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Reforming Medicaid to Serve Wyoming Better

In the past several years, Wyoming has accomplished several key changes to its Medicaid program. A series of reforms regarding long-term care, and other methods to improve care delivery and coordination, have stabilized the overall spending on Medicaid—and reduced expenditures on a per-beneficiary basis.

However, the commitment by both the new Administration and Congressional leaders to examine Medicaid reform closely presents Wyoming with the possibility to accelerate its current reform efforts. Seema Verma, the new head of the Centers for Medicare and Medicaid Services (CMS) and a former Medicaid consultant, has publicly committed to provide states with greater flexibility and freedom to innovate.¹ Likewise, legislation advancing fundamental Medicaid reform has begun to advance in Congress.

Whether through a block grant, *per capita* allotments, or enhanced waiver authority from the federal government, states like Wyoming can and should receive greater freedom to manage their programs, in exchange for a series of fixed federal payments. Upon receiving this flexibility, Wyoming can put into place additional reforms that will improve care for beneficiaries, encourage transitions to employment and employer-based health coverage where appropriate, reduce health costs, and save taxpayer funds. These reforms would modernize Medicaid to incorporate the best of 21st century medicine, help Baby Boomers as that generation ages into retirement, and alleviate the fiscal challenges Wyoming faces in managing its Medicaid program.

The Problem

Enacted into law in 1965, the Medicaid program as originally designed provided federal matching funds to states to cover discrete populations, including the blind, needy seniors, and individuals with disabilities. Over time, expansions of the program to new populations, and changes in the delivery of health care, have made the Medicaid program large, costly, and unwieldy for states to manage. A significant body of evidence demonstrates that, after more than a half-century, Medicaid is long overdue for a modernization.

Cost: According to government-provided data, Medicaid now approaches Medicare for the title of largest taxpayer-funded health care program. According to non-partisan government actuaries, state and federal taxpayers combined will spend an estimated \$595.5 billion on Medicaid in the current fiscal year—\$368.9 billion by the federal government, and \$226.6 billion by states.² By comparison, the Congressional Budget Office projects that this fiscal year, Medicare will spend a net of \$598 billion, excluding premium payments by enrollees.³ Even as the Baby Boomers retire in the coming decade, Medicaid will stay on pace with Medicare when it comes to total expenditures—Medicaid spending will total an estimated \$57.5 billion in fiscal year 2025, compared to an estimated \$1.005 trillion in net Medicare spending the same fiscal year.⁴

On the state level, rising spending on Medicaid has crowded out other key state priorities like education, transportation, and law enforcement. While states often cut back on those other programs during recessions, Medicaid spending continues to grow in both good economic times and bad. For instance, for fiscal year 2017, states adopted a total of \$7.7 billion in spending increases on Medicaid when compared to fiscal 2016—less than the growth of K-12 education spending (\$8.9 billion increase), but more than spending on higher education or corrections (both \$1.1 billion increases).⁵ But in fiscal year 2012—as states



recovered from the last recession—states sharply cut K-12 education (\$2.5 billion decrease) and higher education (\$5 billion decrease) to finance a massive increase in Medicaid spending (\$15 billion increase).⁶

With program spending growing at a near-constant pace, Medicaid has grown substantially over the past several decades to become the largest line-item in most state budgets. In fiscal year 2016, Medicaid consumed an average of 29.0 percent of state spending from all fund sources, and 20.3 percent of general fund expenditures.⁷ By comparison, in fiscal year 1996, Medicaid consumed 20.3 percent of state spending, and 14.8 percent of general fund spending—and in fiscal year 1987, Medicaid consumed only 10.2 percent of state spending, and 8.1 percent of general fund spending.⁸ With program spending nearly tripling as a size of their overall budgets from 1987 through 2016, Medicaid growth has limited states’ ability to provide for other critical state priorities—or return some of taxpayers’ hard-earned cash back into their pockets.

Quality: Unfortunately, many Medicaid programs suffer from poor access to physicians, high rates of emergency room usage, and poor quality outcomes. A *New England Journal of Medicine* survey using “secret shopper” methods found that two-thirds of Medicaid children were denied appointments with specialty physicians, compared to only 11% of patients with private insurance coverage. Moreover, those Medicaid patients that did receive appointments had to wait an average of more than three weeks longer than privately insured children.⁹ Perhaps unsurprisingly, beneficiaries themselves think much less of Medicaid coverage due to their lack of access:

You feel so helpless thinking, something’s wrong with this child and I can’t even get her into a doctor...When we had real insurance, we could call and come in at the drop of a hat.¹⁰

