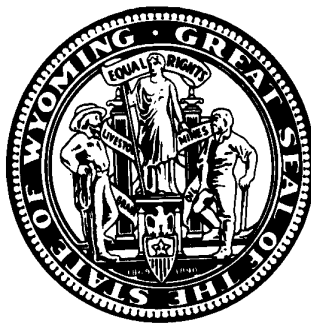


THE WYOMING APPROACH

FOR MEDICAID EXPANSION

Alternate Benefits Plan Options



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EXECUTIVE SUMMARY

In this report, the Wyoming Department of Health (WDH) presents five options for a Wyoming-specific approach to provide health care coverage to the potential Medicaid expansion group. These options are offered in response to a request from Wyoming Governor Matt Mead for the WDH to research and present choices for an approach for coverage that best fits Wyoming.

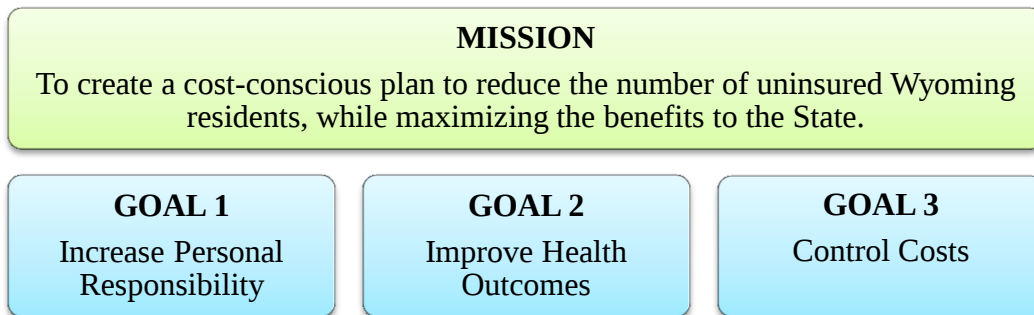
The five options are presented below with no particular priority:

- **Option One: Marketplace/Exchange.** Eligible individuals in the Medicaid expansion group select private plans on the Marketplace/Exchange. Wyoming Medicaid pays the premiums for the plans (with federal match), ensures plans meet certain state and federal requirements, and ensures supplemental or wrap-around coverage.
- **Option Two: Adult CHIP / through Managed Care Authority.** The State contracts with a private insurance carrier (or carriers)/ or managed care organization (MCO) to provide health care coverage to the expansion group. Option Two is modeled after Wyoming's Kid Care CHIP program. In Kid Care CHIP, a public-private partnership, the State sets out criteria for the health plan and Wyoming Blue Cross / Blue Shield administers it.
- **Option Three: "Medicaid Fit."** Wyoming Medicaid provides health care coverage to the expansion group through the existing Medicaid program. However, the benefits package includes fewer benefits/more limited benefits than traditional Medicaid and is tailored to the new population. Cost sharing is set at the maximum level, when appropriate.
- **Option Four: Traditional Medicaid.** Wyoming Medicaid provides health care coverage to the expansion group through the existing Medicaid program. Under this option, the expansion group receives the same benefits (traditional Medicaid/non-waiver) as currently-enrolled beneficiaries.
- **Option Five: Wyoming Unique.** The State creates a plan for covering the expansion group that is unique to Wyoming. A Section 1115 waiver is used to gain additional flexibility from Medicaid regulations than would be required by the other options. Cost sharing is set at the maximum level, when appropriate.

Each option is more clearly described in the pages that follow. This report concludes with a recommendation from the WDH.

INTRODUCTION

Governor Mead requested that the Wyoming Department of Health (WDH) research and propose options for a Wyoming-specific approach to health care coverage for a potential Medicaid expansion group. To meet this request, the WDH formed an internal team that, with gubernatorial guidance, agreed upon a mission and goals to guide its work in the development of options for a Wyoming-specific approach for coverage.



The team studied federal guidance to determine the parameters by which the State could expand its Medicaid program and receive the enhanced federal match. The team also researched other state Medicaid expansion plans, as well as other state waiver programs to develop potential options that would be acceptable in Wyoming. Upon the conclusion of this research, the WDH internal team agreed to propose five options which are presented and explained in the following pages.

The report begins with a brief discussion of necessary decision points that will be encountered by Wyoming decision-makers contemplating a Medicaid expansion. It will then explain the parameters within which states may expand their Medicaid programs. The WDH internal team agreed to present five options for a Wyoming-approach for health care coverage. This report details those options along with pertinent considerations.

