

State Services for Maternal and Infant Care

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Joint Labor, Health and Social Services
Interim Committee Meeting



Wyoming
Department
of Health

June 2-3, 2022

Primary WDH Programs - Summary

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→ **Medicaid and CHIP**

- ◆ Health insurance coverage for pregnant women $\leq 154\%$ FPL
- ◆ Health insurance for newborns and children $\leq 200\%$ FPL

→ **Women, Infants and Children (WIC) program**

- ◆ Food, formula, nutrition education, breastfeeding support.
- ◆ Low-income mothers (pregnant through 1 year of breastfeeding) and children under 5 who are $\leq 185\%$ FPL

→ **Public Health Maternal and Child Health Programs**

- ◆ Infant Home Visitation
- ◆ Newborn Screening
- ◆ Children's Special Health

Medicaid benefits - pregnant women

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- Initial income eligibility \leq 154% of the Federal Poverty Level (FPL).
- Once eligible, coverage is continuous, regardless of changes to income or household composition, through **60 days postpartum**
- Medicaid coverage for pregnant women includes:
 - ◆ Inpatient/Outpatient Hospital
 - ◆ Medical
 - ◆ Pharmacy
 - ◆ Dental & Vision (limited for individuals 21 and over)
- No copays or other cost sharing

Medicaid benefits - newborns

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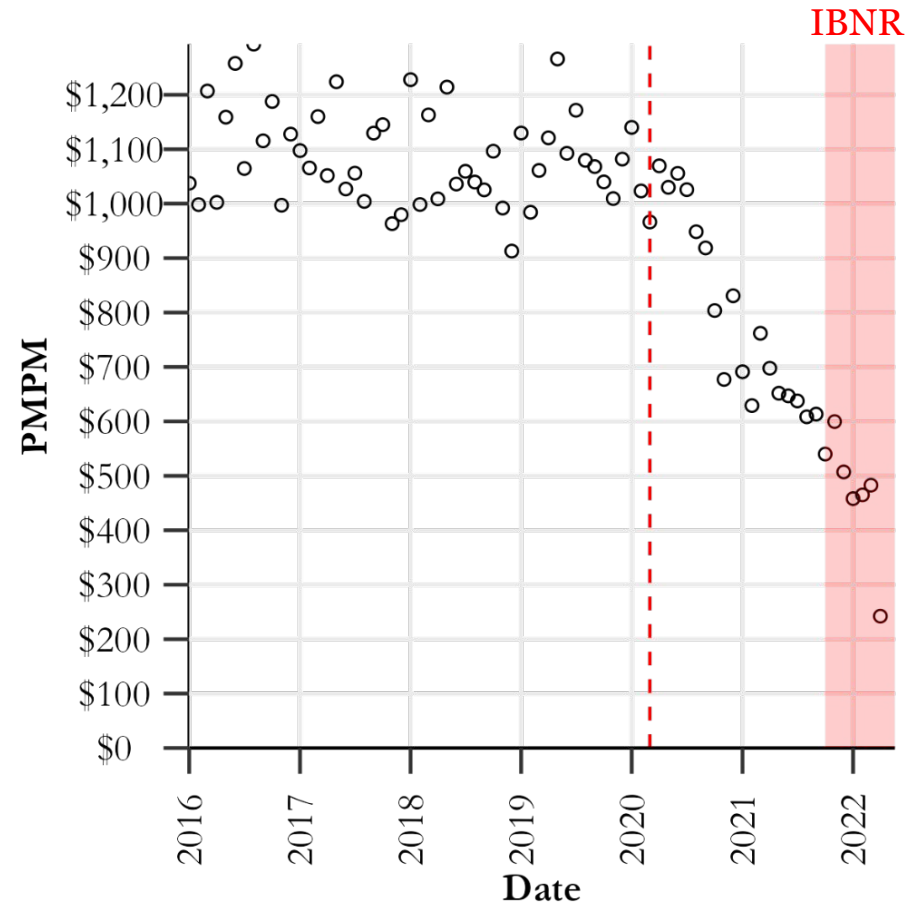
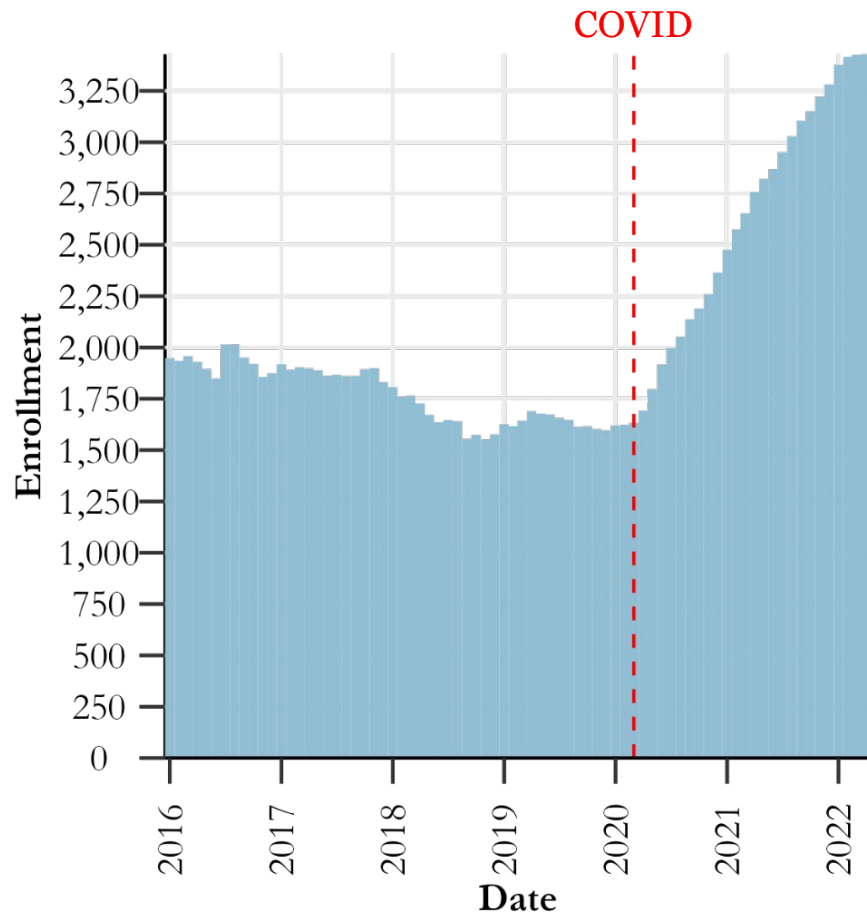
- Children born to a Medicaid eligible woman are automatically eligible for the first year of life
- Medicaid coverage for infants includes:
 - ◆ Inpatient/Outpatient Hospital
 - ◆ Medical
 - ◆ Pharmacy
 - ◆ Dental & Vision
- No copays or other cost sharing