Even supporters of Medicaid call an enrollment card nothing more than a “hunting license”—a card that grants beneficiaries the ability to go try to find a physician that will actually treat them.¹¹

Because of the difficulties beneficiaries face in obtaining timely access to physicians, Medicaid patients often end up with worse outcomes than the general population as a whole. The Oregon Health Insurance Experiment—which compared outcomes for identically situated groups of uninsured individuals, some of whom enrolled in Medicaid and some of whom did not—concluded that patients who enrolled in Medicaid received no measurable improvements in their physical health than those that remained uninsured.¹² Moreover, the newly enrolled Medicaid patients increased their emergency room usage by 40 percent when compared to those who did not obtain coverage—and those disparities persisted over time.¹³ Such results tend to bolster previous findings that patients with Medicaid coverage may end up with worse outcomes than uninsured patients.¹⁴

Impact in Wyoming: A January 2015 brief by the Kaiser Family Foundation, and a 2014 Government Accountability Office (GAO) report on Medicaid variations by state, provide helpful metrics comparing Wyoming’s Medicaid program to its peers. The Kaiser brief analyzed per-beneficiary spending in Medicaid for “full-benefit” patients—that is, excluding any partial benefit enrollees.¹⁵ As the table below shows, as of 2011, Wyoming’s spending on aged beneficiaries led the nation—nearly double the national average—and its spending on individuals with disabilities ranked high as well.

Moreover, per-beneficiary spending in Wyoming grew at a rapid, above-average pace for the aged and disabled populations. During the years 2000 to 2011, costs per beneficiary nationally grew by an average of 3.7% for aged beneficiaries and 4.5% for individuals with disabilities. By comparison, in Wyoming spending rose an average of 6.8%—again, nearly twice the national average—for aged beneficiaries, and an above-average 5.45% for individuals with disabilities during the same 2000-2011 period.¹⁶

	Aged	Individuals w/Disabilities	Adults	Children
United States	\$17,522	\$18,518	\$4,141	\$2,492
Wyoming	\$32,199	\$25,346	\$3,986	\$1,967
Difference	\$14,677	\$6,828	-\$155	-\$525
Wyoming Rank	Highest	7th Highest	31st Highest	46th Highest



The 2014 GAO report provides additional context as to why Wyoming has relatively high levels of spending on aged and disabled populations.¹⁷ Whereas the Kaiser report studied spending for the years 2000 through 2011, GAO analyzed spending for federal fiscal year 2008 only. However, like Kaiser, GAO also found that Wyoming’s per-enrollee spending on aged (\$21,662) and disabled (\$24,644) beneficiaries significantly exceeded national averages (\$17,609 and \$19,135, respectively).¹⁸

In addition to analyzing per-beneficiary spending by state, the GAO study also examined factors known to influence spending—and on these, Wyoming and its rural neighbors also ranked high. Wyoming ranked more than ten percentage points above the national average for the percentage of aged beneficiaries receiving long-term care services (48.7% in Wyoming vs. 37.7% nationally), and for the percentage of aged Medicaid enrollees ever institutionalized during the year (35.7% in Wyoming vs. 24.5% nationally).¹⁹ Crucially, most of Wyoming’s neighbors—North Dakota, South Dakota, Montana, and Colorado—also have percentages of aged seniors receiving long-term care services, and receiving institutional care, well above national averages, and in some cases higher than Wyoming. These data suggest that the difficulties of life in rural and frontier communities may result in above-average rates of institutionalization, as aged or disabled individuals cannot live far from care support structures.

The prior reports indicating high levels of spending on Wyoming’s Medicaid program do not consider the significant reforms the state has implemented to date. Efforts to increase the percentage of beneficiaries receiving home and community-based services, rather than institutional care, have driven the percentage of members receiving long-term care in the home above 50%.²⁰ As a result, spending on Medicaid has remained relatively flat from fiscal years 2010 through 2015. Per enrollee costs have actually declined over that period, particularly for the aged population.²¹

However, the Kaiser and GAO studies illustrate the challenges and the opportunities the Medicaid program faces in Wyoming. Despite the reforms put in place to date, spending on the aged and disabled population remains at comparatively high levels. While spending on aged beneficiaries has declined from \$32,199 per enrollee in 2011 to \$26,222 in fiscal 2015, even that lower level remains higher than the national per-beneficiary average in 2011 (\$17,522).

But if Wyoming can build upon its existing Medicaid reforms to improve care for the aged and vulnerable population—coordinating care better, and ensuring that individuals who can be treated at home are not inappropriately diverted into institutional settings—then beneficiaries will benefit, as will taxpayers. If Medicaid enrollees receive better care, their lives will improve in both measurable and immeasurable ways. Likewise, simply bringing spending on aged and disabled beneficiaries down to national averages will drive millions of dollars in savings to the Medicaid program.

