

Don,

The WDH has met the conditions outlined in Footnote #5 of the 2022 Budget Bill, in support of the supplemental request for the second year funding in Wyoming Home Services (Unit 5002). Specifically:

- **5(b)(i):** Using ARPA direct funds to supplant the funding for Wyoming Home Services was deemed impermissible by the Attorney General's office.
- **5(b)(ii)(A):** The department has worked with all of its Wyoming Home Services providers to develop a means testing requirement within the program. While not fully implemented yet (footnote requirement is June 30, 2023), we have begun conducting means testing on **new** applicants for service as well as current participants on a voluntary basis. Full implementation of the means testing requirement can, and will, be implemented before June 30, 2023, as required unless legislative provisions are modified. The WDH would welcome additional discussion during JAC hearings as to the initial results and effectiveness of the means testing requirement. At that time, the WDH can provide updated data and initial results on program participant income.
- **5(b)(ii)(B):** Performance metrics were already established for the Wyoming Home Services Program through the Department's "HealthStat" initiative. Metrics are reviewed and updated every year. Attached to this response is the Department's most recent HealthStat Report (which is provided to the Legislature and Governor annually). The Wyoming Home Services HealthStat report can be found on Page 27 of the attached.
- **5(b)(ii)(C):** Please see the attached report, issued on September 1, 2022. The department worked with multiple stakeholders and all providers to develop a Section 1115 waiver concept that may benefit continued and sustainable operations of the Wyoming Home Services Program. During the inclusive design and development process with Wyoming stakeholders, the department also initiated negotiations with the Centers for Medicare and Medicaid Services (CMS). Both processes were beneficial, and several waiver options were developed as a result. While the department ultimately did not recommend moving forward with the waiver application (for reasons outlined in the attached report), we welcome additional legislative discussion on the future sustainability of the Wyoming Home Services Program and long-term care services in general, including leveraging policy vehicles like federal waivers.

Please let me know if you have any questions or need additional information.

Respectfully,

Stefan Johansson

Director

Wyoming Department of Health

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FFY 2021 PROGRAM PERFORMANCE

Title III-C2 Home Delivered Nutrition Program

Current Efforts

- In FFY2019 changes were made to the Emergency Meal policy for both Title III-C1 and Title III-C2 programs. Reimbursement for emergency (shelf-stable) meals is now a separate agreement from the Title III-C1 and Title III-C2 reimbursement. Nutrition grantees are not required to participate, but are given the option.
- Title III-C2 grantees are working hard to increase the number of people they are serving during the COVID-19 pandemic. The grantees have been quick to adapt to closures and changes in serving meals to older adults.
 - Because congregate meals were not being served, take-out and delivered meals were offered to congregate participants during the COVID-19 pandemic. These meals were reimbursed from the Title III-C2 program based on guidance from the Administration on Community Living (these meal counts are shown on the Healthstat Title III-C2 document).
 - Data entry in A&D for FFY2020 and FFY2021 was adapted based on meals served during the COVID-19 pandemic. CLS will be able to identify each type of meal that was served during COVID-19.
- Title III-C1 and Title III-C2 grantees received Families First funding in response to the COVID-19 pandemic. This funding was only expended during FFY2020.
 - \$400,000 CMC2 funding was awarded to pay for congregate meals.
 - \$800,000 HDC2 funding was awarded to pay for take-out and any delivered meals.
 - Families First funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC3 CARES funding in response to the COVID-19 pandemic. This funding was expended during FFY2020 and FFY2021.
 - \$2,400,000 HDC3 funding was awarded to pay for any meals (congregate, takeout, delivered) served during the COVID-19 pandemic.
 - HDC3 funding was reimbursed by expenditures, not by meals served.
- Title III-C1 and Title III-C2 grantees received HDC5 Consolidated Appropriations Act funding in response to the COVID-19 pandemic. The project period for this funding award is through September 30, 2022.
 - \$840,000 HDC5 funding was awarded to pay for expenses related to the pandemic (increased meal service, increased supply cost, increased personnel cost, etc).
 - HDC5 funding is reimbursed by expenditures, not by meals served.

Challenges

- As the expected annual average growth rate of people between ages 65 and 79 years of age is expected to be approximately 3.3% per year, the nutrition program must be capable of serving an increased number of eligible participants each year. The nutrition program must also be prepared to reach and recruit an increased number of potential eligible participants. Targets for FFY2022 are based on the expected 3.3% increase per year.
- Due to the COVID-19 pandemic, Title III-C2 grantees were reimbursed for all takeout and delivered meals that were served to Title III-C1 congregate participants. Therefore, there will be no accurate FFY2020 and FFY2021 data to determine the future funding formulas. Title III-C2 meal counts for future funding formulas will be based on FFY2019 meal count numbers, as approved by the Administration for Community Living.



Wyoming Home Services

Program Description

Wyoming Home Services program is a state funded grant program contracted to 23 providers, one per county, to provide in-home services to persons 18 years and older in Wyoming who are at risk of placement in nursing homes, assisted living facilities, or other institutional care. Services are primarily care coordination, homemaking, and personal care.

Program Expenditures and People Served

	2019	2020	2021
Total Program Cost*	\$2,663,638	\$2,854,145	\$2,675,372
People Served	1,920	1,882	1,664
Cost per Person	\$1,387	\$1,517	\$1,608
Non-600 Series**	1.00%	1.00%	1.00%

* State general fund only; does not include local matching funds or program income, which were included in previous reports

**600 series is defined as direct service contracts

Program Cost Notes

- The SFY 2021 funding sources for WyHS Program come from: State allocation \$2,675,372 (67%); Local matching funds of \$866,305 (22%); and Program Income (participant contributions) \$434,040 (11%). Total program cost for all sources was \$3,975,717.

Program Staffing

- 0.37 FTE
- 0 AWEC
- 0 Other

Program Metrics

- **Program Income generated.** For SFY 2021, average participant contribution for the year was \$261.
- **Local Match generated.** For SFY 2021, WyHS providers generated a collective total of \$737,455 over their required match.
- **Waiting list.** In SFY 2021, the WyHS waiting list ranged from a low of 96 to a high of 172. The waiting list shows the need for home and community-based services; however, worker shortage is often a barrier to providing services. SFY2020 waiting list range was 93 –169.

Events that Have Shaped the Program

- The waiting list number has increased from the previous year.
- In SFY 2017, the program received a reduction in state general funds of \$931,443 for the biennium.
- In SFY 2017 the program moved to a reimbursement model.
- One-time funding made available in SFY2020. This allowed some supplemental funding for additional services to seniors.
- In SFY2021 the program had two long-standing providers withdraw from service due to anticipated program cuts. New providers have since taken over, however, there were delays in transitioning services under these new providers. This resulted in a decrease in the number of clients served.



SFY 2021 PROGRAM PERFORMANCE

Wyoming Home Services

Program Core Purpose

To provide in-home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older who are at risk of premature institutionalization.

OUTCOMES

Performance Metric	SFY 2021 Target	SFY 2022 Target	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
% of WyHS Participants with an ADL of 2 or higher	85%	85%	79% (1,501)	78% (1,516)	79% (1,488)	79% (1,450)	75% (1251)
% of WyHS Participants with an IADL of 2 or higher	98%	98%	98% (1,852)	98% (1,889)	98% (1,843)	98% (1,848)	96% (1602)
Average # of people on the waiting list	70	100	99	82	90	131	121

Please note: Waiting list numbers have changed from previous years due to duplications in the formulas of data tracking tools.

OUTPUTS AND EFFICIENCIES

Performance Metric	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	2020 Q1-Q2	2020 Q3-Q4	2021 Q1-Q2	2021 Q3-Q4
OUTPUTS									
# of participants served	1,896	1,933	1,920	1,882	1,664	1,617	1,558	1,471	1,329
# of service units provided	84,268	88,992	85,457	81,839	69,902	42,361	39,478	37,321	32,581
# of homemaking units provided	48,264	49,029	49,136	49,954	41,563	24,116	21,840	21,716	19,847
# of personal care units provided	12,936	13,095	13,680	13,903	9,926	7,003	6,900	5,642	4,284
EFFICIENCIES									
Average State cost per person	\$1,205	\$1,476	\$1,387	\$1,517	\$1,608	\$908	\$890	\$972	\$936
Average State cost per unit of services	\$27	\$32	\$31	\$35	\$37	\$36	\$35	\$38	\$35
Average cost per participant	\$225	\$183	\$191	\$211	\$260	\$120	\$131	\$167	\$142

Please note: Cost per person and cost per unit of service is now calculated using state funds expended only and not total program cost

Wyoming Home Services

Story Behind the Performance

History

- The Wyoming Home Services Program began in 1987.
- The Wyoming Home Services (WyHS) program is a 100% state funded program.
- Grantees are required to match 5% of State funds expended. However, most Grantees choose to match significantly more, understanding the value that WyHS services add to their communities.
- For SFY2020 the program received \$225,000 in additional funding from the legislature.

