16

Talking points

Health Reform, 1995-2002

Recommendations for the People of Wyoming

Wyoming Health Reform Commission

49 recommendations were made, spanning the spectrum of state and federal legislation, restructuring of government programs, enhancement and expansion of existing resources and "radical" changes in funding streams

- There has been some change in nearly every area addressed by the majority of the recommendations; whether what occurred is directly attributable to the Health Reform Commission is difficult to ascertain

- Most of the recommendations have been addressed part way, or slightly differently than proposed, by a combination of legislation, institutional shifts, and nonprofit partnerships

- *In the area of funding, an example of what didn't happen is:*
  Recommendation 8, *Reversion of Punitive Damage Awards*
  The Wyoming Health Reform Commission recommends that 75 percent of punitive damages awarded in Wyoming be paid to the State of Wyoming

  An example of what did (partially) happen is:
  Recommendation 48 *Taxes on Tobacco Products and alcohol*
  The Wyoming Health Reform Commission recommends that taxes on cigarettes, other tobacco products and alcohol must be increased to finance health care reform recommendations **(but only the cigarette tax was increased, and the funds were not earmarked)**

- *In the area of health care coverage, an example of what didn't happen is:*
  Recommendation 1 *Incremental Approach to Universal Coverage*
  The Wyoming Health Reform Commission recommends that Wyoming adopt the following goal: Universal Health Coverage by the year 2002. The Commission recommends that the State of Wyoming pursue this goal by incrementally increasing affordable access to coverage, whether publicly or privately provided.

- *An example of what did happen (partially) is:*
  Recommendation 2, *Health Care coverage for High Risk Individuals,*
  The Wyoming Health Reform Commission recommends extending health care coverage to pregnant women and children, to age 1, to 185% of the federal poverty level (FPL) and to children, from age 11 through age 18, to 100% of the FPL. Coverage should be through the Medicaid program,

to obtain federal funding, and should test an alternative approach to Medicaid. This recommendation includes a request for additional staff and the associated costs for the Department of Family Services (DFS) to determine eligibility for those groups. DFS should simplify and streamline the eligibility process including replacing the existing computer system. **(The income guidelines for pregnant women and children to age 1 have not been expanded above 133% FPL. Children age 6-18 are covered up to 100% FPL in Medicaid due to mandatory federal guidelines. The 2003 Legislature passed, and the Governor signed, HB0065, which repealed the current child health insurance program and recreated the program as a private health insurance program for uninsured children families with an income of not more than 200% of FPL. The bill also established a health benefits plan committee consisting of 10 prescribed members who will develop the benefits package and review the form and level of benefits available at least on a biennial basis.)**

- *Several changes were recommended to increase access to health insurance, and those changes were enacted – in part on the federal level – and remain in place:*

  Recommendation 14, *Portability between Small Groups, The Wyoming Health Reform Commission recommends that any non-COBRA group health insurance policy written in Wyoming shall have a provision that someone who has been continuously covered under a policy for at least three months prior to termination be allowed to continue coverage under that policy, after the insured is no longer covered by the group policy, for up to 12 months* **(This was enacted and has become to be known as our "mini-Cobra" statute).**

  Recommendation 15, *Define Standard Pre-Existing Condition Limit Language for all Policies Written in Wyoming, The Wyoming Health Reform Commission recommends to standardize the period for which health insurance coverage can be denied based on pre-existing conditions. It recommends that the "look back" period be limited to six months (vs. three years) and that full coverage must begin after a period no longer than 12 months of being continually covered.* **(This has been enacted and is consistent with the federal HIPAA law. There are some limited exceptions as identified in HIPAA at 146.145 and 148.220).**

  Recommendation 17,v*The Wyoming Health Reform Commission recommends legislative action to: Extend the provisions of small group reform enacted in 1992 to cover groups of up to 50 employees as opposed to the current 25 employees, Allow the Insurance Department to revise rules lengthening the waiting period for employer participation on new hires from 60 days to as long as 180 days. Employers may choose shorter waiting periods, Extend the provisions of small group reform to apply to groups participating in purchasing cooperatives as they evolve in the State of Wyoming* **(This was enacted and is compliant with the definition of a small employer under HIPAA. The employer imposed waiting period**

was lengthened to 180 days. This gave greater flexibility to employers so that they wouldn't have to extend coverage unless there was an indication that the employee was going to stick around. No small group purchasing coops have evolved).

- *Recommendations the Health Reform Commission made that are likely to creep back, in some form, before the Health Care Commission:*

  Recommendation 19: *Creation of Wyoming Health Insurance Purchasing Cooperatives, The Wyoming Health Reform Commission recommends legislative action to:*

  1. *Allow the State of Wyoming to organize an insurance purchasing cooperative allowing individuals and small groups with 100 employees or fewer to join together for the purpose of purchasing insurance.*
  2. *Employers participating in the co-op with 50 or fewer employees shall comply with small group reform of Wyoming law;*
  3. *Individual policies shall comply with individual policy reform of Wyoming law.*
  4. *Individuals could move between plans offered by purchasing cooperative without being subjected to preexisting condition limitations except with regard to the increased benefits made available by such movement between plans.*
  5. *The purchasing cooperative shall hold the master contract for the carriers, HMOs or other approved plans doing business through the cooperative, and the individuals shall become certificate holders through the master contract.*
  6. *The Insurance Department shall have regulatory authority over the purchasing cooperative, the carriers, HMOs, and other plans offering policies through it, and the employers and individuals purchasing those policies.*

  Recommendation 9, *Cap on Non-Economic Damage Awards, The Wyoming Health Reform Commission recommends that Article 10, Section 4 of the Constitution be amended to allow the Wyoming legislature to establish specific financial limits to the non-economic damages an injured party may recover, in cases alleging medical malpractice.*

  Recommendation 21, *Insurance Reforms at the Federal Level, The Wyoming Health Reform Commission recommends that the Governor contact the Congressional Delegation regarding the following actions required at the federal level or that join resolutions be passed by the Wyoming Legislature requesting Congress to:*

1. *Amend the Internal Revenue Code to allow health insurance premiums to be 100% deductible to individuals for determining taxable income;*
2. *Amend the Internal Revenue Code to allow for the creation of tax exempt Medical Savings Accounts (MSAs);*
3. *Remove the exemption from the state insurance regulation for employee welfare benefit plans under the Employee Retirement Income Security Act of 1974.*

Other Health Reform Commission recommendations seeing at least partial fruition include:

Telemedicine – A plan is in place and funding is being sought

Office of Rural Health – The Office is funded and has hired a community health planner to work on community health initiatives

Recruiting and retention of health care providers – The Office of Rural Health is partnering with a nonprofit to recruit and retain mid-levels and physicians

Health care professional training – The opportunities provided by the University of Wyoming have expanded in the last 10 years

Mental health – The number of mental health providers has increased and the integration of the mental health system has progressed

Trauma system – a trauma system is being implemented in all Wyoming hospitals

Health care access – There are more rural health clinics in the state and many hospitals have converted to Critical Access Hospital status, increasing their economic viability

Recommendations in areas where there has been minimal policy shifting:

Mandatory school health education and youth physical fitness

"Adequate and sustained" funding to address priority public health needs of the state

Miner's Hospital Fund earnings dispersion

Health Reform, 1995-2002

Recommendations for the People of Wyoming

Wyoming Health Reform Commission

Recommendation 1

Incremental Approach to Universal Coverage

The Wyoming Health Reform Commission recommends that Wyoming adopt the following goal: Universal Health Coverage by the year 2002. The Commission recommends that the State of Wyoming pursue this goal by incrementally increasing affordable access to coverage, whether publicly or privately provided.

