POLICY REPORT

Upcoming Meetings

Title 25 Subcommittee - Tuesday, August 30
Cheyenne

Joint Revenue Legislative Committee - September 22-23
Buffalo

WDH Budget Woes

Wyoming Department of Health (WDH) has made $90 million in cuts to help the state absorb decreasing revenues. The General Fund cuts cause an additional $43.4 million in Federal Fund loss for a total decrease of $133.5 million for the coming biennium. This is in addition to the $10 million cut out of the WDH budget during the 2016 Budget Session.

WDH administers 70 programs, but 89 percent of WDH spending is in five areas. 1) Medicaid, 2) Mental Health/ Substance Abuse, 3) Preschools, 4) State Hospital, and 5) The Life Resource Center. The WDH budget is 10 percent administrative with the rest distributed to healthcare providers.

Joint Labor, Health and Social Services

WMS traveled to Lovell, Aug. 25-26 to participate in the Joint Labor, Health and Social Services (JLHSS) Legislative Committee meeting. The agenda was packed with a diverse selection of topics. WMS listened to discussion on pertinent issues, talked with lawmakers about WMS priorities for the coming session, and provided testimony on the multi-payer claims database. To see the full committee agenda, CLICK HERE

Telehealth and Telepharmacy

Public complaints surrounding remote medical services such as TeleDoc filed with the WY Board of Pharmacy lead to policymakers contemplating statutory solutions. Complaints were primarily from patients who used remote telehealth services and received a prescription but were ultimately unable to fill it because the pharmacist was unable to sufficiently establish physician-patient relationship. When pharmacists attempted to contact the prescribing provider emails were undeliverable, and

Changes for WY KidCare

Congressional action is requiring changes to the state's Child Health Insurance Program (CHIP), known as KidCare in Wyoming. Currently the program is funded with 88 percent federal funds and 12 percent state funds. Wyoming's average CHIP family is a family of four with both parents working full-time but uninsured or under-insured. Monthly income for that family of four ranges from $2,694 - $4,050 (133-200 percent of FPL).

The new parameters may require that KidCare institute an aspect of managed care while continuing participation in the Transformed Medicaid Statistical Information System (T-MSIS) and EPSDT practices. Proposed amendments to the state CHIP legislation can be seen HERE. Congress must vote to reauthorize CHIP funding by Sept. of 2017. If they do not, options for Wyo. children include being moved to the exchange to purchase plans, expanding employer sponsored health insurance coverage with state subsidy, or expanding Medicaid to 154 percent FPL for kids.

phone numbers didn't connect pharmacists with the prescribing physician.

The Boards of Medicine, Pharmacy and Nursing all gathered together to create a policy-based solution that each board, and others, could implement voluntarily without having to pursue a legislative approach. The policy paper resulting from this workgroup was submitted to the legislative committee for their approval in hopes that it would satisfy legislators concerns. CLICK HERE to read the working group's proposed policy. Additionally, the Board of Pharmacy proposed legislation to amend existing telepharmacy statutes. To view those proposed changes, CLICK HERE.

Medicaid Funding - Budget Concerns

Medicaid accounts for approximately $85 million of the state budget per biennium wth $56 million from state general fund and $29 million in federal funding. The State recently made a 3.3 percent rate reductions for provider reimbursement effective July 1, 2016 with attempts to target some of those in an effort to protect more fragile provider groups. Wyoming Department of Health approached the cuts with by begrudgingly cutting preventive services in an effort to protect existing services. All adult vision and dental services were cut due to severe budget constraints. A detailed view of where money is allocated can be seen in this summary report provided by WDH. CLICK HERE to view the budget reduction summary report.

Maintenance of Certification (MOC)

The WMS Board of Trustees is looking to make an aggressive move to protect Wyoming physicians from reimbursement penalties tied to Maintenance of Certification (MOC). Kentucky, Michigan, Oklahoma, and Missouri have all introduced or enacted legislation to address MOC concerns as they relate to mandates upon physicians with negative reimbursement, licensure or employment consequences.

States have taken a variety of approaches, so far all through legislative remedy, to try to either enact prohibitions of state licensure boards using board certification as a requirement of state licensure, keep hospitals from using board certification as a requirement of privileging, and/or ensuring that insurance

Title 25

The Wyoming Legislature's Joint Title 25 Subcommittee met in Cheyenne on Tuesday with a new payment model for Community Mental Health and Substance Abuse Centers highlighting the debate.

Stefan Johansson, Administrator of the Wyoming Department of Health's Policy, Research, and Evaluation Division presented the changes and said the new payment model would help the Department of Health to gain better data through one centralized data system for Title 25 and substance abuse.

Phase I of the model, a managed care system, would involve a capped fee-for-service model with tiered bonus payments to Community Mental Health Centers who are able to avoid hospitalizations, help clients gain employment or housing.

