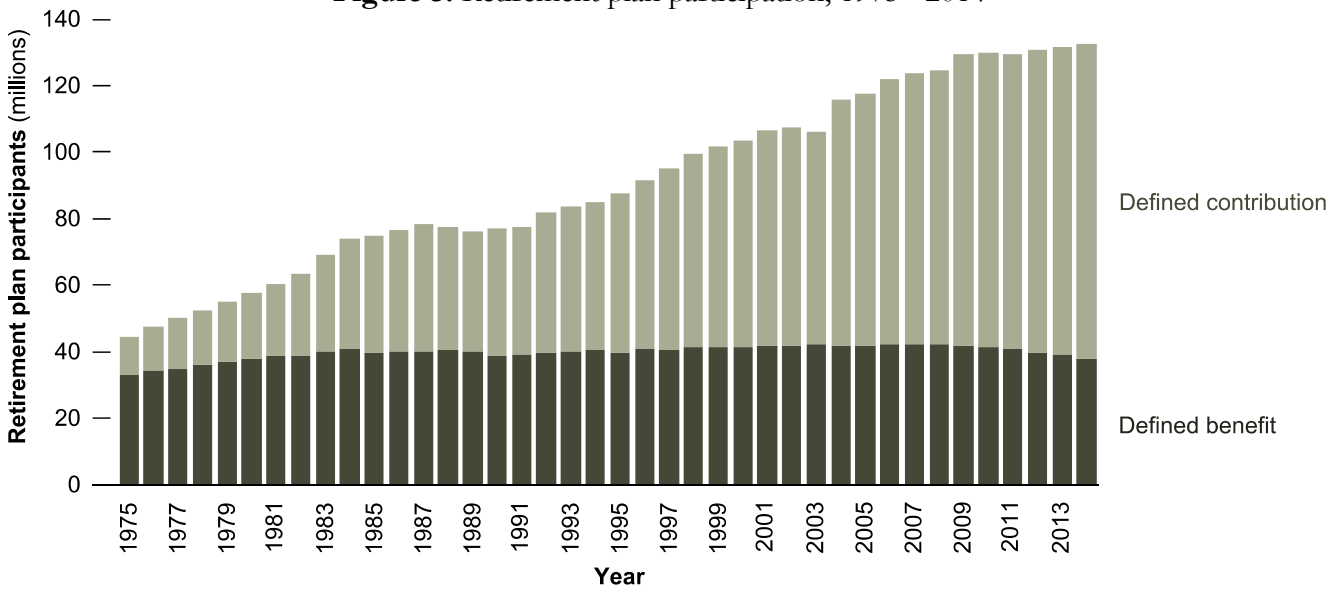
- Income (or principal) from employer-sponsored defined-contribution plans and individual investment accounts or annuities;
- Defined-benefit (pension) plan payments;
- Long-term care insurance (and increasingly, hybrid LTC/life insurance policies); and,
- Home equity.

Before the 1990s, most workers relied on defined-benefit (employer pension) plans for retirement security. As shown in Figure 5, on the next page, these plans are dwindling, especially relative to employer-sponsored defined-contribution plans (i.e., 401(k)).

[9] 2006 - 2016 Genworth Cost of Care Surveys

[10] ASPE, Table 3B. The average LTC cost expectancy for all Americans is approximately $138,000.

Figure 5: Retirement plan participation, 1975 - 2014[11]



Defined-contribution plans, of course, require individuals to take responsibility for their own savings and investment strategy.

Most retirees, however, fail to accumulate sufficient assets to be able to guarantee a significant cash flow in retirement. A 2015 analysis of Survey of Consumer Finances (SCF) data by the Government Accountability Office[12] found that:

- Approximately 41% of households between the ages of 55 and 64, and 52% of households between the ages of 65 and 74, have no retirement savings.
- 27% of households between the ages of 55 and 74 have neither retirement savings nor a defined-benefit plan. Further, households between the ages of 55 and 64 had a median net worth of $9,000, and median home equity of $53,000.
- Of those with some retirement savings, the median amount was $104,000 for households between the ages of 55 and 64, and $148,000 for households between the ages of 65 and 74. These assets represent an inflation-protected cash flow of approximately $3,720 to $7,788 per year, respectively.
- Social Security makes up an average of 52% of household income for households over age 65.

These figures indicate that, for the average retiree, accumulated personal assets will not provide sufficient cash flow to pay for the annual costs of long-term care, even in the least-expensive settings.

This increasing financial fragility is reflected in the greater number of people over 65 who are still in the workforce, which has increased from 12.5% in 2000 to 18.6% in 2016.[13]

---

[11] Private Pension Plan Bulletin Historical Tables and Graphs 1975-2014, Employee Benefits Security Administration, US Department of Labor. September 2016. http://www.gao.gov/assets/680/670153.pdf

[12] Government Accountability Office. "Most households approaching retirement have low savings." GAO-15-419. May 12, 2015. http://www.gao.gov/products/GAO-15-419

[13] "The New Reality of Old Age in America." Washington Post. Sept, 2017. https://www.washingtonpost.com/graphics/2017/national/seniors-financial-insecurity

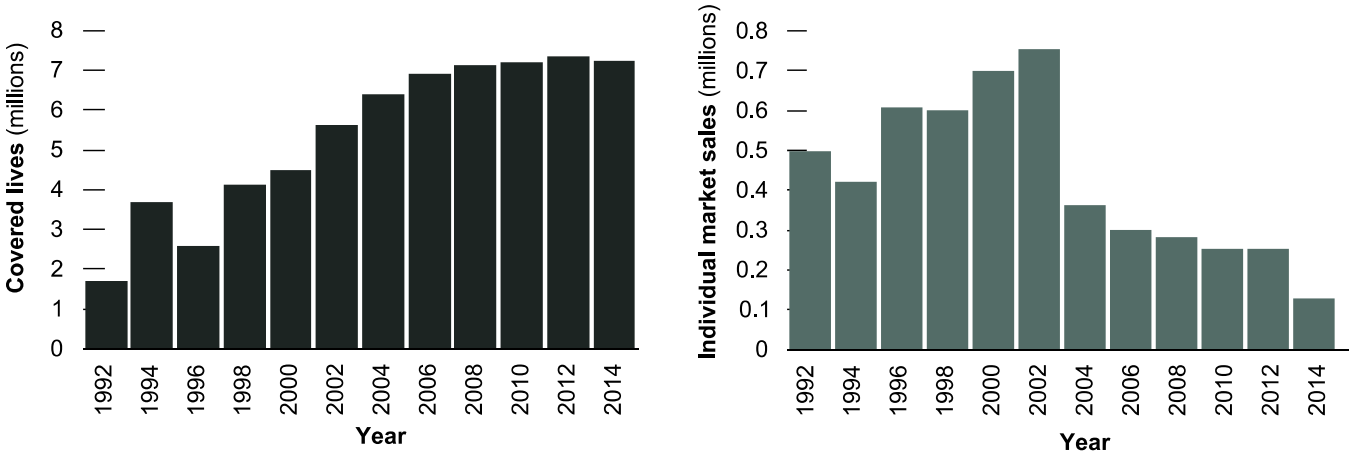
The long-term care insurance market is neither large nor robust