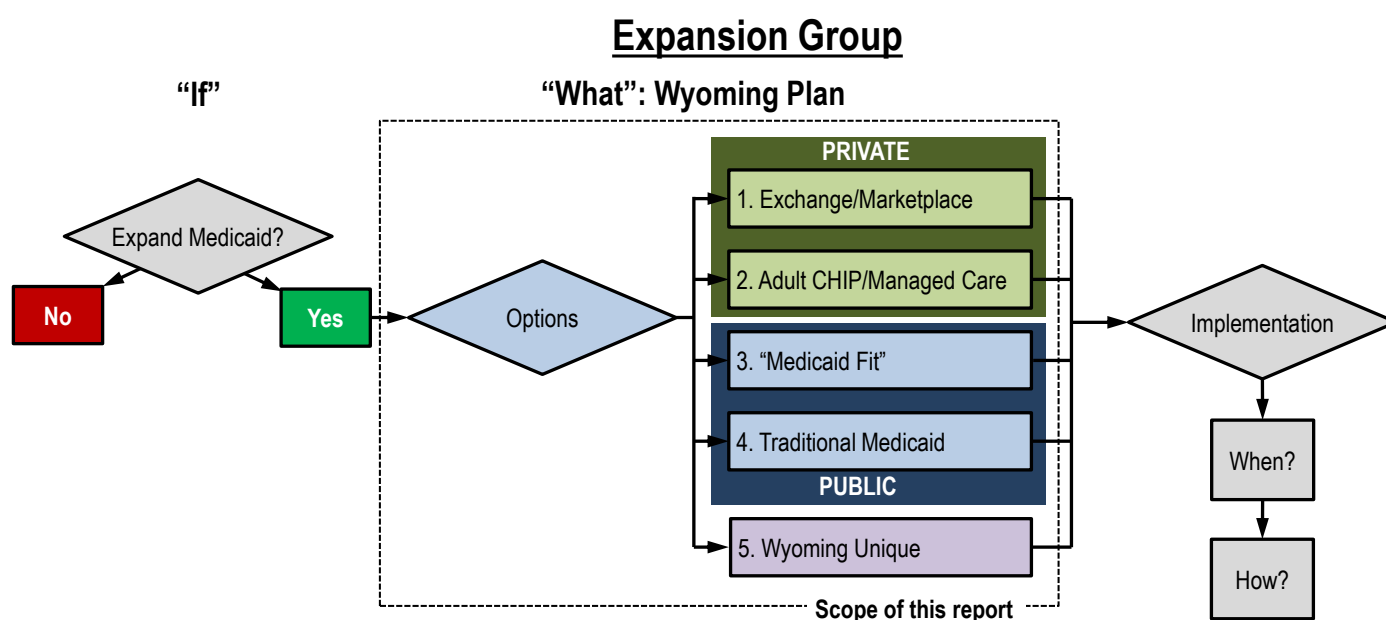
This report assumes that Wyoming has made the decision to offer coverage to the expansion population, and so any discussion of positive/negative/neutral considerations is specific to the option presented and not to whether or not coverage is offered.

THE DECISION POINTS

The decision whether to expand a state's Medicaid program is monumental, but it is only the first step in a process with several critical decision points.

The first essential question is **if** the state is going to expand its Medicaid program. Once Wyoming makes the decision to expand coverage to individuals up to 138% of the Federal Poverty Level (FPL), it must determine **what** type of coverage it will offer through the benefits package. After the benefits package is established, the state must decide **when** it is going to pursue expansion, and **how** it will accomplish its expansion.

The graphic below illustrates this decision-making process:



In the fall of 2012, the Wyoming Department of Health (WDH) wrote a report entitled *The Optional Expansion of Medicaid in Wyoming: Costs, Offsets and Considerations for Decision-Makers* to inform decision-makers grappling with the first decision: the "if." In this report, the WDH estimated that it could save more than 47 million dollars in General Fund money over the course of seven years if the State expanded the Medicaid program. The savings would be made possible because the *optional* expansion of Medicaid would reduce the reliance on other WDH safety net programs, and thus allow the WDH to scale back funding to those programs. In other words, expanding Medicaid (which carries an enhanced federal match) would allow the State to realize several offsets and thus save the State money.

In the same report, WDH explained that if the State chose not to pursue the *optional* expansion of its Medicaid program, the *required* expansion of Medicaid to newly eligible children and the coverage of the “woodwork” population would end up costing the State approximately 79 million dollars over the course of seven years. This cost would occur because the WDH would not have the flexibility to maximize certain offsets but would still have to serve additional people in Medicaid (woodwork and newly eligible children). For additional information on the first decision point: the “if”, please look to the WDH report referred to above.

The second decision point, the “What?” is the focus of the following pages. As previously stated, this report assumes that the decision has been made to pursue the *optional* expansion of Wyoming’s Medicaid program.

THE RULES (ABBREVIATED)

States that choose to expand their Medicaid programs pursuant to the Affordable Care Act (ACA) must do so in accordance with federal regulations in order to receive an enhanced federal match (100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond). These federal regulations, however, do allow states some flexibility beyond what is allowed in the traditional Medicaid program. For example, states do not have to offer traditional Medicaid benefits to the expansion group, but instead may design different benefits packages called “alternate benefits packages,” or ABPs.

The alternate benefit package designed for the expansion group must cover the ten Essential Health Benefits (EHBs), transportation services, family planning services, and care provided by rural health clinics and Federally Qualified Health Centers (FQHCs).¹

The Essential Health Benefits set out by the ACA include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).²

Several groups cannot be required to enroll in a plan that offers the alternate benefits package, but must be offered traditional Medicaid benefits. These groups include: people with disabilities, dual-eligibles, the “medically frail,” certain low-income parents, pregnant women, and other special groups.³ Due to these exemptions, no matter what alternate plan is selected, a portion of the expansion group may be exempted from required enrollment in the ABP.

