Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA)

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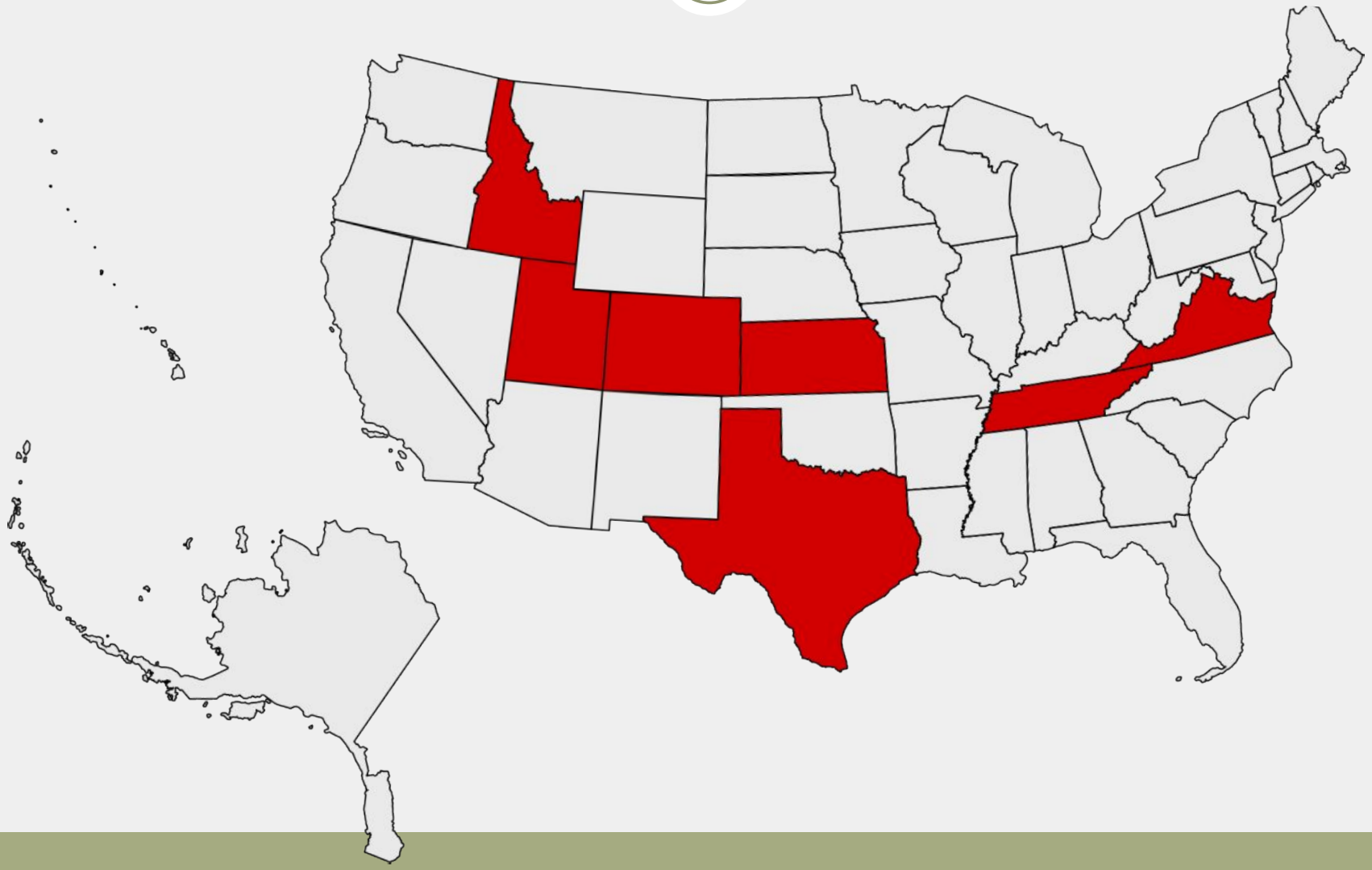
Summary

- → REPLICA is model legislative language pertaining to **EMS personnel licensure**;
- → A minimum of **10 states** must adopt the language through the regular legislative process for REPLICA to take effect;
- → Much like the physician and nursing licensure compacts, Wyoming would benefit by **streamlining the licensure process**, by reducing liability for EMS personnel, and by moving to standardized competency testing.

REPLICA Adopted in 7 States



Summary

- At the August 26, 2016 meeting of the Joint Health Labor and Social Services Interim Committee, the Committee requested that the Office of EMS (OEMS) gather information from around the state as to the **level of interest and support** for REPLICA;
- OEMS scheduled a series of "**town hall**" meetings in various locales and a webinar on REPLICA on October 12.

Summary

- OEMS provided notification of the meetings through three separate listservs:
  - Ambulance service administrators (all ambulance services)
  - Physician Medical Directors (all ambulance services)
  - Trauma Program Coordinators (all hospitals)
- Additionally, OEMS utilized our licensure system to notify:
  - All 4,673 email addresses in the system
  - Includes all 3,229 EMS personnel licensed in Wyoming.
- The OEMS sent four notices regarding the town hall meetings and two notices regarding the webinar reaching an approximate total of 28,038 contacts

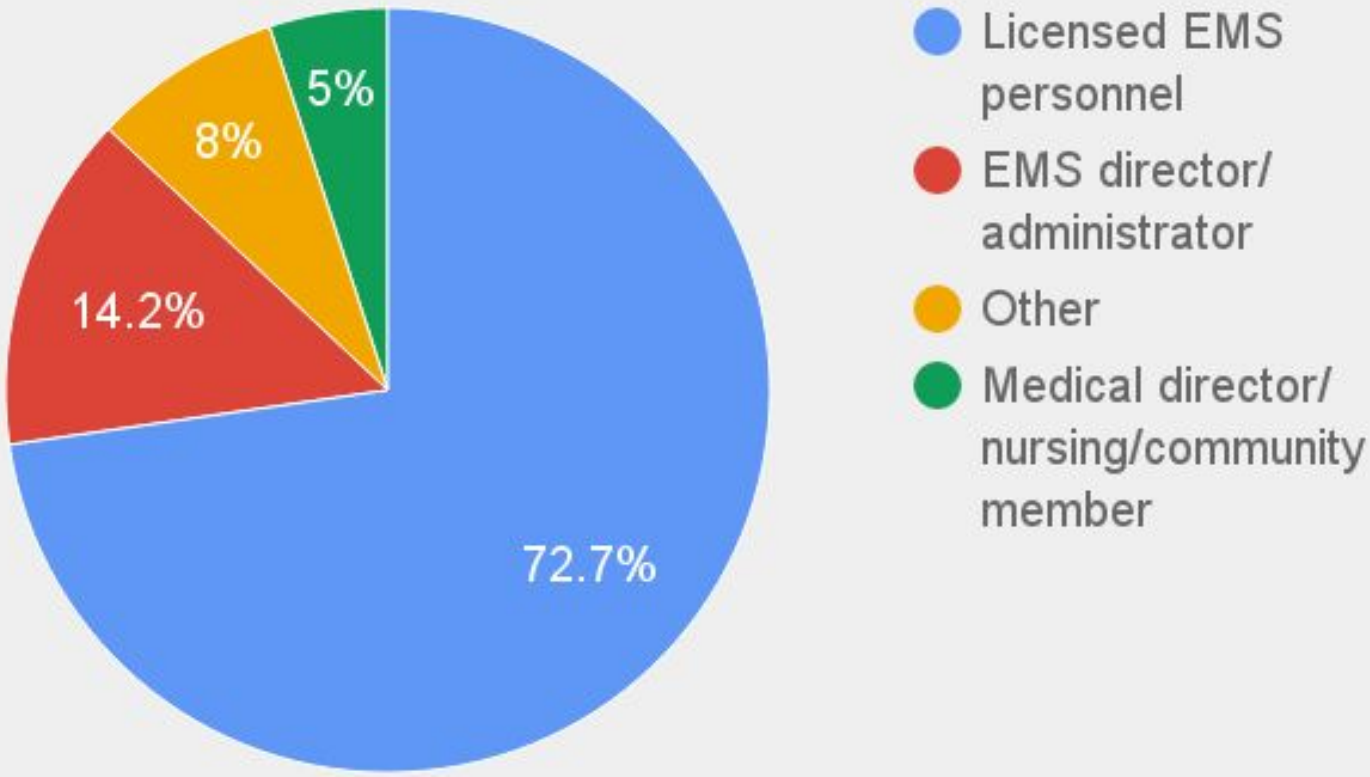
Meetings and Attendance

REPLICA Meetings/Attendance						
Date	**City**	**No.**		**Date**	**City**	**No.**
6-Sep	Worland	10		27-Sep	Gillette	28
7-Sep	Cody	22		28-Sep	Newcastle	21
9-Sep	Jackson	7		13-Oct	Cheyenne	0
10-Sep	Afton	7		15-Oct	Webinar	57
10-Sep	Kemmerer	6		16-Nov	Pinedale	12
26-Sep	Casper	4		28-Sep	Newcastle	21
					Total	**174**

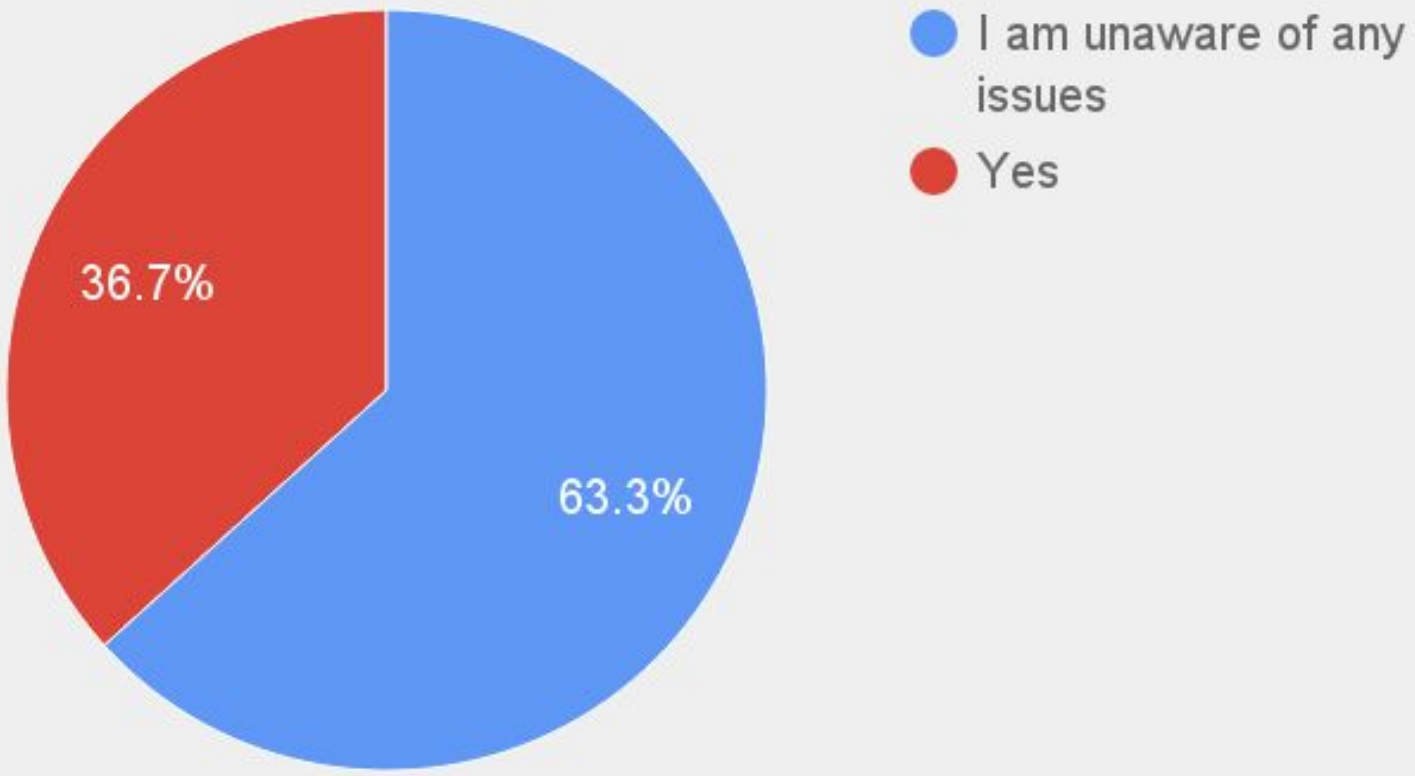
Meeting Content

- **Overview** of REPLICA and the issues it intends to address, as well as the decision to utilize NREMT
- Participants were provided an opportunity to ask **questions**
- Asked to complete a five question **survey** (webinar participants were given access to SurveyMonkey)
  - SurveyMonkey link was distributed through the same email means as the notifications
  - A total of 120 surveys were completed - 69% completion rate