Medicaid benefits - newborns

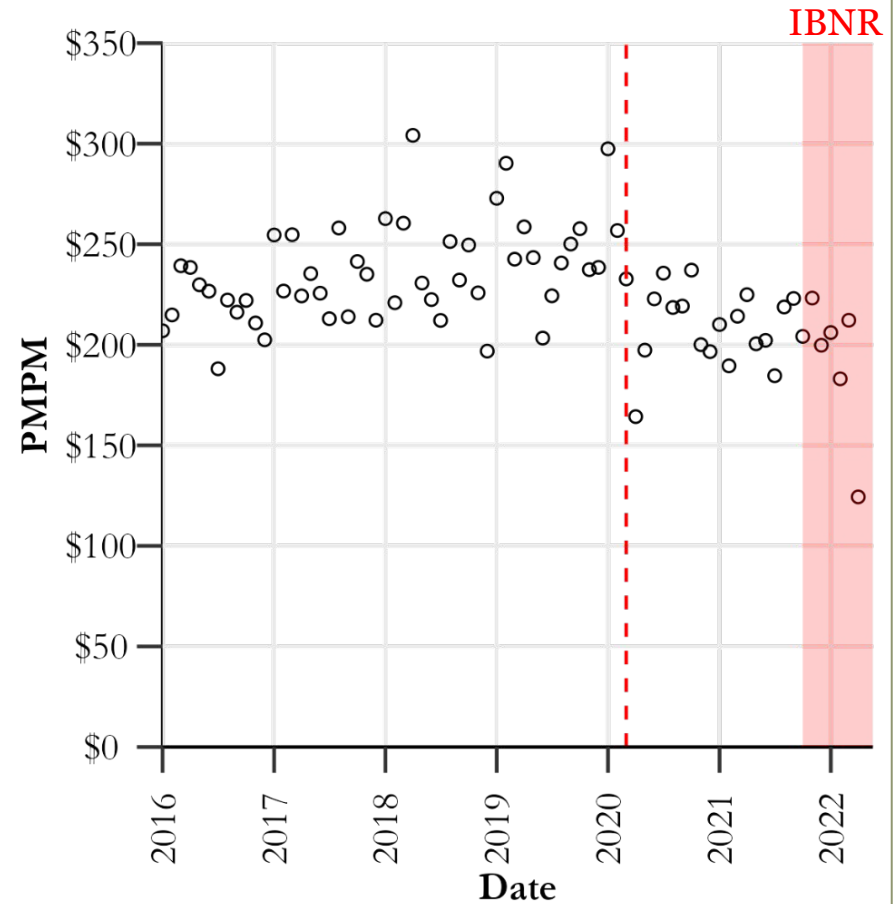
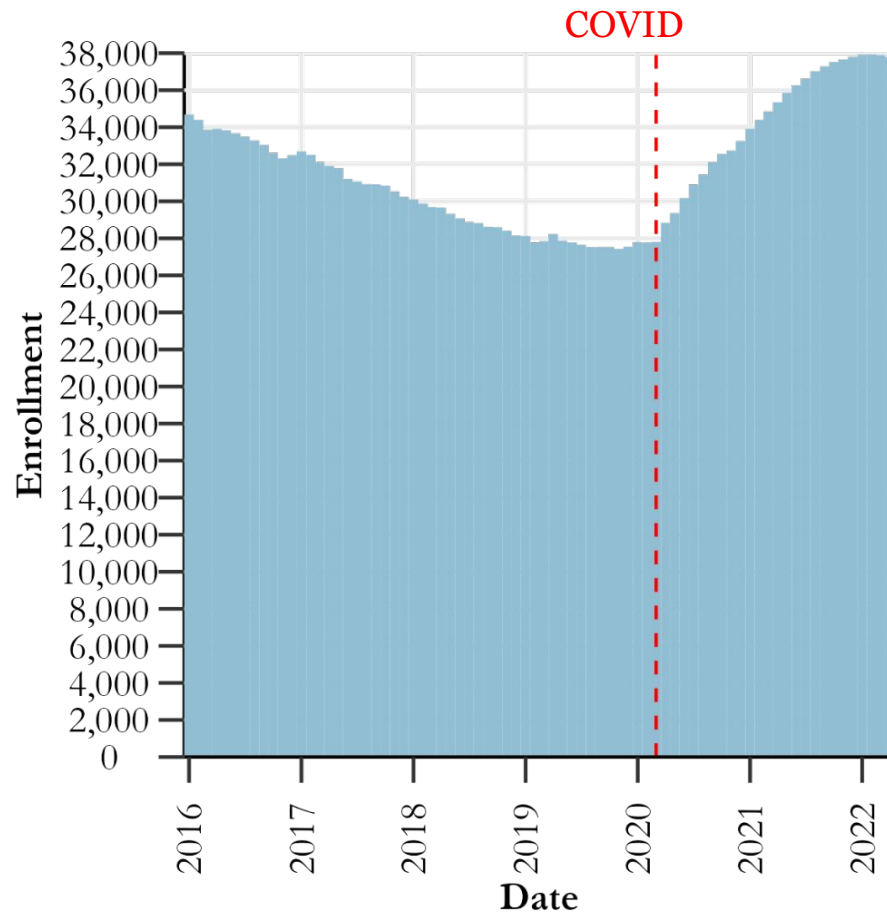
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- Many children transition to Medicaid or CHIP after eligibility determination following the one year automatic coverage period
- Eligibility for ages 18 and under is based on household income:
 - ◆ Age 0-5: $\leq 154\%$ FPL
 - ◆ Age 6-18: $\leq 133\%$ FPL
 - ◆ M-CHIP: $\leq 200\%$ FPL

Medicaid Enrollment and PMPM - Pregnant Women



Medicaid Enrollment and PMPM - Children



Women, Infants, and Children (WIC)

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Women, Infants, and Children (WIC) serves low-income women who are pregnant, breastfeeding, or who just had a baby, and families with children under the age of 5.

- WIC health care professionals (nutritionists and nurses) provide quality nutrition education and services; breastfeeding promotion and support; a nutritious monthly food prescription (package); and access/referrals to maternal, prenatal, and child health care services
- Current participants include: 563 pregnant women; 544 breastfeeding women; 367 postpartum women (non breastfeeding); and 1,601 infants

Public Health Nurse Infant Home Visitation

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- W.S. § 35-27-101 through -104
- Purpose: pre- and post-natal visits with pregnant women and infants, to include health assessments, screenings, assistance with breastfeeding, referral to community services, and education
- Uses evidence-based model (Maternal Early Childhood Sustained Home-visiting)
- 505 current participants (as of 5/19/22). 829 possible total caseload

Other Public Health Services

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- Newborn screening (W.S. 35-4-801) for metabolic or genetic diseases and major hearing defects
- Gap-filling financial assistance to mothers and infants who receive care at a Level III out-of-state hospital
- In-person and telehealth genetics clinics
- Prevention funding to counties for both substance use and suicide

Pregnancy Outcomes and Newborn Care

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Birth trends

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CY	All births	Medicaid births	Medicaid %
2008	8,015	3,353	42%
...
2015	7,715	2,757	36%
2016	7,384	2,704	37%
2017	6,904	2,439	35%
2018	6,549	2,206	34%
2019	6,566	2,148	33%
2020	6,133	1,993	32%

Wyoming Infant Outcomes

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- Infant mortality rate (VSS): **5.4/1,000 live births**
 - ◆ ~36 deaths/year
 - ◆ Similar to U.S. rate: 5.6/1,000 live births
- Majority (~63%) of deaths occurred in first 4 weeks of life
- 9.5% of babies born preterm (<37 weeks)
 - ◆ ~ 637 preterm births per year
 - ◆ 23rd highest rate in U.S. (2020)

Mothers - socioeconomic characteristics

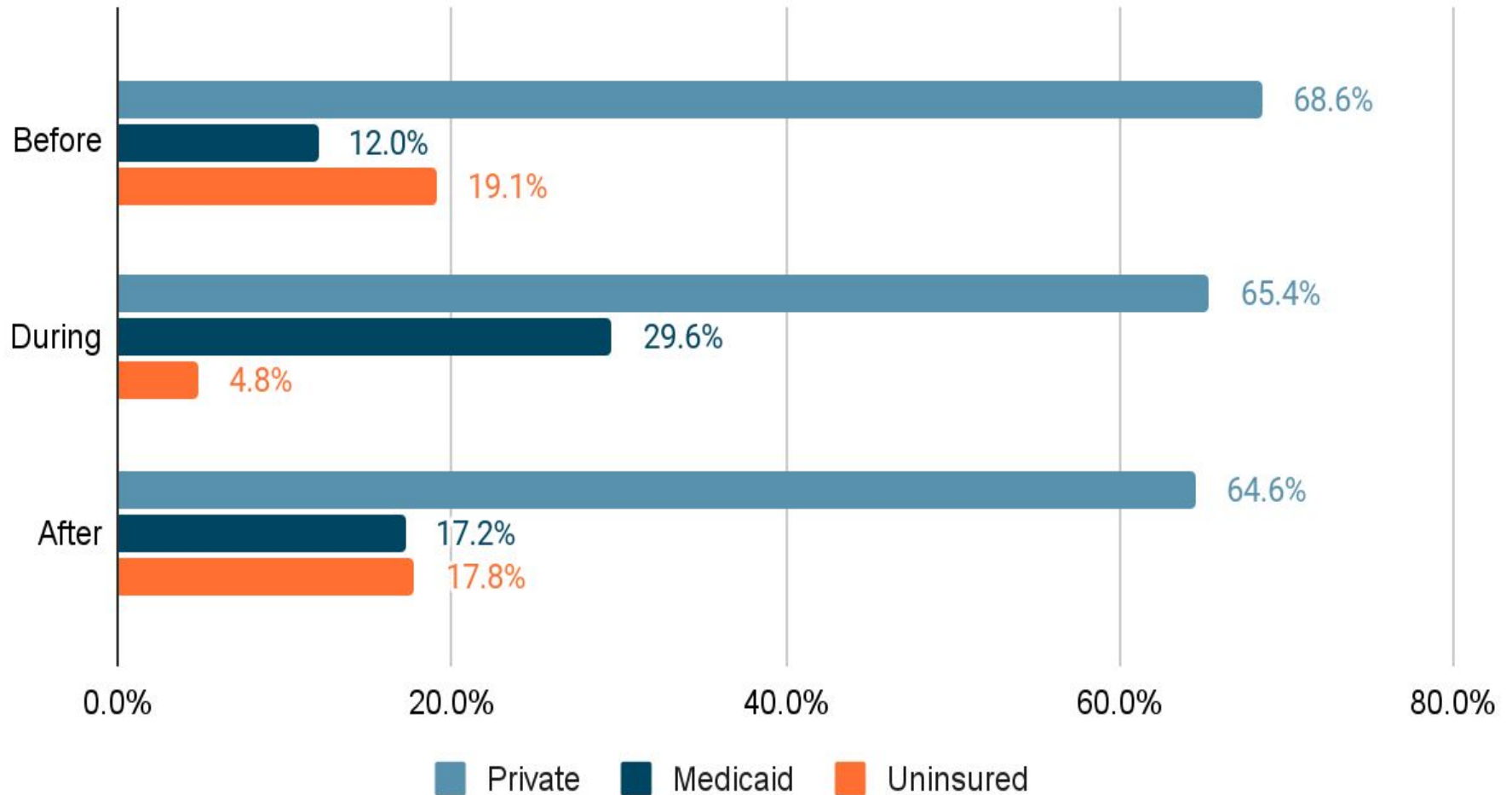
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Wyoming Pregnancy Risk Assessment Monitoring System (PRAMS) survey participants are sampled from eligible birth certificates from live-born infants to Wyoming resident women. This excludes women who had a pregnancy end in fetal death, abortion or miscarriage. There were 493 responses, representing a 55% response rate. Survey data is then weighted by demographics to represent the 2019 birth cohort.

Indicator	Est.	95% CI
< 20 years old	5.3%	3.3 - 8.3%
< High school education	9.2%	6.5 - 13.0%
< 100% FPL	31.8%	26.9 - 37.2%
Food insecurity (reporting eating less than needed due to lack of money)	9.8%	7.0 - 13.7%

Note: all indicators here are reported from the 2019 public PRAMS report for consistency. The Department can provide more precise estimates from 2016-2020 PRAMS or VSS on request.