The Vision

Ultimately, the Medicaid program would work best if transformed into a block grant or *per capita* allotment to states. Under either of these proposals, states would receive additional flexibility from the federal government to manage their health care programs, in exchange for a series of fixed payments from Washington. The American Health Care Act, passed by the House of Representatives on May 4, contains both options, creating a new system of per capita spending caps for Medicaid, while allowing states to choose a block grant for some of their Medicaid populations.²²

While fundamental changes to Medicaid’s funding formulae must pass through Congress, the incoming Administration can work from its first days to give states more freedom and flexibility to manage their Medicaid programs. Specifically, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the power to waive certain requirements under Medicaid and the State Children’s Health Insurance Program (SCHIP) for “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of the programs.²³

Unfortunately, the Obama Administration often refused or watered down Section 1115 waiver requests from Republican governors. For instance, the last Administration repeatedly refused requests from governors to impose work requirements for able-bodied adults as a condition of participation in the Medicaid program.²⁴ Ironically, Obamacare actually made the process of obtaining waivers more difficult; one section of the law imposed new requirements, including a series of hearings, that states must undertake when applying for a waiver.²⁵ In the years since, federal legislative changes have sought to streamline the process for states requesting extensions of waivers already granted.²⁶



In the hands of the right Administration, waiver authority could provide states with a significant amount of flexibility to reform their Medicaid programs. Among the finest examples of such reform is the Rhode Island Global Compact Waiver, approved in the waning days of the George W. Bush Administration on January 16, 2009. The waiver combined and consolidated myriad Medicaid waivers into one comprehensive waiver, with a capped allotment on overall spending. Rather than considering the silos of various program requirements, or specific waivers on discrete issues, Rhode Island was able to examine Medicaid reform holistically—focusing on the big picture, rather than specific bureaucratic dictates from Washington.²⁷

Given flexibility from Washington, Rhode Island succeeded in controlling Medicaid expenditures—indeed, in reducing them on a per beneficiary basis. Overall spending remained roughly constant from 2010 through 2013, while enrollment grew by 6.6%.²⁸ Per beneficiary costs declined by 5.2% over that four-year period—a decline in absolute terms, even before factoring in inflation.²⁹ Perhaps most importantly, an independent report from the Lewin Group found that the Global Compact was “highly effective in controlling Medicaid costs,” while “improving members’ access to more appropriate services.”³⁰ In other words, Rhode Island reduced its Medicaid costs not by providing less care to beneficiaries—but providing more, and more appropriate, care to them.

The Rhode Island example has particular applicability to Wyoming’s Medicaid program. Just as Wyoming spends above national averages on Medicaid care for the aged and individuals with disabilities, so too did Rhode Island have a highly institutionalized population prior to implementing its Global Compact. Moreover, Wyoming’s current system of discrete waivers—two (including one pending with CMS) under Section 1115, and seven separate long-term care waivers under Section 1915 of the Social Security Act—lends itself towards potential care silos and unnecessary duplication. Consolidating these myriad waivers into one global waiver would allow Wyoming to “see the forest for the trees”—focusing on overall changes that will improve the quality of care. Implementing a global waiver will also give Wyoming the flexibility to accelerate reforms regarding delivery of long-term supports and services to the aged and disabled population, while introducing new consumer-oriented options for non-disabled beneficiaries.

Specific Solutions

A block grant, *per capita* allotment, or waiver along the lines of Rhode Island’s Global Compact provides the vision that will give states the tools needed to reform Medicaid for the 21st century. Fortunately, states have experimented with several specific reforms that can provide more granular details regarding how a reformed Medicaid program might look. Proposals in documents such as House Republicans’ “Better Way” plan, released last year, and a report issued by Republican governors in 2011, provide good sources of ideas.³¹ Both individually and collectively, these solutions can 1) improve the quality of care beneficiaries receive; 2) better engage beneficiaries with the health care system, and where appropriate, provide a transition to employment and employer-sponsored coverage; 3) reduce health costs overall; and 4) provide sound stewardship of the taxpayer dollars funding the Medicaid program.

Delivery System Reform

With a Medicaid program based around fee-for-service medicine—which pays doctors and hospitals for every service they perform—Wyoming in particular would benefit from reforms that encourage greater value and coordination in health care delivery. As explained above, the state’s above-average spending on aged and disabled beneficiaries speaks to the way in which uncoordinated care can result in health problems for patients—and ultimately, greater expenses for taxpayers.