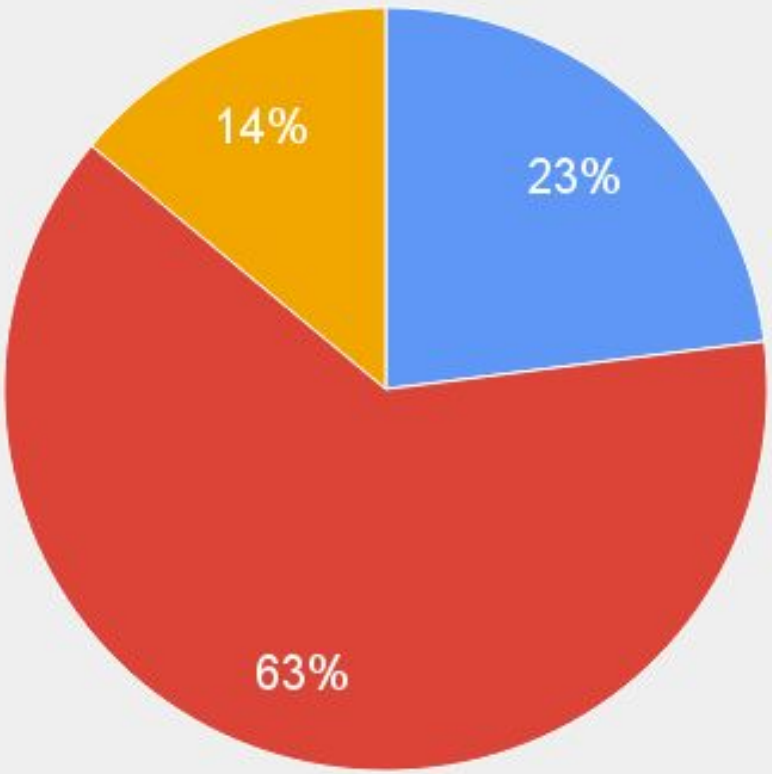
What is your role in the EMS or emergency care system?



To your knowledge, has your local EMS system experienced issues related to personnel licensing?



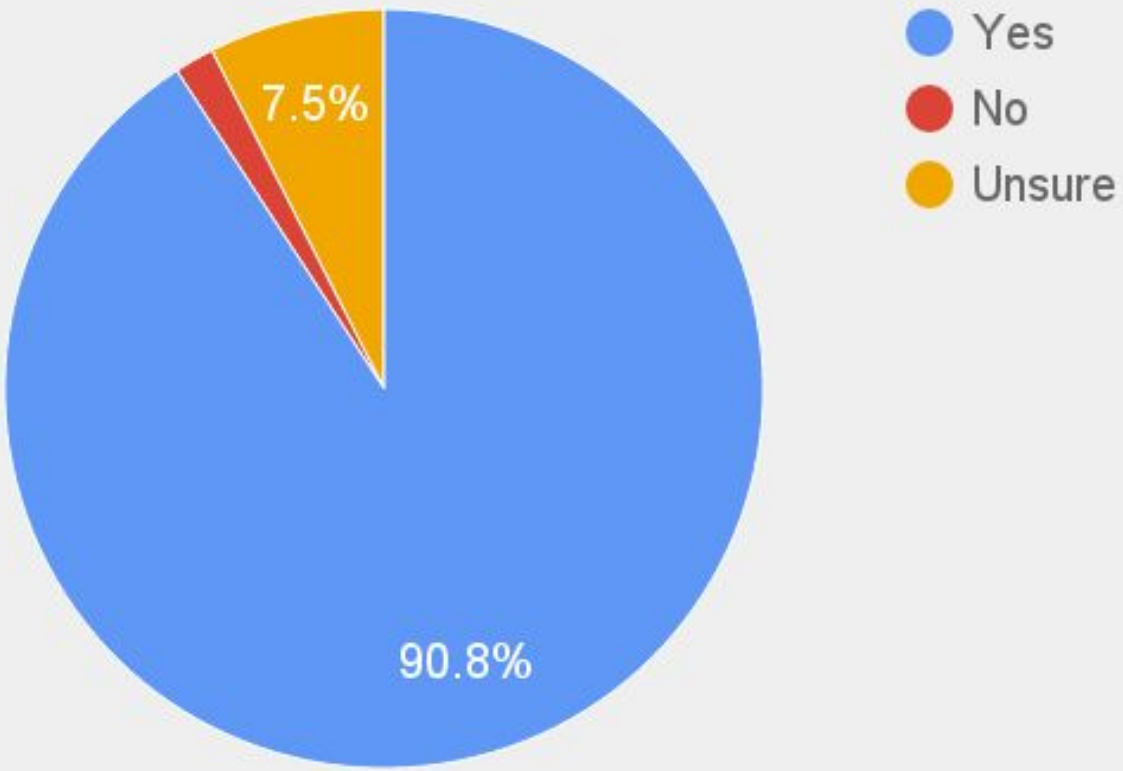
If yes, please briefly describe the issues.



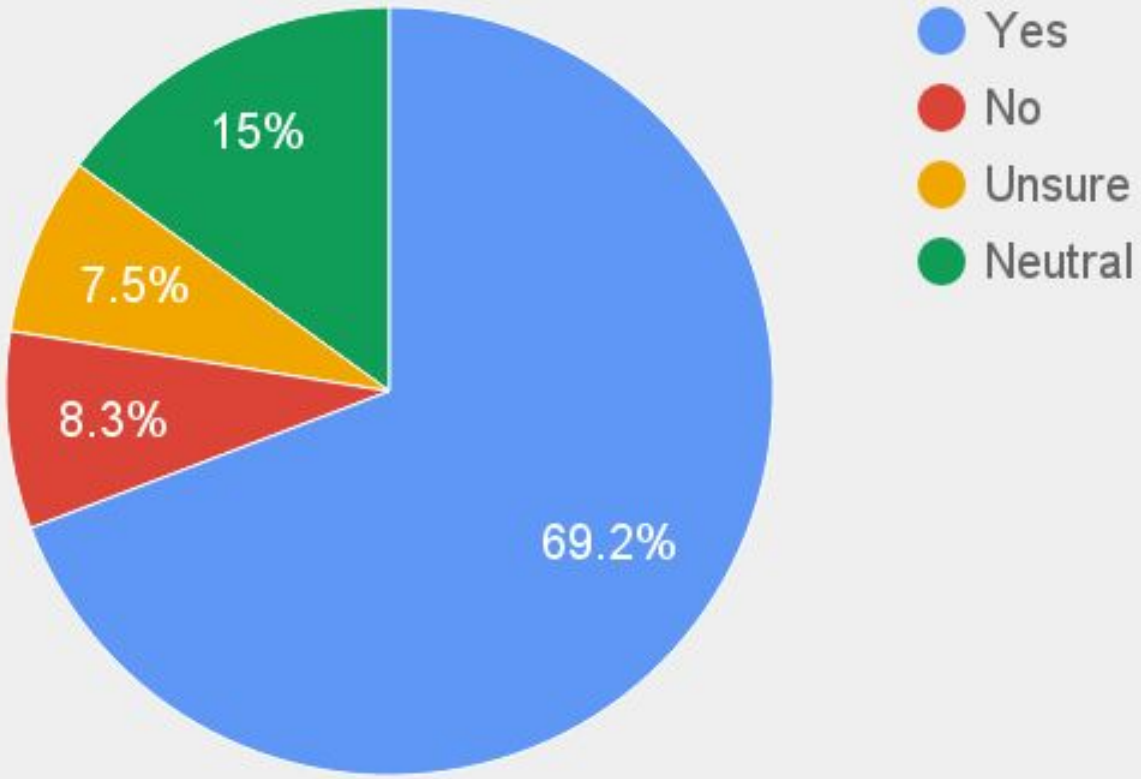
Answers to this question were free text.

The graph represents the general characterization of statements

Do you believe that Wyoming should adopt REPLICA as a partial solution to cross-border issues?



Do you believe Wyoming should require successful completion of the NREMT regardless of REPLICA?



General Comments

- Survey respondents were given a free text field to submit any other comments or items for consideration.

- Comments were overwhelmingly positive, and are provided in the handout to the Committee

Questions?

Wyoming Department of Health

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DD Rate Rebasing Update

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Wyoming Department of Health

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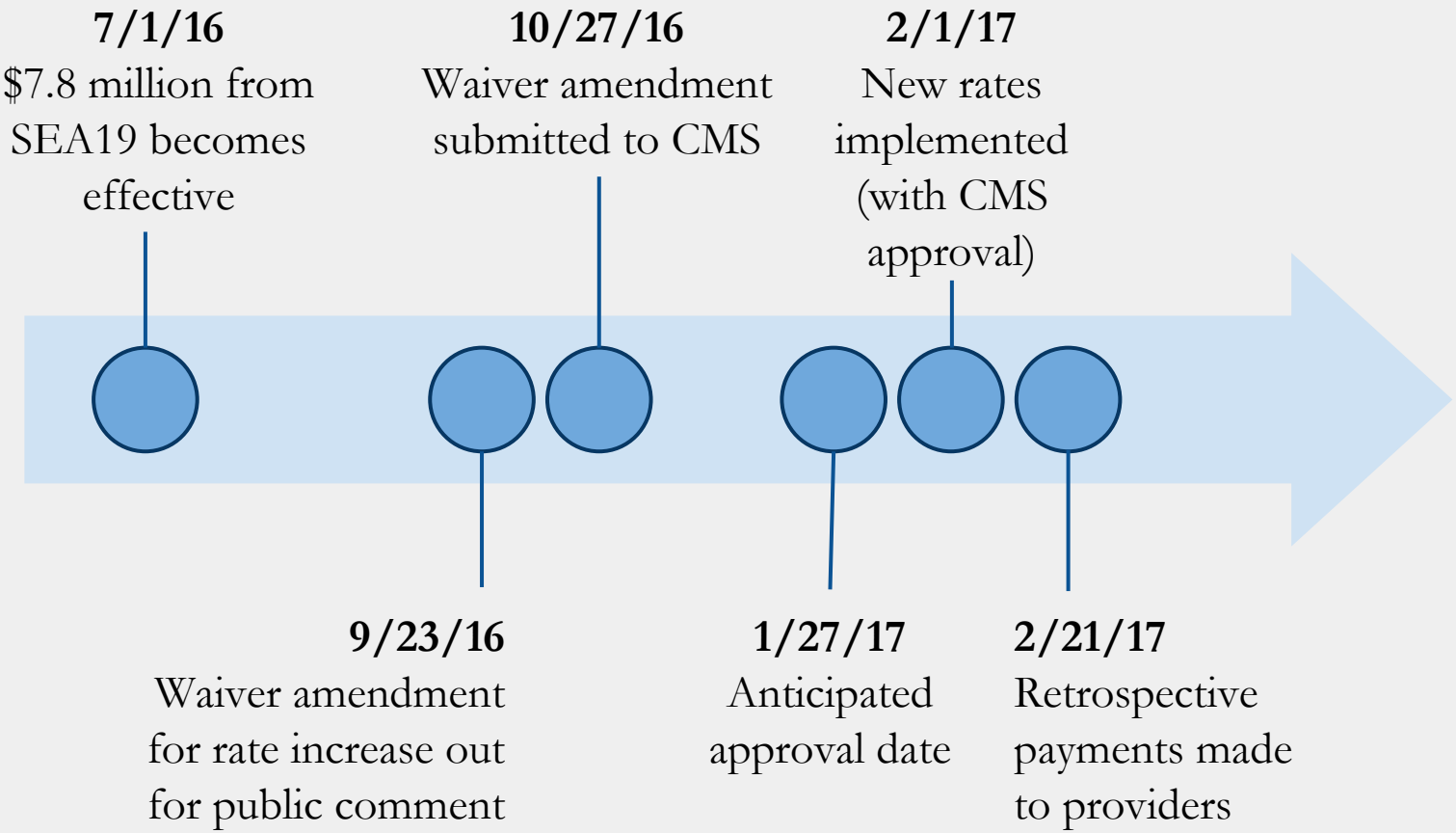
Section 327 (2016 Budget Bill) Rate Increase Timeline



Questions?