That is one that the new commission is going to have to tackle. We've made some inroads with small group reform and expansion of our SCHIP (for kids), and our state's high-risk pool (although affordability is still a concern).

Lloyd Wilder, Department of Insurance

Recommendation 2

Health Care coverage for High Risk Individuals

The Wyoming Health Reform Commission recommends extending health care coverage to pregnancy women and children, to age one, to 185% of the federal poverty level (FPL) and to children, from age 11 through age 18, to 100% of the FPL, as the first increments in seeking universal coverage. Coverage should be through the Medicaid program, to obtain federal funding, and should test an alternative approach to Medicaid.

This recommendation includes a request for additional staff and the associated costs for the Department of Family Services (DFS) to determine eligibility for those groups. DFS should simplify and streamline the eligibility process including replacing the existing computer system. This extension of coverage should be funded at an estimated annual cost of $6,533,776.

The income guidelines for pregnant women and children to age 1 have not been expanded above 133% FPL. Children age 6-18 are covered up to 100% FPL in Medicaid due to mandatory federal guidelines.

Patty Guzman, Kid Care Manager

The 2003 Legislature passed, and the Governor signed, HB0065, which repealed the current child health insurance program and recreated the program as a private health

insurance program for uninsured children families with an income of not more than 200% of FPL. The bill also established a health benefits plan committee consisting of 10 prescribed members who will develop the benefits package and review the form and level of benefits available at least on a biennial basis. The appropriation was $827,837 (general funds) to match federal dollars (effective 7/1/03).

Wyoming Primary Care Association legislative summary

The Department of Family Services started building the new eligibility system for Medicaid, Food Stamps, TANF, and Childcare in 2002. DFS contracted with SSi North America to build the system. This is a four-year project, being completed in five phases. In 2002, the 6500 system requirements and the 50 interfaces required of the new system were gathered. In 2003, Release 1 system design is being completed and will be ready for piloting in October. In 2004, the remaining design work will be completed as Release 2 for full statewide implementation in April 2005. The DFS contractor will then complete a year of warranty; in 2006, DFS will assume full operational responsibility. The DFS contract with SSi to build the system is for $23,329,388. In addition, DFS is incurring equipment and personnel costs so the whole development will end up costing closer to the legislatively-appropriated $30 million. This new system, based upon current caseloads as of April 2003, will serve 60,470 Medicaid recipients, 26,535 Food Stamp recipients, 707 TANF recipients, and state-supported children being served by 4,000 day care providers. There are many new system functionalities. These include Interactive Interview, Scheduling and Calendaring, Rules Engine, Client Merge, Client Website, Childcare and Provider Website/Resource Directory, All Benefits to be delivered electronically (i.e. via Smart Card or Electronic Funds Transfer), Automated eligibility for all programs, Automatic Notice Generation, and scanning of verification data. Medicaid is fully implemented in this integrated resources information system (IRIS), based upon the eligibility guidance received from the Department of Health. Kid Care is not being incorporated at this time at the request of the Department of Health.

Wyoming Department of Family Services

Recommendation 3

Consolidation of the Health Care Administration

The Wyoming Health Reform Commission recommends that the State contract for the development and operation of a central electronic medical claims collection system. The system should use a standard format consistent with the format used by Medicare. State medical programs including all group health plans doing business with the State or its political subdivisions should be required to accept claims submitted through this system. Claims collection services should be made available to other payers.

Since this recommendation was written in 1994, the world of Electronic Data Interchange (EDI) has taken the health care industry by storm. In November 1991, the Workgroup for Electronic Data Interchange (WEDI) was established in response to the challenge to

reduce administrative costs in the nation's health care system. A voluntary, public-private task force, WEDI developed an action plan to streamline health care administration by standardizing electronic commerce across the industry. In July 1992, WEDI published a report that outlined the steps necessary to make electronic data interchange (EDI) routine for the health care industry by 1996. Most of the elements of the action plan were incorporated into the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (See discussion under Recommendation 24: Standardized Forms.)

Recommendation 3 is specifically concerned with the development of a Wyoming-wide medical claims clearinghouse that would receive claims from all providers in a standard format and would route them to all State-sponsored payers for processing. The Commission envisioned a system owned and operated by an independent board of providers and payers and funded by subscriber fees and transaction fees. The system would be part of a larger strategy to collect and analyze health care data across State health plans and to set the stage for consolidation of health care administrative functions. Although no formal plan to implement this system has ever been proposed, many of the original objectives are being met today through a gradual evolution of State program administration and the health care industry as a whole.

Health care payers and providers in Wyoming and throughout the country have access to many options for electronic claims submission. Providers who wish to bill electronically maintain some type of practice management computer system to prepare and submit claims, reconcile payments, maintain general office accounts and inventories, and create patient records. The software may be capable of dialing up a payer and submitting claims directly, or it may be connected to a "switch vendor" or clearinghouse that directs the claims to one of several payers. Some payers offer direct data entry through a point of sale (POS) system, which allows the provider to enter a claim directly into the payer's own system for immediate adjudication and payment. Payers who allow or require electronic claims submission will typically provide either a POS system or proprietary software for the provider's use, or will contract with a clearinghouse to accept claims from other vendors or clearinghouses and transmit them to the payer's system for adjudication and payment. Most payers who accept electronic claims also have the capability of issuing electronic payments and remittance advices. Implementation of standard transactions and code sets under HIPAA will accelerate the use of electronic billing and clearinghouses.

In Wyoming, the Department of Health has been an early adopter of electronic claims technology beginning with the implementation of its Medicaid Management Information System (MMIS) in 1993. The MMIS now processes more than 2 million health care claims per year with an average turnaround time of 1.3 days. The MMIS accepts electronic claims through dial-up connections, tape transfers, and a pharmacy point of sale system that provides real-time claims adjudication. More than 80 percent of claims are submitted electronically, including nearly 100 percent of Medicaid pharmacy claims. Electronic funds transfer is available through the State Auditor's office. Providers have access to electronic verification of eligibility through POS devices, dial-up connection,

internet or an automated voice response system. Beginning in October 2003, the MMIS will begin using an EDI clearinghouse to receive and transmit all standard transactions mandated by HIPAA. Soon after, the Medicaid internet site will be upgraded to allow providers to submit requests for prior authorization and receive electronic remittance advices.

Most other major payers in Wyoming also make use of electronic transactions and data sharing. Great West (State Employees' Group Insurance), Blue Cross/Blue Shield, Union Pacific, Tricare and others encourage providers to bill electronically. An estimated 95 percent of all pharmacy claims are submitted and paid through POS services that calculate deductibles and coinsurance, adjudicate and pay claims, and issue Drug Utilization Review (DUR) warnings to the pharmacist if there is a potential for drug interactions or other concerns. The only major State payer that does not fully utilize electronic commerce technology is the Workers' Compensation program.