Mothers - insurance status



Mothers - pregnancy characteristics

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Indicator	Est.	95% CI
Prenatal care beginning in 1st trimester	86.6%	82.4 - 90.0%
Caesarean delivery	25.4%	21.1 - 30.3%
Breastfeeding initiation (ever)	91.9%	88.4 - 94.5%
Breastfeeding to 8 weeks	74.3%	69.2 - 78.8%
Received any post-natal home visitation	24.0%	19.8 - 28.8%

Maternal health

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Indicator	Est.	95% CI
Obesity (BMI ≥ 30)	26.3%	21.8 - 31.4%
Type I or Type II Diabetes before pregnancy	1.7%	0.9 - 3.4%
Hypertension, pre-pregnancy	3.0%	1.7 - 5.4%
Depression, pre-pregnancy	21.1%	17.0 - 25.9%
Postpartum depressive symptoms (“often” or “always”)	15.3%	11.8 - 19.6%

Tobacco and alcohol use

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Indicator	Est.	95% CI
Tobacco use 3 months prior to pregnancy	23.6%	19.3 - 28.6%
Tobacco use during last 3 months of pregnancy	11.4%	8.4 - 15.4%
Alcohol use 3 months prior to pregnancy	66.4%	61.1 - 71.3%
Alcohol use during last 3 months of pregnancy	7.2%	4.9 - 10.4%

Substance use

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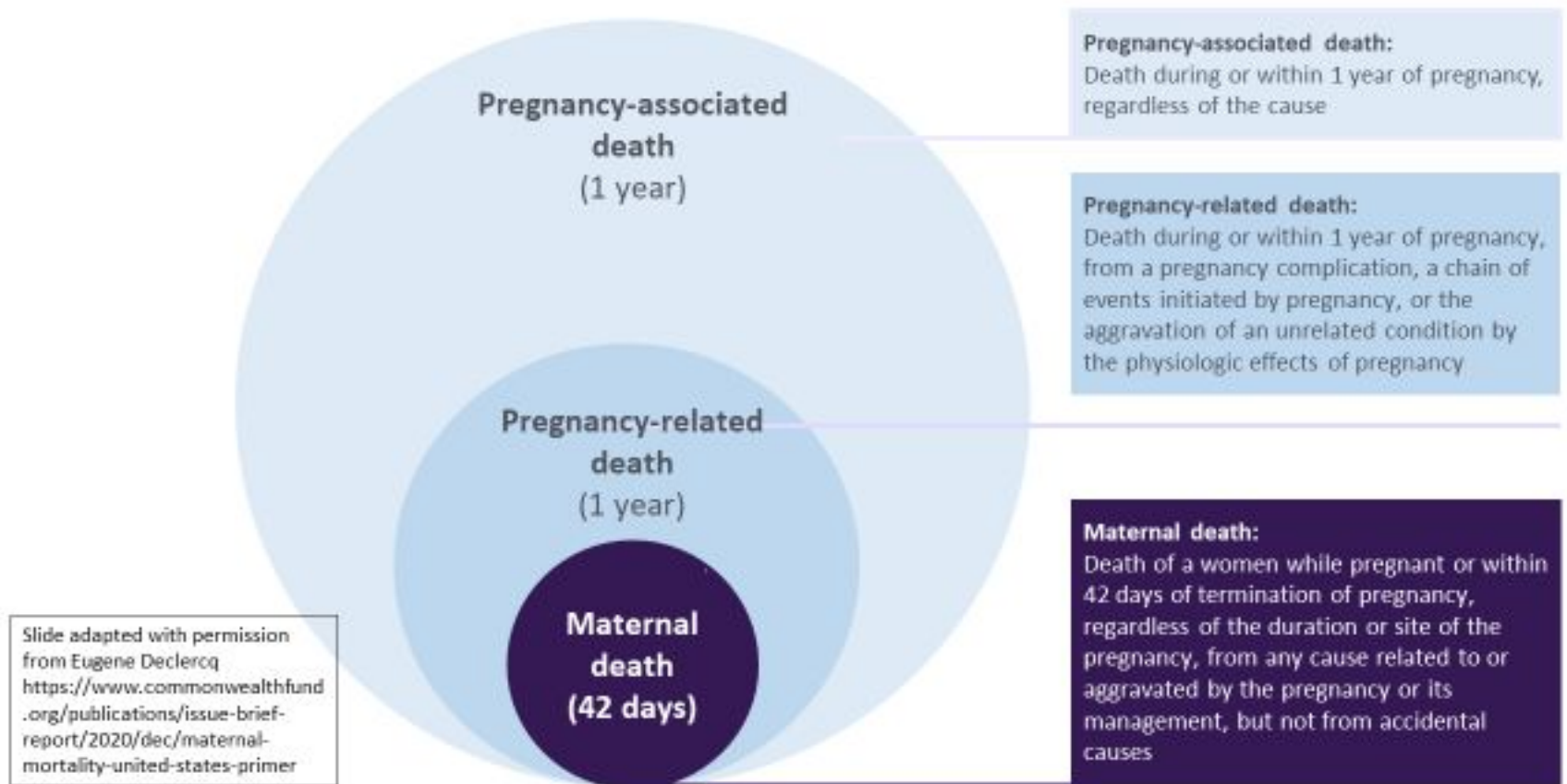
- Based in Medicaid and MHSA data, an est. **100 - 150** low-income pregnant women seek treatment for substance use issues **not** related to alcohol or tobacco at some point during pregnancy.
 - ◆ This represents 5 - 8% of all low-income pregnant women.
 - ◆ Estimate is consistent with SAMHSA surveys (5 - 9%)
 - ◆ Primary drug problems mostly meth (~37%), marijuana (31%) and opioids (12%)
- Est. **50 - 75 (2-3%) Medicaid newborns** diagnosed each year with SA withdrawal (not alcohol or tobacco)
- ~ **6-8%** of newborns diagnosed as being affected by any substance, including alcohol/tobacco

Maternity Mortality Review Committee

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- Established 2021
- MMRC will review all pregnancy associated deaths or any death with an indication of pregnancy within 365 days to Wyoming residents
- Purpose is to make policy recommendations for service improvement, particularly in the case of preventable deaths
- The MMRC makes 5 key decisions in their review:
 - ◆ Was the death causally related to pregnancy or its management?
 - ◆ What was the underlying cause of death?
 - ◆ Was the death preventable?
 - ◆ What were the factors that contributed to the death?
 - ◆ If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if taken, might have changed the course of events?

Maternal Mortality Definitions



Slide credit: CDC Division of Reproductive Health

Preliminary MMRC Findings 2018 - 2020

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- **13 pregnancy-associated** deaths in 2018 - 2020
 - ◆ 12 reviewed, one is awaiting completion of legal proceedings.
- **6** of 12 deaths were classified as **pregnancy-related**.
 - ◆ 5 were not related, 1 could not be determined.
- **Mental health conditions** were the underlying cause of death in 4 of 6 pregnancy-related deaths.
- **Substance use** was involved in all 6 cases.

Preliminary MMRC Findings 2018 - 2020

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- **3** mothers were **known to have lost insurance coverage** before the time of death.
 - ◆ In 3 of 6 deaths, mothers had Medicaid at the time of delivery. 2 had lost eligibility 60-days postpartum.
 - ◆ In 1 of the deaths, the mother lost private insurance coverage after delivery.

Medicaid Postpartum Coverage

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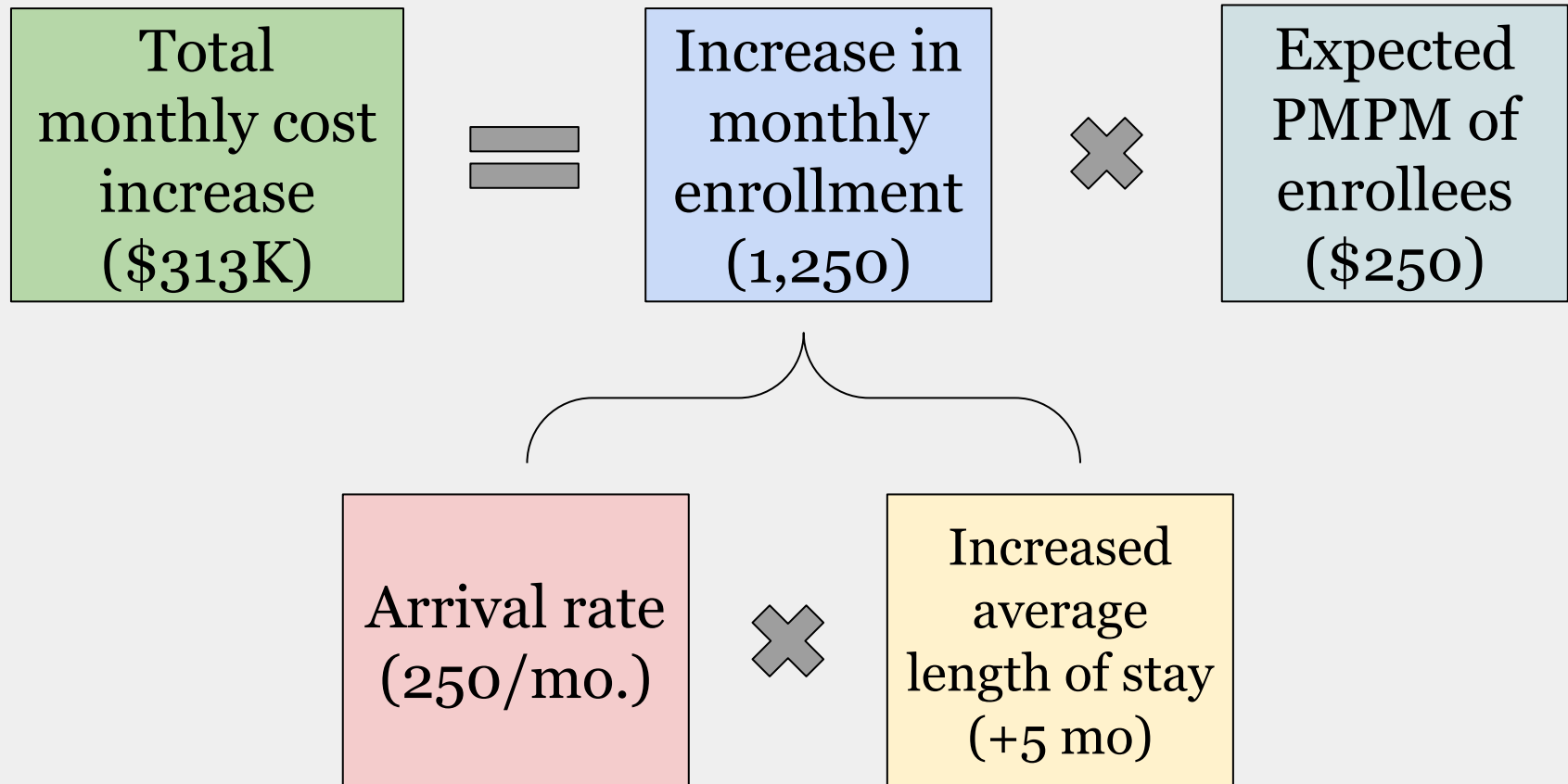
Experience - Public Health Emergency