Trends

- The WyHS waiting list has fluctuated during the years based upon availability of workers.

Efficiency

- Participants pay a fee for services based on a suggested sliding fee scale and their ability to pay. No participant is denied services based upon their inability to pay.
- The program income generated through participant contributions is put directly back into the program to enhance the program.
- The Aging Needs Evaluation Summary (AGNES) is done annually with mini-evaluations done every three months to monitor the eligible participant's well-being.
- We believe the overall level of care for clients decreased due to losing two providers who heavily concentrated their efforts on home health.

Current Efforts

- WyHS is currently provided in every county throughout Wyoming. Each county's provider chooses the services they provide in their county based upon the county's need and feasibility for the provider.
 - Homemaker services are the most offered service.
 - Personal Care services are offered in all but 2 counties, but are cost prohibitive due to the hiring and availability of certified nursing assistants (CNAs).

Challenges

- Finding alternative resources for older adults and disabled adults will be the most difficult issue faced in the next fiscal year. We believe many individuals will go without these resources in some communities.
- Providers struggle to find additional financial resources to support the growing need for services. Many providers exceed their matching responsibilities for this program in order to meet current needs in their communities.
- Workforce shortages. The need to hire CNAs and RNs in order to provide personal care services causes problems with providing affordable care.



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Stefan Johansson
Director

Mark Gordon
Governor

MEMORANDUM

Date: September 1, 2022

To: Joint Appropriations Committee
Joint Labor, Health, and Social Services Interim Committee

From: Stefan Johansson, Director *Just fully for*
Wyoming Department of Health

Subject: Legislative Report: Wyoming Home Services 1115 Waiver

Ref: J-2022-382

Footnote 6 to Section 048 of the 2022 Budget Bill requires the Department to report on its negotiations with the Centers for Medicare and Medicaid Services (CMS) on transforming the Wyoming Home Services (WyHS) program into a Medicaid 1115 Waiver. The footnote reads:

6. (a) The director of the department of health, with the consent of the governor, shall enter into negotiations with the United States department of health and human services regarding the operation of the Wyoming home services program under a waiver of Section 1315 of Title XI, Part A of the federal Social Security Act, as amended, with the intent of providing home and community based services to individuals who may not currently qualify for such services under Medicaid.

The department of health shall report to the joint labor, health and social services interim committee and joint appropriations committee not later than September 1, 2022 on the following:

- (i) The costs of any proposal;
- (ii) Services to be provided and proposed provider network;

- (iii) Proposed eligibility criteria and assessment, including means testing;
- (iv) Proposed beneficiary cost-sharing requirements;
- (v) Outcome measurements to be implemented by the department of health for the services rendered.

Attached please find the report that meets this requirement.

SJ/FF/jg

Attachment: Legislative Report

c: Governor Mark Gordon
Legislative Service Office (electronic copy)
State Department Depository (electronic copy)

WYOMING HOME SERVICES 1115 WAIVER

A REPORT

TO THE

JOINT APPROPRIATIONS COMMITTEE

AND THE

JOINT LABOR, HEALTH, AND
SOCIAL SERVICES COMMITTEE



Wyoming Department of Health
September 1, 2022

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EXECUTIVE SUMMARY

The Wyoming Home Services (WyHS) program pays for a limited set of home- and community-based services (HCBS) for senior citizens and people with disabilities who are at risk of placement in nursing homes or other institutional settings. Services are largely paid for by the State General Fund.

In the 2022 Budget Session, the Legislature directed significant changes to the program. In addition to implementing means-testing, the Department was to initiate discussions with the federal government on the potential of incorporating the WyHS program into Medicaid as an 1115 Waiver.

By September 1st, 2022, the Department was to report back to the Joint Labor, Health, and Social Services and the Joint Appropriations Committees regarding the potential waiver proposal. This is that report. In summary:

- Depending on the options chosen by the Legislature, the proposal in the subsequent sections of this report would cost the State between \$34 - \$41 million over ten (10) years, draw down an additional \$54 to \$68 million of Federal funds, freeze enrollment and wind down the existing WyHS program, and create 150 to 450 new waiver slots.
- Services under the new waiver would be comparable to the current Medicaid Community Choices Waiver; that is, more intensive and more standardized than the current WyHS program. The provider network would be limited to existing WyHS providers and senior centers, and they would be paid through a flexible and administratively simple per-member per-month (PMPM) payment.
- As with the current WyHS program, eligibility would only be based on a “pre-institutional” threshold of need and not limited by income or assets. However, members would be expected to make significant contributions to the cost of their care.
- The primary outcome — delayed institutionalization — would be measured rigorously through a randomized controlled trial.

We believe this proposal was one of the best possible proposals given the constraints of State statute, the footnote language, federal rules and regulations, and provider interests.

Unfortunately, without hard limits on income and asset eligibility, it is not likely to be approved by CMS.

Because pursuing the expansion of HCBS remains the single best strategy to mitigate the looming demands on State-paid long-term care, the Department recommends either:

- Pursing a targeted 1115 waiver just for a limited expansion of eligibility, while leveraging the Community Choices Waiver provider network and administrative infrastructure; or,
- If the Legislature wishes to continue using WyHS as the vehicle for this effort, adopting explicit income and resource limits for the program in statute.

CURRENT PROGRAM

The Wyoming Home Services (WyHS) program was created in 1987 with an initial \$300,000 appropriation and the charge of “providing community based in-home services for senior citizens.”¹

Originally administered by the State Commission on Aging, the program was absorbed by the newly-created Wyoming Department of Health in 1990. In addition to the change in administration, the program’s governing statute was updated in 2007² to focus the mission on providing services to people at risk of premature institutionalization.

As W.S. § 9-2-1208(a) currently reads:

(a) Subject to the availability of funds, the department of health shall administer a state program to provide community based in-home services for Wyoming senior citizens and disabled adults eighteen (18) years of age and older. Priority shall be given to persons at risk of placement in nursing homes, assisted living or other institutional care settings and the program may serve persons who are not senior citizens if the program's services are needed to avoid institutional placement.

Costs, people served, and services provided

Generally speaking, the program costs around \$2.7 million per year in General Funds and serves around 1,700 people, though both costs and people served have been declining in recent years, as illustrated in Table 1, below.

Table 1: WyHS funding (SGF) and people served

SFY	SGF	Clients
2016	\$3,213,217	2,147
2017	\$2,285,066	1,896
2018	\$2,853,958	1,933
2019	\$2,663,638	1,920
2020	\$2,854,145	1,882
2021	\$2,675,372	1,664

It’s important to note, however, that State General Funds only make up ~70% of program funding. The remainder comes from a 20% match from local providers and ~10% from client cost sharing on a sliding-fee scale. Total expenditures are therefore closer to \$3.7 million per year.

¹ Chapter 58, Session Laws of Wyoming 1987. Original SF137 “In home care for elderly.”

² Chapter 57 Session Laws of Wyoming, 2007. Original HB16.

Services provided by the program are statutorily authorized in W.S. 9-2-1208(b), and include homemaking, personal care, respite care, hospice, and adult daycare. Provision of these services is not uniform around the State, however, as providers have discretion to focus on certain services over others. Table 2, below, illustrates the count of clients by county who receive certain services. Note that some services are authorized but not actually provided (e.g. Adult Day, Hospice).