Consolidation of administrative functions for State-sponsored health care is partly a reality, but more can be done. In 2000 the Wyoming Medicaid program modified the MMIS to accept an unlimited number of distinct "benefit plans" to which individual beneficiaries can be assigned. For each benefit plan, the State sets criteria such as benefit packages, service limitations, funding source, federal or state reporting requirements, and co-payments or deductibles that apply. Each benefit plan can have a unique fee schedule attached so reimbursement can be tailored. This innovation has allowed the Department to use the MMIS to process claims for several programs in addition to Medicaid. Some of the benefit plans now in use include: Medicaid Children, Medicaid Adults, Medicaid Nursing Home, Prescription Drug Assistance Program (PDAP), the AIDS Drug Assistance Program (ADAP), Children with Special Health Needs (CSHN), State Licensed Shelter Care, State Foster Care, Marginal Dental Program, Maternal Dental Program, Breast and Cervical Cancer Screening Program, and the five Medicaid Home and Community-Based Services (HCBS) Waivers. The State Children's Health Insurance Program (KidCare) plan is also carried in the MMIS but will be moving to a private insurance purchase program October 1, 2003.

Other features of the MMIS that are shared by these programs include the eligibility verification and claims inquiry functions, prior authorization, coordination of benefits with other insurances, and extensive reporting capability. Complete claims data for all plans is stored in the Decision Support System (DSS), which contains seven full years of data and has extensive tools for data analysis, financial reporting, and fraud/abuse investigation. Operation of a federally certified MMIS is a requirement for all state Medicaid programs and generates federal matching funds at 90 percent for implementation or enhancement, and 75 percent for operations. Because these systems represent such a large investment for states, there is a significant movement in some states toward expanding the use of the MMIS to incorporate other State programs. The State of Georgia, for example, has just implemented a new MMIS based in part on Wyoming's own system that will bring their Workers' Compensation and public employees' group insurance plans together with Medicaid in order to consolidate administration, take advantage of the vast functionality available, and make billing

simpler and more uniform for providers across all the programs. In Wyoming, the Department of Health has had some discussion with Workers' Compensation about providing claims processing services for that program, but it will most likely require significant executive direction to make it happen. However, consolidation of administrative functions between departments while retaining unique policy authority remains a very viable possibility for Wyoming.

In 2003, the Governor's Office assembled a Steering Committee and entered into a contract with Human Capital Management Services (HCMS) of Cheyenne to integrate, aggregate and analyze health data from State sources including Medicaid, KidCare, State Employees' Group Insurance and Workers' Compensation. The data is de-identified to avoid any breach of confidentiality or privacy, and the resulting analysis is expected to reveal areas of overlap and inefficiency in the health care system while at the same time providing a global view of the medical services the State purchases across the board. Plans for the near future include bringing in health care data from the University, the community colleges, and eventually perhaps the school districts as well for an even more comprehensive view of the use of taxpayer dollars in the health care market.

Iris Oleske, Wyoming Department of Health, Medicaid

Recommendation 4

Timeline for Universal Coverage

The Wyoming Health Care Reform Commission adopted Recommendation 1, Incremental Approach to Universal Coverage. That recommendation specified that the state of Wyoming would take an incremental approach in increasing affordable access to health care coverage through a range of public and private options. Recommendation 2, Health care Coverage for High Risk Individuals, identified the initial groups of individuals to be covered, establishes timelines for covering those groups and discusses some of the issues that must be considered in establishing that coverage.

See recommendation 1

Recommendation 5

Cooperative Health Care Agreements

The Wyoming Health Reform Commission recommends an exception to Wyoming anti-trust laws which would allow agreements among two or more health care providers for the sharing, allocation or referral of patients; or the sharing, or allocation of personnel, instructional programs, support services, and facilities, medical diagnostic or laboratory facilities or procedures or other services customarily offered by health care providers.

The thinking back then was to allow creative ways to work together to have co-op ownership of facilities or equipment, rather than encourage each and every community to

invest in its own. But in order to do that, there needed to be some protection from strict anti-trust provisions, which prohibit the sharing of financial information etc., etc.

The result was the passage of Health Care Cooperative Arrangements for Anti-trust Exceptions by the legislature, which became law July 1, 1995. Gov. Geringer signed Chapter 24 rules in 1996 -- I think it's somewhere around W.S. 35-24-112, but that may only be one portion of it. We've never used it -- there has never been an application to form a cooperative. Instead, the competition between health care providers has sorted out into other areas -- visiting clinics ala Gem City Bone & Joint -- and economic factors driving hospitals to have the current equipment considered to be the "existing standard of care."

Tom Pringle and Dan Stackis mounted an effort to repeal the statute in the fall of 1998 and went to considerable effort to research the topic and prepare a summary. I have a copy of the "Antitrust Summary Report" they put together. We met a couple of times, and decided that it didn't hurt anything, and that its use in the future was unknown, but that it might allow some form of cooperation ... so I guess we just decided not to do anything.

Wendy Curran, Wyoming Medical Society

Recommendation 6

Coverage of Children Pursuant to Court Orders

The Wyoming Health Reform Commission recommends legislative action to:

1. *Ensure that health coverage is provided to children whose parents are required by court order to provide such coverage.*
2. *Allow the Department of Health, Division of Health Care Financing to garnish the wages of a person who is required by court order to provide coverage for a child eligible for medical assistance and who has received payment from a third party for the costs of medical services but has not sued the payment to reimburse the other parent or provider; and*
3. *Prohibit insurance companies from taking eligibility for Medicaid into account when enrolling individuals for health insurance.*

1. Federal and state laws have been enacted to ensure compliance with medical child support orders. In Wyoming, medical child support orders are mandated by Title 20, Article 4 of the Wyoming statutes and fall under the jurisdiction of the Department of Family Services Child Support Enforcement Division. The National Medical Support Notice is used to enforce the provision of health care coverage for children of non-custodial parents who are required to provide health care coverage through an employment-related group health plan in accordance with a child support order. DFS has implemented a computer system called POSSE to track and enforce child support requirements, including medical child support orders. Wyoming Medicaid partners with

DFS in a data exchange in which verified health insurance information on non-custodial parent policies is passed from the Medicaid Management Information System (MMIS) to POSSE, and information about the medical child support order is passed from POSSE to the MMIS.

2. The Wyoming Medical Assistance Act has been amended to include the following provision:

42-4-208. Recovery for cost of health care.

(a) The department, to the extent necessary to reimburse its costs, shall be entitled to recover from any parent who:
(i) Is required by court or administrative order to provide coverage of the cost of health services to a child eligible for medical assistance under this act; and
(ii) Has received payment from a third party for the costs of such services but has not used the payments to reimburse either the other parent or guardian of the child or the provider of the services.
(b) The department shall be entitled to enforce any judgment entered pursuant to this section by garnishment or any other available statutory remedy.
(c) Claims for current and past due child support shall take priority over claims made under this section.

3. The Wyoming Medical Assistance Act has been amended to include the following provision:

42-4-204. Department subrogated to right of recovery of applicant or recipient; utilization of personal health insurance; insurance coverage of recipients.
(c) Notwithstanding the provisions of title 26, no individual or group accident, health or accident and health policy or medical expense policy or medical service plan contract, delivered, issued for delivery or renewed in this state on or after July 1, 1995, shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who received medical assistance under this chapter. No such policy, plan or contract, when enrolling an individual, shall take into account the individual's eligibility for medical assistance under this chapter. This subsection applies to all such policies, plans and contracts issued by any person including, but not limited to:
(i) An insurer;
(ii) A group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974;
(iii) A health maintenance organization;
(iv) An entity offering a service benefit plan.