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Multi-Payer Claims Database
State Administered Health Insurance

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Wyoming Department of Health

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Legislative Requirements

- Footnote 3 to Section 048 of SEA 19 (2016 Budget Bill) requires that the Department

  "…study state administered health insurance options for individuals and businesses within Wyoming and any potential cost savings to the state of Wyoming from implementation of various options. The department of health shall summarize the current health insurance market in Wyoming, including provider and plan types…"

Legislative Requirements

- Footnote 4 to Section 048 of SEA 19 (2016 Budget Bill) requires the Department to

  "… study and, if determined appropriate, join or develop a volunteer multi-payer claims database. The study shall consider only the inclusion of information from the employees' and officials' group insurance plan, Medicaid, and any other health insurance program that receives contributions from state funding sources."

Study Outline

Part I: What is health insurance?

- Purpose, market failures
- Cost-containment - supply and demand-side
- Medical care and health

Part II: Health insurance in Wyoming

- Market
- Costs

Part III: Multi-payer claims database

- Why
- What/How
- Options

Part IV: State-administered health insurance

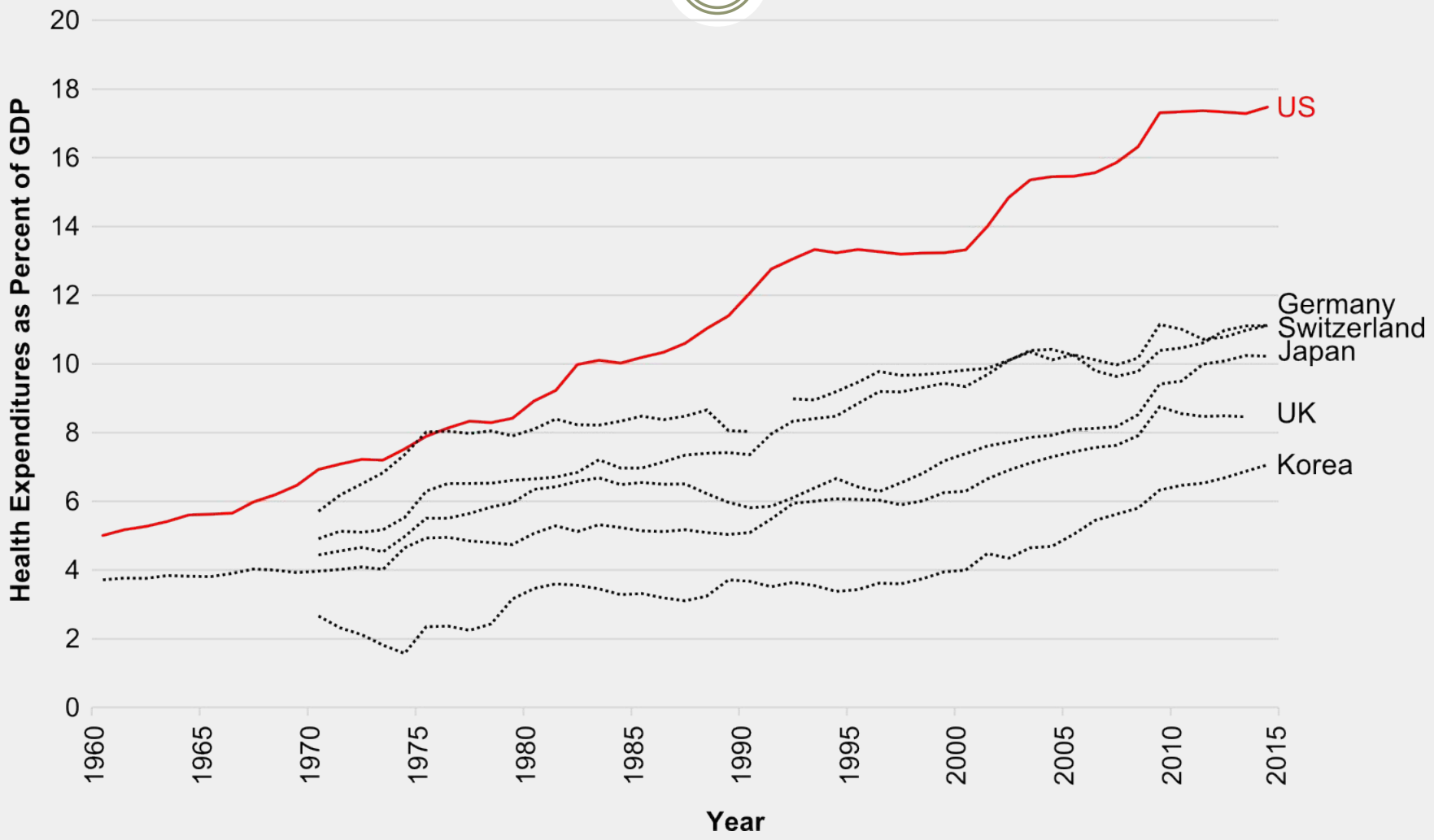
- Options

What is the problem?

→ <u>Health care is too expensive</u>

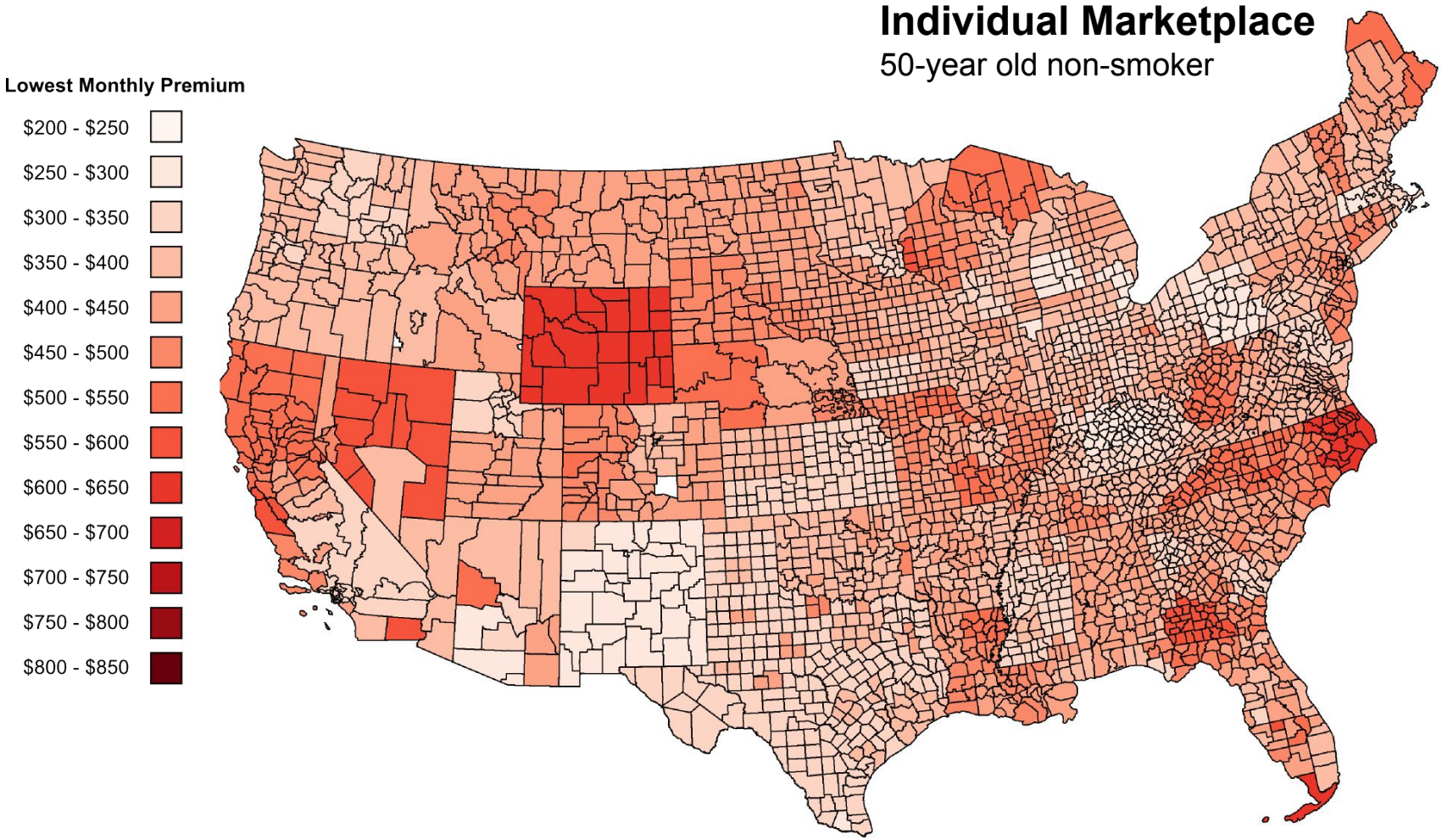
- US spends almost **18%** of its GDP on healthcare. This is twice the fraction of other developed nations.
- This represents a large opportunity cost.
- Health outcomes are relatively poor.
- Wyoming has some of the highest healthcare costs in the nation.