Additional flexibility is allowed to states to require cost sharing from any newly eligible adult, particularly from individuals with incomes between 100% and 138% of FPL. Further flexibility can be gained through a Section 1115 waiver. Section 1115 allows the Secretary of Health and Human Services (HHS) to waive certain provisions of the Social Security Act (pertaining to Medicaid) and permit Federal Financial Participation (FFP) in experimental ‘demonstration’ projects that are likely to assist in promoting the statutory objectives of the Medicaid program.⁴

While waivers are not permanent, states like Oregon and Massachusetts have relied on them to build semi-permanent Medicaid systems over the last decade, and states like Indiana and Arkansas are submitting Section 1115 waivers to re-structure unique state Medicaid plans.

¹ Explaining Health Reform, Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, *Focus on Health Reform*, The Kaiser Family Foundation, August 2010 at pg. 3.

² Essential Health Benefits factsheet: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

³ Explaining Health Reform, Benefits and Cost-Sharing for Adult Medicaid Beneficiaries, *Focus on Health Reform*, The Kaiser Family Foundation, August 2010 at pg. 3.

⁴ Social Security Act §1115(a).

THE “WHAT?” | ALTERNATE BENEFITS PACKAGE OPTIONS

The WDH team considered and evaluated multiple possibilities for an approach to provide health care coverage to the Medicaid expansion group. Upon the culmination of its research and evaluation, the WDH internal team agreed to propose five options.

These options are presented in the sections that follow in no particular order. While the options are presented in no particular order, the WDH does offer its recommendations at the conclusion of this report.

Option One: Marketplace/Exchange operates Qualified Health Plans

Under Option One, Wyoming would purchase health coverage for the expansion group on the Federally-Facilitated Exchange (hereinafter Marketplace/Exchange). The expansion group would choose their plans through the Marketplace/Exchange and private insurance companies would directly provide insurance coverage, establish networks and rates, pay providers and perform other administrative functions. The State would pay premiums and ensure federal and state Medicaid requirements are met.

Private insurance companies have already designed benefit packages to be certified as Qualified Health Plans (QHP) to be sold on the Marketplace/Exchange. The plans must, at a minimum, cover the ten essential health benefits established by the ACA.

Federal regulations require additional benefits be offered to the expansion group (because they are Medicaid clients) that are not likely to be included in a regular QHP. The State would, therefore, have to ensure those benefits are provided to the expansion group on top of what it is offered through the Marketplace/Exchange.⁵ These benefits are sometimes referred to as “wrap-around” benefits.

While the Centers for Medicare and Medicaid Services (CMS) has recently issued guidance that describes a state’s ability to provide premium assistance to Medicaid recipients through a state plan option (without a waiver), to do so, a state must prove the option is cost effective (or budget neutral) and also must allow those selecting individual coverage the alternative of selecting traditional Medicaid instead of private coverage.⁶ Additional flexibility from these and other federal regulations is being sought by some states that are requesting approval of Section 1115 waivers to provide premium assistance for purchase of QHPs in the Marketplace/Exchange.

⁵ The State would have to ensure the expansion group receives these additional benefits by providing supplemental coverage through a private plan, providing an additional “wrap-around” policy, or providing these services through Wyoming Medicaid.

⁶ CMS FAQ, Medicaid and the Affordable Care Act: Premium Assistance, March 2013.

A Section 1115 waiver allows the “waiver” of certain Medicaid requirements to support innovative demonstrations that further the objectives of the Medicaid program.⁷ The United States Department of Health and Human Services (HHS) will consider the approval of a limited number of premium assistance demonstrations. HHS will only consider demonstration proposals that:

- sustain budget neutrality (are cost effective)
- provide Medicaid clients with a choice of at least two QHPs
- provide necessary wrap-around benefits and limit cost sharing
- exclude certain groups with more complex health care needs (those described in the Social Security Act section 1937(a)(2)(B) i.e. the medically frail) from private coverage and cover those groups with traditional Medicaid
- end no later than December 31, 2016⁸

It is interesting to note that while states must expand Medicaid eligibility to the entire expansion group (0-138% FPL) in order to receive the enhanced federal match, a state may limit the demonstration waiver to those with incomes above 100% FPL.⁹

The table below offers additional considerations and information about Option One.

Option One: Marketplace/Exchange
Operations: Expansion group would select insurance coverage on Marketplace/Exchange; Medicaid would pay the premiums and ensure compliance with federal and state regulations; private insurers would provide coverage/operate plans.
Benefit Package: Most likely fewer benefits than traditional Medicaid. Qualified Health Plans are required to cover the minimum ten Essential Health Benefits. State would likely have to provide supplemental or “wrap-around” coverage.
Time to Implement: At least 12 + months from State approval.
Adaptability to WY: Unknown; plans/rates would be market-driven, but Marketplace/Exchange would be federally run.
Certainty: Uncertain. Wyoming has no experience with the soon-to-be-created Marketplace/Exchange and because it is federally run, Wyoming has little to no control over the Marketplace/Exchange.
Additionally, it is not possible to know whether the federal government will allow the State to purchase coverage for its Medicaid expansion population on the Marketplace/Exchange, as the Marketplace/Exchange will be federally run.
Positives
Viability of Exchange. Adding thousands of Medicaid clients to the pool of insured in the Marketplace/Exchange could strengthen its viability by having more individuals share risk.