In addition to this statute, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Medicaid be recognized as creditable coverage for purposes of maintaining health coverage.

Iris Oleske, Wyoming Department of Health, Medicaid

Recommendation 7

Amendments to Wyoming HMO Statutes

The Wyoming Health Reform Commission recommends that Wyoming's HMO law (Chapter 34 of Title 26) be amended to reflect model legislation put forth by the National Association of Insurance Commissioners (NAIC). Such changes would better protect Wyoming consumers when managed care organizations begin to make greater inroads into the state. Additionally, the commissioner recommends that the "any willing provider" language found is W.S. 26-22-503(a)(iii) also be inserted into the HMO legislation.

These were enacted and permit a physician to share information with the patient on alternative measures to treat an illness or condition without threat of reprisal by the HMO. It also implemented the "any willing provider language". The "any willing provider" provision is a barrier to the formation of tightly cost managed HMOs entering the state. Attempts to remove it have been defeated in past legislative sessions.

Recommendation 8

Reversion of Punitive Damage Awards

The Wyoming Health Reform Commission recommends that 75 percent of punitive damages awarded in Wyoming be paid to the State of Wyoming.

Not implemented.

Recommendation 9

Cap on Non-Economic Damage Awards

The Wyoming Health Reform Commission recommends that Article 10, Section 4 of the Constitution be amended to allow the Wyoming legislature to establish specific financial limits to the non-economic damages an injured party may recover, in cases alleging medical malpractice.

Not implemented.

Ken Kamis, Health Reform Commission member

Recommendation 10

Alternative Dispute Resolution (See Rec. 12)

The Wyoming Health Reform Commission recommends that the Civil Rules Committee of the Wyoming Supreme Court recommend to the Wyoming Supreme Court an amendment of Rule 40 of the Wyoming Rules of Civil Procedure requiring that all cases in which either party requests a settlement conference, the Court shall conduct such conference or assign the case to a third party intermediary for non-binding alternative dispute resolution.

The Supreme Court either rejected or did not consider this recommendation.

Ken Kamis, Health Reform Commission member

Recommendation 11

Ongoing Health Care Reform Oversight

The Wyoming Health Care Commission recommends the creation of a state Commission to guide the reformed health system. The Commission's charge will be to monitor and evaluate reforms recommended by the present Health Reform Commission as well as to study and recommend new reforms. It is recommended that the Commission be comprised of seven members appointed by the Governor, representing each of the seven Appointment districts, to serve staggered two-year terms until the year 2002, at which time the continuation or dissolution of the Commission would be reviewed by the Governor. It is recommended that this Commission be funded at an annual level of $83,545.

The Commission was not created. The health reform Commission was started by Gov Sullivan and finished under Gov. Geringer ... It was not at the top of Jim's concerns and the accessibility to coverage and care was pretty well addressed ... Nobody was an advocate for addressing the AFFORDABILITY issue, too many toes to step on, tort reform is unlikely with the current make-up of the legislature, and leaders generally believed that the last thing we needed were more regulations ... Ergo, nothing materialized until the opportunity to spend federal dollars on the uninsured problem came about ...This commission was a logical evolution from the SPG process.

George Bryce, Health Reform Commission member/Health Care Commission member

Gov. Sullivan formed the Commission but the Health Reform Commission report was issued shortly after he left office. Therefore, incoming Governor Geringer inherited the report. Health care and health care reform were not priorities of Gov. Geringer. As I recall, he did not include a request in his budget to fund ongoing activities regarding health care reform.

Ken Kamis, Health Reform Commission member

Recommendation 12

Alternative Dispute Resolution (See Rec. 10)

The Wyoming Health Reform Commission recommends that if Recommendation 10 regarding Alternative Dispute Resolution is not adopted by the Supreme Court by January 1, 1995, the Governor recommend to the Legislature that Recommendation 6 be enacted through Legislation.

Did not occur.

Ken Kamis, Health Reform Commission member

Recommendation 13

Amendment of PPO Statutes

The Wyoming Health Reform Commission recommends that the current Wyoming law on preferred provider organizations (PPO) be amended to allow insurance companies to contract directly with providers to form such networks.

This has been enacted and is found at W.S. 26-22-501, et seq. We haven't a great many PPOs operating in the state.

Wyoming Insurance Department

Recommendation 14

Portability between Small Groups

The Wyoming Health Reform Commission recommends that any non-COBRA group health insurance policy written in Wyoming shall have a provision that someone who has been continuously covered under a policy for at least three months prior to termination be allowed to continue coverage under that policy, after the insured is no longer covered by the group policy, for up to 12 months.

This was enacted and has become to be known as our "mini-Cobra" statute. It has served the market well.

Wyoming Insurance Department

Recommendation 15

Define Standard Pre-Existing Condition Limit Language for all Policies Written in Wyoming

The Wyoming Health Reform Commission recommends to standardize the period for which health insurance coverage can be denied based on pre-existing conditions. It recommends that the "look back" period be limited to six months (vs. three years) and

that full coverage must begin after a period no longer than 12 months of being continually covered.

This has been enacted and is consistent with the federal HIPAA law. It has been good in that we now have a standard that is universally accepted and leveled the playing field and that is consistent in the group and individual health markets. There are some limited exceptions as identified in HIPAA at 146.145 and 148.220.

Wyoming Insurance Department

Recommendation 16

Allow for Sharing of Information of Payers and Benefits

The Wyoming Health Reform Commission recommends that payers be allowed to share information when requested to do so to avoid duplicate payment of benefits.

This was a Medicaid provision that I believe was enacted.

Wyoming Insurance Department

Recommendation 17

The Wyoming Health Reform Commission recommends legislative action to:

1. *Extend the provisions of small group reform enacted in 1992 to cover groups of up to 50 employees as opposed to the current 25 employees.*
2. *Allow the Insurance Department to revise rules lengthening the waiting period for employer participation on new hires from 60 days to as long as 180 days. Employers may choose shorter waiting periods.*
3. *Extend the provisions of small group reform to apply to groups participating in purchasing cooperatives as they evolve in the State of Wyoming.*

This was enacted and is compliant with the definition of a small employer under HIPAA. The employer imposed waiting period was lengthened to 180 days. This gave greater flexibility to employers so that they wouldn't have to extend coverage unless there was an indication that the employee was going to stick around. No small group purchasing coops have evolved.