Table 2: WyHS FY2021 service provision

County	FY22 Grant Amount	Clients served, by service									
		Care Coordination	Homemaking	Personal Care	Respite	Chore	PERS	Med Setup	Home Mods	Adult Day	Hospice
Albany	\$85,470	46	44								
Big Horn	\$103,084	19	23	7			7				
Campbell	\$96,154	105	95	14		15					
Carbon	\$205,591	101	75	31			52				
Converse	\$165,166	137	111	24			41				
Crook	\$71,032	69	32	7			38	3			
Fremont	\$212,233	133	58	51			62	1			
Goshen	\$105,394	86	73	26		29					
Hot Springs	\$72,765	56	54								
Johnson	\$105,394	54	53	20				9			
Laramie	\$237,932	33	7	25				1			
Lincoln	\$98,464	43	22	6			28				
Natrona	\$206,746	100	98	2			1				
Niobrara	\$71,321	58	24			18	42				
Park	\$118,099	28	24	7				5			
Platte	\$77,385	101	77	10			43				
Sheridan	\$247,461	98	99	25							
Sublette	\$65,258	39	33	3							
Sweetwater	\$163,722	45	33	6		4					
Teton	\$91,823	30	26	11				2			
Uinta	\$122,141	72	47	32			32	20			
Washakie	\$76,808	100	49	11			61				
Weston	\$87,780	69	55	23		7					

WyHS eligibility and churn

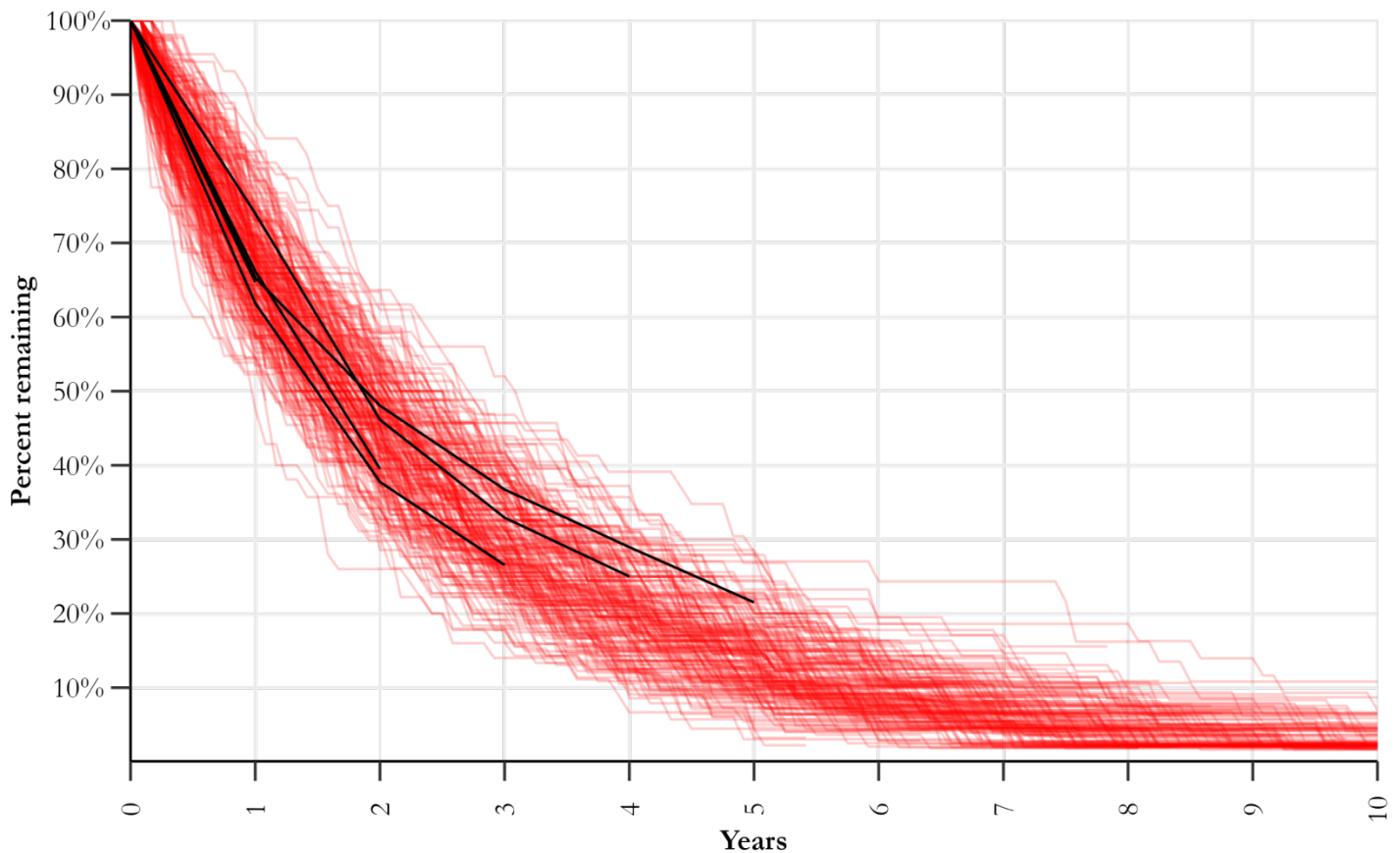
Client eligibility is entirely needs-based. Providers administer an assessment called the Aging Needs Evaluation Summary (AGNES) that quantifies client need along three dimensions: nutrition risk, activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

In past years, clients were asked to contribute financially based on their ability to pay, though services were not to be denied if payment was not received. Today, however, WyHS financial eligibility is moving to a means-testing framework, pursuant to Footnote 5(b)(ii)(A) to Section 048 of Senate Enrolled Act 12 from the 2022 Budget Session.

Generally speaking, members do not remain on WyHS for long. The probability of a member leaving the program in any given year (known as “churn”) increases with age, from around 30% at age 65 to ~40-45% by age 95. This kind of churn is higher for men.

Figure 1, below, illustrates how many people from any given cohort remain on WyHS after a certain number of years. On the figure, the black lines illustrate annual experience with five cohorts since 2016, and the red lines show estimates from a statistical model, which allow us to use that experience to project that most members of any given cohort will leave WyHS within 5-10 years.

Figure 1: Observed (black lines) and estimated (red lines) churn off WyHS



PURPOSE OF THE 1115 WAIVER

In addition to requiring the addition of means-testing and development of performance metrics in the existing program, Footnote 5(b)(ii)(C) also required the Department of Health to initiate negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding the operation of the program under an 1115 waiver.

Footnote 6 spells this out in more detail:

6. (a) The director of the department of health, with the consent of the governor, shall enter into negotiations with the United States department of health and human services regarding the operation of the Wyoming home services program under a waiver of Section 1315 of Title XI, Part A of the federal Social Security Act, as amended, with the intent of providing home and community based services to individuals who may not currently qualify for such services under Medicaid.

The department of health shall report to the joint labor, health and social services interim committee and joint appropriations committee not later than September 1, 2022 on the following:

- (i) The costs of any proposal;
- (ii) Services to be provided and proposed provider network;
- (iii) Proposed eligibility criteria and assessment, including means testing;
- (iv) Proposed beneficiary cost-sharing requirements;
- (v) Outcome measurements to be implemented by the department of health for the services rendered.

The direction to the Department, therefore, boils down to *beginning* the process of a waiver application, working with CMS to evaluate what might (and what might not) be feasible and then reporting back to Joint Labor and Joint Appropriations on some of the details of what the application might look like.

What are Medicaid “waivers”?

The word “waiver” refers to waiving the statutory provisions of the Medicaid program through a negotiated agreement with CMS. There are many kinds of waivers; most have focused on either expanding services, expanding eligibility, or trying out alternative service delivery models as a way of containing costs.

Wyoming operates several waivers in its Medicaid program. The largest are the Community Choices Waiver, the Comprehensive Waiver, and the Supports Waiver. All offer alternatives to institutional placement for people with physical disabilities, intellectual disabilities, and acquired brain injuries.

The 1315 (also known as “Section 1115”) waiver specified in the Footnote, however, is the most flexible and “creative” of waivers. Section 1115 allows applications for experimental demonstrations that might be found by the Secretary of the Department of Health and Human Services to be “likely to assist in promoting the objectives of [the Medicaid program],” which, per §1901 of the Social Security Act, is to furnish medical and rehabilitative assistance to low-income and disabled individuals.

Under these waivers, most (all but 52) of the statutory requirements in Medicaid can be modified. However, in addition to promoting the objective of the Medicaid program, 1115 waivers must be budget neutral to the federal government, must be rigorously evaluated, and can only be implemented after a long and tortuous application process that includes ample opportunity for the public to comment.

1115 waivers are also not a sure thing. There is no statutory requirement for the HHS Secretary to approve — or even respond to — any application within any timeframe. Wyoming has submitted two (2) applications in the last ten years, and both are still listed as “Pending” on the CMS tracker.³ This kind of limbo is the most likely fate for any waiver that CMS is unlikely to approve.

What is the purpose of applying for a Medicaid waiver?

At this point, we need to note that this application is not just an exercise in bureaucracy. Rather, it represents an opportunity to fundamentally reshape WyHS, to the benefit of its members. If approved, the waiver would mean:

- Increased and more diversified funding for the program, with the addition of 50% federal matching funds;
- More intensive and standardized services for beneficiaries;
- Coordination with Medicaid benefits; and,
- A rigorous evaluation of whether or not the program is effective.

More importantly, however, the waiver could offer another tool to the State in dealing with the looming demand of long-term care, much of which will fall to the single largest payer for nursing home services, Wyoming Medicaid.