Promote Home and Community-Based Services (HCBS): The Lewin Group’s analysis of Rhode Island’s Global Compact Waiver delineated many of the ways in which that state reformed its Medicaid program to de-institutionalize aged and disabled beneficiaries. Between the January 2009 approval of the waiver and the December 2011 report, Rhode Island achieved impressive savings from providing more coordinated, and “right-sized,” care to patients:

- Shifting nursing home services into the community saved \$35.7 million during the period examined by the study;
- More accurate rate setting in nursing homes saved an additional \$15 million in 2010 alone;



- Better care management for adults with disabilities and special needs children saved between \$4.5 and \$11.9 million; and
- Enrollment in managed care significantly increased the access of adults with disabilities to physician services.³²

The results from the Rhode Island waiver demonstrate the possible savings to Wyoming associated with reform of long-term services and supports (LTSS)—savings that the Lewin report confirms came not from denying care to beneficiaries, but by improving it.

Other states have also taken actions to promote HCBS. Testifying before the Congressionally-chartered Commission on Long-Term Care in 2013, Tennessee’s head of Long-Term Supports and Services proposed several solutions, focused largely on turning the bias in favor of nursing home care toward a bias in favor of HCBS—to use nursing homes as a last resort, rather than a first resort.³³ Her proposals included a possible limit on nursing home capacity; converting nursing home “slots” into HCBS care “slots;” and requiring patients to try HCBS as the default option before moving to a more intense (i.e., institutional) setting.³⁴ Integrating these proposals into a comprehensive waiver would not only provide Wyoming residents with more appropriate care, it could also save taxpayers money.

Managed Care: Wyoming could benefit by exploring the use of managed care plans to deliver Medicaid services to beneficiaries. Providing plans with a capitated payment—that is, a flat payment per beneficiary per month—would give them an incentive to streamline care. Moreover, a transition to managed care would provide more fiscal certainty to the state, as payment levels would not change during a fiscal or contract year.

In June 2014, a report commissioned by the Wyoming Legislature and prepared for the Wyoming Department of Health recommended against pursuing full-risk managed care, despite an admitted high level of vendor interest in doing so.³⁵ Three years later, Wyoming should explore the issue again, as both the Department of Health and medical providers in Wyoming have additional experience implementing other forms of coordinated care. The 2014 report notes that managed care plans have numerous tools available that could help reduce costs, particularly for high-cost patients, including data analytics, case managers, and quality metric incentives. Given the unique capacities that managed care plans bring to the table, it is worth exploring again the issue of whether full-risk plans could improve care to Wyoming beneficiaries while providing fiscal stability to the state.

While managed care could provide significant benefits to Wyoming, the state may be hamstrung by Medicaid’s current requirement that beneficiaries have the choice of at least two managed care plans. Given that Wyoming has only one insurer participating on its insurance Exchange this year, and a heavily rural population, this requirement may not be realistic or feasible. If approved by CMS, a waiver application could enable only one managed care plan to deliver care to rural Wyomingites.

Provider-Led Groups: In addition to managed care products organized and sold by insurance companies, Wyoming could also explore the possibility of creating groups led by teams of providers to manage care delivery. Similar to the accountable care organization (ACO) model promoted through the Medicare program, these provider-led groups could provide coordinated care to patients, either on a fully- or partially-capitated payment model.

In recent years, at least 18 state Medicaid programs have either adopted or studied the creation of various provider-led organizations.³⁶ Adopters include neighboring states like Utah and Colorado, as well as southern states like Louisiana and Alabama. Whether a hospital-led ACO, or a group of doctors providing direct primary care to patients, these provider-led organizations would have greater incentives to coordinate care for patients, hopefully resulting in better health outcomes, and reduced spending for the Medicaid program.

Payment Bundling: One other option for reforming delivery systems lies in bundled payments, which would see Medicaid providing a lump-sum payment for all the costs of a procedure (e.g., a hip replacement and associated post-operative therapy). Such concepts date back more than a quarter-century; a Medicare demonstration that began in the summer of 1991 reduced spending on heart bypass patients by \$42.3 million—a savings of nearly 10 percent.³⁷ More recently, Pennsylvania’s Geisinger Health System helped bring the payment bundle model into the national lexicon, implementing a 90-day “warranty” on heart bypass patients beginning in February 2006.³⁸