Wyoming Insurance Department

Recommendation 18

The Wyoming Health Reform Commission recommends legislative action to:

1. *Revise existing law covering individual health insurance to accomplish the following goals:*
    a. *Promote the availability of individual health insurance coverage to persons not covered by employment based insurance regardless of their health status or claims' experience;*
    b. *Prevent abusive rating practices and require disclosure of rating practices to purchasers;*
    c. *Establish a modified community rating system with medical underwriting based on age, gender, geographic location, discounts, family size and coverage under workman's compensation plans.*
    d. *Establish rules regarding renewal of coverage;*
    e. *Apply a six month look back period and twelve month limitation period for preexisting conditions;*
    f. *Eliminate preexisting condition limitations (or apply transfer benefits provisions) when coverage is continuous from other group or individual major medical policies;*
    g. *Provide for the adoption of "basic" and "standard" health benefit plans offered to all individuals;*
    h. *Continue using the Wyoming Health Insurance Pool as an insurer of last resort;*
    i. *Improve the overall fairness and efficiency of the individual health insurance market.*
2. *This individual market reform shall apply to all policies issued separately as well as within an insurance purchasing cooperative.*

Other than the HIPAA applications of standard pre-ex and continuation of the state's high risk pool (WHIP), no individual market reforms were passed.

Recommendation 19

Creation of Wyoming Health Insurance Purchasing Cooperatives

The Wyoming Health Reform Commission recommends legislative action to:

1. *Allow the State of Wyoming to organize an insurance purchasing cooperative allowing individuals and small groups with 100 employees or fewer to join together for the purpose of purchasing insurance.*
2. *Employers participating in the co-op with 50 or fewer employees shall comply with small group reform of Wyoming law;*
3. *Individual policies shall comply with individual policy reform of Wyoming law.*
4. *Individuals could move between plans offered by purchasing cooperative without being subjected to preexisting condition limitations except with regard to the increased benefits made available by such movement between plans.*

5. *The purchasing cooperative shall hold the master contract for the carriers, HMOs or other approved plans doing business through the cooperative, and the individuals shall become certificate holders through the master contract.*
6. *The Insurance Department shall have regulatory authority over the purchasing cooperative, the carriers, HMOs, and other plans offering policies through it, and the employers and individuals purchasing those policies.*

Great debate, but no action. Coops are difficult to put together and administer, and generally require choice of plans and large numbers to be successful.

Wyoming Insurance Department

Recommendation 20

Standardized Benefit Packages – Small Group Reform and Wyoming Health Insurance Pool

The Wyoming Health Reform Commission recommends the re-establishment of a Health Benefit Plan Committee to review and revise the standard and basic plans offered through small group reform and in the Wyoming Health Insurance Pool (high risk pool), to report to the Insurance Department, no later than December 1, 1995, for appropriate action during the 1996 legislative session.

This was enacted and the HBPC reviews the small group and WHIP benefit plans biennially for currency with the market. Basic and Standard small group plans are basically a moot point now with the passage of HIPAA. HIPAA requires that a small employer insurer guarantee issue all plans for which a small employer qualifies. The Basic and Standard plans are fall-back plans.

Wyoming Insurance Department

Recommendation 21

Insurance Reforms at the Federal Level

The Wyoming Health Reform Commission recommends that the Governor contact the Congressional Delegation regarding the following actions required at the federal level or that join resolutions be passed by the Wyoming Legislature requesting Congress to:

1. *Amend the Internal Revenue Code to allow health insurance premiums to be 100% deductible to individuals for determining taxable income;*
2. *Amend the Internal Revenue Code to allow for the creation of tax exempt Medical Savings Accounts (MSAs);*
3. *Remove the exemption from the state insurance regulation for employee welfare benefit plans under the Employee Retirement Income Security Act of 1974.*

No information available in time for this report.

Recommendation 22

Guaranteed Renewability

The Wyoming Health Reform Commission recommends that all health insurance policies issued in Wyoming be guaranteed renewable at the option of the insured; the only exceptions being non-payment of premiums or fraud, or in the event of non-renewal of all policies by line of business in the state of Wyoming subject to W.S. 26-19-305.

This was enacted and is a good consumer protection.

Wyoming Insurance Department

Recommendation 23

Portability

The Wyoming Health Reform Commission recommends that pre-existing condition exclusions, as defined and limited in Commission Recommendations 15, be applied to an insured only upon initial application for health insurance and, if that insured stays continuously covered, not be reapplied when an insured changes jobs or insurance coverages.

This was enacted and goes beyond the provisions of HIPAA as we allow portability credit for pre-existing conditions not only from group to group, but group to individual, and vice versa. This, too, is a good consumer protection.

Wyoming Insurance Department

Recommendation 24

Standardized Forms

The Wyoming Health Reform Commission recommends that the Department of Insurance use its authority to prescribe the use of standard inpatient, outpatient, dental and prescription drug forms or formats by all providers and all payers in Wyoming. The Commission recommends an implementation date of July 1, 1997. This recommendation is intended to enhance the efforts towards electronic media claims.

This 1994 recommendation for the standardization of medical claim forms was prescient for its time. The Administrative Simplification provisions in Title II, Subtitle F, of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, "the Act") have emerged as today's new priority for all segments of the health care industry. HIPAA was established with the intent of reducing costs and administrative burdens

related to health care by making possible the standardized, electronic transmission of many administrative and financial transactions that are currently carried out manually or in a bewildering array of electronic formats. Section 1172 of the Act makes any standard adopted by the Secretary of the U.S. Department of Health and Human Services (DHHS) applicable to all health plans, clearinghouses, and health care providers who transmit health information in an electronic format. (Medicare, TriCare and State Medicaid programs are deemed to be health plans for the purposes of HIPAA implementation.) Payers are prohibited from refusing to conduct an electronic transaction as a standard transaction. Delays in processing or activities that might adversely affect such standard transactions are also prohibited. Additionally, the Act establishes a timetable for compliance with HIPAA regulations. Civil and monetary penalties may result in the event that a health plan is non-compliant. To date, DHHS has adopted electronic standards for the following transactions:

Health claims and encounter data (Institutional, Professional, Dental, Pharmacy)
Eligibility for a health plan
Health claim status
Referral certification and authorization
Enrollment/disenrollment in a health plan
Health care payment and remittance advice
Health plan premium payments
Coordination of benefits

The Secretary has also mandated the use of the following standard code sets:

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2
International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volume 3 Procedures
Current Procedural Terminology, Fourth Edition (CPT-4)
Health Care Financing Administration Common Procedure Coding System (HCPCS)
National Drug Codes (NDC)
Code on Dental Procedures and Nomenclature
National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy List

The final rule for electronic transaction standards and uniform code sets was published in the Federal Register on August 17, 2000. Implementation of this portion of the HIPAA law was required by Federal law to be completed no later than October 2002; however, payers and providers were allowed to file for a one-year extension for compliance under the Administrative Simplification Compliance Act. Therefore, most health care entities are required to be compliant with electronic standards for claims transactions and code sets no later than October 16, 2003. The final rule for Privacy relating to individually identifiable health care information was published in the Federal Register on December

28, 2000; the deadline for implementation of the privacy rule was April 14, 2003. The final rule establishing a National Employer Identifier was published May 31, 2002, and compliance is mandated by July 31, 2004. The final rule for system security standards was published February 20, 2003 and compliance is mandated by April 20, 2005. Additional rules to be finalized in the near future will prescribe standards for a national provider identifier, a national payer identifier and electronic claims attachments.

Medicaid agencies, State Children's Health Insurance (SCHIP) Programs, Medicare and all public and private insurance companies and health care plans are required to comply with these standards, as are all health care providers and claims clearinghouses. Any health care provider who submits health care claims electronically is also required to comply with the standards. In addition, Medicare is requiring all providers to submit claims electronically after October 16, 2003, with a limited exception for small providers. (Medicare now reports 98 percent electronic claims submission nationwide.) Wyoming Medicaid does not have a blanket requirement for electronic billing, but more than 80 percent of claims are received electronically, including nearly 100 percent of pharmacy claims.