The primary alternative to self-insuring for long-term care is private long-term care insurance. The unfortunate truism about long-term care insurance is that "if you can afford it now, you won't need it later, and if you'll need it later, you can't afford it now."[14] In other words, people who can afford the premiums and have the foresight to purchase long-term care insurance have often accumulated enough assets to 'self-insure' their long-term care.

Additionally, the outlook for the industry as a whole is not promising. Few people have long-term care insurance policies, and fewer people are purchasing them each year. As with national trends, few Wyomingites purchase long-term care coverage. In 2015, the National Association of Insurance Commissioners (NAIC) estimated the total number of covered lives in the State at 11,050.[15] If current trends hold, even fewer will be buying coverage in the future.

Figure 6, below, shows how the total number of lives covered by long-term care insurance nationally has plateaued since the mid-2000s, and how the number of new policies written has decreased over the same time period.

Figure 6: Total covered lives, long-term care insurance (left) and individual market sales (right)[16]



This stagnant and rapidly-aging base of covered lives has gradually manifested itself in two trends, shown on Figure 7, on the next page:

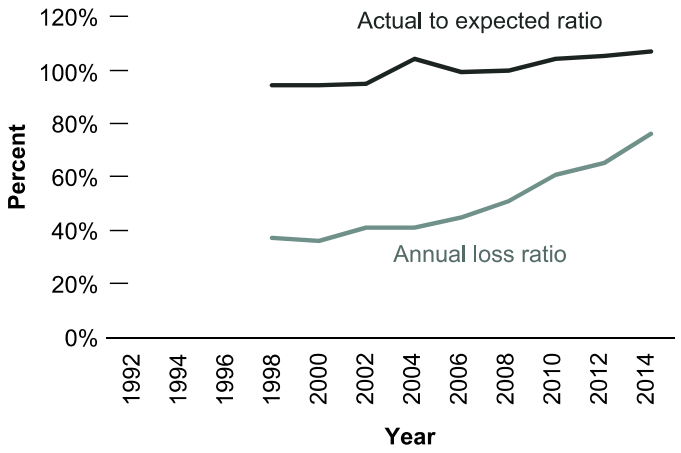
- Annual loss ratios (the ratio of paid claims to premium received) have crept upwards from 40% in the late 1990s to 80% today.
- The ratio of actual-to-expected losses has increased from the mid-90% to just over 107% today.

[14] Allen, James. Nursing Home Administration. Springer Publishing, 2016. pg. 351.
[15] National Association of Insurance Commissioners, Long-term care insurance experience reports. 2015. http://www.naic.org/documents/prod_serv_statistical_ltc_lr.pdf
[16] Center for Insurance Policy and Research. The State of Long-Term Care Insurance. May 2016. http://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf

In addition to these worsening ratios, new policy premiums have increased, largely due to corrections in underlying pricing assumptions relating to:

- Voluntary lapses; i.e., the number of people that give up a policy before it pays back;
- Overly-optimistic morbidity assumptions; and,
- Worse than expected interest earnings on reserves.

Figure 7: LTC insurance loss ratio and actual to expected ratio



In summary, the authors of the NAIC/CIPR study note that, "all of these factors together have resulted in significant financial shortfalls for insurers in the face of increasing claims liabilities."[17]

The State of Wyoming will shoulder an increasing burden of the cost of long-term care

All of these factors – (1) an aging population (2) that is increasingly unprepared for retirement, combined with (3) the high cost of long-term care and (4) the decline of private insurance alternatives -- means that a growing majority of older people will rely on public long-term care assistance.

In Wyoming, that means an increasing reliance on Medicaid and other Department of Health long-term service and support programs.

[17] Ibid.

Wyoming Medicaid

The primary payer of long-term care services in the State is Wyoming Medicaid, which pays for approximately 64% of all nursing home bed-days. In addition to Skilled Nursing Facility (SNF) care, Medicaid also serves elderly and disabled members in the community through three additional programs:

- Long Term Care (LTC) Waiver;
- Assisted Living Facility (ALF) Waiver; and the
- Program of All-Inclusive Care of the Elderly (PACE) in Laramie County.

Note that, to enhance administrative efficiency and reduce administrative barriers for clients, the LTC Waiver and ALF waiver services were recently (SFY 17-18) merged and renamed the "Community Choices" waiver. All ALF Waiver clients were moved to the Community Choices Waiver by June 30, 2017.

Generally speaking, these three programs are considered home- and community-based services (HCBS), while SNF services are considered institutional settings. Trends in expenditures and enrollments for the largest HCBS programs (LTC and ALF waivers) vs. SNF services are shown in Tables 2 and 3, below.

Table 2: Long-term Care and Assisted Living Facility Waivers[6]

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

Table 3: Nursing Facility

SFY	Expenditures	Member Months	Avg. Enrollment	PMPM
2011	$79,967,179	20,307	1,692	$3,938
2012	$79,243,110	20,569	1,714	$3,853
2013	$77,134,902	20,232	1,686	$3,813
2014	$75,382,096	20,092	1,674	$3,752
2015	$74,242,244	19,667	1,639	$3,775
2016	$88,192,883	20,250	1,688	$4,355
2017	$89,955,370[16]	20,592	1,716	$4,368

Of note in the tables:

- Per-member per-month costs for HCBS settings are approximately 40% of the PMPM in SNF settings. This could be due to multiple factors:

[18] Estimate that includes incurred but not reported projection.

- While all clients meet an institutional level of care, nursing homes tend to serve more acute clients, as shown in Table 4 in subsequent pages.