Problem: health care is too expensive



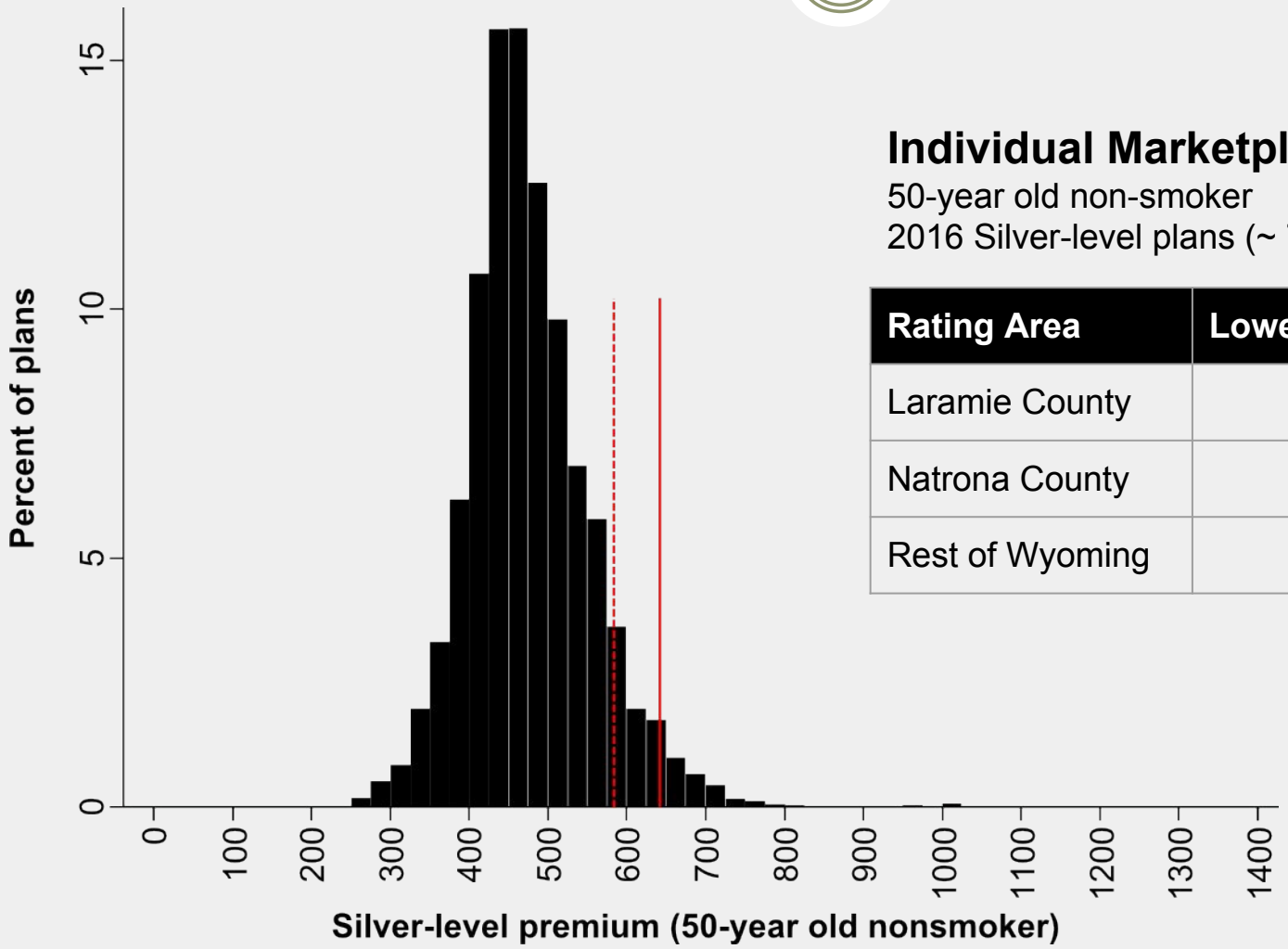
data: CMS, Federal Reserve Bank of St. Louis, OECD Health Statistics

Problem: health care is too expensive



data: RWJF HIX 2.0

Problem: health care is too expensive



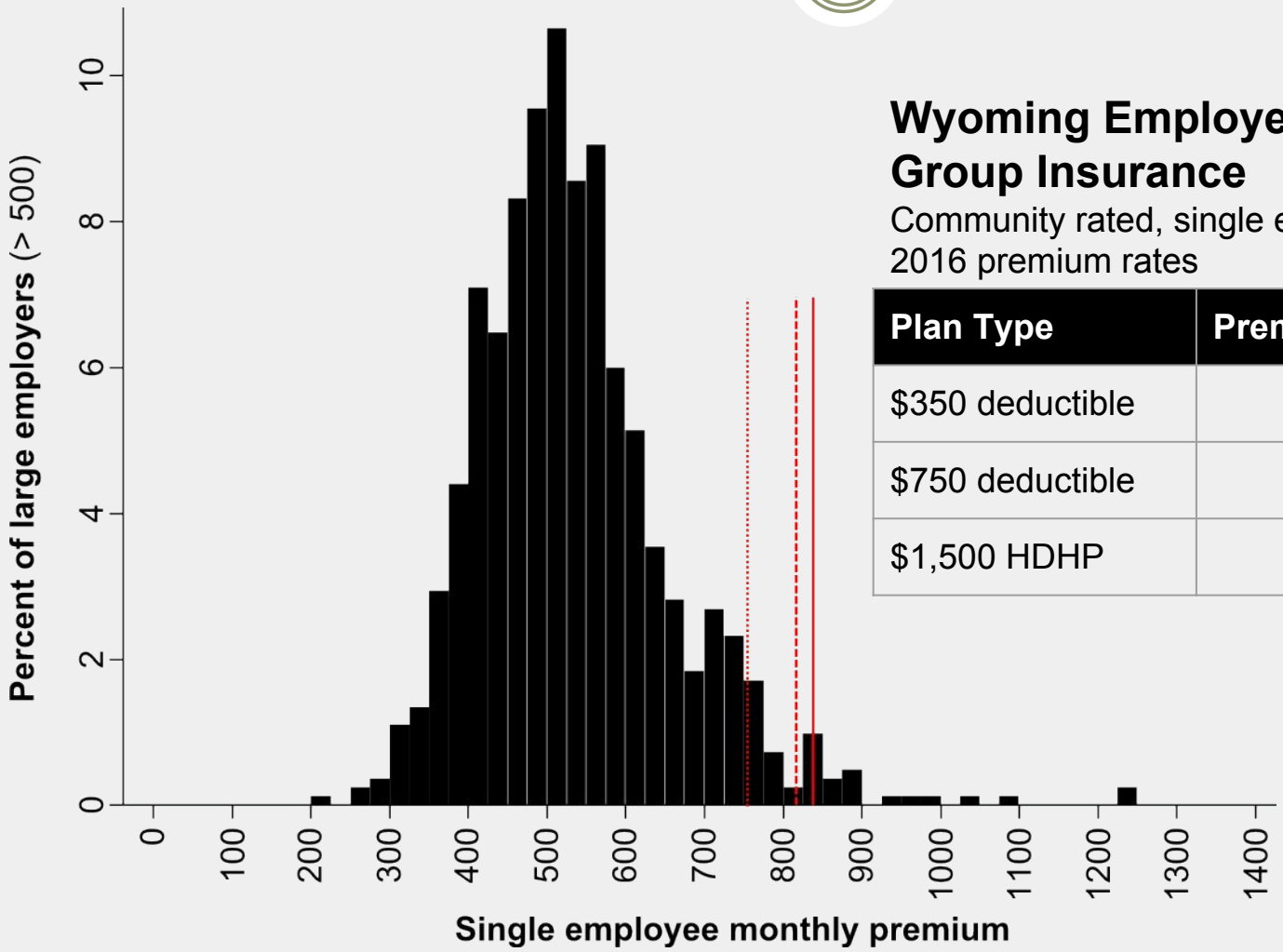
Individual Marketplace

50-year old non-smoker
2016 Silver-level plans (~ 70% AV)

Rating Area	Lowest Premium	Pctile
Laramie County	$586.41	93
Natrona County	$643.47	97
Rest of Wyoming	$643.47	97

data: RWJF HIX 2.0

Problem: health care is too expensive



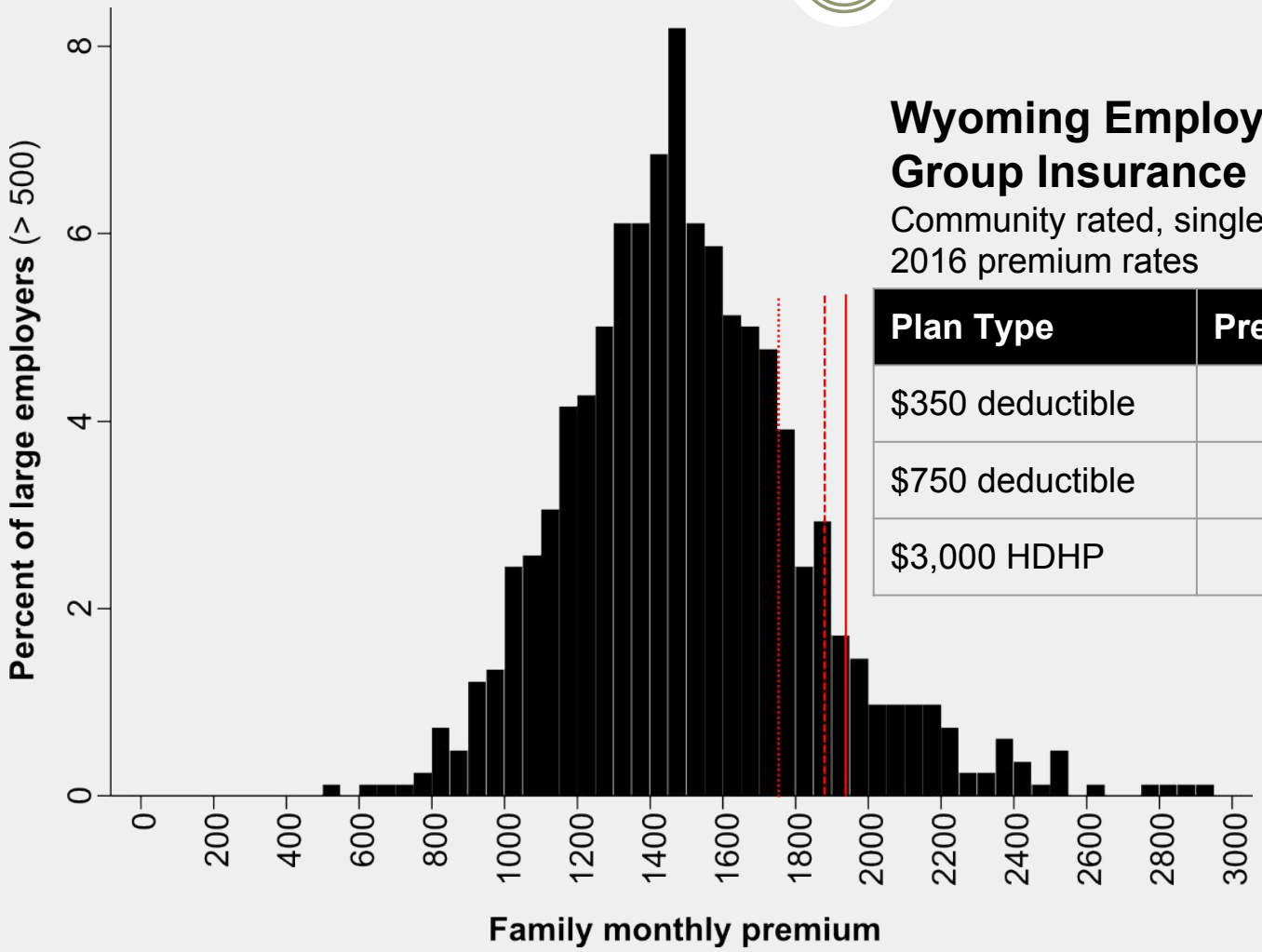
Wyoming Employees and Officials Group Insurance

Community rated, single employee
2016 premium rates

Plan Type	Premium	Pctile
$350 deductible	$840.95	98
$750 deductible	$811.63	97
$1,500 HDHP	$751.85	97

data: KFF/EBRI survey, 2015

Problem: health care is too expensive



Wyoming Employees and Officials Group Insurance

Community rated, single employee
2016 premium rates

Plan Type	Premium	Pctile
$350 deductible	$1,946.76	91
$750 deductible	$1,880.64	88
$3,000 HDHP	$1,746.86	81

data: KFF/EBRI survey, 2015

Problem: health care is too expensive

→ Why?

- Not entirely clear.
- Relatively large administrative and regulatory costs (hundreds of payers).
- After admin, costs are function of price and quantity (utilization).
- **Prices** of health care services more problematic.

Multi-Payer Claims Database

How would a claims database help?