Iris Oleske, Wyoming Department of Health, Medicaid

Recommendation 25

Increased Affordability and Utilization of Wyoming Health Insurance Pool

The Wyoming Health Reform Commission recommends extension of the Wyoming Health Insurance Pool (WHIP) through June 30, 2000 (section 26-43-113 should not sunset) and its continued use as the insurer of last resort. The Commission recommends that premiums charged to eligible policy holders be reduced to 125% of the market levels (versus 200%) for no less than a two year period. The annual deficit financing mechanism should be adjusted so that the first $1,250,000 will be shared on a 50/50 basis. All other deficits of WHIP shall be the responsibility of the assessable insurers.

This was enacted for the period noted. The sunset has now been extended to June 30, 2005, and the premium level is now back at "not to exceed 200% of the standard market." The funding formula for funding pool losses has been modified to: the first $1.25 million is 80/20 and the next $1.25 million is 50/50, and anything over $2.5 million is 100% the responsibility of the assessable insurers.

In the last session of the legislature we enacted SF 0020, (group association health plans), SF 0035 (Rx drugs etch assistance), SF 0143(Adverse selection reduction - small group), HB 0024 (Limitation on use of genetic information) and HB 0064 (SCHIP expansion).

Wyoming Insurance Department

Recommendation 26

Standardized Benefit Packages

The Wyoming Health Reform Commission recommends that the new Health Reform Oversight Commission design a minimum mandatory package of benefits to be offered throughout the insurance market. The Commission recommends that a package of benefits be designed during 1995 to be recommended for legislative action in the 1996 session.

The Health Reform Oversight Commission was not created. *See Recommendation 11.*

Recommendation 27

Funding for the Office of Rural Health

The Wyoming Health Reform Commission recommends that the Office of Rural Health, created by W.S. 9-2-116 through 9-2-119, effective July 1, 1993, but not funded, be funded at the level of $520,151 per year.

Funding for the Office started in FY 1995. The budget for the 1995-96 biennium was around $277,000. The budget has been around $500,000 for the following bienniums. The budget for 2003-2004 is $571,833.

Wyoming Department of Health

Recommendation 28

Recruitment and Retention of Health Care Providers

The Wyoming Health Reform Commission recommends that the actual recruitment and retention activities of the Office of Rural Health be contracted out to a private nonprofit organization with public/private oversight.

Wyoming Health Resources Network (WHRN) was created in 1995 (See Recommendation 29, No. 6, Section 3, "Recruitment, Retention and Training of Mid-Level Providers"). Since January of 1996, WHRN has placed 73 permanent healthcare providers, including 43 physicians, 21 physician assistants, and 9 nurse practitioners, in 19 of the 23 Wyoming counties. WHRN lists all vacancies that facilities are recruiting for, but are most successful with primary care providers. Of the 43 physicians placed, only two have been sub specialists (general surgery and emergency medicine) with the remainder being primary care providers (family practice, internal medicine, obstetrics and gynecology, pediatrics and psychiatry). All midlevel placements have been in primary care area.

WHRN has also assisted facilities by providing 48 temporary, or locum tenens, providers. The locum providers allow physicians and midlevel providers to take well-deserved time off that they might otherwise be deprived of. Locum cover existing practices temporarily

to allow for sick leave, vacations and other short-term absences and resulting in retention of otherwise burned out, overwhelmed practitioners. WHRN is able to offer competent practitioners saving a site both time and money, in part because the provider is already Wyoming licensed and oftentimes resides in the state. The locum provider is ready to step in and continue providing care to patients and communities.

Pennie Hunt, Wyoming Health Resources Network

Recommendation 29

Office of Rural Health Additional Functions

The Wyoming Health Reform Commission recommends that the Office of Rural Health be assigned additional functions beyond what is currently outlined in the State Statutes, to include:

1. *Coordinating the development of a statewide telemedicine capability in cooperation with the Wyoming Telecommunications Council;*
2. *Assisting in the establishment of Rural Health Clinics;*
3. *Assessing the availability of NPs and PAs statewide and determining (in coordination with other organizations) additional training needs for such health care providers; also, facilitating the incorporation of mid-level providers into Wyoming's health delivery system as appropriate;*
4. *Providing technical assistance, upon request, to Wyoming hospitals which are looking for alternative methods of efficiently and effectively providing services to their communities;*
5. *Monitoring federal legislation, pending bills, rules and regulations, etc., that may impact the Wyoming health care education and delivery systems, and providing assessments of the potential impact of these federal activities to Wyoming policy makers, administrators, and the public as early as possible so that appropriate responses can be initiated to maintain and improve health care in Wyoming;*
6. *Establishing and implementing a Community Health Access Initiative to encourage and support community-based primary care and health promotion/disease prevention initiatives.*

> 9-2-117. Office of rural health care created; duties.
> (a) The office of rural health care is created within the department of health. The office shall:
> (i) Serve as a clearinghouse for information on primary health care services in communities and rural areas of Wyoming and provide for dissemination of information by appropriate means to interested citizens of the state;
> (ii) Provide technical assistance and consultation services to communities and rural areas, including hospitals located in these communities and rural areas, and thereby assist citizens' groups, local officials and health professionals to:
> (A) Recruit and retain health care professionals and support personnel as required;
> (B) Assess health care needs and priorities of families living in rural areas;
> (C) Identify sources of funding and programming, including information on rural health care districts and the best beginnings program in Albany County;
> (D) Establish strong working relationships with health care professionals throughout the state;

(E) Encourage the development of risk management programs;
(F) Assist in the development of rural health clinics;
(G) Design and implement programs enhancing state primary care services and state health promotion and disease prevention efforts.
(iii) Contract, if necessary, with other entities to carry out duties prescribed under this section, and to conduct an active and ongoing recruitment program for physicians and other health care professionals and to engage in the following activities:
(A) Assist communities in their effort to recruit and retain physicians and other health care professionals;
(B) Assist communities in the contact and evaluation of potential candidates;
(C) Conduct community studies to ascertain viable support for health care professionals;
(D) Assist physicians and other health care professionals and their families to find communities that will meet their needs and expectations;
(E) Maintain close liaison with government and private sources of health care providers;
(F) Assess the availability of nurse practitioners and physician assistants in the state and in coordination with other appropriate organizations, determine additional training needs for these health care professionals;
(G) Facilitate incorporation of mid-level providers into the state health delivery system.
(iv) Develop a consortium of state agencies, private health organizations, professional and community organizations in a continuing effort to improve needed rural, primary care and other health care services for the people of Wyoming;
(v) Administer the loan repayment programs created by W.S. 9-2-118 and 9-2-119;
(vi) In cooperation with the state telecommunications council established under W.S. 9-2-1026.2, coordinate and plan the development of a statewide telemedicine capability using existing telecommunications infrastructure and services to the extent possible. In accordance with W.S. 9-2-1026.2, the office and the council shall report plans and recommendations to the governor and the legislature.