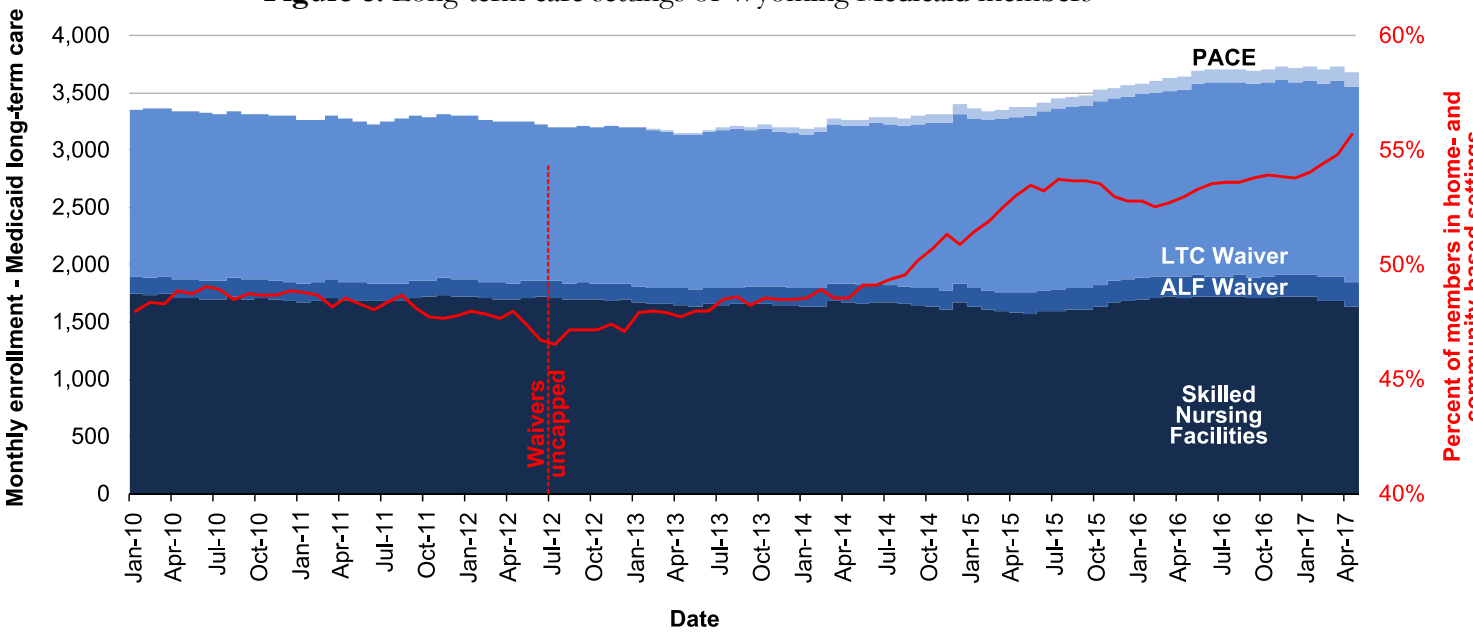
- Most HCBS clients are likely "dual-eligibles" (Medicaid and Medicare), so Medicare pays for a larger fraction of health expenditures. In a nursing home, more care is provided on an all-inclusive basis paid for by Medicaid.

- The ~ $600 increase in SNF PMPM and ~$15M increase in total expenditures between SFY 2015 and SFY 2016 is due to a rate increase approved by the Legislature and effective July 1st, 2015. There has also been a 6% increase in paid bed-days between SFY 2016 and 2017, indicating a recent increase in SNF enrollment and longer lengths of stay.

- Despite this recent uptick, overall enrollment growth in long-term care over the last decade has largely been in HCBS settings.

Figure 8, below, illustrates this enrollment trend in a more granular (monthly) fashion.

Figure 8: Long-term care settings of Wyoming Medicaid members



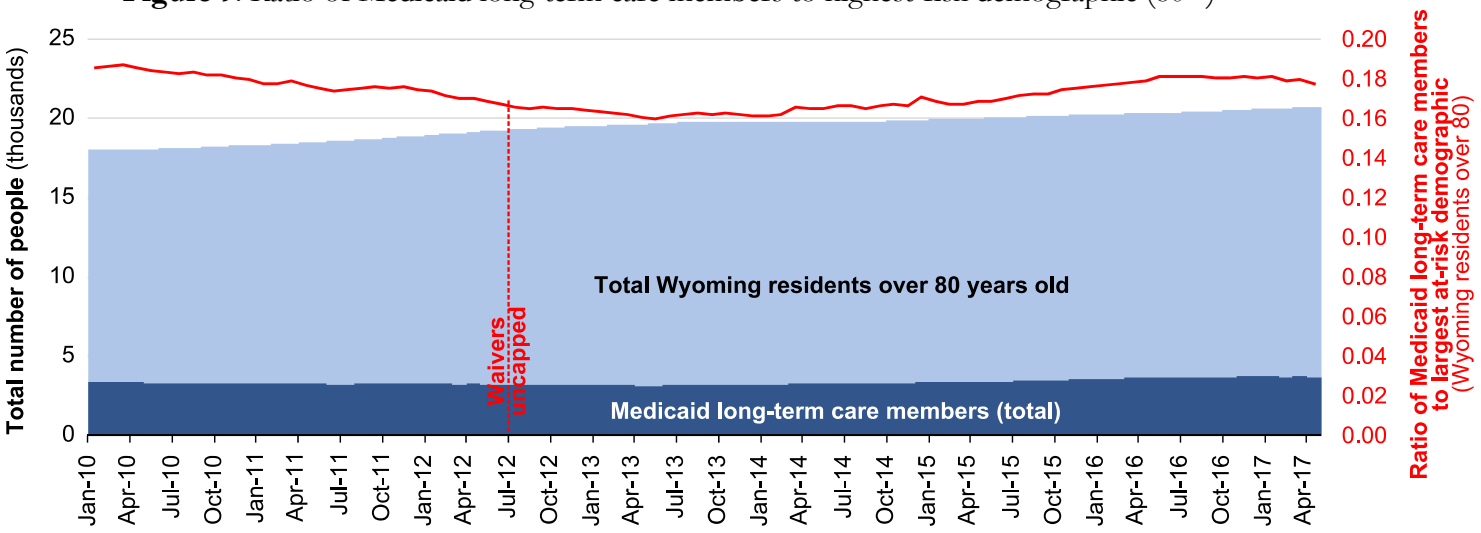
Home and Community-based Services (HCBS)

Note on the figure above the legislative decision to "uncap" the LTC and ALF waivers in SFY 2013. This has led to a gradual increase in the percentage of individuals served in HCBS settings, from approximately 47% to over 56% today. This trend is beneficial both to members (who often prefer to remain in their own home) and to the State (since the PMPM costs to Medicaid are less than half of institutional care).