Long-term care costs will increase dramatically over the next twenty years

There are major factors driving this slow-moving and predictable “silver tsunami”:

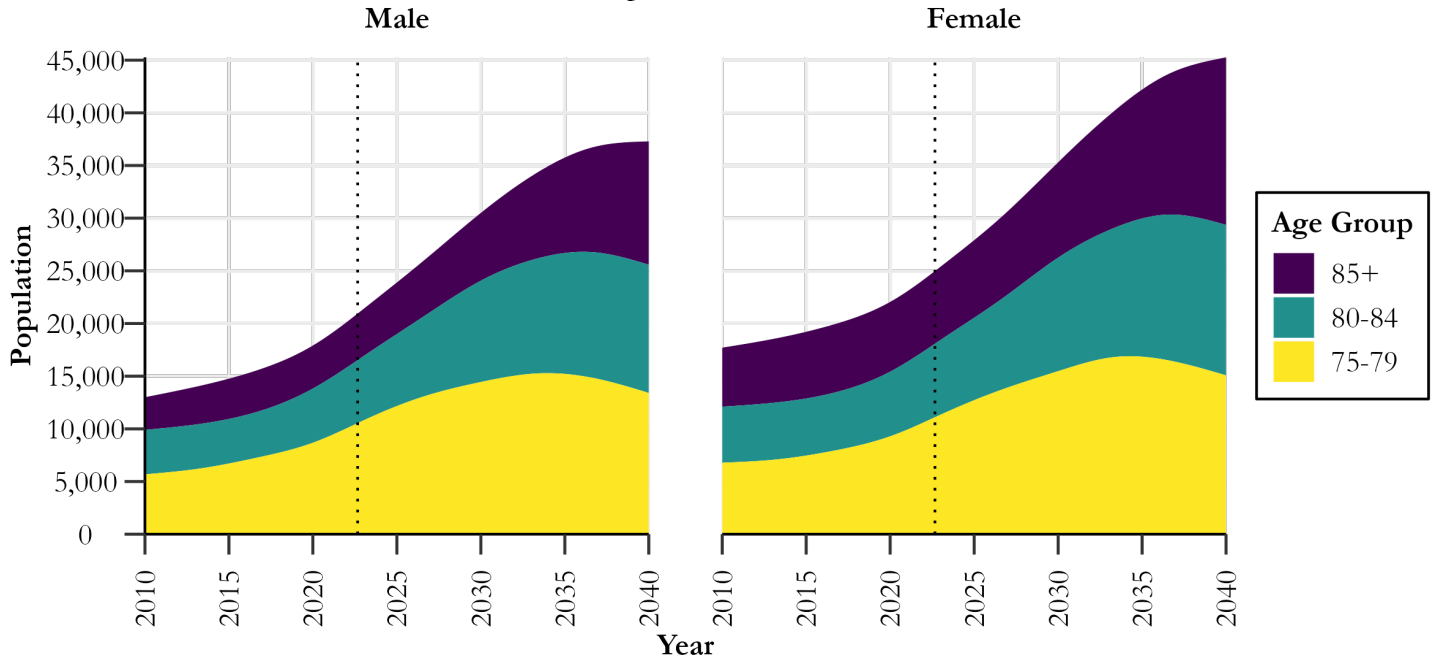
- Wyoming has a rapidly aging population. This is just demographic math. As Figure 2, on the next page illustrates, the count of people at highest risk for requiring nursing home services — people 75 years old and up — is projected to grow much faster as the Baby Boom generation reaches advanced age.

³ <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/>

Though, in fairness, it should be noted that Wyoming did receive a denial letter on the Wyoming Air Ambulance Waiver.

Note how the figure shows that we have already passed the inflection point in growth for these three age groups.

Figure 2: Growth in Wyoming’s population at highest risk of long-term care. Dotted line is at September, 2022.



- Unfortunately, these older Americans are also more likely to be sicker. The proportion of adults over age 65 reporting at least four chronic diseases has increased from 11.7% to 17.4% between 1998 and 2008.⁴ Similarly, the proportion of new nursing home entrants who are moderately to severely obese has increased from 14.7% in 2000 to 25% in 2010.⁵
- A growing elderly population and stagnant younger population means the “dependency ratio” of working-age adults per older individual is steadily decreasing, from approximately 16 working age adults for every person over 80 today to approximately 10 in 2030.⁶ This not only means that there will be fewer taxpayers, but also fewer paid and unpaid caregivers.
- Of people turning 65 today, the odds of requiring some amount of paid long-term care are approximately 50-50.⁷ For those that end up requiring nursing home care, the average is around 2-3 years. Note, however, the distribution is significantly right-skewed, as shown on Figure 3, on the next page. This means that the average isn’t particularly meaningful; a not-insignificant fraction of folks might spend ten years or more institutionalized.

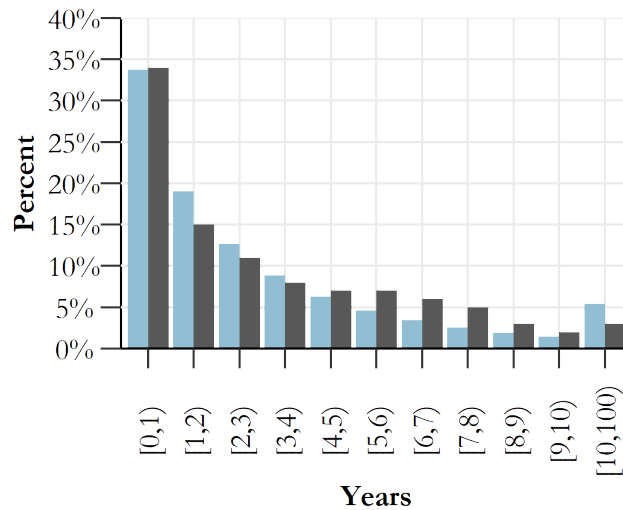
⁴ Hung, et al. BMC Geriatrics 2011, 11:47 “Recent trends in chronic disease, impairment and disability among older adults in the United States.” <http://www.biomedcentral.com/1471-2318/11/47>

⁵ “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>

⁶ Wyoming demographic projections; Economic Analysis Division.

⁷ HHS ASPE. “Long term services and supports for older Americans.”

Figure 3: Distribution of years in a nursing home, for those with any nursing home care. Private long-term care insurance estimates in gray, Medicaid estimates in blue.⁸



- Private-pay costs for long-term care are expensive. According to Genworth’s venerable cost of care report, in 2021 the average private room in a Wyoming nursing home cost \$104,573.⁹
- Older Americans will be unprepared to pay for long-term care costs out-of-pocket. One major factor here has been the decline of defined benefit plans in comparison to defined contribution plans.¹⁰ Most people simply do not have significant retirement savings, so a lack of a traditional pension can set people up for financial failure. A 2015 analysis of Survey of Consumer Finances (SCF) data by the Government Accountability Office,¹¹ for example, 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. 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.
 - Social Security makes up an average of 52% of household income for households over age 65.

⁸ Analysis of Wyoming Medicaid claims data for QMB/SLMB/Family Care Adults entering nursing home care (i.e., excluding spend-downs), compared with data from the PWC publication “Formal cost of long-term care services.”

⁹ <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>

¹⁰ 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>

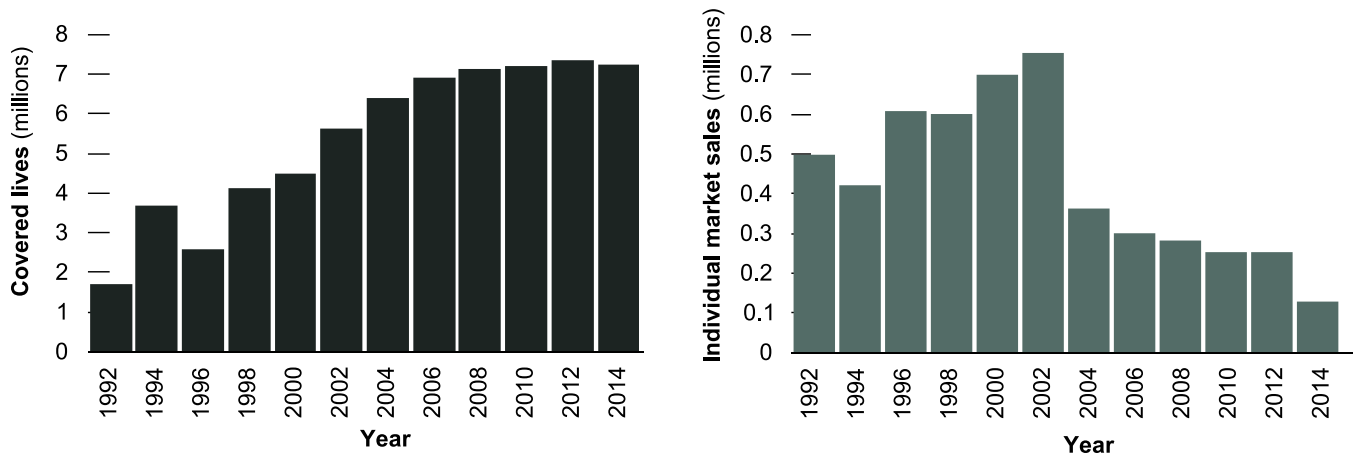
¹¹ Government Accountability Office. “Most households approaching retirement have low savings.” GAO-15-419. May 12, 2015. <http://www.gao.gov/products/GAO-15-419>

- While private insurance is often used to mitigate risk in general, in this particular case, the long-term care insurance market has significant weaknesses.