In recent years, government payers have increasingly adopted the payment bundle as a means to improve care quality and limit spending increases. Beginning in 2011, Arkansas' Medicaid program worked with its local Blue Cross affiliate to improve health care delivery through payment improvement, and has implemented an episode-of-care payment model (i.e., a payment bundle) as one of its efforts.³⁹ Likewise, Medicare has moved ahead with efforts to embrace bundled payments—offering providers the option of a retrospective or prospective lump-sum payment for an inpatient stay, post-acute care provided after the stay, or both.⁴⁰

A reformed Medicaid program in Wyoming could offer providers the opportunity to utilize bundled payment models as one vehicle to deliver better care. Ideally, Medicaid need not mandate participation from providers, as Medicare has done for some payment bundles, but instead help to encourage broader trends in the industry.⁴¹ While not as dramatic a change as a move toward managed care, the bundled payment option may appeal to some providers as a “middle ground” for those not yet ready to embrace a fully capitated payment model.

De-Identified Patient Data: In a bid to harness the power of “big data,” the federal government has made de-identified Medicare patient claims information available to companies that can analyze the information for patterns of care usage. Those initiatives have recently expanded to Medicaid, with one start-up compiling a database of 74 million Medicaid patients.⁴² Wyoming could ask outside vendors or consultants to analyze its claims data for relevant patterns and trends—yielding valuable insights into the delivery of care, and potentially improving outcomes for beneficiaries. By releasing its own Medicaid data and encouraging companies to analyze it, Wyoming will encourage the development of Wyoming-specific solutions to the state's unique health care needs.

Consumer-Directed Options

As part of a move towards modernizing Medicaid, Wyoming should adopt several different consumer-directed elements for its health coverage. These provisions would give beneficiaries incentives to act as smart shoppers, using ideas proven to lower the growth of health care costs. Providing appropriate incentives to beneficiaries will also make Medicaid coverage more closely resemble private health insurance plans—providing an easy transition for beneficiaries who move into employer-based coverage as their income rises.

Health Opportunity Accounts: In 2005, provisions in the Deficit Reduction Act created Health Opportunity Accounts.⁴³ The language in the statute called for several demonstration projects by states, who could offer non-elderly and non-disabled beneficiaries the choice to enroll in Health Opportunity Accounts on a voluntary basis. The Opportunity Accounts would be used to pay for medical expenses up to a deductible, at which point traditional insurance coverage would take over. While the Opportunity Accounts under the demonstration would function in many respects like a Health Savings Account (HSA)—the state and/or charities would fund the accounts, and beneficiaries could build up savings within them—they included a twist. Upon becoming ineligible for Medicaid, beneficiaries could access most of their remaining Opportunity Account balance for a period of up to three years, to purchase either health insurance coverage or “job training and tuition expenses.”⁴⁴

By creating an HSA-like account mechanism, and giving beneficiaries the flexibility to use their Opportunity Account funds on job training or health insurance expenses upon becoming ineligible for Medicaid, the Opportunity Account demonstration promoted both smart health care shopping and employment opportunities for Medicaid beneficiaries. Unfortunately, in 2009 a Democratic Congress and President Obama passed legislation prohibiting the approval of any new Health Opportunity Account demonstrations—effectively killing this innovative program before it had a chance to take root.⁴⁵

Thankfully, some states have continued to incorporate HSA-like incentives into their Medicaid programs. In the non-Medicaid space, HSAs and consumer-directed options have demonstrated their ability to reduce health care costs. A 2012 study in the prestigious journal *Health Affairs* found that broader adoption of the HSA model could reduce health care costs by more than \$57 billion annually.⁴⁶ If extended into the Medicaid realm, slower growth of health costs would save taxpayers—in Wyoming and elsewhere.

The upcoming reauthorization of the State Children's Health Insurance Program (SCHIP)—currently due to expire on September 30, 2017—gives Congress an opportunity to re-examine Health Opportunity Accounts. Regardless of whether



lawmakers in Washington reinstate this particular model, however, account-based health coverage in Medicaid deserves a close look in Wyoming as part of a comprehensive reform waiver. Although the Opportunity Account mechanism was somewhat prescriptive in its approach, allowing beneficiaries to keep some portion of remaining account balances upon becoming ineligible for Medicaid represents an innovative and sound concept. Such a program could represent a true win-win: Both the state and beneficiaries receive a portion of the benefits from lower health spending—cash which the beneficiary can use to help adjust to life after Medicaid.

Right to Shop: Thanks to several states’ reform of transparency laws, patients can now engage in a “right to shop” in many locations across the country.⁴⁷ The movement centers around the basic principle that consumers should share in the benefits of savings from choosing less expensive locations for medical and health procedures. Particularly for non-urgent care—for instance, medical tests or radiological procedures—variations among medical facilities provide patients with the opportunity to achieve significant savings by choosing a less costly provider.