1. Telemedicine

The following represents the Wyoming Office of Rural Health, telehealth manager's action steps for telemedicine:

During 2002, state-wide telemedicine networks and applications were researched and reviewed for appropriateness of implementation in Wyoming. A state-wide survey of interest in telehealth activities and applications was conducted with providers, hospitals, optometrists, and many others, to assess level of current telehealth practice and interest in telehealth development. A telehealth connection was established between the Wyoming Veteran's Home and the Veteran's Administration Hospital in Sheridan, for the delivery of telepsychiatry. The potential for the development of more collaborative projects between the state and the VA system remains very positive.

During 2003, collaboration with the University of Wyoming, College of Health Sciences, to develop a proposal for $3,000,000 in federal earmarked funds to assist with statewide telemedicine efforts. Both Senators Thomas and Enzi are supporting this proposal.

During 2004, if awarded the funds, a network of telehealth applications will be developed throughout the state. Initial development of clinical applications will focus on areas of need and interest identified by the Wyoming Telehealth Survey 2002. Sites for development will be determined through a RFP process to include primary providers, clinics, hospitals and mental health providers. Distance education and support systems

will be created to deliver Continuing Medical Education units to providers, provide professional support systems and a method for case conferencing.

During 2005, technical assistance will be provided to telehealth sites to create an operational system. Consortiums may include state government and the university with community colleges, family practice residency programs, the Rural Underserved Opportunities Program, community hospitals, nursing homes, school districts, mental health clinics and primary care clinics, where feasible. Best practices in the delivery of telehealth services to the Wyoming population will be developed.

In 2006, the telemedicine network will be fully operational. Efforts to establish a sustainable system, including adequate and appropriate reimbursement for services and economical technology applications and telecommunications connections, will be emphasized.

2. Establishment of Rural Health Clinics

There are 18 rural health clinics in Wyoming now (there were five in operation when the Health Reform Commission made its report), in Baggs, Basin (2), Dubois, Green River (2), Hulett, Lovell (2), Lusk, Medicine Bow, Moorcroft, Newcastle, Saratoga, Sundance, Thermopolis (2), and Upton. The clinic in Dubois was recently approved for funding as a Community Health Center satellite to the Community Health Center of Central Wyoming in Casper.

3 Recruitment, Retention and Training of Mid-Level Providers

Wyoming Health Resources Network (WHRN) is a public-private partnership formed in 1995 by the Wyoming Department of Health, Wyoming Hospital Association, Wyoming Medical Society and Wyoming Nurses Association to improve and enhance rural health services and promote healthier individuals and communities in Wyoming. WHRN's Board has grown to include representatives of the state Legislature, mental health, health education, nursing education, nurse practitioners, physician assistants, and other interested partners.

WHRN's mission is: To improve and enhance rural health services and promote healthier individuals and communities in Wyoming. WHRN's goals are to support and enhance the health care infrastructure and delivery system, operate a clearinghouse for information on a variety of health issues, provide technical assistance and leadership in building healthy communities, advocate for good health practices and inform policy makers, and to serve as an open forum for an unbiased exchange of ideas.

WHRN recruits health care practitioners; produces numerous publications, including a web site (www.whrn.org); offers leadership in statewide forums on health care issues and manages Wyoming Department of Health community grant funds to enhance access to and utilization of those funds designed to promote wellness in the state.

WHRN's primary focus is recruiting and works with health care providers in Wyoming (hospitals, clinics, medical practices), the University of Wyoming, the Wyoming Department of Health, the Wyoming Hospital Association, the Wyoming Medical Society, the Wyoming Primary Care Association, the Office of Rural Health and others to attract nurse practitioners, physician assistants, physicians and locum tenens physicians to the state. Much of Wyoming is federally declared a primary health care practitioner shortage area but many communities lack the knowledge and resources to recruit individual practitioners, while facilities (hospitals, clinics) do not have the money to hire "headhunters" and advertise, screen and interview potential new medical staff without someone to first narrow the field, identify candidates, act as in an intermediary and encourage relocation in Wyoming when a candidate seems to "fit" our state.

One of WHRN's primary goals is to place providers in communities that match their interests as well as that of their family. Based on the criteria submitted by the recruiting site, appropriate candidates are referred to the site for possible interviews. Matching the site's needs and the candidate's interests helps ensure a successful retention rate. In a recent survey of WHRN placements, it was determined that the state enjoys a 76% retention rate (not included were locum tenens or permanent providers beginning practice in the summer of 2003).

While WHRN provides recruitment and retention services by contractual agreement with the Wyoming Department of Health, our minimal placement fees supplement the budget, as does an annual participation fee paid by most hospitals in the State. Our placement fees are roughly one quarter to one-third what a national search firm charges. The participation fee entitles the payee to an unlimited number of vacancy listings and to a reduced placement fee. Not only hospitals are supporters -- WHRN welcomes searches on behalf of clinics and private practices.

Technical assistance, in the form of handbooks, workshops and on-site training, is also offered by the WHRN staff. The handbook was a collaboration of some 40+ states belonging to the National Rural Recruitment and Retention Network (3RNET), a consortium of non-profit entities recruiting healthcare providers to rural America. A recruitment and retention workshop has been designed for in-house staff recruiters and others involved in the effort. The first statewide R & R workshop was presented in Casper in 2001. WHRN staff is available for additional programs. On-site visits can be arranged for a "mini training" for staff who may be involved in the site's recruiting efforts. They will be given a handbook along with crucial contact names and recruiting tips and techniques.

An educational program developed by WHRN staff is aimed at the Family Practice Residents in the Casper and Cheyenne University of Wyoming programs. The presentation includes tips such a, what to expect in a site interview, how to negotiate a contract and other tips.

The WHRN Grants Clearinghouse has facilitated the flow of more than $1.4 million in community health grants to communities. Grant seekers make one stop for technical

assistance with multiple grant programs when completing applications or reporting on projects. Several Wyoming Department of Health programs use the Clearinghouse's unified application form, easing the application process. WDH program managers using the Clearinghouse can better focus on program integrity, with many of the day-to-day contract management tasks handled by the Clearinghouse. WHRN provides resources to those seeking and writing grants. Because WHRN has a statewide handle on multiple grant programs, it can facilitate the flow of best practices information among communities through its network of contacts.

Pennie Hunt, Wyoming Health Resources Network, Inc., Director

4. Hospitals

The Wyoming Office of Rural Health applies for and receives Medicare Rural Hospital Flexibility Program (FLEX) and Primary Care Office grants which are used to provide technical assistance to Wyoming hospitals. The Office of Rural Health assists with the conversion of hospitals to Critical Access Hospital status, creation of rural health clinics operated by hospitals, facilitation of recruitment and retention of health care professionals in hospitals and their rural health clinics, and hospital network building. The Office of Rural Health also provides grant funding to purchase new ambulance equipment and desktop computers to improve operations and state reporting, to county and community based volunteer EMS providers across Wyoming

Wyoming Health Department

5. Monitoring federal legislation

The Wyoming Office of Rural Health communicates periodically with the staffs of Wyoming's congressional delegations, receives email notification of pending legislation from federal government and nonprofit association list serves, and watches various and assorted health care agency-directed publications for notification of potential changes in health care policy. The State Office of Rural Health offers an online newsletter (http://wdh.state.wy.us/sorh) publicizing federal activities and sends email notification to hospitals, health professionals, and local and state government officials regarding potential shifts in policy.