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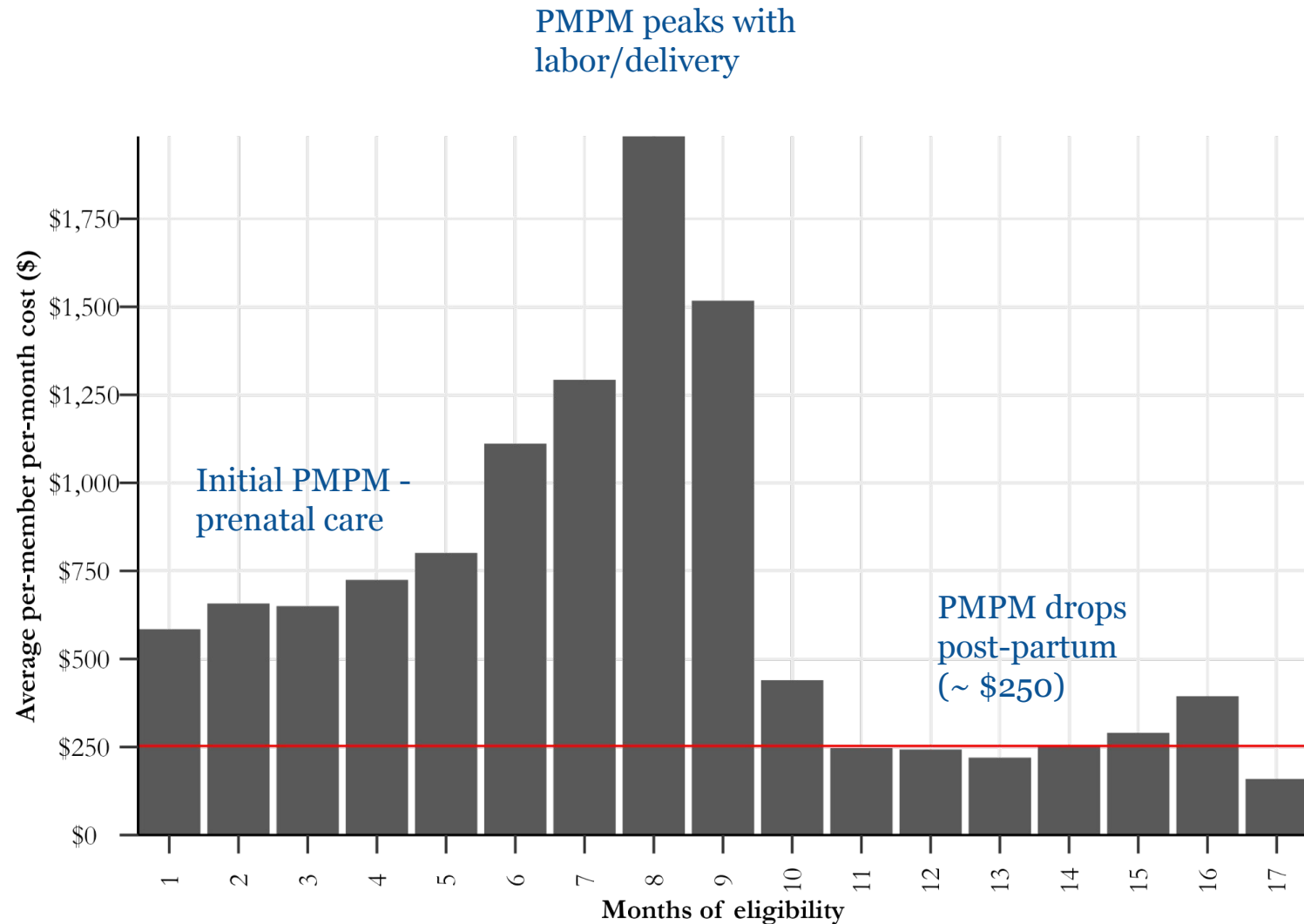
- During the COVID Public Health Emergency, Wyoming Medicaid is generally prohibited from disenrolling members.
- Where pregnant women were previously limited to 60-days postpartum, they are now **not** disenrolled.
- Natural experiment to see:
 - ◆ Churn patterns without 60-day limit
 - ◆ Per-member per-month costs
- Data gives us good estimate of what 1-year postpartum extension would cost.