Note further that the total number of individuals on Medicaid long-term care has grown slowly, from approximately 3,300 people in 2010 to approximately 3,700 today, while the number of individuals served in SNF settings has remained relatively flat (see Table 3).

Figure 9, on the next page, illustrates that the growth in long-term care Medicaid enrollment is largely consistent with aging demographics. The chart shows total long-term care enrollment compared against the highest-risk demographic (all individuals over age 80), in terms of both absolute numbers (blue) and a ratio (red).

Figure 9: Ratio of Medicaid long-term care members to highest-risk demographic (80+)[19]



Because the ratio of Medicaid long-term care members to the highest-risk demographic has remained relatively stable since 2010 (at 0.18 enrollees per individual over 80), it appears that HCBS services are generally substituting for institutional care, rather than contributing to overall growth.

This is further substantiated by the stable, if not increasing, average acuity level of the LTC and ALF waivers, as measured by the total number of points on the LT-101 assessment, as shown in Table 5, below.

Table 5: ALF/LTC vs. SNF average number of points[20]

CY	LTC/ALF		SNF	
	Mean	Median	Mean	Median
2010	16.42	15	20.77	20
2011	16.53	15	20.83	21
2012	16.76	16	20.64	21
2013	16.95	16	20.75	21
2014	16.99	16	21.05	21
2015	17.11	16	21.44	21
2016	17.49	16	21.57	21

This substitution effect has led to significant cost avoidance. If the 200 additional people currently in HCBS in SFY 2016 had been served in SNFs instead, Wyoming Medicaid long-term care expenditures would be approximately $6.3 million higher per year (PMPM difference of $2,640 * 200 individuals * 12 months).

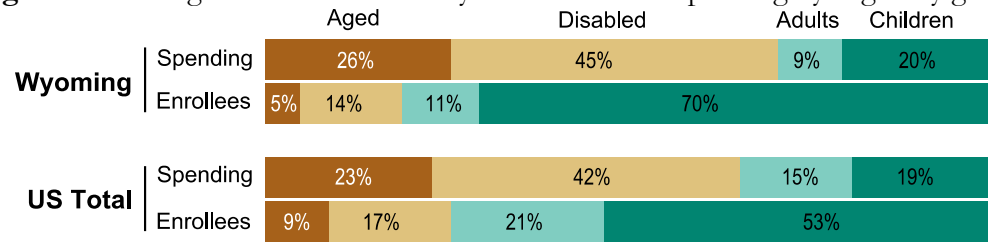
[19] Medicaid enrollment data from MMIS. Population data from US Census estimates, A&I Economic Analysis Division.

[20] Measured for member-months with an LT-101 conducted within 400 days. Due to more frequent LT assessment requirements for LTC and ALF waivers, the average sample was 1,500 individuals for LTC/ALF and 700 for SNF.

Institutionalization as a cost driver for Medicaid

Despite this progress, there is significant room for improvement. Wyoming has the highest cost per aged full-year equivalent Medicaid enrollee in the nation, at $42,921.[21] The aged category, for example, makes up 5% of Medicaid enrollees in Wyoming but consumes 26% of total spending. As shown in Figure 10, below, the national figures for this group are 9% and 23%, respectively.

Figure 10: Average full-benefit monthly enrollment and spending by eligibility group.



Regression analysis can associate 47% of the variance in per-aged enrollee Medicaid costs across States with three variables. These include:

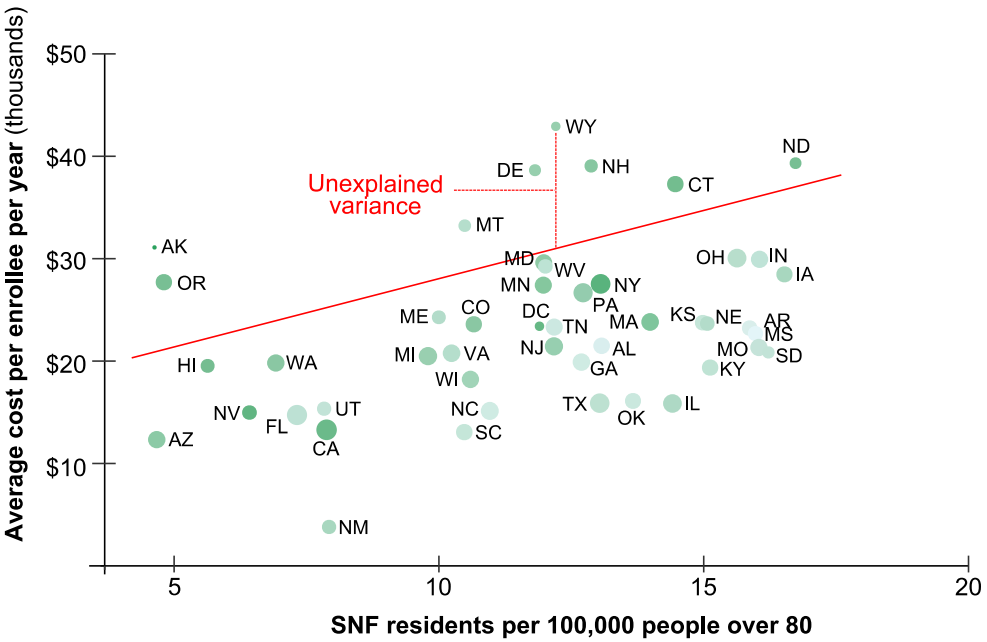
(1) Degree of institutionalization, has a positive correlation with cost.

(2) Mean wages for Certified Nursing Assistants. As expected, higher wages lead to higher cost.

(3) Population size of the underlying 80+ demographic, with smaller states having higher costs.

Figure 11, below, is a scatterplot comparing States on these three variables. The vertical axis shows the per-enrollee aged Medicaid costs, the horizontal axis the degree of institutionalization, the size of the dot the population size (on a logarithmic scale), and the intensity of the green color the mean CNA wage.