One truism with long-term care insurance is that “if you need it, you can’t afford it, and if you can afford it, you won’t need it.” In other words, if you’re wealthy enough to afford long-term care insurance premiums, you can likely ‘self-insure’ your long-term care.

While the industry has grown since the 1990s, Figure 4, below, shows the leveling-off in long-term care policy growth that has crept in since the early 2000s.

Figure 4: Total covered lives, long-term care insurance (left) and individual market sales (right)¹²



This stagnant and rapidly-aging base of covered lives has gradually manifested itself in two trends:

- Annual loss ratios (the ratio of paid claims to premium received) have crept upwards from 40% in the late 1990s to 80% by 2014.
- The ratio of actual-to-expected losses has increased from the mid-90% to just over 107% today.

In addition to these worsening ratios, new policy premiums have increased, largely due to corrections in underlying actuarial assumptions relating to: voluntary lapses and overly-optimistic morbidity assumptions.

All of these factors — (1) an aging and increasingly sick 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.

¹² 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

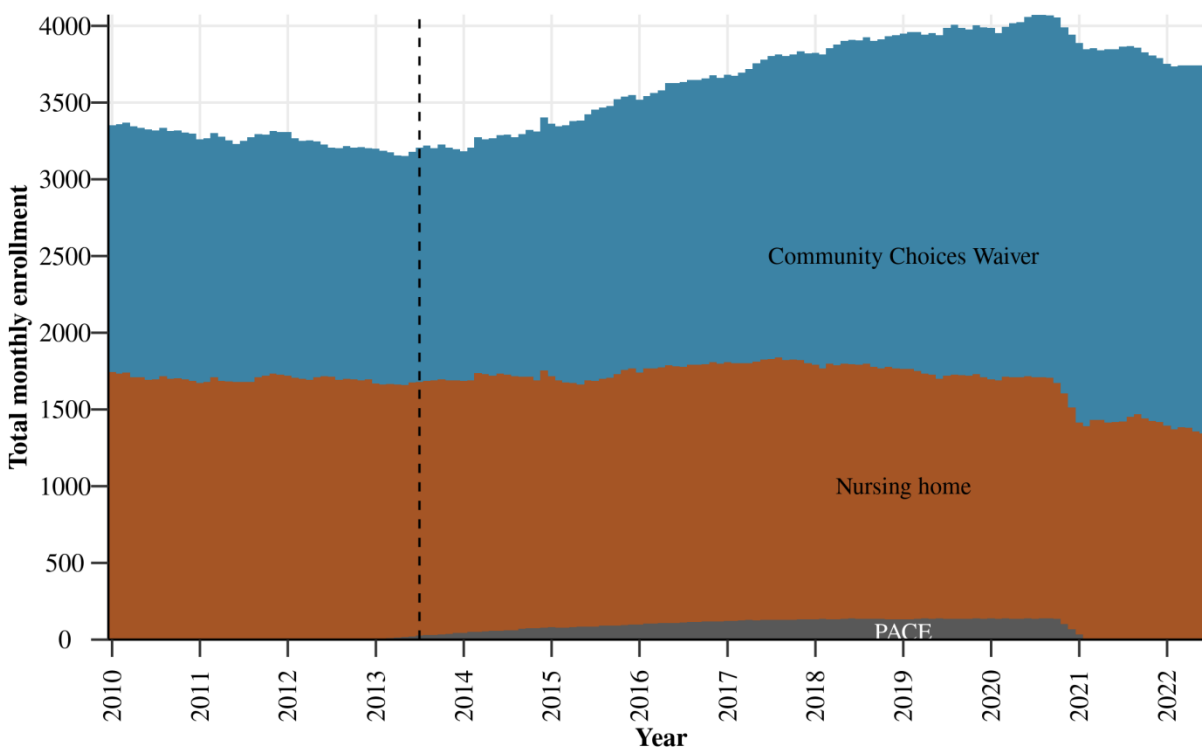
In Wyoming, that means an increasing reliance on Medicaid and other Department of Health long-term service and support programs.

The primary strategy for heading off these increased demands on safety-net institutional care is to continue to expand access to home- and community-based services (HCBS).

For current Medicaid members, HCBS options are widely available, attractive, and making up an increasing share of enrollment, shown in Figure 5, below.

- Since the Community Choices Waiver (CCW) eliminated its wait list in 2014, for example, the share of Medicaid long-term care members in HCBS settings has increased from around 48% to over 64% today.
- By contrast, Medicaid nursing home enrollment has actually dropped below 2010 levels, despite the underlying demographic shifts.

Figure 5: Medicaid long-term care trends



However, many individuals who are not currently eligible for Medicaid *will ultimately become eligible* as they rapidly spend down their assets and enter institutional settings. If these individuals could instead be provided access to the menu of Medicaid HCBS services **in advance** of entering an institutional setting, there may be potential savings to Wyoming Medicaid and its federal partners.

As with the current Wyoming Home Services program, serving these ‘pre-Medicaid’ individuals are the primary target of any 1115 Waiver.

PROPOSED WAIVER DETAILS

This proposal would target these “pre-Medicaid eligible” individuals by offering robust home- and community-based services through the existing network of Wyoming Home Services providers. Providers would be paid an all-inclusive per-member per-month rate, and clients would be expected to contribute for their care based on an income-based affordability standard.

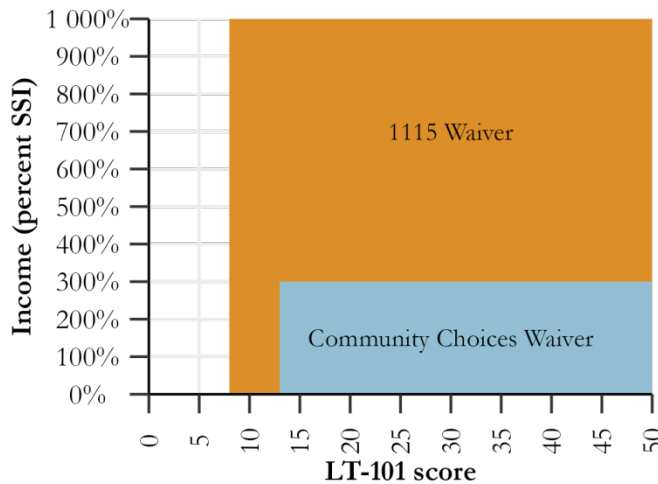
Eligibility based on a common long-term care assessment

All clients would be assessed using the LT-101, the same long-term care screening tool used by the Medicaid Community Choices Waiver. We would set a “pre-institutional” threshold of need on this assessment to qualify, lower than the existing qualifying threshold of 13 points.

While the current assessment used in WyHS does collect many of the same measurements of ADLs and IADLs, standardizing assessments across all Wyoming Medicaid long-term care programs will allow true apples-apples comparisons. As we describe later, using the LT-101 will also allow the Department to use our experience with the Community Choices Waiver in setting actuarially-fair provider rates.

Figure 6, below, shows the conceptual eligibility as a function of needs (LT-101, on the x-axis) and income as percent of the Supplemental Security Income (SSI) on the y-axis, with 300% SSI being the limit for existing waiver programs. On the figure, we assume a “pre-institutional” threshold of 7 points. Clients who have incomes or resources exceeding the Community Choices Waiver limit would also be eligible for the 1115 waiver. Note, however, that the 1,000% percent SSI on the figure is purely to limit the size of the graphic; there would be no specific income eligibility restriction.

Figure 6: Notional waiver eligibility



Closed provider network

The new waiver would be limited to the current network of senior centers and WyHS providers. We anticipate having one provider per county.

More expansive and more uniform services

In order to improve the chances of showing an impact on institutionalization, services provided under the 1115 waiver would be significantly more robust than those currently provided under WyHS. To the greatest extent possible, they would be harmonized with what is provided under the existing Medicaid Community Choices waiver, which include:

- Adult day;
- Case management;
- Home-delivered meals;
- Home health aide;
- Non-medical transportation;
- Personal emergency response system;
- Personal support services; and,
- Respite.

Simpler and more-flexible per-member per-month payments

Instead of paying for these services on a fee-for-service basis, the new waiver would pay providers a flat and all-inclusive per-member per-month (PMPM) rate.