→ Turns raw data into **actionable** information

- Situational awareness
- Identification of higher value providers
- Identification of high-risk members

→ Analysis, not just aggregation, of data is critical. Need **capacity** on the payer-side.

- Payers must be able to understand their own data.
- Algorithms helpful, but need to know what questions to ask.

Multi-Payer Claims Database

- **Claims data is necessary, but not sufficient, in realizing any savings.**
  - Necessary: without it, we have no idea where we're going
  - Not sufficient: payers have to be able to **act** on the information provided from the claims data; i.e.:
    - Benefit design - "skin in the game"
    - Negotiating with providers on prices and risk.
    - Care coordination and wellness incentives.

Multi-Payer Claims Database

➔ **Current "join" option is superior to "develop" option.**

Potential benefits:

(+) Existing research database allows State to benchmark prices/utilization across payers, regions (i.e., including MT)

(+) Direct access to raw data. Gives EGI a data warehouse for medical/pharmacy claims. Data cleaning/normalization.

(+) State participation adds momentum.

Costs:

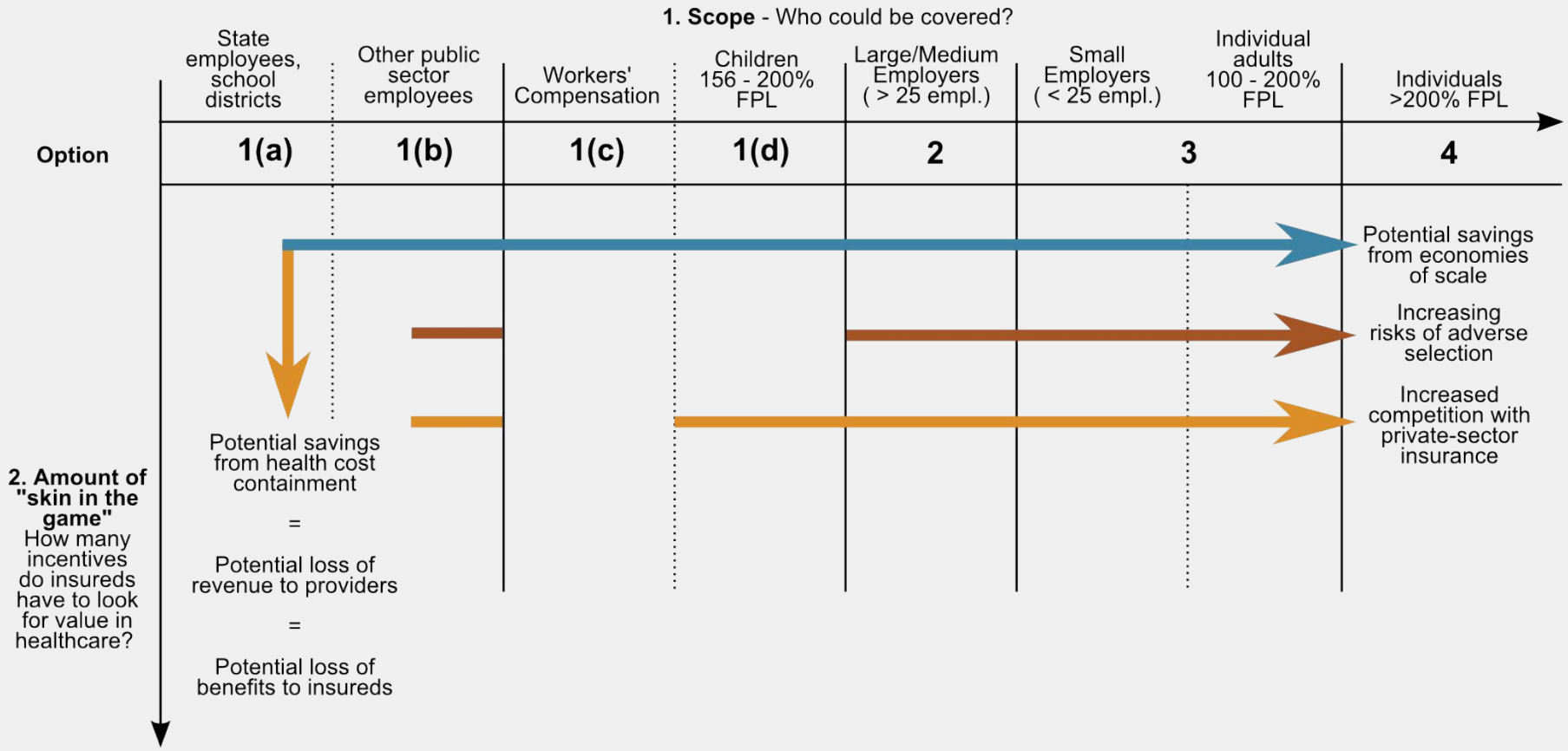
(-) Less flexible/configurable than "develop" option.

(-) Discussed price point: $320K per year.

State Administered Health Insurance

- **Approach:** voluntary options for "buy-in" from:
  - Other public-sector entities
  - Large private sector employers
  - Small/medium employers and individuals
- **All options cost-neutral** (in theory)
- **Potential savings** from:
  - Administrative consolidation, economies of scale
  - Increased payer leverage - greater ability to negotiate prices and risk
- **Health care cost savings require plan changes**

State Administered Health Insurance



Conclusion

Real savings on healthcare costs will hinge on how any State-administered plan is operated; i.e., increasing "skin in the game" for insureds to focus them on cost of health care. Example:

- → Develop broader menu of plan options (e.g. actuarial values from 60% to 90%, instead of current 79.5% to 86.7%).
- → Minimize cross-subsidies between these options.
- → Encourage the growth of less-generous options by reducing the employer contribution and refunding it to employees as pay increase.
- → Direct members to higher-value providers using benefit design (i.e., reference pricing, narrower networks) and claims data analysis.

Conclusion

Example policies, cont'd:

- ➔ Strategically use market power to negotiate alternative payment methodologies (e.g. bundled payments) with providers.
- ➔ Develop effective wellness programs with meaningful financial incentives (e.g. up to 30% of premium) for healthier behavior.
- ➔ Use claims data to develop care coordination benefit for "Super Utilizers."

Conclusion

As with any decision, there are tradeoffs.

→ Savings by payers **may** translate into:

- Sending patients out of State to higher-value providers
- Less revenue to providers, lower access
- Less generous employee benefits (more "skin in the game")

"Every dollar of health care spending is someone's health care income."

- Uwe Reinhardt

Bottom Line

If the State wishes to attempt to contain costs through market-based health care reform, then these options may be good ideas.

- → Claims database
- → State-administered health insurance

If the State does not wish to pursue this, these aren't good ideas.

Questions?

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University of Wyoming Family Practice Residency Study

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Director's Unit for Policy, Research and Evaluation

Wyoming Department of Health

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Legislative Requirements

- Footnote 2 to Section 167 of SEA 19 (2016 Budget Bill) requires the Department of Health to conduct

  "…a comprehensive review of the state medical residency programs including the services provided; past, present and future revenue streams; alternative service delivery options; and alternative organizational structures…"

Legislative Requirements

- Not a new topic. Studies have been conducted throughout the history of the residencies:
  - **1960-64**: WICHE studies
  - **1972**: Wyoming Medical Society study
  - **1974**: Dr. Joseph Report (foundational)
  - **1983**: UW report
  - **1985**: Legislative report
  - **1988**: Internal UW report
  - **2005**: Legislative report
  - **2009**: UW report

Study Scope

This study focuses on the big picture:

(1) What is the **core purpose** of the residency programs? Is this purpose still valid?

(2) **How** are the programs meeting this purpose?

(3) What **alternatives** does the State have in achieving the same outcomes?

Study Scope

Part I: Background

- The medical education pipeline
- Graduate medical education and funding
- The core purpose of the UW Family Practice Residencies