Figure 11: The relationship between Medicaid costs and degree of institutionalization



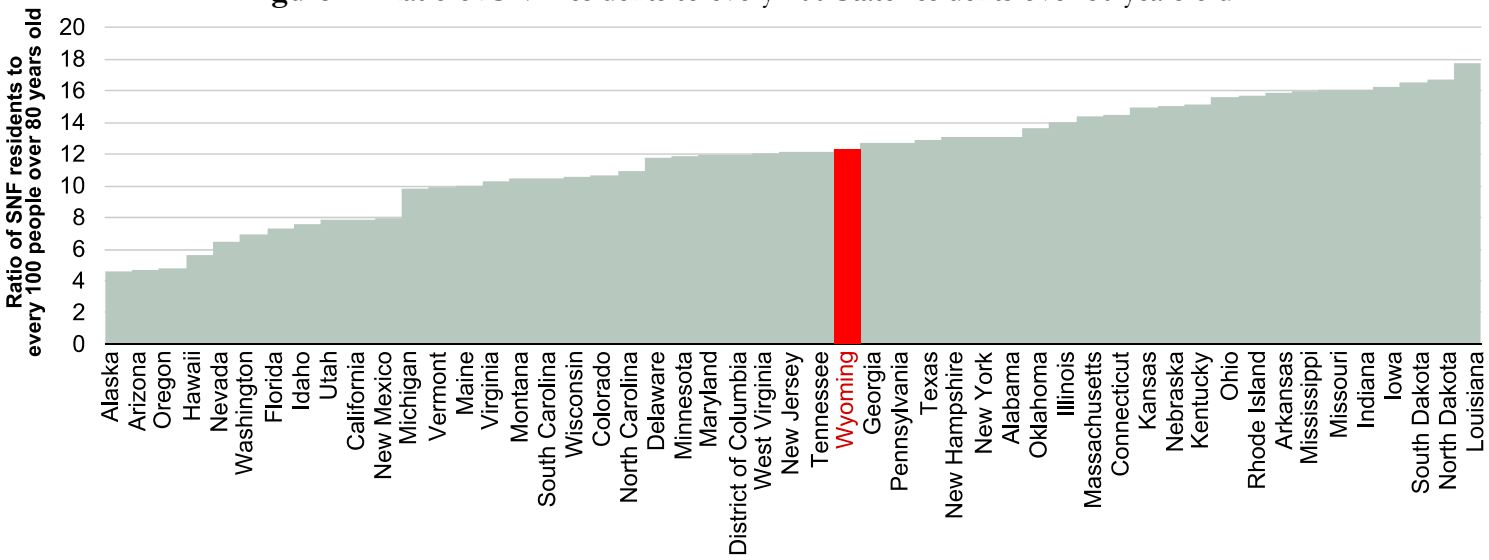
[21] MACSTATs, Exhibit 22. Data from 2013. Wyoming Medicaid is not clear on how the MACPAC numbers were calculated, since the average per-enrollee cost for long-term care members in SFY 2016 was $35,652. MACSTATs are used here, however, since they are calculated uniformly across states.

The red line on the figure represents where Wyoming would be expected to be, given its population size and average wage. It should be noted, however, that Wyoming is an outlier, even after controlling for these factors.

Nonetheless, since population size and average wages are not easily controlled, the only realistic policy lever available to the State to control Medicaid long-term care costs is increasing the percent of individuals served in home- and community-based settings.

Here, as noted previously, there is room for improvement. In terms of the ratio of SNF residents to every 100 State residents who are over 80 years old (the highest-risk demographic), Wyoming ranks 28th in the nation today, shown in Figure 12, below.

Figure 12: Ratio of SNF residents to every 100 State residents over 80 years old



"Dual-eligibles"

As noted previously, part of the reason why home- and community-based care is cheaper for Medicaid than institutional settings may be due to the fact that virtually all older individuals covered by Medicaid also have Medicare as their primary health insurance. These individuals are known as "dual-eligibles."

In a SNF setting, Medicaid pays an all-inclusive daily rate, which covers room, board and nursing care. In home- and community-based settings, waiver services are more *à la carte*, and a significant portion of medical expenses are paid for by Medicare, with Medicaid paying only some of the patient cost-sharing expenses (e.g., Medicare Part A co-insurance).

Traditional Medicare comes in three parts:

- Part A ("hospital insurance") generally covers inpatient stays, associated laboratory and imaging services, limited rehabilitation in a Skilled Nursing Facility, and hospice services;
- Part B ("medical insurance") covers medically-necessary physician and outpatient services; and,
- Part D, which covers prescription drugs.

Cost-sharing in traditional Medicare can be significant. While Medicare covers an average of 84% of all expenses, there is no maximum out-of-pocket limit for Medicare members. For this reason, many choose to purchase private supplemental "Medigap" policies to cover the risk of extensive cost-sharing. While

Medigap policies are privately administered, their benefits are regulated and standardized into discrete plan types (e.g. "Plan A" is the basic policy required to be offered by all insurers, "Plan F" the most generous, etc.).

In some areas, beneficiaries have the ability to enroll in a Part C ("Medicare Advantage") plan, which replaces Part A and B, any supplemental Medigap policy and, in some cases, Part D. With Part C, private insurers receive risk-adjusted premiums to pay for the beneficiaries they enroll. Benefits and cost-sharing vary significantly by Part C plan. Approximately 32% of Medicare beneficiaries are enrolled in Medicare Advantage plans.

Along with increasing long-term care costs, the increase in the aging population will also add to these Medicaid cost-sharing expenses. In addition to individuals in long-term care, Medicaid has two special eligibility groups for whom it pays Medicare premiums and cost-sharing, similar to a Medigap plan:

- Qualified Medicare Beneficiaries (QMBs or "Quimbies"), who have income below 100% FPL;
- Specified Low-Income Medicare Beneficiaries (SLMBs or "Slimbies"), who have incomes between 100 – 120% FPL.