Similar to how managed care networks operate, providers would therefore be at risk for the services needed by their clients — but they would also have significant flexibility to provide the services that, in their best judgment, would best prevent or delay institutionalization for their entire client panel. Ultimately, some clients may need a lot more services than their panel average, some may need less. But the aggregate revenue from the PMPMs should cover all costs of the entire panel.

In order to ensure this average fairness across areas of the State (and to discourage the “cherry picking” of healthier clients by providers), we propose to adjust the per-member per-month payment based on three factors:

- Needs, as assessed by the LT-101;
- Age; and,
- Regional location within the State.

For the first two factors, Table 3, on the next page, uses data from existing Community Choices Waiver members to construct a notional grid of PMPM cells based on LT-101 score and age.

For the third factor, Table 4, immediately below Table 3, shows how these PMPMs would be further adjusted by county of residence using the Wyoming Comparative Cost of Living Index developed by the Department of Administration and Information - Economic Analysis Division.

Table 3: Notional PMPM rates for age and LT-101 cells¹³

		Age						
		65	70	75	80	85	90	95
LT-101 Score	8	\$645	\$735	\$837	\$953	\$1,086	\$1,236	\$1,408
	13	\$655	\$746	\$849	\$967	\$1,102	\$1,255	\$1,429
	18	\$665	\$757	\$862	\$982	\$1,118	\$1,273	\$1,450
	23	\$674	\$768	\$875	\$996	\$1,134	\$1,292	\$1,472
	28	\$684	\$779	\$888	\$1,011	\$1,151	\$1,311	\$1,494
	33	\$695	\$791	\$901	\$1,026	\$1,168	\$1,331	\$1,516
	38	\$705	\$803	\$914	\$1,041	\$1,186	\$1,350	\$1,538

Table 4: Wyoming Comparative Cost of Living Index¹⁴

County	All Items
Teton	168
Lincoln-Afton	108
Laramie	105
Sublette	103
Sheridan	100
Campbell	100
Albany	98
Converse	97
Park	97
Carbon	96
Johnson	96
Natrona	94
Fremont	94
Crook	94
Sweetwater	94
Lincoln-Kemmerer	91
Uinta	90
Hot Springs	90
Platte	89
Weston	88
Big Horn	88
Washakie	87
Niobrara	87
Goshen	85

¹³ Estimates derived from CCW claims data from 2018-2020

¹⁴ <http://ealdiv.state.wy.us/wcli/NewsRelease-4Q21.pdf>

By way of example, assume an 85-year old lady living in Teton County scores 18 points on the LT-101, but does not qualify for Medicaid due to income and assets, so she receives a slot on the new WyHS waiver. The PMPM paid to the provider for this client would be \$1,878, which is \$1,118 (the cell at age 85 and 18 points on Table 3) times a multiplier of 1.68 (Teton County).

Importantly, we would not expect encounter data or other administrative billing data to be reported. The ultimate measure of accountability for these payments will be in the outcome: delayed or prevented institutionalization, as discussed later.

Client cost sharing as a proportion of income

As with the current WyHS program, this waiver does not conceive of capping eligibility *per se* based on income or assets. However, we do incorporate a strong income-based cost-sharing component that means that upper-income and wealthier folks will end up paying full-freight.

This proposal makes two assumptions:

- First, that paying 10% of total income towards long-term care costs should be considered an “affordable” burden. This is an educated guess, and certainly could be refined during the public comment period.
- Secondly, that all assets should be treated as a potential income streams using an annual 4% rate of return.

With these two assumptions, a client’s monthly cost sharing payment would be the lower of:

- $10\% \times (\text{Monthly income} + \frac{\text{Assets} \times 4\%}{12})$; or,
- The total PMPM that would have been paid by the waiver.

In the case of the 85-year old lady in Teton County, let’s assume she has an income of \$5,000/month and \$500,000 in countable assets. Her monthly cost-sharing obligation would be \$667, which is the lower of:

- $10\% \times (\$5,000 + \frac{\$500,000 \times 4\%}{12}) = \667 ; or,
- \$1,878.

In this particular example, the state would reduce its monthly payment to \$1,211 in light of these cost-sharing obligations and expect the provider to collect \$667 from the client. In addition to stretching State and federal funding and giving clients some ‘skin-in-the-game’, this kind of co-insurance simplifies the administrative burden on the State (note, by putting it on the provider), compared with a policy like trying to collect \$667 in premiums each month.

Clients will not be subject to Medicaid asset recovery

Medicaid long-term care members are subject to the State attempting to recoup the cost of care through programs like asset recovery, as established in §1917 of the Social Security Act. For this new

waiver program, because clients are paying significant amounts of cost-sharing, we intend to waive this provision.

Projected enrollment and service costs depend on grandfathering

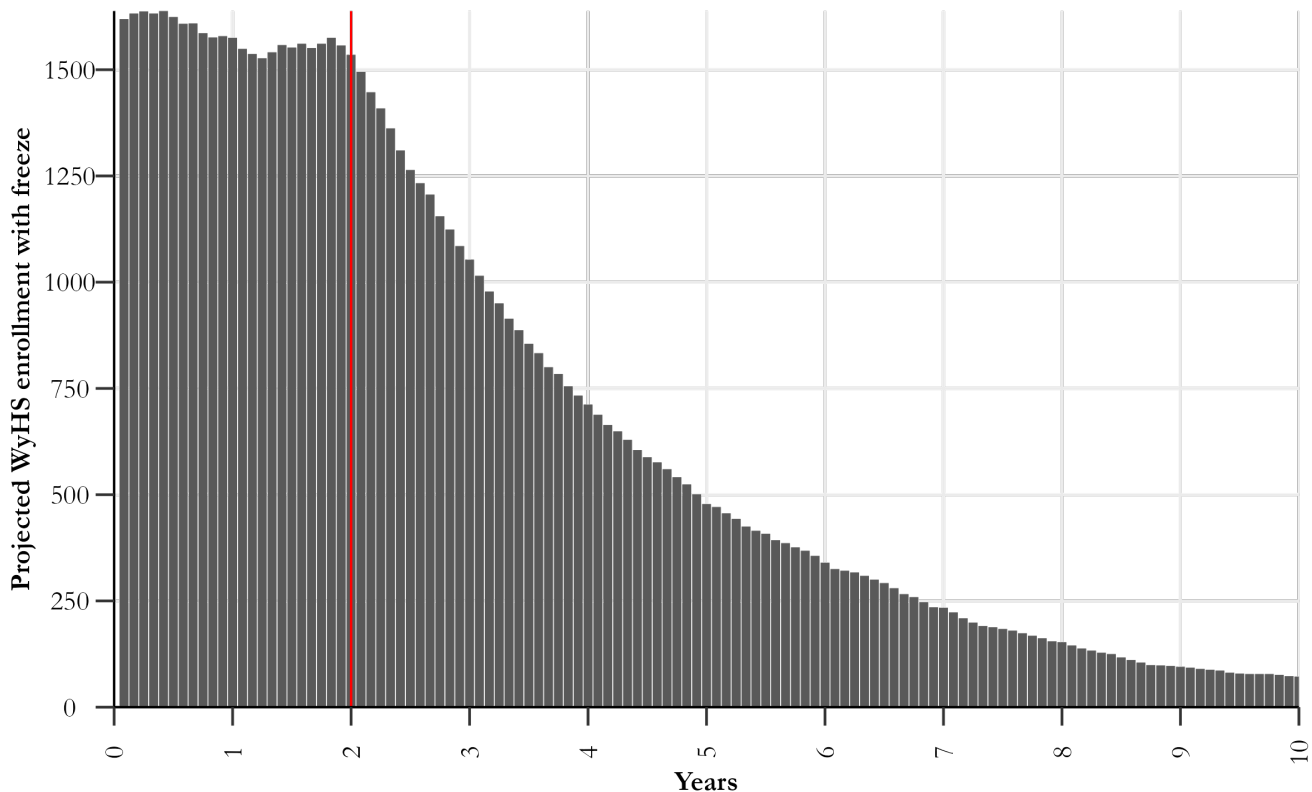
This waiver design, combined with what we know about the types of people on the current WyHS and Community Choices Waiver programs, allows us to make some assumptions about cost. The average PMPM we can expect, for example, is likely to be similar to, but less than that of the Community Choices Waiver (~\$1,250). We also know the rough age distribution of the current WyHS and CCW programs.

Still, there remains significant uncertainty regarding the distribution of LT-101 scores, incomes and assets for people that will enroll. In order to mitigate these risks, we propose limiting the number of slots on the waiver to what the current WyHS budget will bear.

There is one major complication in setting up this waiver program: what do we do with all the members currently served under the *existing* WyHS program? At the per-member per-month costs we’re talking about, and even with 50% federal match, transferring all current WyHS members to the new waiver would cost over \$12 million SGF each year, almost four times the existing budget.