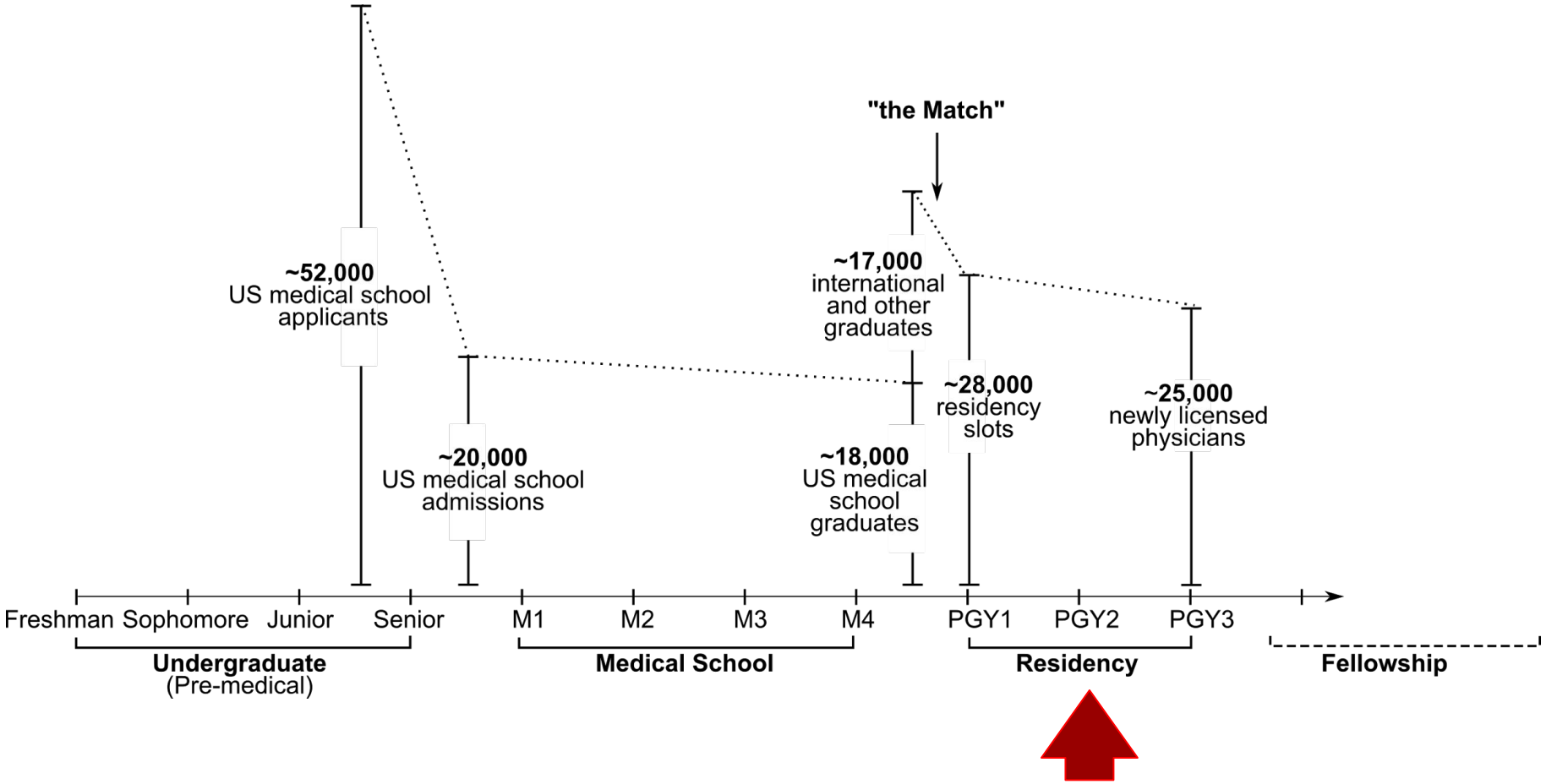
Part II: Operations review

- Services delivered
- Inputs / Outputs
- Efficiencies and outcomes

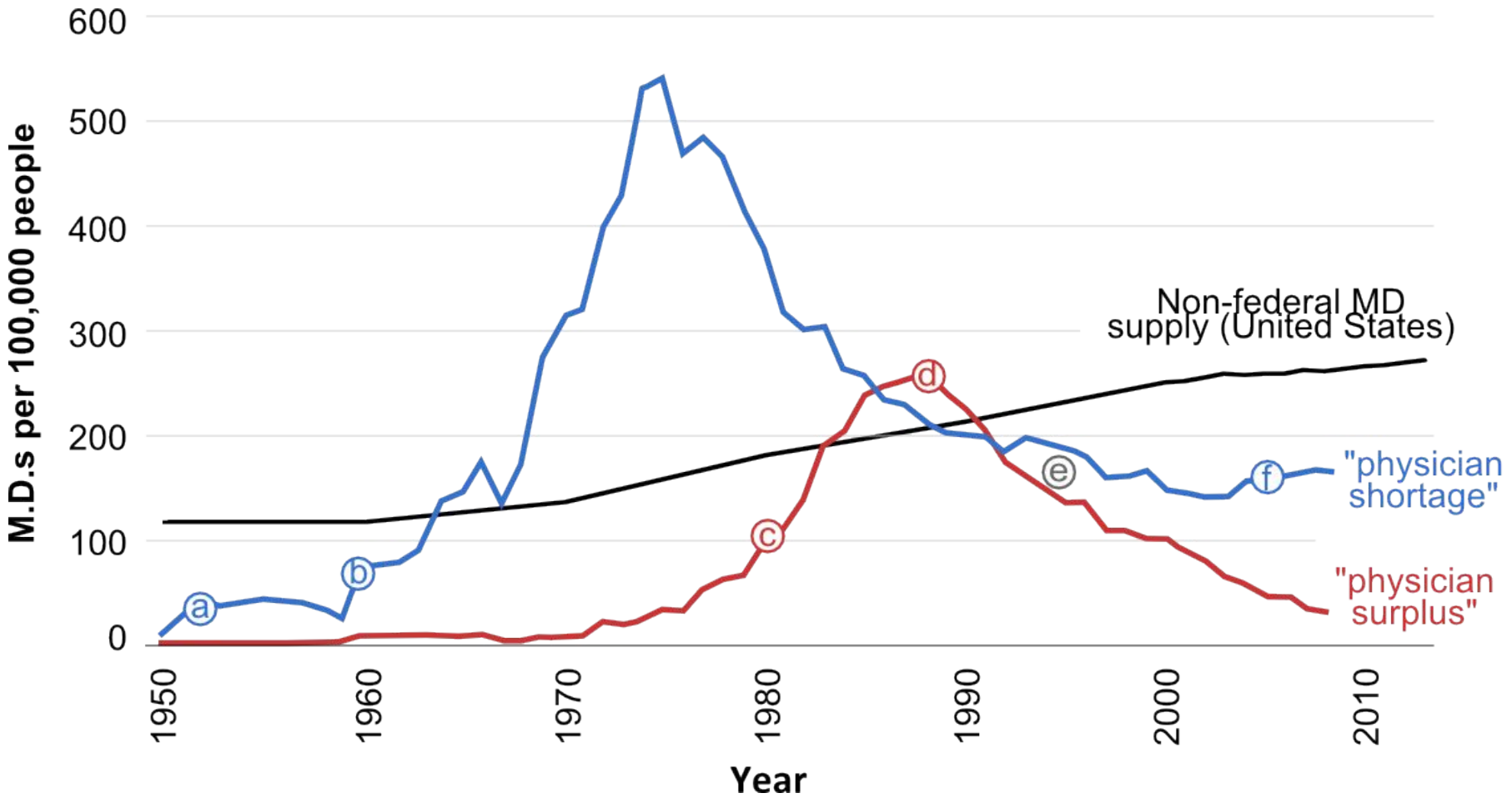
Part III: Alternatives

- Considerations
- Options

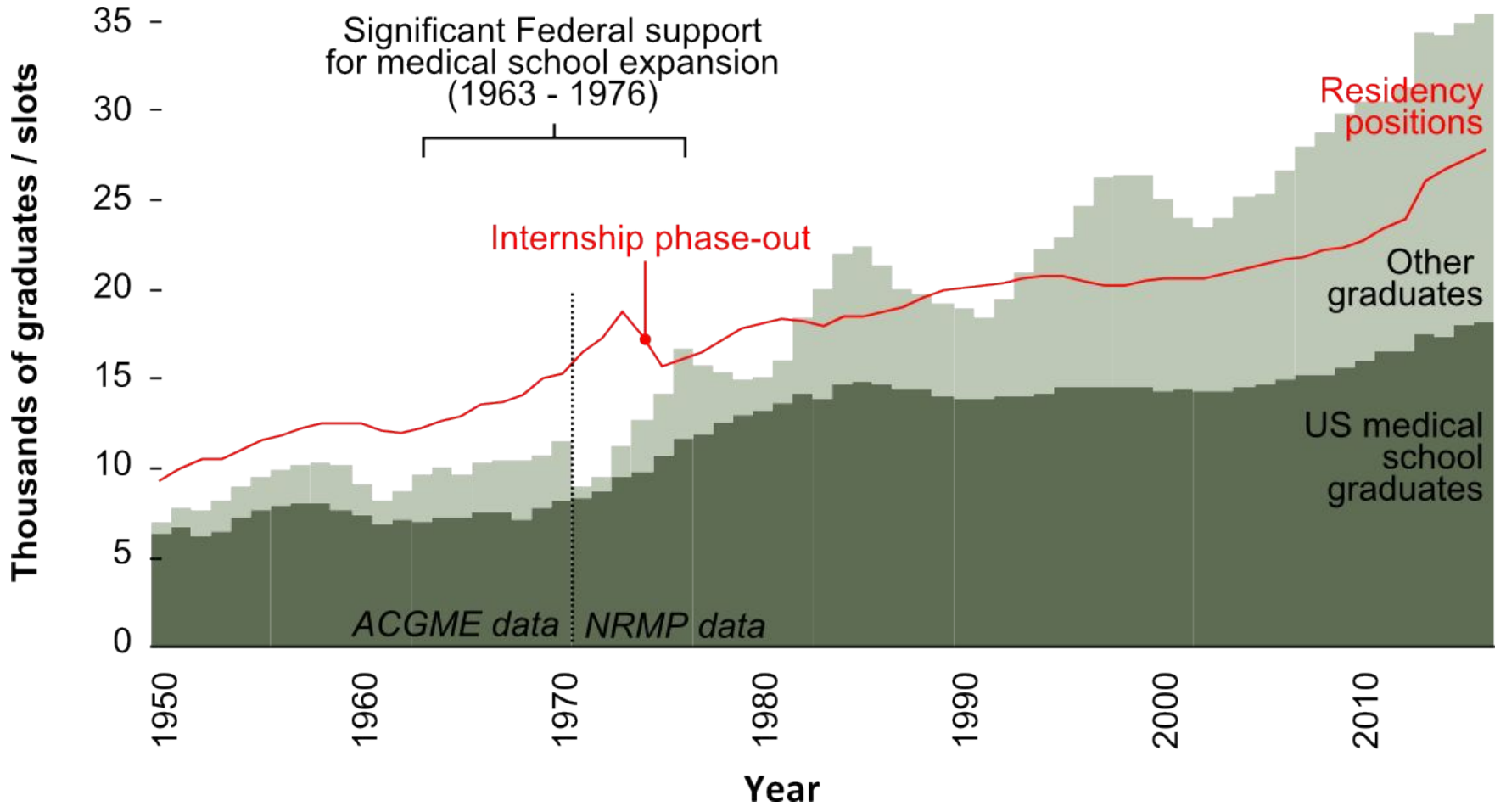
Medical education overview



Physician supply, 1950 - 2010



Medical education, 1950 - 2010



Residency History

UW Family Medicine Residencies established at peak of "physician shortage" crisis.

- Frustration with previous efforts towards medical education in 1950s-1960s (e.g. WICHE)
- Options ranging from est. comprehensive system to contracting out.
- "Hybrid" model recommended by Medical Education Planning committee in Joseph Report.
  - Full spectrum of education in-State, integrated with community providers.
  - Contract out necessary rotations at medical centers.

Residency History

Recommendations adopted by Gov. Hathaway and Gov. Herschler, funded by Legislature in 1975.

- Appropriation in Governor's office due to UW faculty resistance.
- Casper site est. 1976, Cheyenne in 1979.
- Larger medical education system voted down in 1978, but pieces of the vision (e.g. Creighton contracts, WWAMI) gradually implemented later.
- **Unclear why residency program was not established in hospital to begin with.**

Core Purpose

→ Increase the number of family medicine physicians in Wyoming

→ Improve distribution across counties

→ Provide indigent care to uninsured

Costs and Revenue

(annual figures)

	Casper	Cheyenne	Total
Revenue	**$3,581,079.30**	**$1,854,761.18**	**$5,435,840.48**
Costs	**$8,292,213.67**	**$6,921,214.17**	**$15,213,427.84**
100-series	$6,607,638.51	$5,084,936.43	$11,692,574.94
200-series	$1,014,283.57	$682,903.71	$1,697,187.28
300-series	$173,379.25	$111,965.59	$285,344.84
400-series		$3,676.40	$3,676.40
900-series	$496,912.34	$1,037,732.04	$1,534,644.38
SGF Subsidy	**$4,711,134.37**	**$5,066,452.99**	**$9,777,587.36**
SGF Subsidy (%)	**56%**	**73%**	**64%**

Efficiencies

<u>More efficient</u> at training doctors

- Average cost per graduate - $407K
- National average est. $420K - $540K
- Quality of program improving, but is below average.

<u>Less efficient</u> at providing primary care

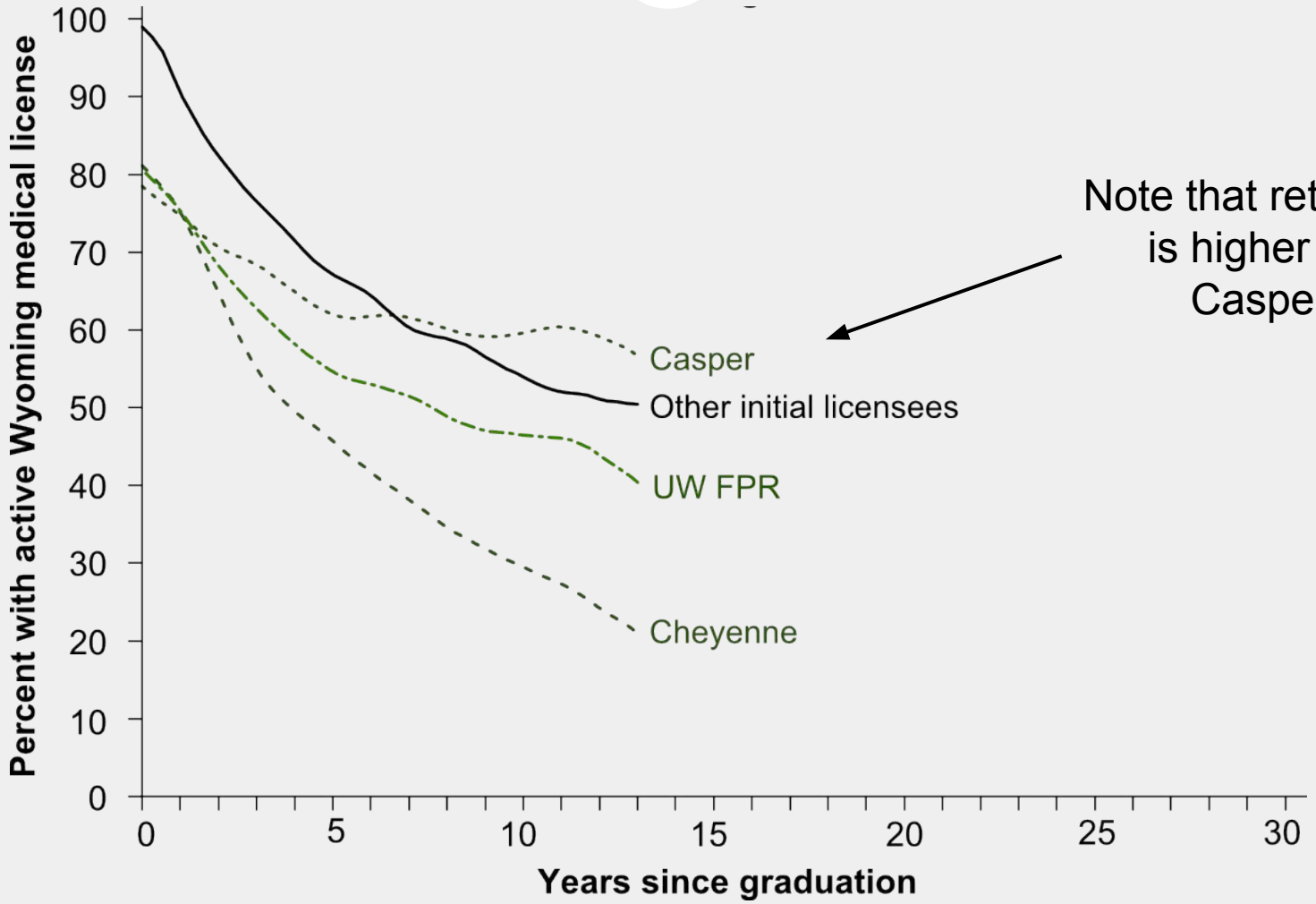
- Marginal cost per FQHC visit - $142
- National/State average - $105