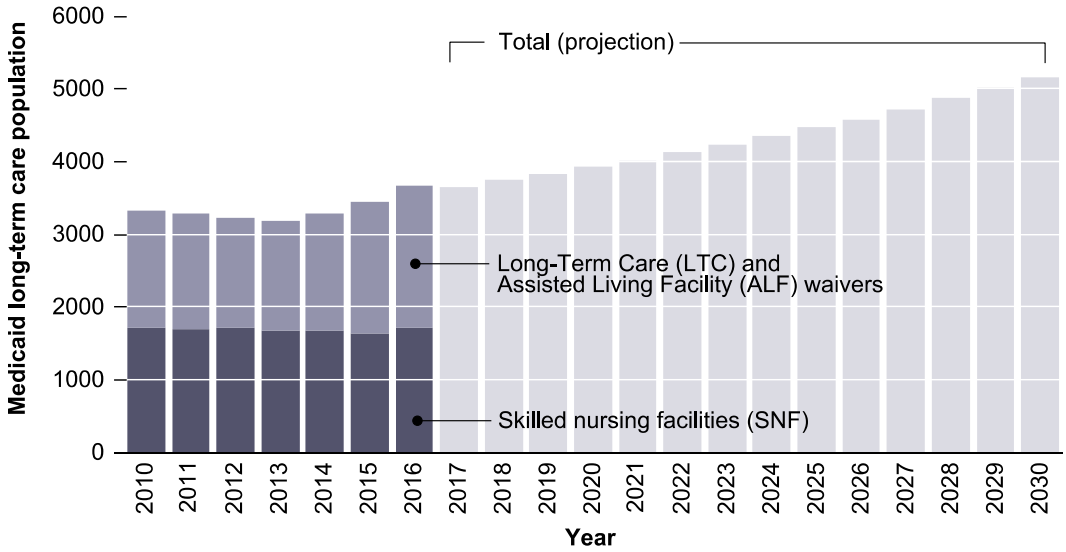
Cost-sharing expenses to Medicaid from these dual-eligibles include:

- Medicare Part A and Part B premiums for QMBs, and Part B premiums for SLMBs;
- Part A and B coinsurance and copayments, known as "crossover" claims;
- Medicare Part D pharmacy "clawback" payments to Medicare, which are based on what the State would have paid in pharmacy costs for these beneficiaries, had Medicare Part D not been established in 2003; and
- Part D-excluded pharmacy coverage, largely over-the-counter (OTC) medication, for certain dual-eligibles.

Projected trends in Medicaid

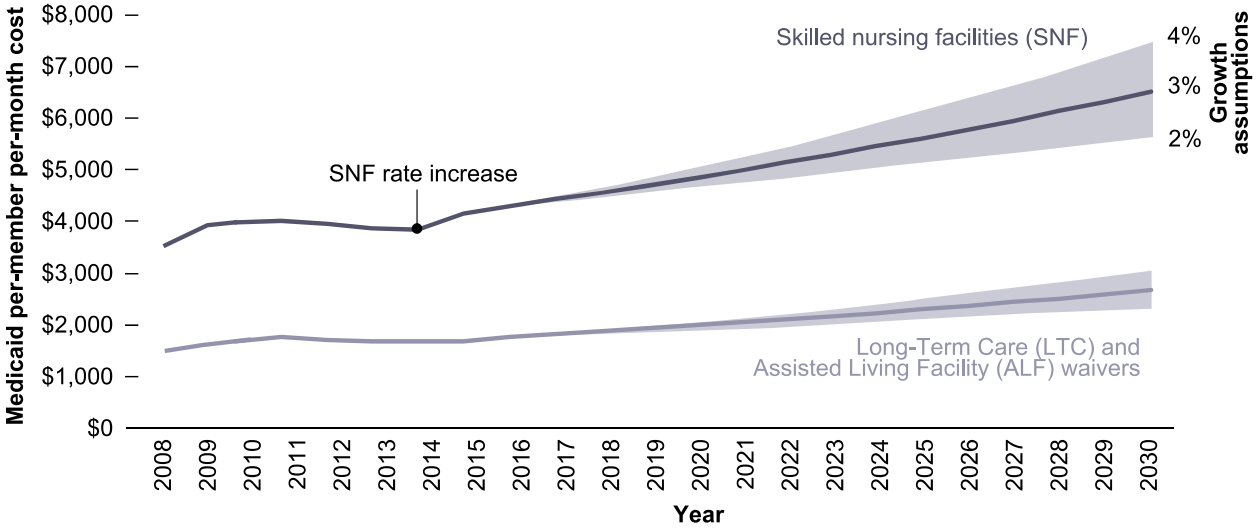
Based on the demographic trends laid out in the first section, Figure 13, below, illustrates how the current Wyoming Medicaid long-term care population is expected to grow from approximately 3,600 individuals to 5,200 individuals between 2017 and 2030.

Figure 13: Projected Medicaid members requiring long-term care



Total long-term care costs for Medicaid are the product of the enrollment shown in Figure 13, combined with per-member per-month (or per-year) costs, shown in Figure 14, below. While the projection assumes 3% annual growth in PMPM costs, for the purposes of sensitivity analysis, a range between 2% and 4% is shown.

Figure 14: Actual and projected per-member per-month cost for long-term care Medicaid members



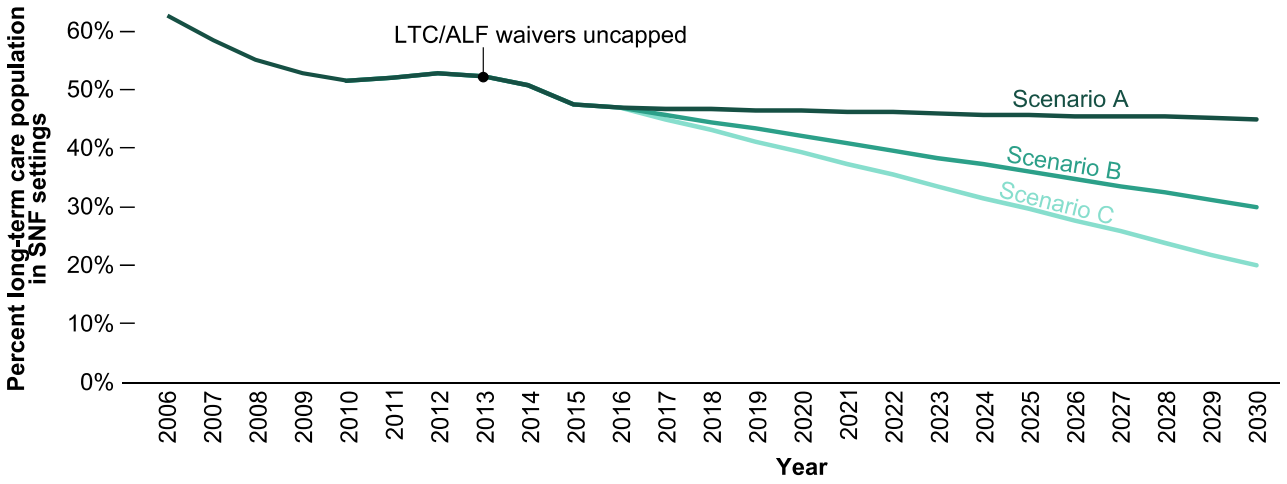
Because nursing home settings are approximately twice as expensive as home- and community-based settings, the projected total cost depends heavily on the percentage of long-term care clients that are served in nursing home environments.