Results from large employers illustrate how price transparency and competition have yielded savings for payers and consumers alike. A California Public Employees’ Retirement System (CalPERS) program of reference pricing—in which CalPERS set a maximum price of \$30,000 for hip and knee replacements—led to savings of \$2.8 million (\$7,000 per patient) to CalPERS, and \$300,000 (nearly \$700 per patient) in lower cost-sharing, in its first year alone. The program led hospitals to renegotiate their rates with CalPERS, which expanded its reference pricing program to other procedures the very next year.⁴⁸

Other estimates suggest that the potential savings from transparency and competition could range into the tens of billions of dollars. One study concluded that reference pricing for a handful of specific procedures could reduce health spending by 1.6 percent—or nearly \$10 billion, if applied to all individuals with employer-sponsored health coverage.⁴⁹ A separate estimate found that eliminating variation in “shoppable” (i.e., high-cost and known in advance) health services could reduce spending on individuals with employer health coverage by \$36 billion.⁵⁰

A reformed Medicaid program should look to bring these positive effects of “patient power” to Medicaid—by allowing consumers to share in the savings from choosing wisely among providers. The right to shop could work particularly well in conjunction with an account-based model for Medicaid reform, which provides a ready vehicle for the state to deposit a portion of savings to beneficiaries. Citizens have literally saved millions of dollars using the right to shop; tapping into those savings for the Medicaid program would benefit taxpayers significantly.⁵¹ Moreover, by incentivizing all providers to price their services more competitively, right to shop will exert downward pressure on health costs—an important goal for our nation’s health care system.

Wellness Incentives: Over the past several years, successful employers have used incentives for healthy behaviors to help control the skyrocketing growth in health care costs. For instance, Safeway used such incentives to keep overall health costs flat over four years—at a time when costs for the average employer plan grew by 38 percent.⁵²

Many large employers have increasingly embraced the results of the “Safeway model,” offering employees incentives for participating in healthy behaviors. According to the most recent annual survey of employer-provided health plans, approximately one-third of large employers (those with over 200 workers) offer employees incentives to complete a health risk assessment (32%), undergo biometric screening (31%), or participate or complete a wellness program (35%).⁵³ Among the largest employers—those with over 5,000 workers—nearly half offer incentives for risk assessments (50%), biometric screening (44%), and wellness programs (48%).⁵⁴ The trend of employer wellness incentives suggests Wyoming should bring this innovation to its Medicaid program.

Even though Obamacare passed on a straight party-line vote, expanding employer wellness incentives represented one of the few areas of bipartisan agreement. Language in the law permitted employers to increase the permitted variation for participation in wellness programs from 20 percent of premiums to 30 percent.⁵⁵ Medicaid programs should have the flexibility to implement such changes to their programs without requesting permission from Washington—and Wyoming should incorporate incentives for healthy behaviors into its revised Medicaid program as part of a comprehensive waiver.

Premiums and Co-Payments: In addition to more innovative models discussed above, a revised Medicaid program in



Wyoming could look to impose modest cost-sharing on beneficiaries through a combination of premiums and co-payments. Applying cost-sharing to specific services—for instance, unnecessary use of the emergency room for non-urgent care—should encourage beneficiaries to find the most appropriate source of care. Reasonable, enforceable cost-sharing would encourage beneficiaries to take responsibility for their care, making them partners in the road to better health.

Transition to Employment and Employer-Based Health Insurance

In many cases, individuals on Medicaid can, and ultimately should, make the transition to employment, and to the employer-based health insurance that comes with many quality jobs. However, the benefits currently provided by Medicaid bear little resemblance to most forms of employer-based coverage. In conjunction with the consumer-directed options discussed above, Wyoming should implement other steps to encourage beneficiaries to make the transition into work, and encourage the adoption of employer-based health insurance.

Work Requirements: Fortunately, the Trump Administration has indicated a willingness to embrace state flexibility in Medicaid—which with respect to work requirements in particular would represent a welcome change from the Obama Administration.⁵⁶ A requirement that able-bodied Medicaid beneficiaries either work, look for work, or prepare for work through enrollment in job-training programs would help transform state economies, as even voluntary job-referral programs have led to some impressive success stories. In the neighboring state of Montana, one participant obtained skills that helped her find not just a job, but a new career:

“I think it’s a success story,” [Ruth] McCafferty says about the [Medicaid] jobs program. “I love this. I’m the poster child!”

McCafferty is a 53-year-old single mom with three kids living at home. Seven months ago, she lost her job in banking, and interviews for new jobs weren’t panning out....