Outcomes

Retention is <u>poor</u>

- Est. **23%** of future "doctor-years" in Wyoming.
- 1970 - 2006 in-State retention of 27% is **third-lowest** in nation (MT - 54%, UT - 53%, ID - 51%, CO - 51%)
- Cost per physician retained in-State: **$1.77M** (65% of which is SGF)
- Over 30 years, this investment represents annual SGF cost of **$51-71K** per graduate.

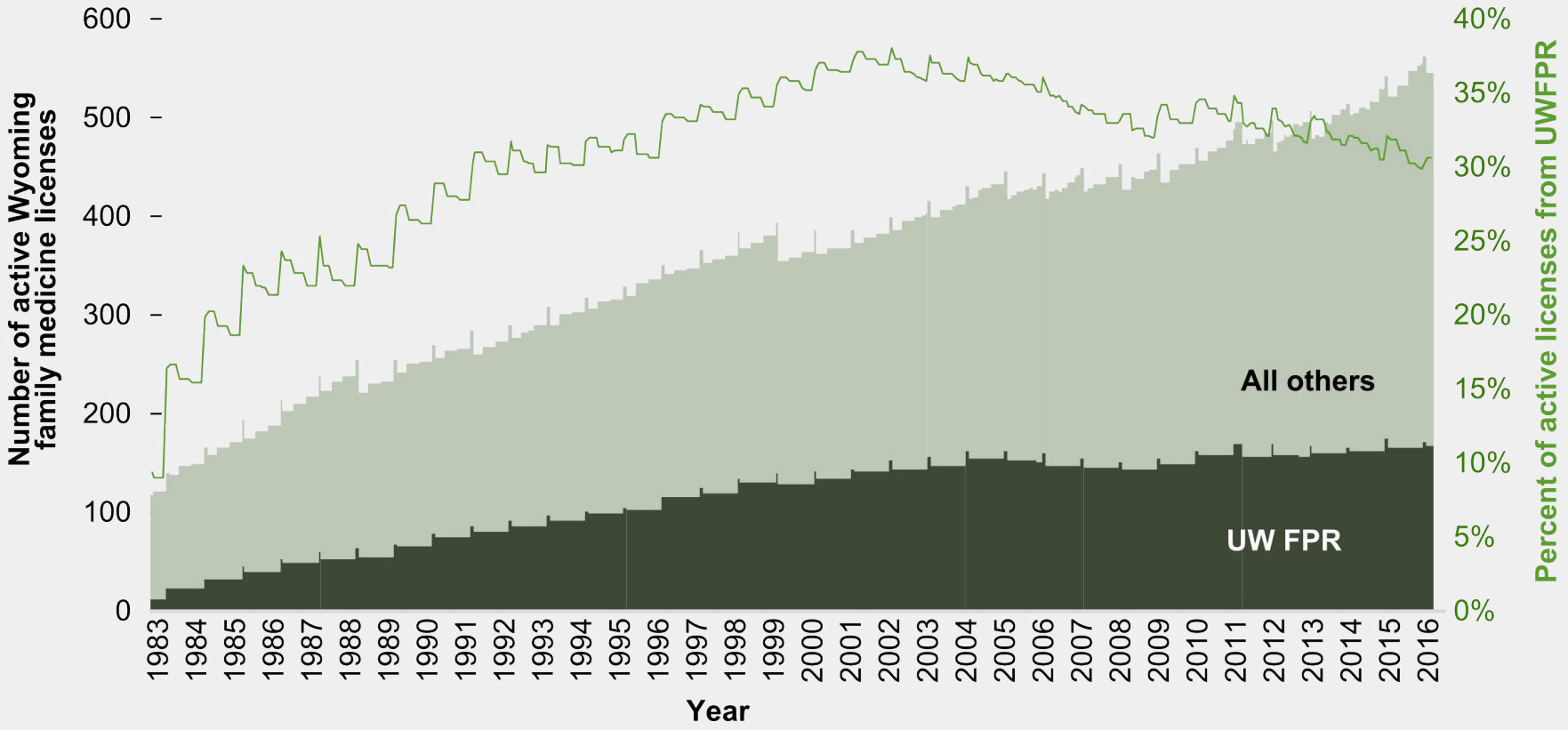
Retention



Note that retention is higher for Casper

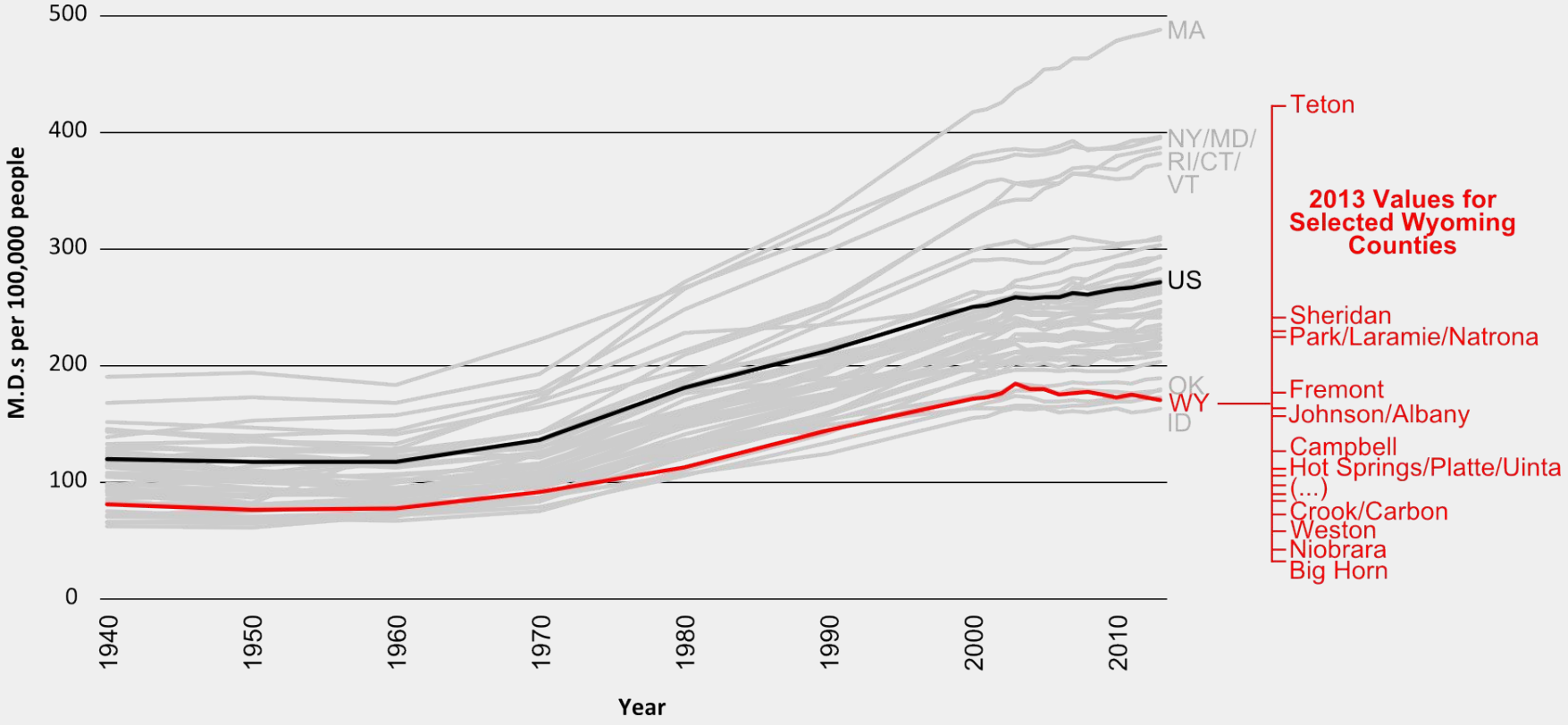
Outcomes

UW residencies have contributed up to 40% of total family medicine physicians in Wyoming



Outcomes

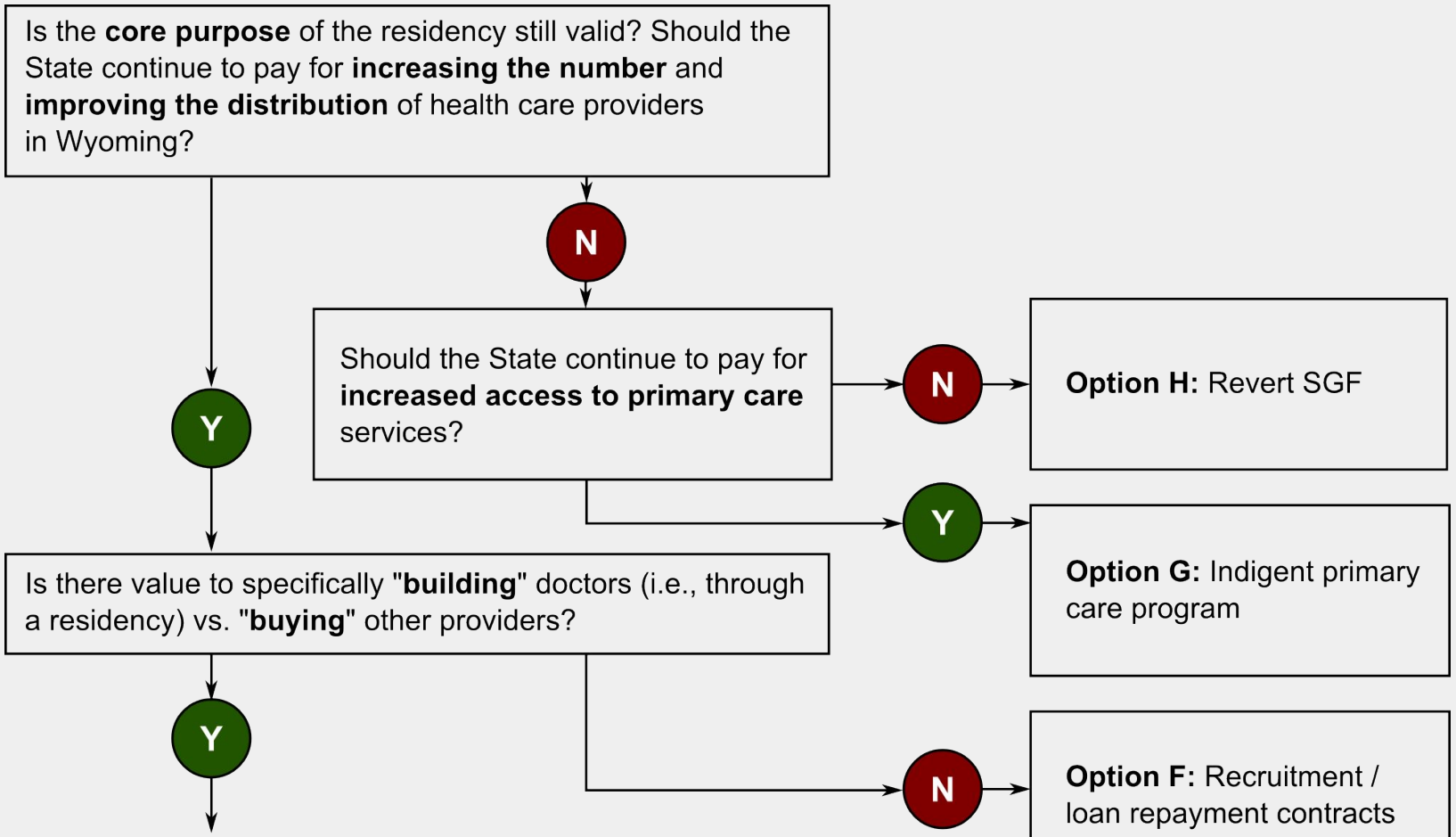
Disparities in physician supply across counties have grown