⁷ Social Security Act §1115(a).

⁸ CMS FAQ, Medicaid and the Affordable Care Act: Premium Assistance, March 2013.

⁹ CMS FAQ, Medicaid and the Affordable Care Act: Premium Assistance, March 2013.

While it could be argued that the addition of Medicaid clients would not be beneficial due to the supposed higher costs of this group, several of the higher-cost Medicaid clients would be exempt from this type of coverage and served through traditional Medicaid. On balance, it is likely the addition of the expansion group would be beneficial to the Marketplace/Exchange. If this option is chosen, a substantive analysis would need to be completed to ensure that the addition of Medicaid clients would not hurt the viability of the Marketplace/Exchange.
Could reduce cost of insurance on Marketplace/Exchange. Because mostly healthy Medicaid clients would be added to the risk pool, premium prices on the Marketplace/Exchange could, in theory, be lower than what they could be without the Medicaid clients. This could occur due to the ability to share risk among a greater number of people. A potential reduction in the cost of insurance could benefit everyone purchasing on the Marketplace/Exchange. Again, if this option is chosen, a substantive analysis would need to be completed to determine the impact to the Marketplace/Exchange of the addition of the Medicaid expansion group.
Similar benefits for all adults between 0% and 400% of FPL on the Marketplace/Exchange should reduce negative impacts of churn. “Churn” is the process of an individual rotating in and out of eligibility as income fluctuates. This is most likely for individuals in the Medicaid expansion group with incomes between 100-138% FPL. Providing Medicaid clients insurance through the Marketplace/Exchange could reduce the negative impacts of churn because an individual could have the same plan whether he is eligible for Medicaid or not, as long as he gets insurance through the Marketplace/Exchange.
Long-term administrative simplicity. Because the State’s administrative responsibility would be limited to certifying the plans and paying the premiums, this option, once established, would reduce the administrative responsibility of the State and its role in the provision of health care coverage for this group.
Innovative model. Using the private marketplace for Medicaid clients would allow the exploration of an alternative approach to delivering services. If successful, this approach could be emulated for other Medicaid populations in the future.
Promotes personal responsibility and choice. While the State would likely be responsible for certifying plans before the plans are allowed to provide coverage to Medicaid clients, the clients would be responsible for choosing their plans. This would allow clients to compare private options and choose the most appropriate plan.
Establish comparable baseline of costs. This option would allow the State to more accurately compare costs and service utilization between the Medicaid and Marketplace/Exchange populations.
Negatives
Cost of premiums may increase costs to the State. While the cost of premiums is unknown at this time, the Congressional Budget Office estimates that purchasing coverage through the

Marketplace/Exchange will be more expensive than covering the expansion group through traditional Medicaid. ¹⁰
May not meet cost-neutrality requirements. Because paying for premiums is expected to be more expensive than traditional Medicaid, it may be difficult for the State to show that this option would be “cost effective” or “budget neutral”. Proving an option is cost effective is a requirement for both premium assistance programs and Section 1115 waivers. In addition to the premium cost, the cost of any wrap-around benefits and administration of those benefits must be included in the analysis for cost effectiveness.
May require supplemental policy or approach to meet all benefit requirements of Medicaid. Even if covered by private insurance through the Marketplace/Exchange, the expansion group would still be entitled to certain Medicaid benefits. If these benefits are not offered through plans on the Marketplace/Exchange, the State would have to provide them.
Loss of State control over rates and benefit design. Because the expansion group would select private plans on the Marketplace/Exchange, most control over rates and benefit design would be with private insurance companies.
Start-up resources and implementation. Purchasing coverage on the Marketplace/Exchange would be a major shift for Wyoming Medicaid that would require resources in both technology and technical assistance.
Section 1115 waiver. There is uncertainty inherent in the waiver-approval process. The State’s plan for health care coverage must meet numerous federal requirements before it can be approved. However, by the time Wyoming were to pursue this option, it is likely that other states (such as Arkansas) would have already gone through this process.
In Wyoming, families would not sign up together. Unless the State decided to cover Medicaid children on the Marketplace/Exchange, it is likely that adults offered coverage through this option would have different coverage and benefits than their children on Medicaid. They would also have different administrators for their health plans.
Many individuals may be exempt. Certain specifically protected groups (e.g. “medically fragile”) must still be offered traditional Medicaid benefits. While this is a “pro” to the Marketplace/Exchange in that fewer “unhealthy” individuals in the Marketplace/Exchange make it more viable, it is also a “con” in that it limits the impact of the innovation to those able to participate in the Marketplace/Exchange.
Benefit package not directly tailored to expected health needs of expansion group. This option could limit the State’s ability to specifically tailor a benefits package for the expansion group. This “con” will be somewhat limited by the requirement to provide traditional Medicaid benefits to certain exempted individuals in the expansion group.