As shown in Figure 15, on the next page, and explained in the previous section, this percentage has fallen over the last decade, from approximately 60% to 45% in 2017. There is no guarantee that this percentage will continue to fall, but, as Figure 12 indicates, there are many states who have current rates of institutionalization that are less than half of Wyoming's rate.

For the purposes of this report, three scenarios are illustrated:

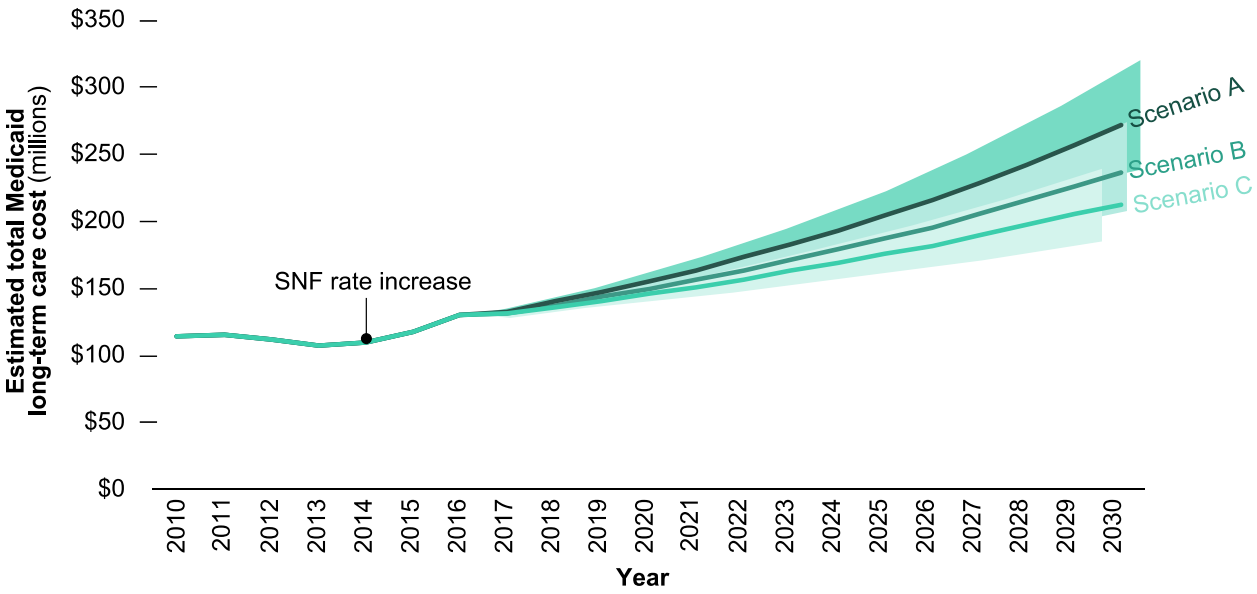
- **Scenario A**: the 'status quo' scenario, where the percentage of clients served in nursing homes remains flat at 45% through 2030;
- **Scenario B**: a scenario where current trends continue and the percentage falls to 30% by 2030; and
- **Scenario C**: a more aggressive trend, where only 20% of clients are in nursing homes by 2030.

Figure 15: Three scenarios for the percentage of long-term care clients served in SNF environments



When these three scenarios are combined with the 2-4% range in PMPM growth assumptions, Figure 16, below, illustrates the variance in total expected cost of long-term care to Wyoming Medicaid out to 2030.

Figure 16: Cost projections for the three long-term care scenarios



Note that these estimates range from a low of $186 million (2% growth in PMPM costs and 20% in SNF settings) to a high of $312 million (4% growth in PMPM costs and 45% in SNF settings), compared with the current level of $130 million.

In order to contain long-term care costs in the future, the State of Wyoming should therefore aim to maximize the percentage of individuals served in home- and community-based settings.

Aging Division Services

In addition to Medicaid, the Department of Health's Aging Division pays for services intended to keep older Wyoming adults in their homes and communities. These programs include:

- Older Americans Act (Title III) programs, which are typically 85% federal funds (FF); and,
- State General Fund programs, to include the Wyoming Home Services Program and Senior Center block grants;

The OAA programs operated by the WDH include:

Title III-B: Supportive services

Purpose: Provides health promotion, socialization, transportation and outreach services to Wyoming adults over age 60.

Funding: 85% FF /7.5% SGF / 7.5% local match

Table 6: Title III-B cost and outputs

Indicator	SFY		
	2014	2015	2016
Total cost	$1,202,494	$1,789,470	$1,520,273
Clients served	17,632	17,220	17,451

Title III-C1: Congregate meals

Purpose: Provides meals and nutrition education to Wyoming adults over 60 in a congregate setting.

Funding: 85% FF /7.5% SGF / 7.5% local match

Table 7: Title III-C1 cost and outputs

Indicator	SFY		
	2014	2015	2016
Total cost	$1,613,596	$1,617,438	$1,642,384
Clients served	18,427	18,768	18,781
Meals served	635,943	648,135	658,149

Title III-C2: Home-delivered meals

Purpose: Delivers meals and nutrition education to Wyoming adults over 60.

Funding: 85% FF /5% SGF / 10% local match

Table 8: Title III-C2 cost and outputs

Indicator	SFY		
	2014	2015	2016
Total cost	$1,268,641	$1,267,220	$1,340,327
Clients served	4,916	5,094	4,954
Meals served	522,245	522,142	533,619

Title III-D: Health Promotion

Purpose: Provides health promotion training (e.g. fitness, medication management classes) to Wyoming adults over 60.