The jobs component of [her Medicaid coverage] means she also got a phone call from her local Job Service office, saying they might be able to hook her up with a grant to pay for training to help her get a better job than the one she lost. She was pretty skeptical, but came in anyway...

Job Service ended up paying not just for online training, but a trip to Helena to take a certification exam. Now, they’re funding an apprenticeship at a local business until she can start bringing in her own clients and get paid on commission.

“I’m able to support my family,” [McCafferty] says. “I’ve got a career opportunity that’s more than just a job.”⁵⁷

Ruth McCafferty is not the only success story associated with Montana’s Medicaid Job Service program. Five in six individuals who participated in the program are now employed, and with an average 50 percent increase in pay, to about \$40,000 per year—enough in some cases to transition off of Medicaid.⁵⁸ Unfortunately, however, because the program is not mandatory for beneficiaries, only a few thousand out of 53,000 Medicaid enrollees have embraced this life-changing opportunity.⁵⁹

In December 2015, the Congressional Budget Office noted that Obamacare’s Medicaid expansion will reduce beneficiaries’ labor force participation by about 4 percent, “creat[ing] a tax on additional earnings for those considering job changes” that would raise their income above the threshold for eligibility.⁶⁰ Rather than discouraging work, as under Obamacare, Medicaid should encourage work, and a transition into working life. Imposing a work requirement for Medicaid recipients, coupled with appropriate resources for job training and education, would help beneficiaries, taxpayers—and ultimately, Wyoming’s economy.

Flexible Benefits: Particularly for non-disabled adults and optional coverage populations, Wyoming should consider offering a more flexible and limited set of insurance benefits than the standard Medicaid package. Congress moved down this route in 2005, using a section of the Deficit Reduction Act to create a set of “benchmark” benefits that certain populations could receive.⁶¹ However, the “benchmark” plan section limits eligibility to certain populations, and excludes provisions permitting states to impose modest cost-sharing for beneficiaries.



As part of a comprehensive waiver, Wyoming should request the ability to shift non-disabled beneficiaries into “benchmark” plans. Moreover, the waiver application should include provisions for modest cost-sharing for beneficiaries, and make those cost-sharing payments enforceable. Receiving authority from Washington to customize health coverage options for non-traditional beneficiaries would give the state the ability to innovate, and tailor benefit packages to beneficiary needs and fiscal realities.

Premium Assistance: Premium assistance—in which Medicaid helps subsidize premiums for employer-sponsored health coverage—could play an important role in encouraging the use of private insurance where available, while also keeping all members of a family on the same health insurance policy. Unfortunately, however, current regulatory requirements for premium assistance have proven ineffective and unduly burdensome. All current premium assistance programs require Medicaid programs to provide wrap-around benefits to beneficiaries.⁶² In addition, two premium assistance options created by Congress in 2009 explicitly prohibit states from using high-deductible health plans—regardless of whether or not the state funds an HSA to subsidize beneficiaries’ medical expenses in conjunction with the high-deductible plan.⁶³

As part of its comprehensive waiver application, Wyoming should ask for more flexibility to use Medicaid dollars to subsidize employer coverage, without providing additional wrap-around benefits. In addition, the state’s application should require non-disabled adults to utilize premium assistance where available—another policy consistent with maximizing the use of private health coverage.

Preventing “Crowd-Out”: Many government-run health programs face the problem of “crowd-out”—individuals purposefully dropping their private health coverage to enroll in taxpayer-funded insurance. Prior studies have estimated the “crowd-out” rate for certain coverage expansions at around 60 percent.⁶⁴ In these cases, coverage expansions enrolled more people who dropped their private coverage than previously uninsured individuals—a poor use of taxpayers’ hard-earned dollars.

States like Wyoming should have the ability to impose reasonable restrictions on enrollment as one way to prevent “crowd-out.” For instance, ensuring enrollees do not have an available offer of employer coverage, or only enrolling persistently uninsured individuals (e.g., those uninsured for at least 90-180 days prior to enrollment), would prevent individuals from attempting to “game the system” and ensure efficient use of taxpayer dollars.

Program Integrity

Estimates suggest that health care fraud represents an industry of massive proportions, with tens of billions in taxpayer dollars lost every year to fraudulent activities.⁶⁵ Medicaid has remained on the Government Accountability Office (GAO) list of “high-risk” programs since 2003 “due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight.”⁶⁶ In its most recent update, GAO noted that improper payments—whether erroneous or fraudulent in nature—increased from a total of \$29.1 billion in fiscal year 2015 to \$36.3 billion in fiscal 2016—an increase of nearly 25 percent.⁶⁷

A reformed Medicaid program in Wyoming would use flexibility provided by the federal government to strengthen programs and methods ensuring proper use of taxpayer dollars. Because any dollar stolen by a fraudster represents one dollar not used to help the patients—many of them aged and vulnerable—that Medicaid treats, policy-makers should work diligently to ensure that scarce taxpayer funds are used solely by the populations for whom Medicaid was designed.