Est. cost of postpartum expansion: ~ \$3.8M per year

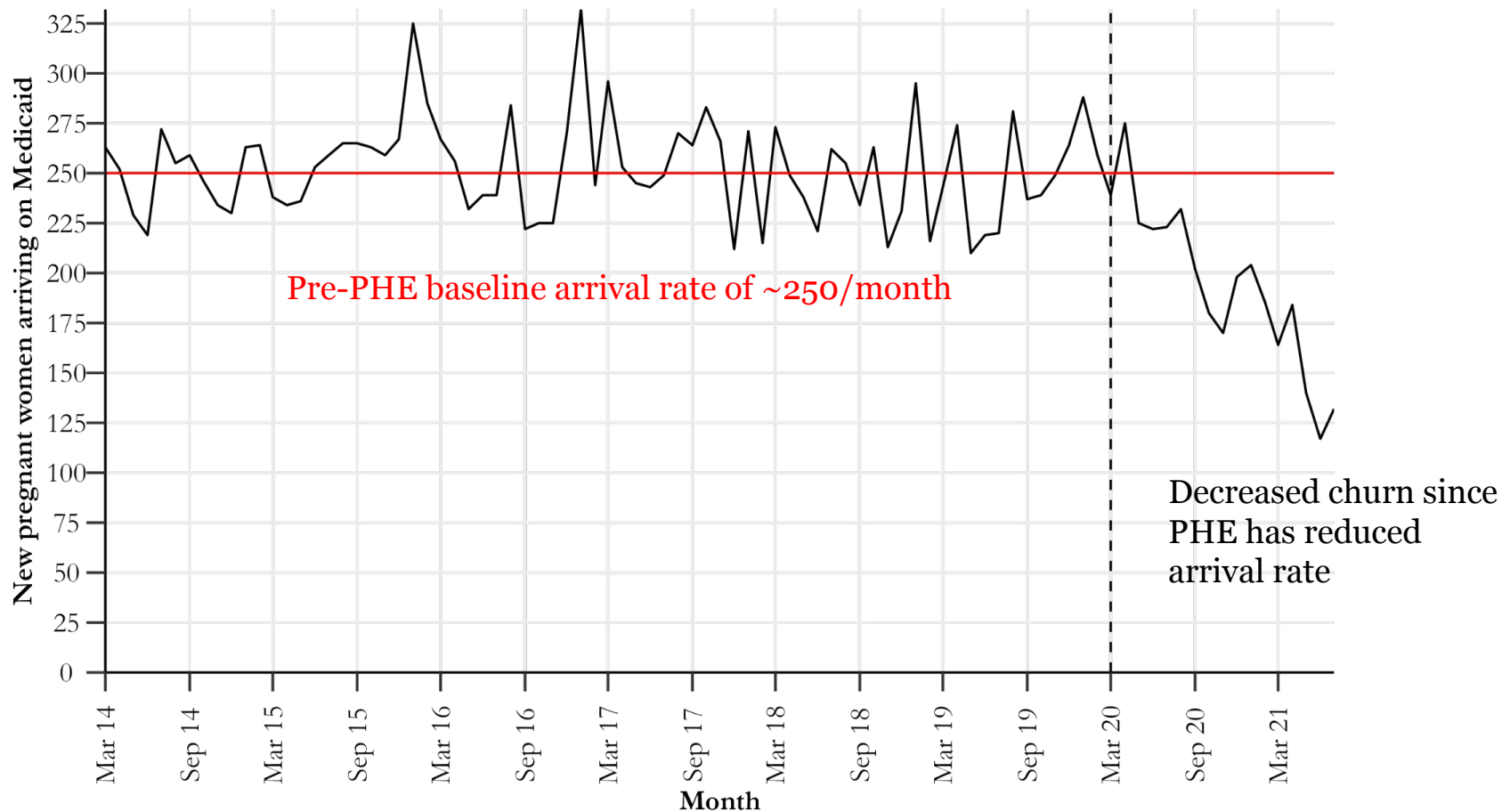
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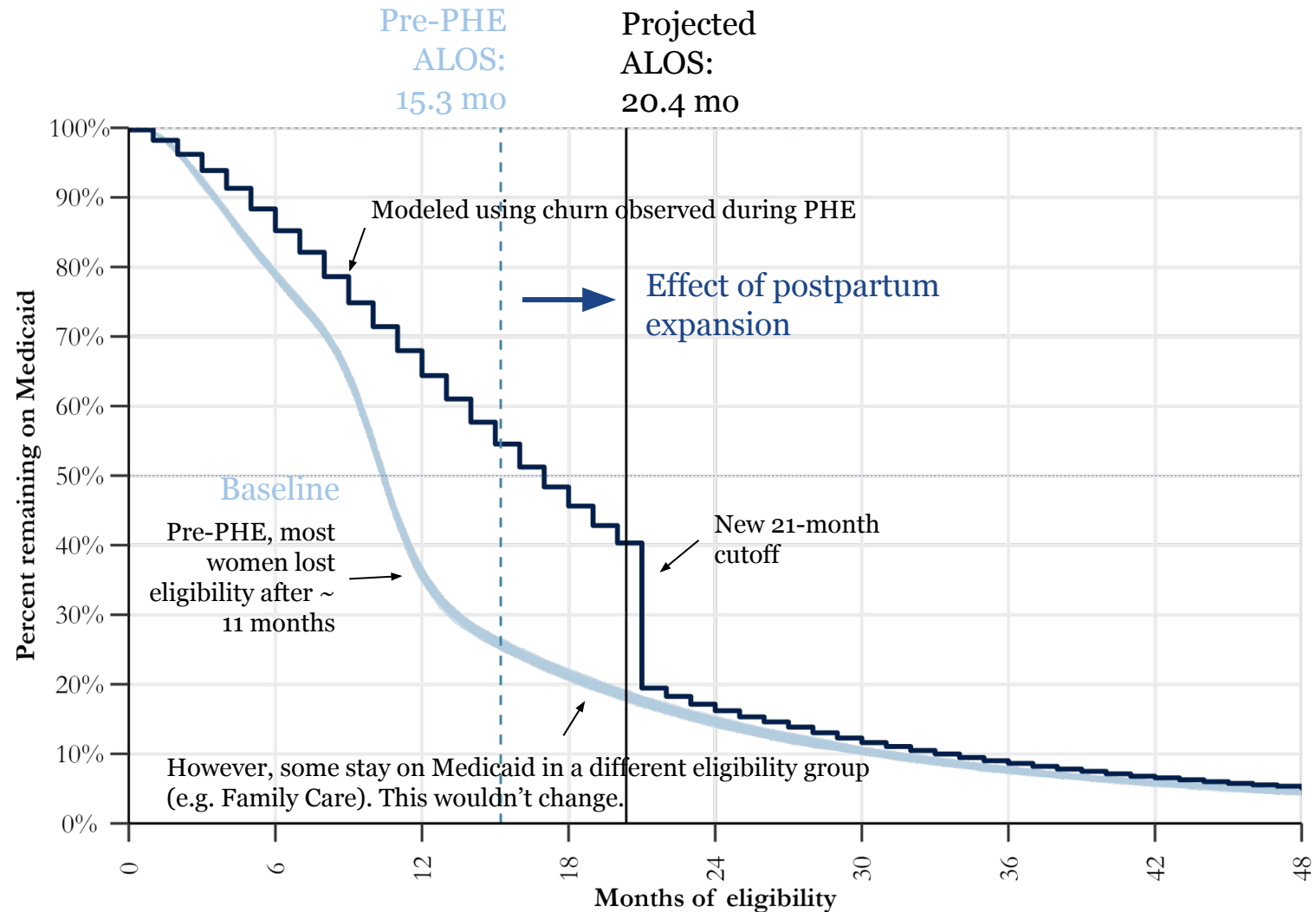
Pregnant Women PMPM by Eligibility Month



Pregnant Women Arrival Rates



Pregnant Women Churn / Average Length of Stay



Behavioral Health Redesign (BHR)

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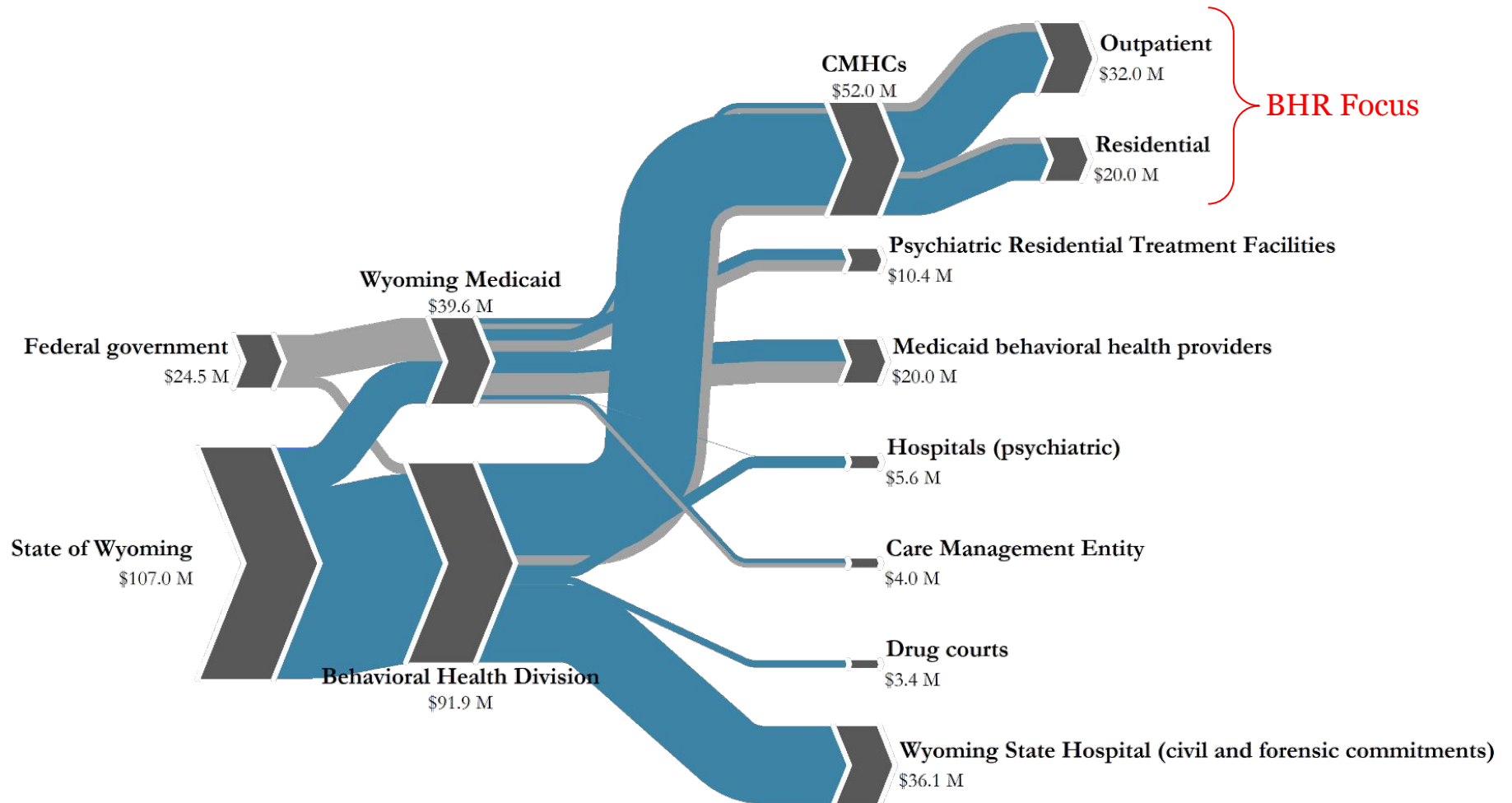
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Behavioral Health Redesign

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- State spends ~\$100M per biennium on behavioral health services from its contracted network of Community Mental Health and Substance Abuse Centers.
- Tension between two primary State objectives:
 - ◆ Ensuring high-needs people receive the services they need to stay in the most integrated, most appropriate and least restrictive environment.
 - ◆ Ensuring access to behavioral health services around the State for the general public.
- How can this massive procurement be redesigned to balance these objectives?

Annual WDH Behavioral Health Funding



Behavioral Health Redesign

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- Desired endstate is relatively modest:
 - ◆ People in State (e.g. WDH, DFS, DOC) institutions are **actively pulled** towards community treatment by providers, thus increasing effective capacity at these institutions without adding beds.
 - External marginal costs will decrease if successful.
 - Potential to share demonstrated savings with community providers.
 - ◆ High-needs people who are not inclined to treatment **do not fall through the cracks**. Recidivism in State institutional systems decreases.
 - ◆ **Outcomes** tracking is meaningful, prioritized, timely, granular and reliable.

Behavioral Health Redesign

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- Process started with passage of House Enrolled Act 56 in the 2021 General Session.
- Significant progress made in summer of 2021 on:
 - ◆ Refining definitions and criteria for priority populations;
 - ◆ Defining outcomes the State wants measured;
 - ◆ Laying out how transitions can happen between institutional settings and community providers.
- WDH reported to JtLHSS in 9/2021 that significant work remained.