¹⁰ Congressional Budget Office. “Updated Estimates for the Coverage Provisions of the Affordable Care Act.” July, 2012. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

Neutral
Federally-Facilitated Exchange. Because Wyoming is not running a state-based exchange, it is unknown how the FFE will impact the viability of this option. Wyoming has no control over the FFE at this time.
Provider network could be less extensive than Wyoming Medicaid. Wyoming Medicaid has wide acceptance in Wyoming; it is unclear whether the provider networks of private plans on the Marketplace/Exchange would be better or worse than Medicaid's.
Provider rates would be determined by private insurers. The State would not control provider reimbursement rates in this option. Rates would be determined by private insurance companies.
Private insurance coverage. This option allows the expansion group to gain experience with private insurance plans and the benefits offered therein.
Limited flexibility if purchased on Marketplace/Exchange. The benefits package would be most affected by regulation of the Marketplace/Exchange run by the federal government. While limited flexibility to the State is certainly a "con", this consideration is neutral due to the uncertainty of its impact.

Option Two: Adult CHIP/Most likely through Managed Care Authority

The second option proposes that the State contract with a private insurance carrier (or carriers) to operate the expansion group program. This option proposes an approach modeled after Wyoming's Kid Care CHIP program. In Kid Care CHIP, a public-private partnership, the State sets out criteria for the health plan and Wyoming Blue Cross / Blue Shield administers it.

To implement, the State would follow state procurement laws and regulations to release a Request for Proposals (RFP) to interested private companies. Interested companies would respond to the RFP with bids that would be evaluated by the State pursuant to set criteria. The best proposal would be offered the opportunity to enter into a contract with the State.

The Kid Care CHIP program issues an RFP every 2-3 years in order to allow private insurance carriers to bid. Carriers are asked to propose plans that provide a basic level of benefits. The contract is awarded to the company that offers the best price (premium), level of benefits, provider network, outreach efforts, cost sharing, marketing, member rights, access to care, grievance procedures and continuation of coverage.

Parameters are placed on the Kid Care CHIP program by the Wyoming Legislature, CMS, and the Kid Care CHIP benefits design committee. The program pays a monthly premium for its enrollees.

The benefits package proposed under Option Two would likely be a commercial plan (or plan with similar coverage) adequate to meet Medicaid regulations and State requirements.

This option would impose the maximum allowable cost sharing when feasible or appropriate. Medicaid regulations limit the amount of cost sharing for this group, but there is greater flexibility for this population than currently allowed under traditional Medicaid, especially for individuals with incomes above 100% FPL.¹¹

Depending on the specifics of the desired approach, the State may have to pursue this option through the waiver authority available to implement managed care delivery systems or Section 1115 waiver authority.

The table below offers additional considerations and information about Option Two.

Option Two: Adult CHIP/ through Managed Care Authority	
Operations:	Wyoming contracts with private insurer (or possibly managed care organization) to cover the expansion group. State ensures Medicaid eligibility requirements are met and manages the contract; private insurer/MCO provides coverage and administers the plan.
Benefit Package:	Similar to commercial plans, but with additional coverage as required by Medicaid regulations.
Time to Implement:	Approximately 12 months from State approval.
Adaptability to WY:	State has flexibility in creating program, RFP and managing contract.
Certainty:	Once this program is established, the State will be able to determine costs and benefits with certainty as they will be set by contract.
Positives	
Partial private sector approach. This approach takes advantage of the strengths of both the public and the private sectors. The parameters of the program would be set by the federal and state governments and the Wyoming Medicaid would continue to manage the contract, but the private partner would conduct day-to-day operations.	
Low administration cost for the State. Because the private carrier would handle daily operations, Wyoming Medicaid's administrative responsibilities would be limited.	
Relatively easy to establish. The program would be relatively easy to create, as the State can emulate Kid Care CHIP. Once the parameters of the program are determined, the State would write and issue an RFP. Interested carriers would submit proposals and those proposals would be evaluated based on previously determined criteria. Upon award of the contract, the contractor would be paid pursuant to the terms of the contract most likely by a previously agreed upon premium.	
Premiums (including built-in administration and other servicing costs) are eligible for enhanced federal match (100% to 90%), while administration expenses are not. The entire premium is eligible for the enhanced federal match pursuant to the ACA. The ACA does not	

¹¹ CMS FAQ. Exchanges, Market Reforms and Medicaid. Dec. 10, 2012.