To deal with this, we propose freezing enrollment and grandfathering the current WyHS program. As discussed previously in the section on churn, enrollment in this SGF-only “old WyHS” program would drop rapidly. Figure 7, below, shows this drop following the freeze denoted by the red line.

Figure 7: Projected “old WyHS” enrollment



There are two potential options to implement this grandfathering:

- Pay for the grandfathering ‘out of hide’ of the existing program budget. This keeps the total SGF obligation at current levels, but limits the size of the new waiver program significantly.
- Pay for the grandfathering in a separate one-time SGF appropriation (~\$7 - \$11M). This would free up the current WyHS budget to be matched by federal funds and open up ~450 slots on the new waiver immediately.

Tables 5 and 6, below, summarize the enrollment and costs for each option.

Table 5: Option 1 - Waiver enrollment and costs with “out-of-hide” grandfathering

SFY	“Old WyHS”		“New WyHS”			Total Costs	
	Enrolled	Costs (SGF/OF)	Enrolled	Costs (SGF/OF)	Costs (FF)	SGF/OF	Total
2023	1575	\$3,404,882	0	\$0	\$0	\$3,404,882	\$3,404,882
2024	1535	\$3,318,409	0	\$0	\$0	\$3,318,409	\$3,318,409
2025	1053	\$2,276,407	150	\$1,128,475	\$1,128,475	\$3,404,882	\$4,533,358
2026	712	\$1,539,223	248	\$1,865,659	\$1,865,659	\$3,404,882	\$5,270,542
2027	478	\$1,033,355	316	\$2,371,528	\$2,371,528	\$3,404,882	\$5,776,410
2028	340	\$735,022	355	\$2,669,860	\$2,669,860	\$3,404,882	\$6,074,742
2029	234	\$505,868	386	\$2,899,014	\$2,899,014	\$3,404,882	\$6,303,896
2030	153	\$330,760	409	\$3,074,122	\$3,074,122	\$3,404,882	\$6,479,005
2031	95	\$205,374	426	\$3,199,508	\$3,199,508	\$3,404,882	\$6,604,391
2032	72	\$155,652	433	\$3,249,230	\$3,249,230	\$3,404,882	\$6,654,113
Total 10-year costs						\$33,962,349	\$54,419,747

Table 6: Option 2 - Waiver enrollment and costs with “one-time” grandfathering

SFY	“Old WyHS”		“New WyHS”			Total Costs	
	Enrolled	Costs (SGF/OF)	Enrolled	Costs (SGF/OF)	Costs (FF)	SGF/OF	Total
2023	1575	\$3,404,882	0	\$0	\$0	\$3,404,882	\$3,404,882
2024	1535	\$10,100,070	0	\$0	\$0	\$10,100,070	\$10,100,070
2025	1053	Carried forward from unexpended FY2024	453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2026	712		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2027	478		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2028	340		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2029	234		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2030	153		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2031	95		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
2032	72		453	\$3,404,882	\$3,404,882	\$3,404,882	\$6,809,765
Total 10-year costs						\$40,744,010	\$67,983,068

One important note, here: both Figure 7 and the numbers in the table regarding the projected enrollment of the “old WyHS” program are drawn from *one* iteration of the statistical model illustrated in Figure 1, all the way back on page 4. In this particular iteration, the grandfathering cost is ~ \$10M.

However, when we look at the estimates of the cumulative cost to serve the “old WyHS” population, there is a larger uncertainty range, around \$7 to \$11 million. For a one-time grandfathering appropriation, we would recommend the expectation of \$9M.

Higher State administrative costs

The current WyHS program is administered with a very light footprint of less than 1 FTE. This new program will require more overhead, both in *applying* for and *administering* a new waiver with approximately 500 people. We estimate startup costs of \$146,000 in State General Funds and annual ongoing SGF administrative costs of ~\$166,000.

Table 7, below, breaks down total administrative costs into the one-time and ongoing annual expenses. It includes required positions (FTE), State General Funds (SGF), Federal Funds (FF) and total costs.

Table 7: Waiver Administrative Costs

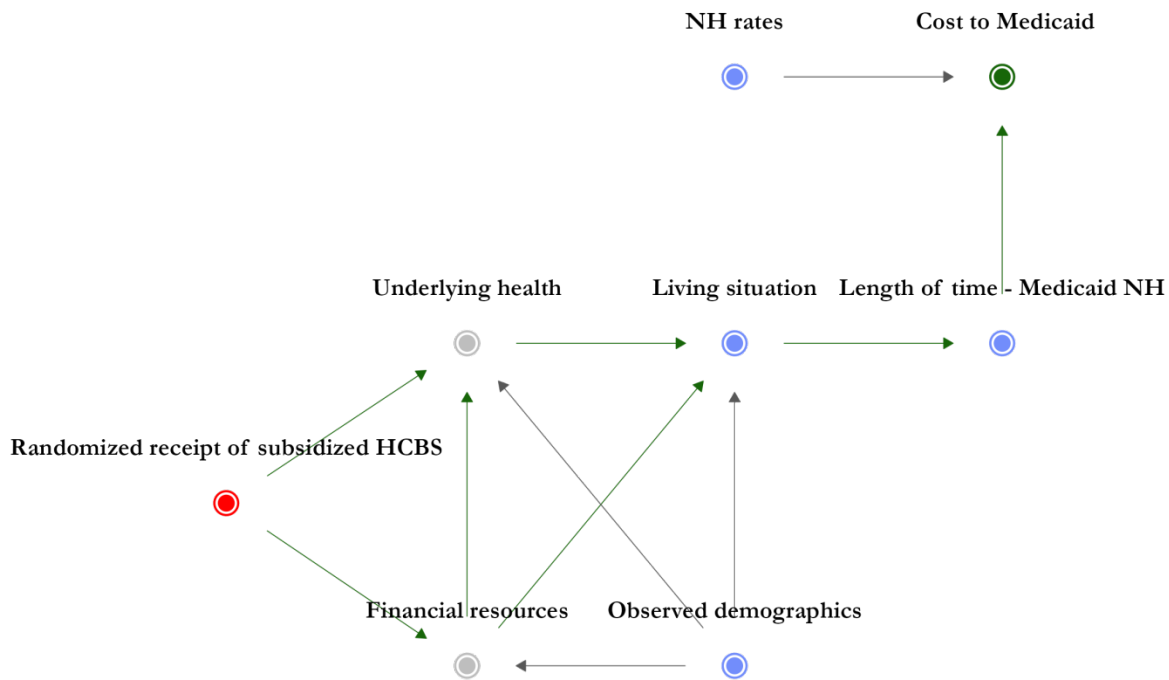
Category	Description	FTE	SGF	FF	Total
One-time	System changes, application process	1	\$146,000	\$706,000	\$852,000
Ongoing (annual)	Managing plans of care, provider enrollment and incident reporting, processing eligibility applications	6	\$166,000	\$218,000	\$384,000

Robust evaluation of primary waiver outcome: delayed institutionalization

We propose a randomized (specifically, a “stepped wedge”) evaluation to assess the cost-effectiveness of providing HCBS to “pre-Medicaid eligible” individuals. Randomized designs are the ‘gold standard’ of research because they provide the best opportunity to discern causal effects, rather than just correlations

The specific research question we intend to evaluate can be described by the causal graph in Figure 8, on the next page. Randomized receipt of subsidized home- and community-based services is the exposure (red). The ultimate outcome is the overall cost to Medicaid (green), which is primarily a function of how long people end up on Medicaid-paid stays in a nursing home.

Figure 8: Causal model for evaluation



This model outlines the three primary causal paths that we anticipate WyHS will affect, shown as green arrows:

- Services paid for by the waiver will improve recipients’ health, which delays or prevents institutionalization, which reduces Medicaid nursing home cost exposure.
- Subsidized HCBS conserves recipients’ finances, which delays the age of going on Medicaid once in a nursing home.
- Subsidized HCBS conserves recipients’ finances, which improves health, which delays institutionalization.

Only the total unbiased effect of being on the waiver can be estimated through this model; we cannot estimate the effect of each individual pathway separately with the data we can collect.

Nevertheless, knowing whether or not waiver services actually delayed or prevented institutionalization is important to three stakeholders:

- The Department of Health; given the flexible PMPM paid to providers and otherwise loose reporting of service delivery, this outcome is the ultimate accountability for payment.
- The Federal government, as 1115 waivers must be budget-neutral — including all potential savings from reduced nursing home stays.
- The Wyoming Legislature, which has consistently asked the Department questions on the cost-effectiveness of alternatives to nursing home care.