Behavioral Health Redesign

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- House Enrolled Act 25 in 2022 Budget Session directed continued work and extended implementation date to 2024.
- Primary work remaining: defining the payment model.
 - ◆ This is the most complex and difficult topic to tackle.
 - ◆ Last year, general agreement on splitting payments into three categories:
 - Fixed payments (~ 40%)
 - Service payments (~ 40%)
 - Outcomes payments (~ 20%)

System Design Principles

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- **Maximize federal and other third party funding** in order to ‘grow the pie’ available to providers while conserving SGF.
- ◆ All eligibility applications and all claims payments must go through existing Medicaid infrastructure.
- ◆ This also allows DFS to use Title IV-E (Foster Care) funding, as well as look for potential Third Party Liability recoveries.
- ◆ Investment requirements in systems and staffing at both the State and the provider level to make this work.

System Design Principles

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- **Use payment to align provider interests with those of the State.**
 - ◆ Adding micromanagement and centralized planning from Cheyenne will not be effective.
 - Never will be enough staff nor enough information to make this work.
 - ◆ Instead, build carefully-constructed economic incentives into the system. Examples:
 - Payment for achieving client outcomes;
 - Acuity-adjusted episode payments for residential infrastructure (“beds”).

Behavioral Health Redesign - Meetings

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Date	Time	Location
5/13/2022	13:00 - 17:00	Cheyenne (Capitol W113)
6/15/2022	9:00 - 13:00	Casper (Thyra Thomson State Building, SCD Conference Room 3017)
7/13/2022	9:00 - 13:00	
8/17/2022	9:00 - 13:00	
9/9/2022	13:00 - 17:00	

Supplemental Payment Program for Psychiatric Residential Treatment Facilities

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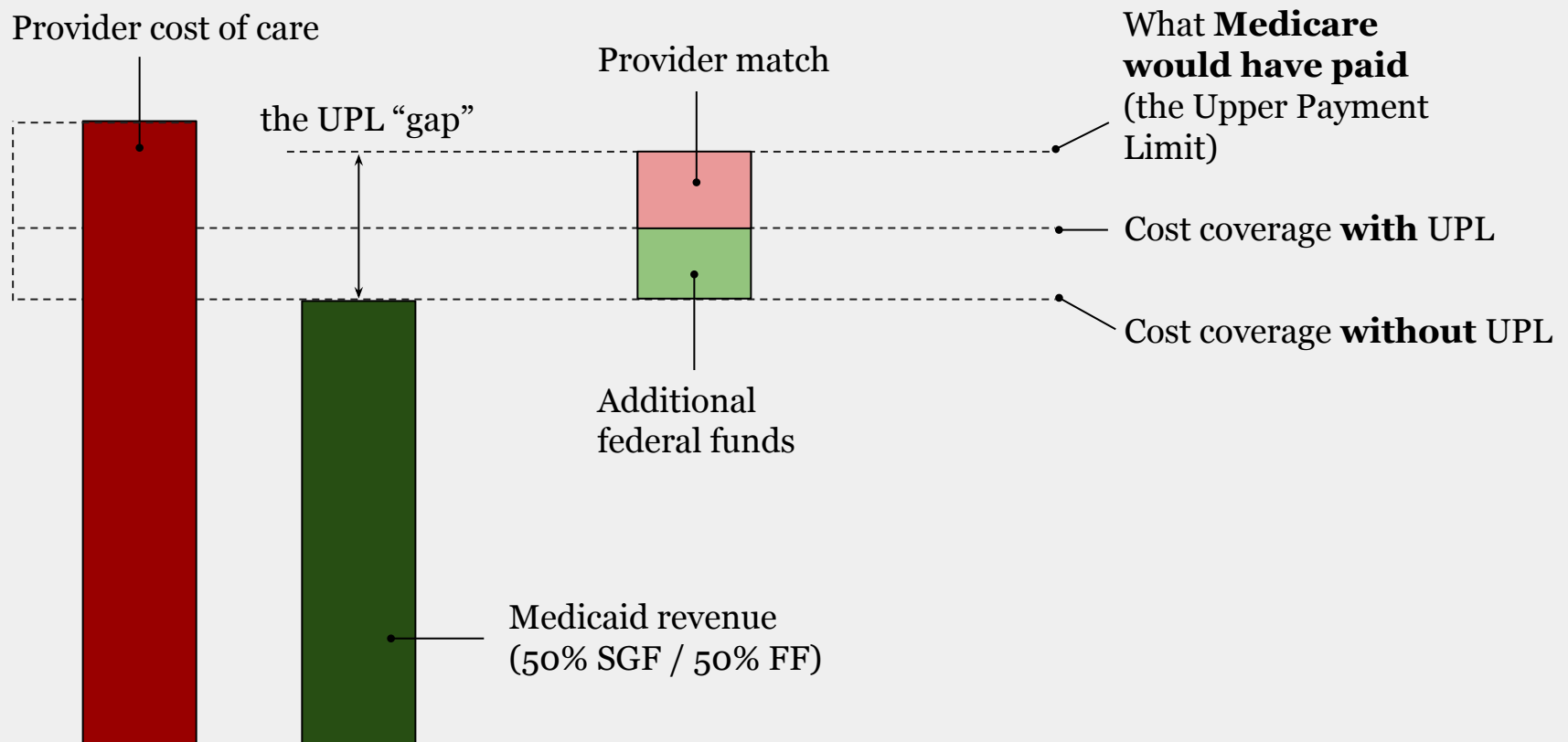


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What are “Upper Payment Limit” programs?

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What are “Upper Payment Limit” programs?

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- These programs allow Medicaid to **provide additional federal funds** to these providers without cost to the State General Fund.
- Generally speaking, use **provider matching funds** to draw down **additional federal funding**, up to what **Medicare** would have paid for the same services (the “Upper Payment Limit”).
- Provider matching funds come from **special-purposes taxes or transfers**.
- Provider taxes must be broad-based, uniform, generally redistributive and **cannot hold providers harmless** (no guarantee of payment);

What are “Upper Payment Limit” programs?

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- Current UPL programs:
 - ◆ Inpatient/outpatient hospitals;
 - ◆ Nursing facilities (private and non-profit/governmental).
- Programs currently being implemented:
 - ◆ Qualified practitioners (physician and other professional services) owned or operated by a private hospital;
 - ◆ Ground ambulance (EMS) services.

What are PRTFs?

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- A Psychiatric Residential Treatment Facility is any **non-hospital** facility with a provider agreement with a State Medicaid Agency to provide the **inpatient psychiatric services benefit** to Medicaid-eligible individuals under the age of 21.
- The facility must be accredited by JCAHO or any other accrediting organization with comparable standards recognized by the State
- PRTFs must also meet the requirements for inpatient psychiatric services to individuals under 21 in CFR §441.151 through 441.182.

What are PRTFs?

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- Currently there are two (2) PRTFs in Wyoming
 - ◆ Saint Joseph's Children's Home
 - ◆ Wyoming Behavioral Institute (WBI)
- There are an additional 13 PRTFs contracted with Wyoming Medicaid located out of state, 4 of which are in regular use.

Wyoming Medicaid PRTF Funding

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- “Step 2” budget reductions resulted in a 2.5% cut in PRTF base rates, consistent with the rate cuts among all Medicaid providers. After these cuts, the SFY 21-22 PRTF biennial budget was **\$17,470,324**.
- Current expenditures are below this amount due to depressed utilization during COVID-19.
- The SFY 23-24 budget did fund PRTF rebasing.
- This will increase **in-state rates by ~12%** and **out-of-state rates by ~5%** for service dates after July 1, 2022

Supplemental Payments for PRTFs

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- Supplemental payment programs can provide a way to pay PRTFs more without additional State General Funds.
- Generally, UPLs are established by reference to Medicare rates. However, there is no Medicare rate for PRTFs, since they provide care for those under 21
- Supplemental payments to PRTFs may be based on costs reports or an objective funding distribution methodology, provided that no facility is reimbursed above its costs.

Mental Health Crisis Care

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Agenda

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- Community Mental Health Center (CMHC)
Structure and Services
- Identified Gaps
- Addressing Gaps

Community Mental Health Centers Structure and Services

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- Wyoming's 23 counties are assigned to **regions** based on geography and population.
- The regional model is designed to treat clients locally through resource sharing between CMHCs.
- Crisis stabilization programs are funded in 4 of the 5 state regions:
 - ◆ **Basin** – Cloud Peak Counseling Center (Washakie)
 - ◆ **Central** – Central Wyoming Counseling Center (Natrona)
 - ◆ **Southeast** – Volunteers of America (Laramie)
 - ◆ **West** – Southwest Counseling Service (Sweetwater)

Crisis Stabilization Service Defined

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- **Mental Health Crisis:** An acute psychiatric episode which, if left untreated, could lead to the placement of the person in a more intensive clinical setting including, but not limited to, inpatient hospitalization.

Crisis Stabilization Service Defined

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- **Crisis Stabilization Services:** Short-term regional residential service for persons experiencing a mental health crisis, with a focus on retaining connections to the family and community.
- ◆ The purpose of crisis stabilization is to provide services in the least restrictive setting clinically appropriate to meet the individual's needs
- ◆ Crisis stabilization services can be used as a “step-down” for persons with mental illness from more restrictive settings, such as inpatient hospitalization or correctional settings.