Verify Eligibility and Identity: A 2015 report by the Foundation for Government Accountability provides numerous cases of ineligible—or in some cases deceased—beneficiaries remaining on state Medicaid rolls:

- Arkansas identified thousands of individuals not qualified for Medicaid benefits in 2014, including 495 deceased beneficiaries;
- Pennsylvania removed over 160,000 individuals from benefit rolls in 2011, including individuals in prison and million-dollar lottery winners; and



- In Illinois, state officials removed over 400,000 ineligible beneficiaries in one year alone, saving taxpayers approximately \$400 million annually.⁶⁸

In the past two years, Wyoming has taken decisive action to crack down on fraud. The eligibility checks begun in mid-2015 removed several thousand ineligible individuals from the Medicaid rolls.⁶⁹ Moreover, Act 57, passed by the state legislature last year, introduced a new comprehensive program to stop fraud.⁷⁰ By verifying eligibility and identity upon enrollment, monitoring eligibility through quarterly database checks, and prosecuting offenders where found, Act 57 should save Wyoming taxpayers, while ensuring that eligible beneficiaries can continue to receive the health services they need.⁷¹

Asset Recovery: A 2015 Government Accountability Office (GAO) report raised concerns about whether Wyoming's Medicaid program is appropriately protecting taxpayer dollars. GAO concluded that Wyoming ranks second in the percentage of Medicaid beneficiaries (20.6%) with additional private health insurance coverage, and third in the percentage of Medicaid beneficiaries (26.02%) with additional public health insurance coverage.⁷² By comparison, GAO concluded that only 13.4% of Medicaid beneficiaries nationwide had an additional source of private insurance coverage—meaning Wyoming has a rate of additional private coverage among Medicaid beneficiaries roughly 50 percent higher than the national average.⁷³

As with the concept of crowd-out—individuals dropping private coverage entirely to enroll in Medicaid—discussed above, Medicaid should serve as the payer of last resort, not of first instance. If another payer has liability with respect to a Medicaid beneficiary's claims, the state has the duty—both a statutory obligation under the federal Medicaid law, and a moral obligation to its taxpayers—to avoid incurring those claims, and seek to recover payments already made when it is cost-effective to do so.

Asset recovery can take several forms. Improving recovery for third-party liability claims could involve participation in electronic data matching between Medicaid enrollment files and private insurer files; empowering any managed care organizations contracted to the Medicaid program to adjudicate third-party liability claims; and prohibiting insurers from denying third-party liability claims for purely procedural reasons, such as failure to obtain prior authorization.⁷⁴ As part of these efforts, Wyoming should have the freedom to hire contingency fee-based contractors as one means to stem the flow of improper payments to health care providers.

Long-term services and supports represent another area where Wyoming can take steps to ensure taxpayer dollars are spent on the vulnerable populations for whom Medicaid was designed. The state can and should utilize existing authority to recover funds from estates, or impose sanctions on individuals who transferred assets at below-market rates in their efforts to qualify for Medicaid.⁷⁵

Conclusion

In the past decade, Wyoming has made numerous reforms to its Medicaid program. The state has begun to re-balance care away from institutional settings where possible, and has implemented several programs to improve care coordination. These changes have helped stabilize Medicaid spending as a share of the budget, and reduce spending on a per-beneficiary basis.

However, given freedom and flexibility from Washington—flexibility which should be forthcoming under the new Administration—Wyoming can go further. This vision would see additional reforms designed to keep patients out of intensive and costly settings—whether the hospital or a nursing home—and an exploration of managed care options. Beyond the aged population, Wyoming would implement consumer-driven principles into Medicaid, giving beneficiaries greater incentives to take responsibility for their own care, and the tools to do so. And many recipients would ultimately transition out of Medicaid entirely, using skills they learned through Medicaid-sponsored job training programs to build a better life.

This vision stands within Wyoming's reach—indeed, it stands within every state's reach. All it takes is flexibility from Washington, and the desire on the part of policy-makers to embrace the vision for a modern Medicaid system. With a comprehensive waiver, Wyoming can transform and revitalize Medicaid. It's time to embrace the opportunity and do just that.

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ENDNOTES

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