offer an enhanced match for Wyoming Medicaid's administrative costs (they are matched at 50%).
Flexibility in deciding what will be offered to this population. However, limitations may occur due to State reliance on private insurance carriers' bids.
Benefits can be targeted to different populations. The Medicaid regulations that authorize the State to create this plan also allow the State to tailor coverage to specific populations or by specific regions of the State. The State does not have to offer the same benefits package to everyone in this program.
Negatives
Adds an extra layer of administration at the private level. While the State's administration costs may be reduced, administrative costs for the private insurance carrier will be factored into the cost of the premium paid. This option could increase the total amount of money going towards administrative costs.
Could be higher cost due to lack of information. There is little information about the potential expansion group in Wyoming, and without historical health information it is difficult to determine a "fair" premium for health insurance. This lack of information increases potential risk for an insurance carrier interested in covering these individuals -- often times increased risk leads to increased cost. It is possible that an insurance carrier would bid higher on this group than it will actually cost. This could serve to lock-in artificially high costs for a period of time.
Lack of competition and choice. Choice and competition would be limited by this option. A contract would be awarded to one (or possibly two) insurance carriers (or an MCO) to cover the expansion group. The experience of the Kid Care CHIP program demonstrates there may be a limited number of interested insurance carriers. Kid Care CHIP has received only one bid in response to their last several RFPs. There may be additional interest in offering coverage to the expansion group, however, because it is much larger than the Kid Care CHIP group.
Loss of control over rates. As the State would be contracting with an insurance carrier to provide insurance to the expansion group, its control over provider rates would be limited. The State would pay the premium agreed upon by the insurance carrier and the State, but the State would have little control over the rates the carrier has agreed to pay providers.
Higher cost versus traditional Medicaid. It costs the State more to cover a child through the Kid Care CHIP program than it does to cover a child through Medicaid, despite more limited benefits and greater client cost-sharing/co-pays in Kid Care CHIP. If this cost difference exists on the same scale for the expansion group, this option would be more expensive than traditional Medicaid.
Neutral
Provider network could be less extensive than Wyoming Medicaid. Wyoming Medicaid has a wide acceptance among all Wyoming medical provider types.

Ability to offer similar coverage to private plans. This option allows the expansion group to gain experience with private insurance plans and the benefits offered therein.
Difficult to Design. With the benefit of flexibility comes the difficulty of design.

Option Three: “Medicaid Fit” | Medicaid Operates Tailored Benefits Package

Option Three proposes that the expansion group be managed in the same way that the existing Medicaid eligibility groups (pregnant women, family care adults, children, and the aged, blind, or disabled) are managed. This option proposes that Wyoming Medicaid would perform all administrative activities, such as rate-setting, fraud and abuse detection, payment of claims and determination of eligibility.

While Option Three proposes the same operational or administrative structure as is already in place for Wyoming Medicaid, it proposes a departure from the traditional Medicaid benefits package. The benefits package proposed under Option Three would include a newly created alternate benefits package designed by the State and tailored to the expansion group. Wyoming has flexibility to design a package that would be benchmarked to, actuarially equivalent to, or otherwise similar to a commercial/private insurance plan. The State has the flexibility to offer different benefits packages to different groups and also to offer different benefits packages to different regions of the State.

Under this option, cost sharing would mirror the private market as much as feasible and appropriate. Medicaid regulations limit the amount of cost sharing for this group, but there is greater flexibility for this group than currently allowed under traditional Medicaid.¹² Further, additional flexibility with cost sharing is allowed for the individuals within this group who have incomes above 100% FPL.

The table below offers additional considerations and information about Option Three.

Option Three: “Medicaid Fit”
Operations: Uses existing Medicaid infrastructure.
Benefit Package: Fewer benefits/more limited benefits than traditional Medicaid. Newly-created alternate benefits package for expansion group.
Time to Implement: 6 - 9 months from State approval.
Adaptability to WY: Fairly adaptable within federal and state Medicaid constraints. States may tailor benefits to the expansion group as a whole, or to smaller groups within the expansion group.
Certainty: Fairly certain, as State controls rates/benefits. Could be implemented without a waiver within existing Medicaid regulations.

¹³ CMS FAQ. Exchanges, Market Reforms and Medicaid, Dec. 10, 2012.

Positives
Large, established provider network. Medicaid has a very high medical provider acceptance rate in Wyoming. A higher degree of physician participation in accepting Medicaid clients might then be associated with better access to both primary and specialist care
Single entity reduces complexity, keeps families together. Choosing one entity (Wyoming Medicaid) to administer health coverage for the expansion group, as well as the existing eligible populations reduces complexity for Medicaid clients. There would be no question where they would go with questions on administration of their health plans. It would also ease the administrative burden on enrollees that have multiple client types (e.g., expansion adults, women, children, etc.) in a single family.
Purchasing power. The state Medicaid program currently holds a fair amount of purchasing power in the health care industry in Wyoming. If an additional 17,000 newly eligible recipients begin using health benefits provided by Medicaid, the State's purchasing power could increase.
Maintains a degree of control and flexibility over benefit design. Choosing the existing Medicaid program to administer health coverage to the expansion group allows Wyoming to retain flexibility in benefit design. This could lead to greater control over the costs associated with specific benefits and the flexibility to make decisions about benefits that lead to improved health outcomes of enrollees.
Different benefits targeted to different populations. The Medicaid regulations that authorize the State to create this plan also allow the State to tailor coverage to specific populations or by specific regions of the State. The State does not have to offer the same benefits package to everyone in this program.
Created to maximize offsets. The State could offer richer benefits in certain categories, such as mental health, to maximize General Fund offsets made possible through the Medicaid expansion.
Low administration cost. Wyoming Medicaid's administrative costs are approximately 4%.
Currently undergoing reform. Per Senate Enrolled Act 82 (2013), the Wyoming Medicaid program is currently undergoing extensive reform to decrease cost and improve health outcomes for recipients.
Negatives
Does not embrace private sector approach. This option does not embrace a private sector approach to health care coverage. However, the benefits package would more closely resemble a commercial plan than does traditional Medicaid's current benefits plan.
Government influence over healthcare market features. While positive from a planning and budget stability standpoint, government control over rates and other features of the Medicaid program could be perceived negatively by some.