Funding: 85% FF /5% SGF / 10% local match

Table 9: Title III-D cost and outputs

Indicator	SFY		
	2014	2015	2016
Total cost	$115,587	$133,105	$84,979
Clients served	2,063	1,876	1,051
Units of service (class/session)	19,010	23,008	6,716

Title III-E: Caregiver Support
Purpose: Provides supportive services (e.g. counseling, respite) to Wyoming caregivers so they can continue providing care to their loved ones.
Funding: 85% FF /7.5% SGF / 7.5% local match

Table 10: Title III-E cost and outputs

Indicator	SFY		
	2014	2015	2016
Total cost	$627,347	$620,693	$572,845
Caregivers served	624	508	411

The State-General Fund programs operated by the Aging Division include:

Wyoming Senior Services Board
Purpose: The WSSB provides grants to senior centers around the State.
Funding: 100% SGF

Indicator	SFY		
	2014	2015	2016
Total cost	$5,708,160	$5,874,699	$5,830,901
People served	N/A	N/A	N/A

Wyoming Home Services
Purpose: Provides in-home services to senior citizens and disabled adults, with the highest priority given to persons at risk of placement in an institutional setting.
Funding: 100% SGF, not including local match and sliding-scale fees

Indicator	SFY		
	2014	2015	2016
Total cost	$4,239,391	$4,168,574	$4,474,583
People served	2,328	2,257	2,156

Problems: coordination and prioritization

These Aging Division programs are essentially administered as grants to senior centers throughout the State. Centers have significant latitude in determining which services to cover, and the amount of information reported back to the State varies from program to program. For example:

- There are no reporting requirements for the Wyoming Senior Services Board.
- In the case of most of the Title III programs, senior centers report aggregate units of service (e.g. classes or meals) delivered.
- For the Wyoming Home Services program, additional individual detail is required (e.g., the name and address of clients).

Thus, while these programs undoubtedly provide needed services to older people in Wyoming, the way they are administered creates two main problems, from the State's perspective:

- It is not clear that services are coordinated or de-conflicted amongst each other or with Medicaid;
- There is no way of knowing if the programs are truly targeting those at highest risk of institutionalization.

[The remainder of this page has been intentionally left blank]

Initial Policy Options

Aside from requesting additional funding -- or cutting nursing home rates -- to pay for additional home- and community-based services, the State must ensure existing spending is targeted efficiently.

All of these options would re-design existing funding and services, with the aim of increasing access to appropriate home-based services that might prevent premature institutionalization.

I. Integrate Wyoming Home Services (WyHS) data processing with Medicaid

This option would leverage the Medicaid claims processing, eligibility, and data warehousing systems for the Wyoming Home Services program, with WyHS SGF funding being used to pay for the services of non-Medicaid clients. This option has several advantages:

- "No wrong door" eligibility for clients – there would only be one application and one long-term care assessment.
- With a single assessment, clients could be objectively categorized by risk of institutionalization, and prioritized accordingly.
- Potential for increased competition. Currently, senior centers receive comprehensive contracts to provide WyHS services. The system could opened up billing to any willing long-term care provider enrolled with Wyoming Medicaid, thereby increasing choice for people receiving services. Alternately, a special taxonomy code for senior centers could be created to keep WyHS funding within this group of providers only.
- Some WyHS clients would be found to be eligible for Medicaid; additional matching federal funds could "grow the pie" of total long-term care dollars available.
- Medicaid claims processing systems would automatically ensure services are de-duplicated (e.g. eliminate any "double-billing"). Additionally, Medicaid will be required to implement Electronic Visit Verification (EVV) technology by 2019, which has been proven to reduce fraud, waste and abuse.
- Medicaid data systems would allow a complete picture of individual long-term care needs over time, allowing the State to refine methods for identifying and prioritizing those at risk of institutionalization.

Disadvantages/costs include:

- Increased complexity for senior centers in billing for services.
- Additional LT-101 eligibility assessment costs, though these costs would serve as revenue for the Public Health Nursing system.
- Additional claims processing costs, and additional capacity required for the State-operated Long Term Care eligibility unit, some of which would be 100% SGF.

II. Allow higher-income individuals to "buy-in" to home-based services on a sliding-fee schedule

This option could be implemented separately, but would be easier to implement in conjunction with a consolidated home-services program.

- Since the State pays lower rates for long-term care services than do individuals who self-pay, this option would make home-based services more affordable for higher-income individuals, allowing them to stretch their retirement savings over a longer time horizon.

- Being able to tap into an existing network of enrolled long-term care providers would simplify finding and accessing services.

- If both the cost savings and network breadth encourage access to appropriate home-based services, premature institutionalization and subsequent rapid spend-down of assets in a nursing home might be reduced.

The primary disadvantages of this option include:

- State rates are lower than private pay rates. If this program merely substitutes public-pay volume for private-pay volume (as opposed to increasing demand overall), provider revenue may be reduced.

- Increased administrative costs to track buy-in. Each model of "buy-in" shifts these costs around:

    - Monthly premium collection, which would add administrative complexity to the State.
    - Sliding-scale copay models, which shift administrative burden to providers.

III. Develop outcomes-based payments for case managers

This option would attempt to reduce medical costs of Community Choices waiver participants by putting more responsibility on case managers to track and manage medical outcomes. Currently, case managers only manage the amount and type of waiver services. Under this option:

- Members would be attributed to a case manager panel (i.e., all outcomes and costs for these members would be directly tied to a single case manager);

- Medical outcomes (e.g, Emergency Department visits, inpatient stays, falls) would be tracked for each panel;

- Risk-adjusted averages would be reported for each case manager; and,

- Payments to case managers would (potentially) be tied to these outcomes.

IV. Explore federal options to increase and share in savings

This option is more speculative and open-ended. There are various opportunities under federal regulations where Wyoming could experiment with long-term care policy and potentially share any savings realized. These include:

- Developing an 1115 demonstration waiver to allow Medicaid home-based services for "pre-institutional" individuals (i.e., those who do not meet eligibility under the LT-101 assessment), under the assumption that providing home-based care earlier would prevent institutionalization later.

This would potentially allow additional federal match for a program operated very similarly to the current Wyoming Home Services program. If WyHS were already administered by Medicaid (Option I), then this waiver would be easier to develop and submit, since rigorous evaluation and monitoring are required as part of an 1115 waiver.

- Developing a State-operated Medicare Advantage plan for dual-eligible enrollees. Currently, Medicaid acts as a Medigap supplemental policy for its low-income dual-eligibles, in that it incurs Medicare cost-sharing and premium costs.

  Under this option, Wyoming Medicaid would cover all medical costs for dual-eligibles, and receive a risk-adjusted premium from Medicare to do so. Because the State would be at risk for medical costs, it would have a strong incentive to coordinate care for duals – an incentive that it does not have now, since the vast majority of any savings would accrue to the federal Medicare program.