Randomized designs do have ethical concerns. We do not test whether or not parachutes work, for example, by randomly assigning skydivers to real and placebo rigs.¹⁵ In this, case, however, we have a capped budget, which necessitates a waitlist. This fact allows us to ethically allocate waiver slots on a randomized basis, since everyone on the waitlist would have an equal shot at getting access to the program.

The “stepped wedge” form of the evaluation allows individuals to move from the waitlist (i.e., the “control” group) to the program (“treatment group”) as slots open up, while allowing the Department to count their experience in either group on a ‘person-month’ basis.

Table 8, below, shows how this concept works, with five individuals and twelve months. On the table, for example, William starts on the waitlist (“C”) in month 1, but joins the waiver (“T”) in month 5. Philip, in contrast, signs up on the waitlist in month 5, but ends up passing away in month 10 before getting a slot on the waiver. All the months with green “T”s are counted in the treatment group and all red “C”s are counted in the control group.

Table 8: “Stepped wedge” design example

Person	Month											
	1	2	3	4	5	6	7	8	9	10	11	12
Ulysses	T	T	T	T	T	T	T	T				
George	T	T	T	T	T	T	T	T	T	T	T	
William	C	C	C	C	T	T	T	T	T	T	T	T
Winfield	C	C	C	C	C	C	C	C	C	C	T	T
Philip					C	C	C	C	C			

Data collection will be administratively simple

Identifying information and demographics will be collected as people register on the waitlist. We will then merge those identifiers with existing Medicaid claims data and vital records data to determine the life trajectories of people both on the waiver and the control group.

Modeling monthly transition probabilities

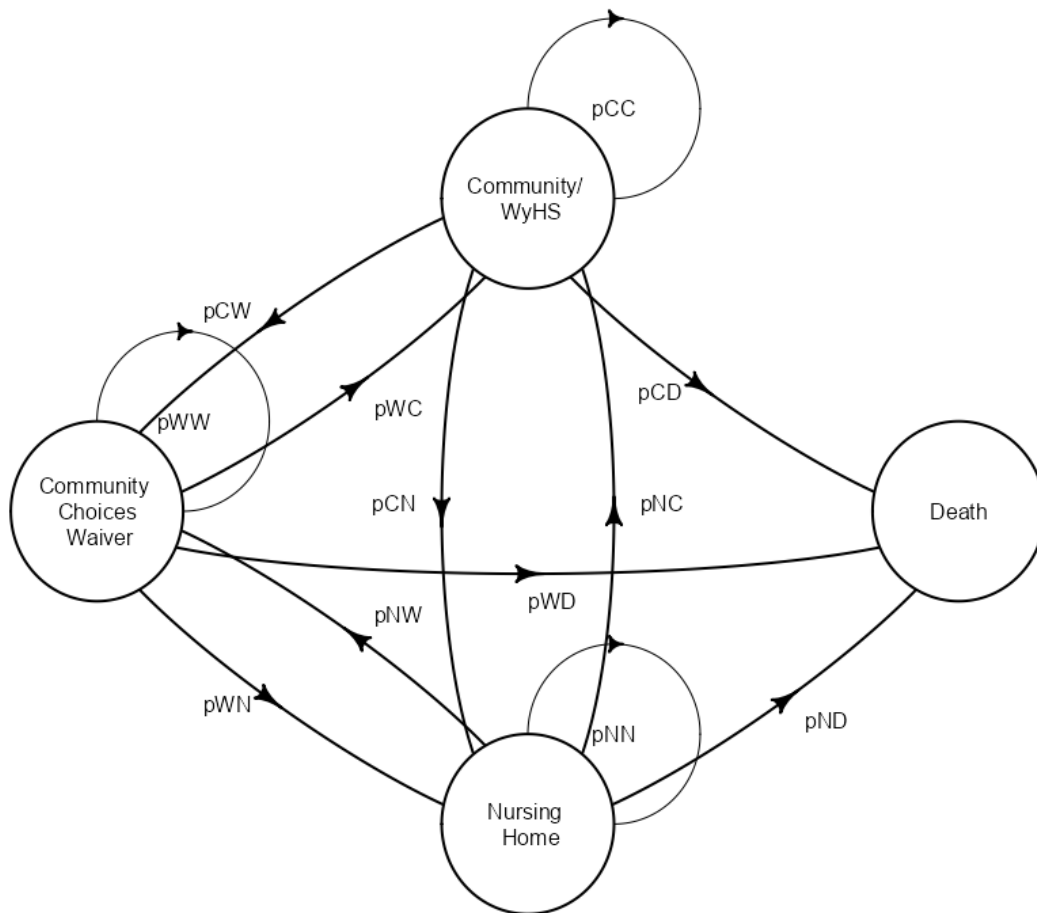
We envision transforming the data into a person-month dataset and modeling individual trajectories as discrete-time transition probabilities. Figure 9, on the next page, sketches out the basic statistical model.

¹⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC300808/>

On the figure, there are four basic long-term care states people can be in each month:

- In the community, including living at home, on 1115 waiver, or in a privately-paid nursing home stay¹⁶,
- On the Medicaid Community Choices Waiver;
- On a Medicaid-paid stay in a nursing home; and,
- Deceased.

Figure 9: Monthly state transition probabilities



In any given month, people can move between states. If they are in the Community, for example, the arrow “ p_{CC} ” on the figure indicates the probability of staying in the Community; “ p_{CW} ” indicates the probability of transitioning to the Community Choices Waiver, “ p_{CN} ” indicates the probability of going to a Medicaid-paid nursing home stay, and “ p_{CD} ” indicates the probability of

¹⁶ Since we are relying on Medicaid claims data, we won’t know whether people enter a nursing home until Medicaid starts paying for the stay.

dying. Note that death is considered an ‘absorbing’ state: no one knows what happens after we die, but we won’t be going back to nursing homes or Medicaid waivers.

The specific transition probability we are interested in is “pCN” — the probability of going from the community to a nursing home — and, to a lesser extent, “pCW” and “pCD”.

However, the model we construct will include treatment effects on all plausible transitions, and we will then use the model to predict counterfactual long-term care trajectories in order to evaluate the overall effect of the waiver on Medicaid costs.

Smaller sample sizes (and waiver budgets) will increase uncertainty in the results

We will use Bayesian methods (via Markov Chain Monte Carlo sampling) to estimate the model effects. This has several advantages:

- We can fully include the hierarchical structure of the model (person-months nested within people), as well as varying effects on any population coefficients. This will help provide better estimates with a potentially unbalanced sample.
- We can run the model periodically through the five-year waiver period without the frequentist problem of taking multiple looks at the data;
- We get full joint posterior distributions of all parameters, allowing us to propagate error through to the final estimates. This means that the result of all this analysis will be an overall distribution in the effect, not just a point estimate with a confidence interval.

Whatever method we use, however, unless the effect is overwhelmingly powerful, we probably won’t have a single, clear-cut answer.

But our chances of being able to detect any effect are directly proportional to the sample size in the study — the number of people on the waiver and on the wait list. This is limited by the program budget, meaning that the precision of any results will therefore be affected by the choice the Legislature makes regarding the two grandfathering options in implementation.

WAIVER FEASIBILITY AND RECOMMENDATION

The previous section was the result of multiple meetings with in-State stakeholders and experts at the Centers for Medicaid and Medicare Services (CMS) over the spring and summer of 2022. We believe it is one of the “best possible” waiver frameworks, given the constraints of (a) the Wyoming Home Services statute, (b) federal rules and regulations around 1115 waivers, (c) the direction in Footnotes 5 and 6 to our budget, and (d) existing provider capabilities and interests.

But it is still likely not approvable in its current form.

The major obstacle is the unlimited income and asset eligibility. CMS has never approved a waiver with this, and is unlikely to do so going forward, even if *de facto* eligibility is limited by significant cost-sharing requirements in this particular proposal. Per our discussions with CMS over the summer, the highest income limit approved in a waiver (State of Washington) was 300% of the Federal Poverty Level, which would be \$40,770 in 2022 for a single person and \$54,930 for a two-person household. Another option might be capping resources at some “ability to private-pay for a year of nursing home” level (State of Minnesota).

If the Legislature still wishes to pursue this specific waiver using the WyHS program as a vehicle, we therefore recommend changes to W.S. § 9-2-1208(a) that specifically limit eligibility to lower-income senior citizens and disabled individuals.

A second option that the Department recommends would be pursuing a smaller 1115 waiver that would only seek to expand eligibility (i.e., similar to the approved Washington and Minnesota waivers described above) for a limited set of home- and community-based services. This targeted waiver would otherwise leverage the existing Community Choices Waiver provider network, payment policies, and administrative infrastructure.

Regardless of the option chosen, the Department maintains that expanding HCBS remains the single best strategy for dealing with the inevitable growth in long-term care costs.