Could create confusion for clients. Offering non-traditional Medicaid benefits under the same operational umbrella as traditional Medicaid could create confusion for recipients.
Neutral
Increased role of state government. By managing the expansion group with a program inside the Wyoming Department of Health, state government would increase its role in the health care system across Wyoming. An increase of approximately 17,000 newly eligible enrollees in the Medicaid program would mean that Medicaid serves 20-25% of the state population, up from approximately 15% today.
Ability to offer similar coverage to private plans. This option would allow a middle ground between private coverage and traditional Medicaid coverage.
Difficult to design. With the benefit of flexibility comes the difficulty of design.

Option Four: Medicaid Operates Traditional Medicaid Benefits

Option Four proposes the use of the existing Medicaid administrative/operational structure to provide health care coverage to the expansion group. Wyoming Medicaid currently administers health care benefits for people that meet certain eligibility criteria (i.e., pregnant women, family care, children, and the aged, blind, or disabled). Generally, eligibility for Medicaid is determined based on a person's citizenship and residency, social security eligibility, family income, and includes consideration for resources and health care needs.¹³

In Option Four, the expansion group would be managed in the same way that all of the existing Medicaid eligibility groups are managed in Wyoming. Each person would apply for eligibility via the Medicaid program,¹⁴ and once eligible, receive health care coverage for services at any provider that accepts Wyoming Medicaid.

Under this option, the Medicaid expansion group would be offered the existing package of Medicaid (non-waiver) benefits. Of the 24 states that have already indicated their intention to expand Medicaid,¹⁵ over half have indicated that they will model the benefits offered to the expansion group after their traditional/existing Medicaid programs. Medicaid currently covers mandatory services as required by the federal government and optional services authorized by the Wyoming Legislature.

¹³ Wyoming Medicaid SFY2012 Annual Report; available at <http://www.health.wyo.gov/healthcarefin/equalitycare/index.html>.

¹⁴ Medicaid eligibility determinations were previously made by a unit within the Department of Family Services. These activities will be moving to the Wyoming Department of Health, Medicaid Program.

¹⁵ <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>

Federally-Mandated Benefits	Optional Benefits ¹⁶ as selected by the Wyoming Legislature
• Administrative transportation • Durable medical equipment (DME) • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • Emergency transportation • Family planning services • Federally Qualified Health Center (FQHC) • Home health care • Indian Health Service Clinic (IHS) • Inpatient hospital • Laboratory and Radiology • Nursing facility services • Nurse practitioner services, includes nurse midwife and Certified Registered Nurse Anesthetist (CRNA) • Outpatient hospital • Physician services • Rural Health Clinic (RHC)	• Ambulatory Surgical Center • Audiologist and hearing aids • Comprehensive Outpatient Rehab Facility • Dental • End Stage Renal Disease Clinic (ESRD) • Hospice • Independent psychologist • Institution for Mental Diseases (IMD) >65 • Intermediate Care Facility for Intellectually Disabled - ICF-ID • Mental Health and Substance Abuse Rehabilitative Services • Nursing facility services under age 21 • Occupational therapist • Optometrist services • Physical therapy (independent) • Prescription drugs • Prosthetics and orthotics • Targeted case management • Transplants (kidney, liver and bone marrow)

The table below offers additional considerations and information about Option Four.

Option Four: Traditional Medicaid
Operations: Uses existing Medicaid infrastructure.
Benefit Package: Traditional Medicaid benefits (non-waiver) package.
Time to Implement: 6 months from State approval.
Adaptability to WY: Same as traditional Medicaid.
Certainty: Certainty with program. Wyoming has years of history with this program. State would control rates and optional benefits.
Positives
Large, established provider network. A higher degree of physician participation in accepting Medicaid clients might then be associated with better access to both primary and specialist care.
Single system reduces complexity, keeps families together. Choosing to administer health coverage for the expansion group via the existing Medicaid program structure would mean reduced complexity of operations. This option would simplify or eliminate any administrative processes needed to manage this new group, presumably increasing the speed at which complete administrative management could take place.
It would also reduce the complexity for Medicaid clients. All members of the family could enroll in one place, in one program.
Purchasing power. The state Medicaid program currently holds a fair amount of purchasing power in the health care industry in Wyoming. If an additional 17,000 newly eligible recipients begin using health benefits provided by Medicaid, the State's purchasing power could increase.
Maintain control over benefit design. Choosing the existing Medicaid program to administer