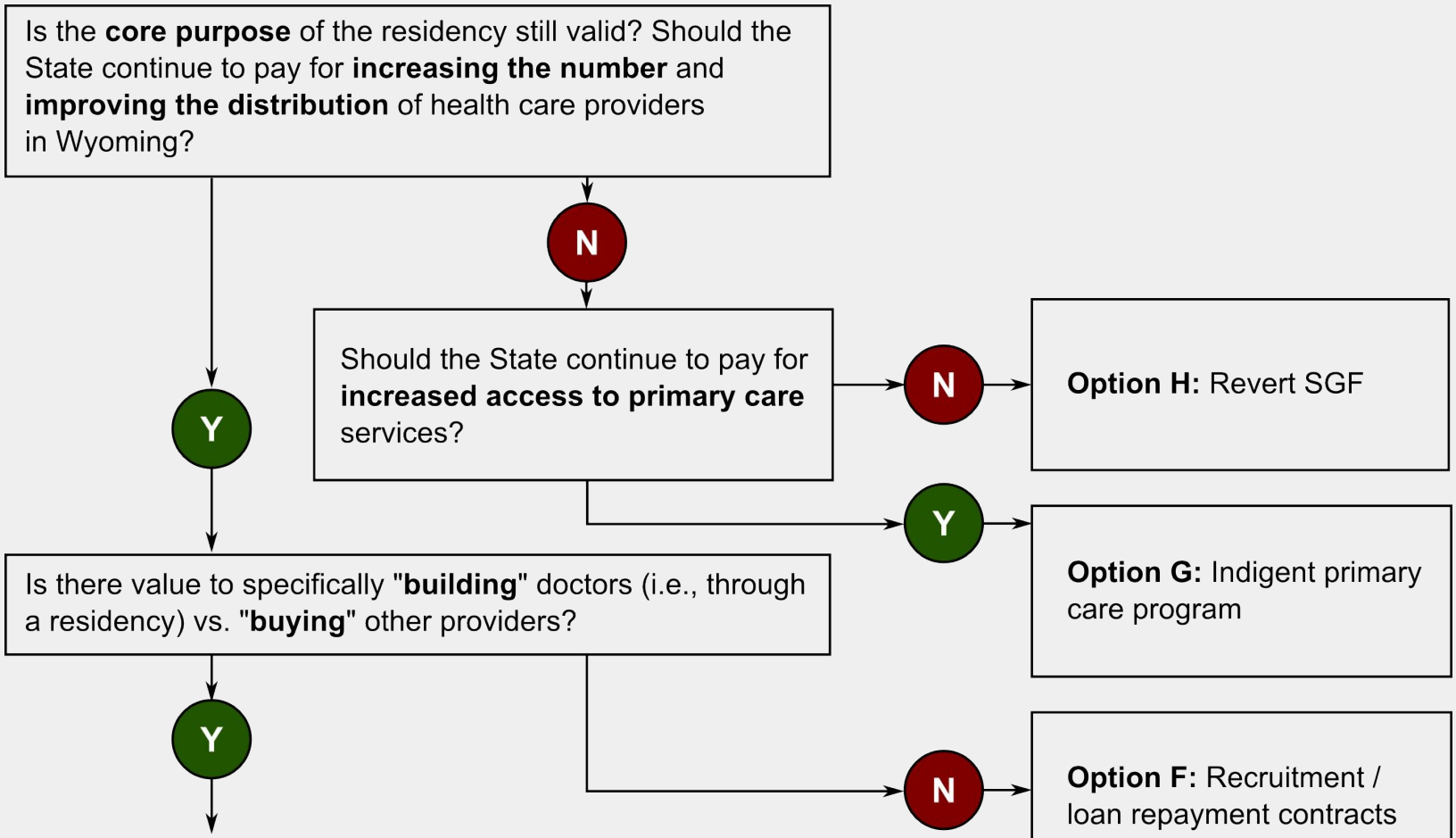
Alternatives

Is the **core purpose** of the residency programs still valid?

Alternatives



Alternatives



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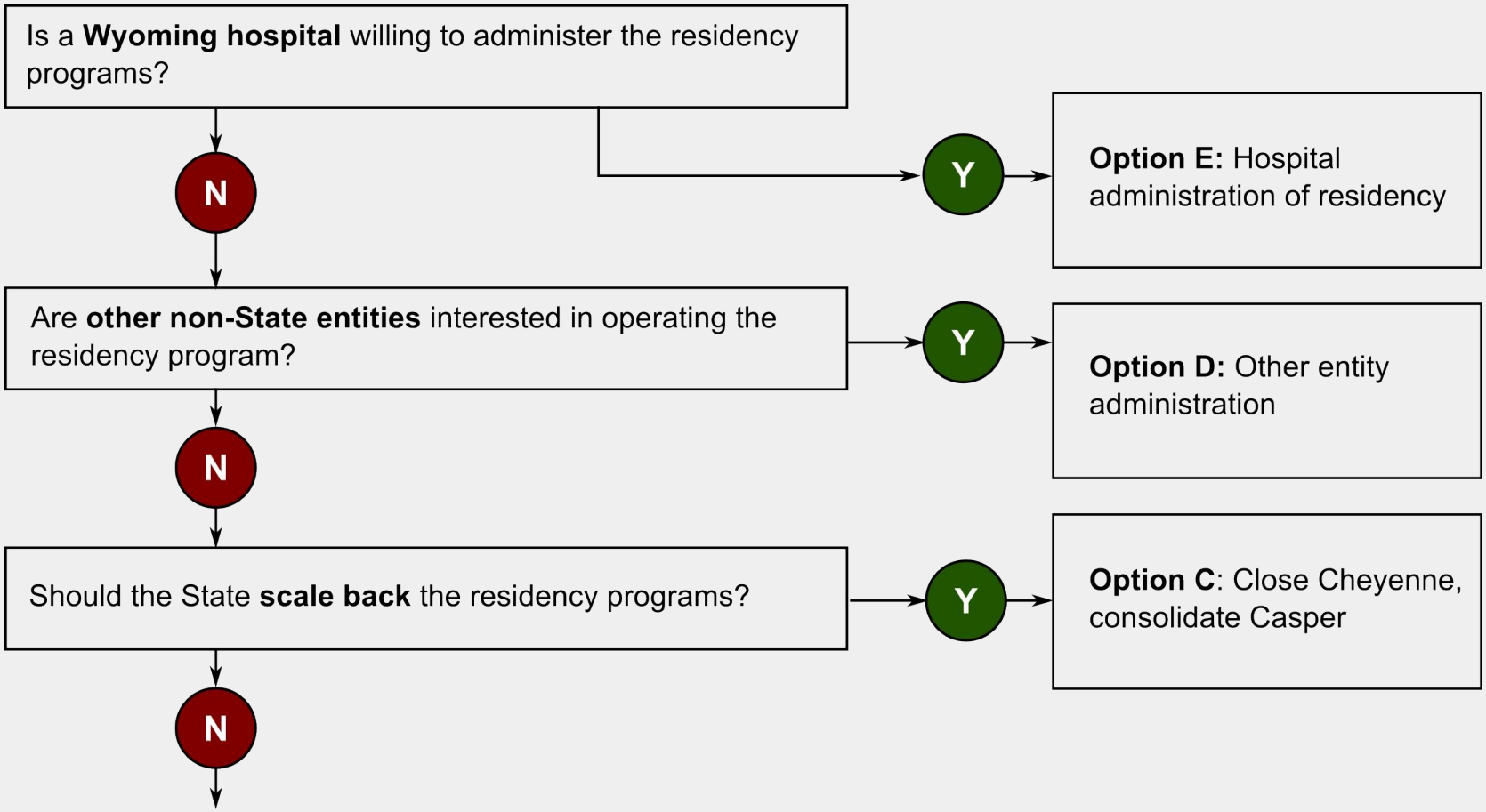

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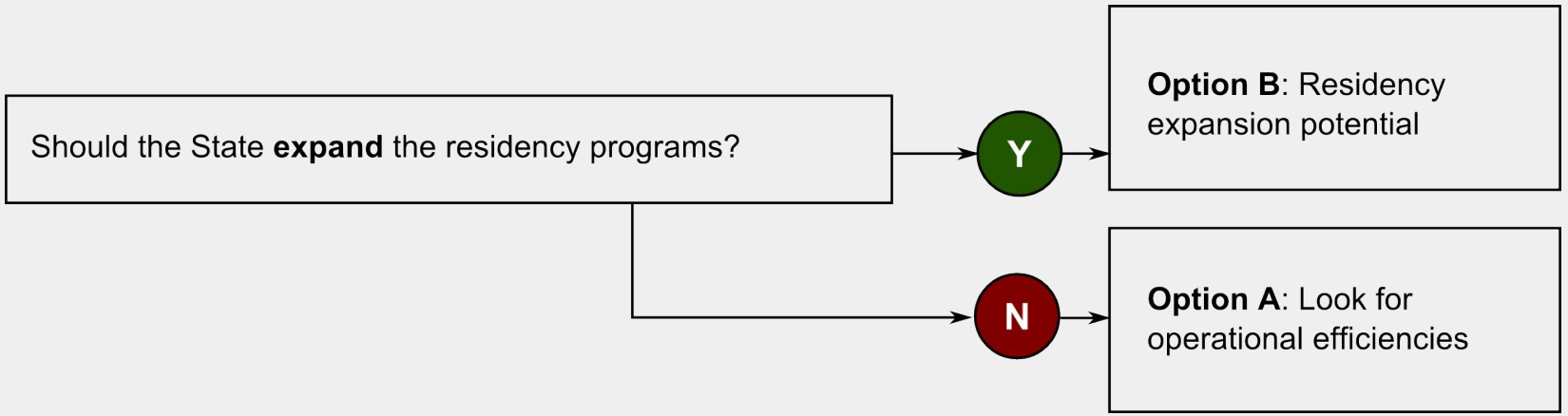

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