Budget

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Region	21-22 Biennial Funding	Beds
Basin	\$ 1,387,750	9
Central	\$ 708,633	4
Southeast	\$ 1,039,680	8
West	\$ 835,623	6
Total	\$ 3,971,686	27

- Crisis stabilization facilities were established in 2007 with an initial General Fund appropriation of \$1,242,175
- Subsequent appropriations and funding changes increased programmatic support to its current level

Identified Gaps

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- Emergency and crisis services for children and adolescents.
- Resources: crisis infrastructure, staffing, logistics and funding.
- Community stakeholder and resource agreements.
- Evidence-based emergency crisis intervention services:
 - ◆ 24-hour crisis stabilization
 - ◆ Mobile crisis services
 - ◆ Crisis intervention teams

Addressing Gaps

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- Behavioral Health Reform Efforts
- Development of a crisis services delivery system characterized by:
 - ◆ National best practices and definitions
 - ◆ Regional crisis access and capacity
 - ◆ Reduction in Title 25 involuntary hospitalization admissions
- Support for Crisis Call Centers with 24/7 Access
- Establishment of Mobile Crisis Response Teams

MTM Services - Crisis Analysis

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- The Behavioral Health Division (BHD) worked with National Council – MTM to evaluate the Wyoming crisis capacity.
- This evaluation was based on national best-practice standards for a three-tiered system to address crisis system delivery:
 - ◆ **Tier 1** – Regional Crisis Call Centers that meet National Suicide Prevention Lifeline (NSPL) standards and support 24/7 access to clinical staff who provide crisis intervention via telephone, text, or chat.
 - ◆ **Tier 2** – Crisis Mobile Response Teams that are available to reach any individual in the service area in a timely manner.
 - ◆ **Tier 3** – Crisis Receiving and Stabilization Facilities providing short-term observation and stabilization in a non-hospital environment.

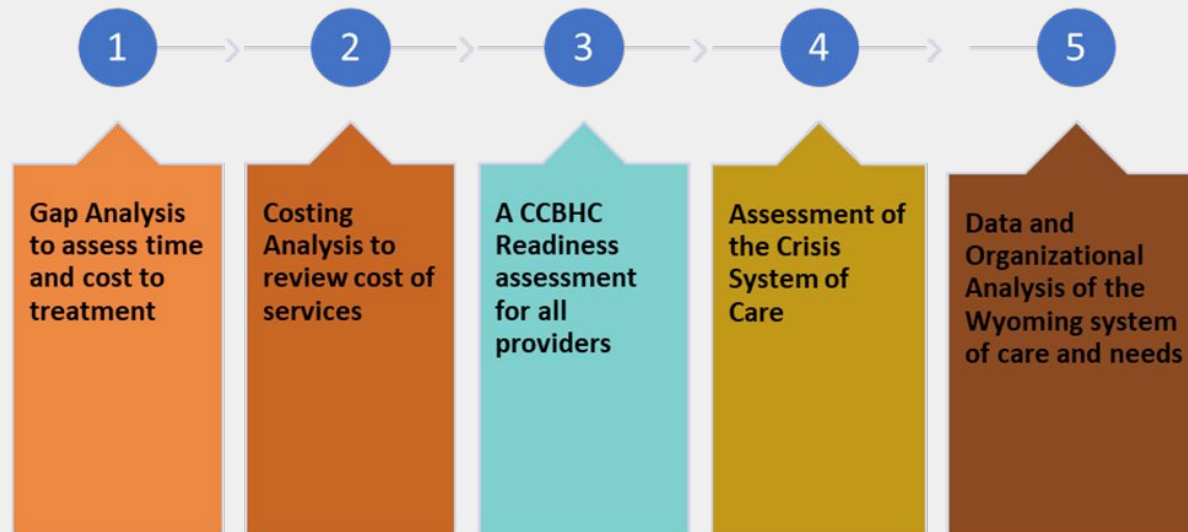
MTM Services

Assessment and Consultation Phases

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Phase I: Crisis Services Analysis and Recommendations

MTM Services conducted a series of assessments of the Wyoming system of care with the following areas of focus:



Phase II: Crisis Services Planning and Development

MTM Services is working with BHD, the provider community and stakeholders to draft updated Crisis Service definitions based on National Best Practices

Wyoming Home Services - 1115 Waiver

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Statute

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W.S. § 9-2-1208: Community based in-home services

(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.

Funding

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SFY	SGF	People Served
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

SGF makes up ~70% of total program cost. The remainder is ~20% local matching funds and ~10% participant contributions.
Including these sources, total cost was **\$3,975,717 in SFY 2021.**

Legislative requirements

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Footnote 6 to Section 048 of Senate Enrolled Act 12 from the 2022 Budget Session:

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.**

Legislative requirements

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Footnote 6 - reporting requirements

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.

Legislative requirements

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- As a requirement of continuing Wyoming Home Services, the Department must **begin** the process of turning the program into a Medicaid “1115 Waiver” (here referred to by the U.S. Code section 1315)
- We will present the resulting proposal, along with full costs and benefits, to JtLHSS and JAC in the Fall of 2022.
- Legislature will provide direction on whether to apply/implement, given these details.
- This transformation will take some time, and will require administrative lift.

What are “Waivers”?

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- The word “waiver” refers to “waiving” certain statutory provisions of the Social Security Act, through an agreement between the State and Centers for Medicare and Medicaid Services.
- Generally speaking, waivers have **expanded services** and **populations covered**.
- Most are focused on **alternative service delivery** as a way of containing costs.
 - ◆ Home and Community Based Service waivers, for example, provide long-term care at much lower cost than nursing home/institutional services.

What are “Waivers”?

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- Several types of waivers. Examples:
 - ◆ § 1915(b) - Managed care
 - ◆ § 1915(c)(i)(j)(k) - Various home and community based services options
 - ◆ § 1115 waivers - Demonstrations
- 1115 is the most “creative” waiver type. Allows application for experimental/pilot demonstration projects that are found by HHS to be “likely to assist in promoting the objectives of [the Medicaid program].” Can waive almost any requirement under § 1902.
 - ◆ Even under § 1115, however, 52 provisions of SSA cannot be waived (§1903 - FMAP, for example)

Fundamental 1115 Waiver Requirements

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- Must be, in the judgement of the Secretary of the Department of Health and Human Services, be likely to **assist in promoting the objectives of the Medicaid program**.
 - ◆ The primary objective of Medicaid is to assist States in **furnishing medical and rehabilitative assistance** to eligible individuals. (§1901 SSA)
- Must be **budget neutral** to the federal government.
 - ◆ Federal costs under the waiver cannot exceed projected federal costs without the waiver.
- State must provide significant **public notice** and **transparency** in the application process.
- Demonstration must be **rigorously evaluated**.

What problems are we trying to solve?

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- This is **not** just an exercise in bureaucracy.
- Formalizing WyHS with an 1115 waiver has the opportunity to fundamentally restructure the program to benefit its members:
 - ◆ Increased and more diversified funding.
 - ◆ More intensive and standardized services.
 - ◆ Coordination with Medicaid benefits.
 - ◆ Rigorous evaluation of whether or not the program is effective.

What problems are we trying to solve?

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- If successful, the shift to an 1115 Waiver will be a significant change for providers in how they do business.
- This requires careful coordination and engagement to design the waiver accordingly.
- Examples of some questions that need to be resolved:
 - ◆ Provider networks. Should they be restricted, or open?
 - ◆ Services offered, intensity of those services, and standardization across the state.
 - ◆ Member eligibility, needs and financial assessments, degree of coordination with Medicaid.
 - ◆ How providers are paid; member cost-sharing.
 - ◆ Evaluating effectiveness.

Way forward

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- Parallel meetings over the summer:
 - ◆ With **stakeholders**, to work out proposal for nuts and bolts;
 - ◆ With **CMS**, to see what is acceptable, and discuss more technical application details (e.g., budget neutrality demonstration).
- Have held initial meetings with both parties, and received good feedback.

Nursing Home Rate Rebasing

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What is “rate rebasing”?

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- Rates are the “unit prices” paid to providers by Medicaid
 - ◆ Example: the amount paid for a **person-day in a nursing home**, or the amount paid for a **simple physician visit**.
- Wyoming Medicaid **sets the rates** it pays for services to all providers.
- Rate increases or decreases require changes to **WDH appropriations**.
- Providers respond to rates by either choosing to serve Medicaid clients or not, though Medicaid clients make up a large share of the “market” in certain areas (I/DD, nursing homes)

What is “rate rebasing”?

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- The goal of rate setting is to balance:
 - ◆ The **total cost** of Wyoming Medicaid (i.e., the budget).
 - ◆ **Access** to providers by adequately covering their costs.
- Specific to long-term care, “rate rebasing” is a way to evaluate the **allowable costs of providing care** and **adjust (usually increase) the rates** within appropriated funds.
- If appropriations are not increased, rates are re-based on a budget-neutral basis to make things as “fair” as possible across providers.

What is “rate rebasing”?