¹⁶ Optional Services are provided at the discretion of each state. Wyoming has legislated coverage of the above optional services for adults. All states cover prescription drugs. Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

health coverage to the expansion group would allow Wyoming to maintain control over the operations of the entire Medicaid program. This would allow the State to retain decision-making authority over the operations of the program including optional services, service delivery, fraud and abuse detection and rates.
Low administration cost. Wyoming Medicaid's administrative costs are approximately 4%.
Currently undergoing reform. Per Senate Enrolled Act 82 (2013), the Wyoming Medicaid program is currently undergoing extensive reform to decrease cost and improve health outcomes for recipients.
Best Value for the State. This option allows the State to provide the most generous benefits package at a relatively low cost to State General Funds due to the enhanced federal match rate.
Fastest to implement. This choice is the least time-intensive option.
Negatives
Not a different/more creative approach. Managing the expansion group with the existing Medicaid administrative structure may not enable Wyoming to fully explore the feasibility and long-term effectiveness of other approaches for the Medicaid population.
Does not embrace private sector approach. This option does not embrace a private sector approach to health care coverage.
Government influence over healthcare market features. While positive from a planning and budget stability standpoint, government control over rates and other features of the Medicaid program could be perceived negatively by some.
Wider array of benefits offered to all clients may increase utilization. Coverage of the complete traditional Medicaid benefits package would allow utilization of covered services. This option would allow more services to be utilized. Greater utilization can lead to greater costs. (However, it should be noted that the enhanced federal match would largely insulate the State from most impacts of such increase).
Neutral
Increased role of state government. By managing the expansion group with a program inside the Wyoming Department of Health, state government would increase its role in the health care system across Wyoming. An increase of approximately 17,000 newly eligible enrollees in the Medicaid program would mean that Medicaid serves 20-25% of the state population, up from approximately 15% today.
Costs known with more certainty. The Cost Study completed by Milliman, Inc. (2012) provides cost estimates for this option through the year 2020.

Option Five: Wyoming Unique | State-created Plan

Option Five proposes the creation of a plan for covering the expansion group that is unique to Wyoming. A Section 1115 waiver would be used to gain additional flexibility from Medicaid regulations than would be required by the other options. Section 1115 allows the Secretary of Health and Human Services (HHS) to waive certain provisions of the Social Security Act (Medicaid regulations) to allow experimental demonstration projects that are likely to assist in promoting the statutory objectives of the Medicaid program.¹⁷

Basic requirements for any expansion under a Section 1115 waiver include:

- States must expand Medicaid eligibility up to 133% FPL (138% if five percent income disregard is incorporated) to receive the enhanced (100%) federal match
- Federal spending must be budget-neutral
- Numerous process, reporting and evaluation requirements¹⁸

The creation of a Section 1115 waiver is time and resource intensive; however, the result would be flexibility from certain Medicaid regulations. While it is impossible to know exactly how much flexibility a state could gain until approval has been given to the state waiver, possibilities could include the flexibility to tailor benefits, require use of medical homes, develop cost-sharing instruments and incentivize prevention and wellness.

Because this option allows the most flexibility from Medicaid regulations and the content of the plan has not been determined, the WDH is unable to fully describe/evaluate this option as it did with the four previous options.

The table below offers additional considerations and information about Option Five.

Option Five: Wyoming Unique Plan
Operations: Unknown.
Benefit Package: Most likely fewer benefits/more limited benefits than traditional Medicaid. Experimental package of benefits and cost-sharing instruments proposed through Section 1115 waiver process.
Time to Implement: Over 12 months from State approval.
Adaptability to WY: Most adaptable, as Wyoming would create plan
Certainty: Uncertain process (approval), but benefits and cost-sharing allow greater long-term certainty of cost.

¹⁷ Social Security Act §1115(a).

¹⁸ Including: 30-day state-level public notice and comment period; 45-day federal-level review and comment period; description of demonstration goals, research hypotheses and evaluation plan; annual reporting requirements on outcomes, beneficiary impact/satisfaction, and financial performance. See 42 CFR Part 431, Subpart G.

CONCLUSION | WDH RECOMMENDATION

In this report, the Wyoming Department of Health has set out initial details for five options for a Wyoming-specific approach to health care coverage for a potential Medicaid expansion group. While each option has positive and negative attributes, it is the consensus of the WDH internal team that certain options are better suited for Wyoming than others. The WDH internal team agrees that among the options set out in this report, Option 3: “Medicaid Fit” best “fits” Wyoming.

“Medicaid Fit” provides an opportunity to tailor benefits to the expansion population and maximize General Fund offsets, while relying on an existing state administrative entity (Wyoming Medicaid) that is accountable to the Governor and Wyoming Legislature. “Medicaid Fit” provides a middle ground between private insurance and traditional Medicaid. It also allows families with multiple members on Medicaid to stay together and work with only one administrative entity (Wyoming Medicaid) for their health care benefits.

Covering the expansion population through “Medicaid Fit” allows the State, and the expansion population, to benefit from the positive reforms currently taking place in Wyoming Medicaid, including: greater coordination in care, medical homes, behavioral health homes and enhanced case management. Further, “Medicaid Fit” utilizes the existing Medicaid provider network, which has, for medical providers, a 95% acceptance rate in Wyoming. Additionally, Wyoming Medicaid has low administrative costs (approximately 4% of the cost of the group).

It is the opinion of the WDH internal team that “Medicaid Fit” best fulfills the mission to create a cost-conscious plan to reduce the number of uninsured Wyoming residents, while maximizing the benefits to the State. Beyond Option 3 “Medicaid Fit”, the WDH would order by preference the other options as follows: Option 4: Traditional Medicaid, Option 5: Wyoming Unique, followed by Option 1: Marketplace/Exchange and lastly Option 2: Adult CHIP.