"We haven't gotten recommendations perfect, but we feel this is a good compromise for where payment reform groups are currently," Johansson said.

reimbursement payment could not be reduced from standard rates based on board certification alone.

WMS leadership and staff have been working throughout the summer with lawmakers, agency heads and other policy leaders to try and navigate a very complicated issue in hopes of protecting physicians without harming existing system components currently benefiting Wyoming doctors. WMS is in conversations with the Wyoming Department of Insurance, Wyoming Board of Medicine, major Wyoming private payers and key legislators sympathetic to WMS concerns. While the issue is not currently at play in our state, WMS very much wants to stay ahead of a growing issue that is proving to cause problems for doctors in other states.

Certified Surgical First Assistant (CSFA) legislation

CSFAs are coming together and seeking legislation to establish regarding their profession in the operating room. They want to establish state licensing in order to hold the profession more accountable and deny insurance companies the ability to not pay claims citing their non-licensure as reason for doing so. Several independent CSFAs have approached WMS and our leadership asking for our organization's support in their efforts. Draft legislation is not yet available for review, but will be distributed to WMS leadership as soon as it is.

Tax exemption on services in jeopardy

WMS was contacted by a representative of a quickly forming state coalition comprised of small businesses and organizations concerned with the legislature's Joint Revenue committee agenda item to review state tax exemptions. Information and potential draft bills released thus far have not yet explicitly defined healthcare service tax exemptions, but WMS is on alert and anticipates the possibility that these tax exemptions will at some point be up for discussion. WMS lobbyists will be attending the Joint Revenue meeting scheduled for later in September in Buffalo.

Multi-payer Claims Database

The Wyoming Legislature directed Wyoming Department of Health (WDH) to study two topics during the 2016 interim period: 1) a voluntary multi-payer claims database (MPCD) and; 2) expanding the Wyoming Employee's and Officials Group Insurance Program into a State-administered health insurance plan that other entities (i.e., political subdivisions, private employers, and potentially individuals) could join.

WDH elected to combine the two studies into one given the close relationship of both topics. They claimed that both aimed at containing costs and increasing quality in healthcare through market-based approaches and therefore aligned well to be combined into one study.

At the Joint Labor Health and Human Services (JLHHS) hearing in Lovell ,WDH representatives presented an interim report that aimed to describe the "how," and "why," a claims database and/or a State-administered health insurance plan might increase healthcare value.

WDH surmised for the Committee that a multi-payer claims database (MPCS) had potential to add value by first explaining that a MPCD turns raw and often-unintelligible claims data from multiple healthcare payers into information that can be acted upon. The database could arguably provide:

- ✦ Situational awareness of cost and utilization trends, by payers, groups, regions and over time;
    - Cost, by provider type or service area, and payment levels, by provider and payer;
    - Utilization rates, from emergency department visits to inpatient admits and re-admits;
- ✦ Identification of the providers who offer the most value to insured members;
    - Overall costs for episodes of care;
    - Standardized pricing comparisons;
    - Quality outcomes, adjusted for patient acuity;
- ✦ Proactive identification of high-risk members through predictive risk-scoring;
    - Risk models can be developed from administrative claims data, but could be adapted to use electronic medical records as well.

WDH explained that for a claims database or state-administered health plan to be successful or even viable, underlying data must be used to inform real policy action to contain healthcare costs. Each of these actions comes with tradeoffs. In other words, reduced costs for one entity effectively reduces benefits for another. Specifically:

- ✦ A plan that uses its market share to negotiate more favorable payment terms and additional risk sharing will not be popular with providers, particularly if it means sending patients out of state;

- ✦ A plan that uses narrower networks as part of this negotiating strategy may also increase the prevalence of balance billing;
- ✦ If providers lose enough revenue, fewer may be willing to practice in Wyoming, a State with significant healthcare provider shortages;
- ✦ A plan that is actually able to compete with fully-insured products will necessarily crowd out private insurance to some degree, as well as agents and brokers.

The Wyoming Medical Society testified to the committee that we have no formal position on the study results from WDH, but cautioned the committee and legislature to move slowly in the event they chose to pursue a MPCD in Wyoming. WMS testified that physicians, like so many of the other players in healthcare policy, are hungry for objective data but understand the serious risks involved when data is taken out of context, misunderstood or intentionally manipulated to serve as a means to a specific end.

WMS warned of the risk that a MPCD could incentivize providers to only see the healthiest and best-insured of patients. It also argued any database would have to mitigate for factors of economic standing, education levels, and general health as they would relate to patient compliance with physician direction, means to access basic health and wellness such as proper diet and exercise which would all factor in to outcome data for many procedures.

WDH will present a final study later in the year. In the meantime, WDH is forming a small working group of invested policy leaders to which WMS has been invited and will participate in order to represent and voice concerns as well as support of various concepts within the conversation.