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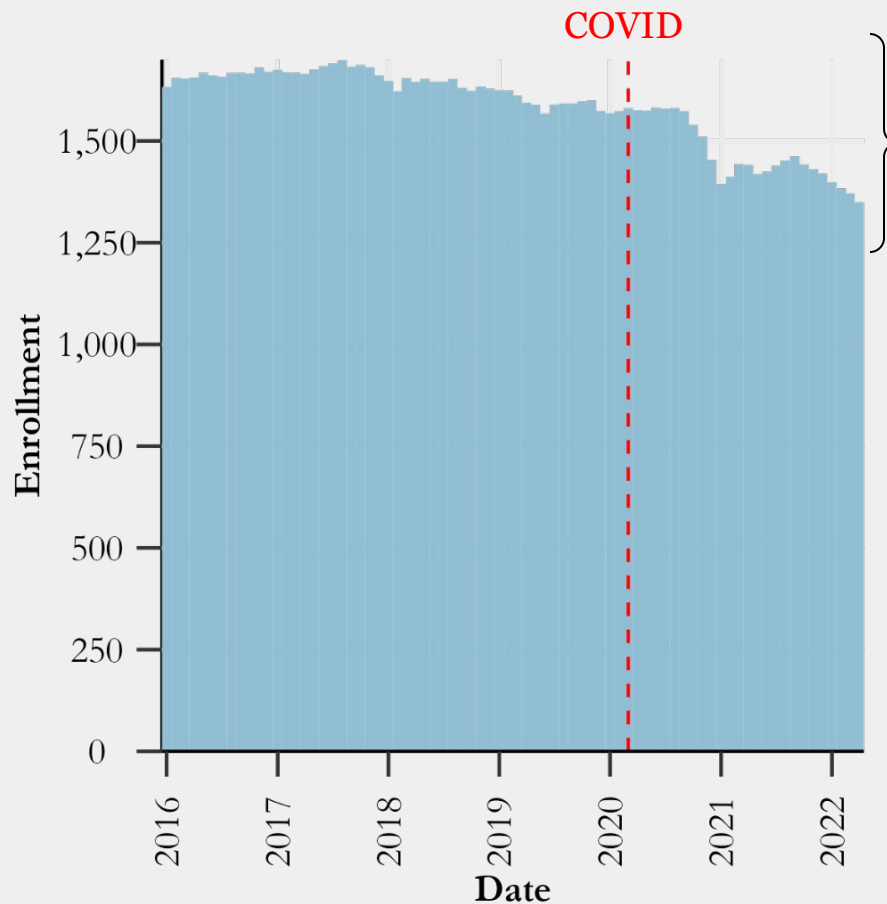
→ **Two ways to evaluate rates in long-term care:**

- ◆ **Hospitals and nursing homes** submit standardized cost reports to CMS.
 - Rates are established based on cost coverage within available appropriations and “seen” as what percent of **allowable costs** are covered.
- ◆ **Waiver providers** (for both individuals with I/DD and aging/physical disabilities) do not submit standardized cost reports.
 - Lengthy and detailed studies are conducted (at significant effort) to determine costs.

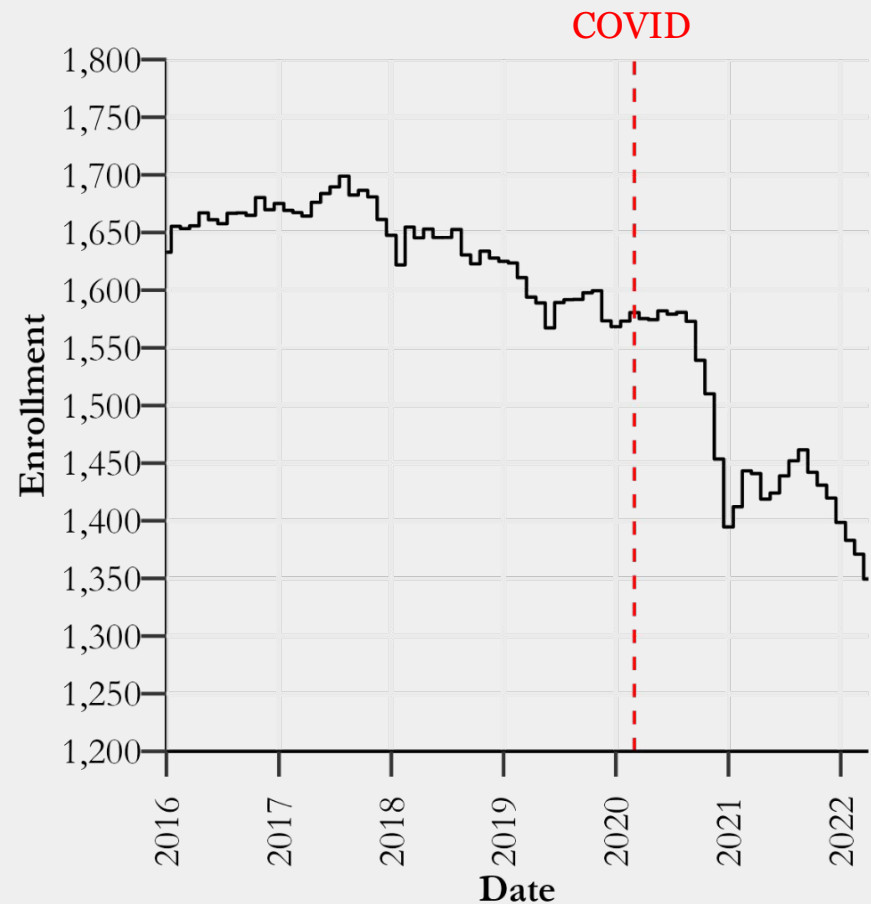
Nursing home eligibility and cost trends

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Medicaid nursing home enrollment

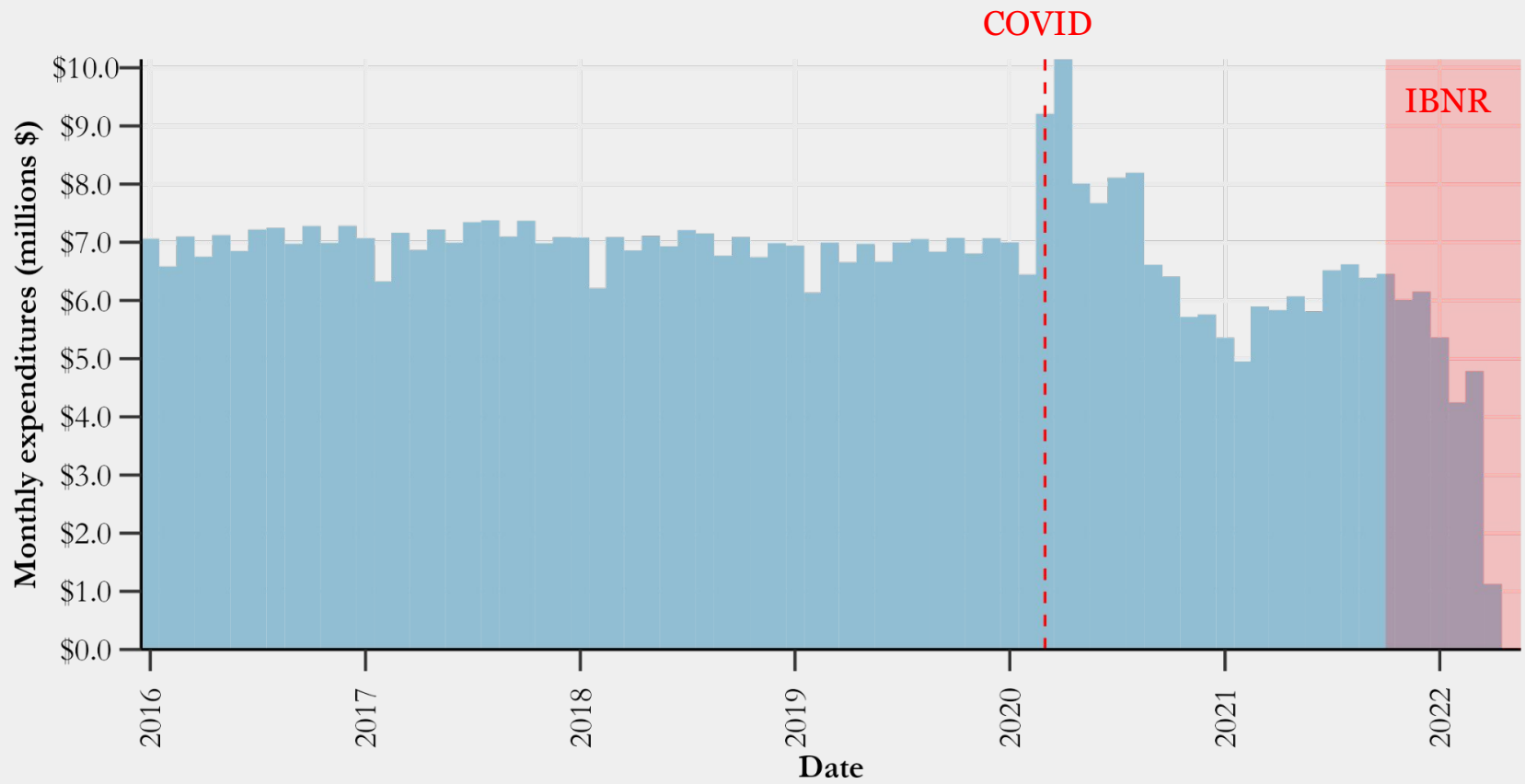


Trend (zoomed in)



Nursing home eligibility and cost trends

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Nursing home cost coverage

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Cost Report Year	w/o UPL	w/ UPL
2013	83%	91%
2014	82%	90%
2015	80%	88%
2016	80%	89%
2017	76%	86%
2018	74%	84%
2018	72%	82%
2019	71%	80%
2019	75%	84%

Note: Includes temporary PHE-related increase (5%)

Nursing home rebasing estimates

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- Last **funded** nursing home rebasing was done effective July 2015.
- WDH recommended an appropriation of ~ **\$7.4M SGF + \$7.4M FF** in 2022 Budget Session to increase nursing home cost coverage from ~83% to ~90%.
- Generally speaking, each percentage point increase in nursing home cost coverage requires ~**\$1.13 million SGF + \$1.13 million FF**.