Wyoming Health Department

6. Community Health Access Initiative

The Wyoming Office of Rural Health – in cooperation with Wyoming Health Resources Network, Inc., the Wyoming Department of Health Community and Family Health Division and Maternal and Child Health Program – began funding a Community Health Access Initiative in the late 1990s. The initiative was first housed within Wyoming Health Resources Network, Inc. and offered community health planning technical assistance across the state to promote community coalition building and data-based

strategic planning to improve population health. The initiative is now housed in the Wyoming Office of Rural Health and has expanded to more broadly encompass health care access and poverty-related health status, and the hospital emergency room primary care delivery burden.

Wyoming Department of Health

Recommendation 30

Development of a Health Data Network

The Wyoming Health Reform Commission recommends that a public and/or private Health Data Network be established. Toward this end, the Commission recommends that a Request for Proposal be prepared and distributed to interested parties for the development of a plan to meet Wyoming's health data needs. Depending on the dollars involved in developing such a plan, a successful proposal could be accepted by the Commission and work begun immediately, or if the expense if beyond the Commission's budget, a recommendation for appropriation would be made to the 1995 legislature.

(In November 1994 the Commission voted to negotiate a contract between the Wyoming Health Reform Commission, the Wyoming Department of Health and the selected firm, not to exceed $100,000, for design of a health data network for Wyoming.)

The Department of Health selected the Montana-Wyoming Foundation for Medical Care to do a study, which served as a framework to establish a health data network. The Department did this pursuant to language in an amendment to the 1996 state appropriations bill. In 1996-97, the Wyoming Health Information Exchange (WHIE) was formed by the Wyoming Hospital Association, Wyoming Medical Society, Blue Cross Blue Shield and the Wyoming Health Department, using the study as a template for the new entity. By-Laws and Articles of Incorporation were written, a board was formed and capital contributions were injected by the principal organization. It was staffed early on behalf of the Health Department by Sue Mydland and then later by Jim Rolf. Primarily because the board experienced difficulty in dealing with the broad scope and complexity of the tasks identified by the WHIE, the group disbanded and turned the remaining funds over to WHRN. WHRN began a relationship with the University of Wyoming through Rex Gantenbien, since Rex was writing a grant to establish the Center for Rural Health Research and Education (CRHRE, http://health.uwyo.edu/). WDH ceased to fund Jim Rolf's position, after Don Rolston became the department's director.

Dan Perdue, Wyoming Hospital Association
Wyoming Department of Health

In June 2001, the Center for Rural Health Research and Education (CRHRE) at the University of Wyoming entered into a partnership with the Wyoming Health Resources Network, using funding originally directed to the Wyoming Health Information Exchange. The mission of the CRHRE is "to provide a centralized Internet source of

information and tools that enables health care practitioners, administrators, educators, researchers, and students to improve the quality of health in rural areas." The establishment of this workforce registry contributes to this mission by creating and maintaining a centralized, Internet-accessible listing of all licensed health care and allied health workers and facilities in the State of Wyoming. In addition to being a valuable resource to health-care policy planners and workforce recruiters, the registry will also serve as a public source of information on caregivers and care facilities in the state.

The workforce registry also supports the Wyoming Health Resource Network (WHRN) in its mission to improve and enhance rural health services and promote healthier individuals and communities in Wyoming. Through the information contained in the registry, the WHRN or other agency will be able to identify shortage areas and areas of that state that may experience future shortages through studies of location, anticipated retirement, etc. The registry will also assist WHRN in identifying particular health care fields that should be recruited for given locations.

As of 6/30/03, the following activities have been (or are nearly) completed, as outlined in the contract with WHRN.

- Identify sources for names, practice addresses, and occupational information of licensed health care practitioners and facilities in these categories
- Collect, review, collate and enter the data.
- Acquire a high-performance database server, to be housed in the CRHRE, as well as appropriate networking hardware and database development software.
- Create an Internet-accessible database or databases for various categories of practitioner and facilities information.

This database was completed with 2000 licensing data, but is being revised for a better interface and updated to include 2002 licensing data, the most recent available to us. Data entry for the updated database is currently ongoing and should be completed by August 15, 2003. When complete, the database will contain names and addresses for most health care practitioners and facilities licensed in the state and will be searchable by name, location, and specialty. We hope to secure additional funding so that we can continue to maintain this database with annual updates and enhancements to the research capabilities.

In addition, we have created a geographic information system (GIS) interface to some of this data. Not all licensing organizations gave permission for us to put the names and addresses of their clients into public format, and so we have only made public some examples of this data, at http://www.health.uwyo.edu/CRHRE_IMS. Other data is available through a private site that can be made available to individuals with permission from the licensing agency.

In July 2002, the Wyoming Department of Health (WDH) was awarded a State Planning Grant project by the Health Resources and Services Administration. Linda O'Grady of the WDH Community and Family Health Division is the grant administrator, and Dr. Rex

Gantenbein, director of the University of Wyoming Center for Rural Health Research and Education (CRHRE), is the principal investigator. The purpose of the project is to develop a strategic plan that will help more of Wyoming's residents get access to affordable health insurance. As a contractor with WDH, the CRHRE's activities in this project include data collection and analysis on the uninsured in the state, and strategic research on options and solutions that could help provide affordable insurance for those currently without it. In addition, UW provides coordination and technical support to WDH for the project, including an Internet videoconferencing link between Laramie and Cheyenne that allows the management team and others to meet electronically.

Rex Gantenbein, CHRHE

Recommendation 31

Disputed Denial of Medical Benefits for Lack of Medical Necessity by Insurance Companies

The Wyoming Health Reform Commission recommends that the Wyoming State Insurance Commissioner establish specialist review panels of Wyoming licensed health care provider who job will be to review disputed denials of medical necessity made by insurance companies. When requested by an insured who disputes his insurance company's denial of benefits based on "lack of medical necessity," the specialty panel will review the facts of the denial and issue an advisory opinion to the Insurance Commissioner about the medical necessity of the recommended medical treatment. The specialist panel's opinion will be advisory only but will be made available for review during any subsequent legal action pursuant to the denial of benefits.

This was not enacted. This was patterned after some states that enacted external review panels which were implemented to counter the backlash and horror stories about for profit HMOs who decisions to withhold or deny care resulted in damage to the member or loss of life, etc. This was not perceived as an issue in Wyoming where we have only one HMO, formed by the local doctors and the hospital, and operating on a not-for-profit basis. Of the insured market, our HMO penetration is about 4 percent.

Wyoming Insurance Department

Recommendation 32

Training of Medical and Other Health Professional Students

The Wyoming Health Reform Commission recommends that a team from Wyoming which includes state legislators, attend the November 1994 WWAMI State Legislators Conference in Seattle, Washington, to explore their successful model for training and retaining primary care physicians. This team would then work with the University of Wyoming, College of Health Sciences, to assess the potential for this model of physician, mid-level and other allied health professional training for Wyoming.

The WWAMI program is a successful, ongoing initiative providing support and opportunity for medical education to some 40 medical Wyoming medical students each year. The affiliation with the University of Washington spill over into our residency training activities and also provides networking for affiliated UW faculty with resources at the University of Washington.

The legislative meetings are also a success and continue to run each year...alternating each year between Wyoming (usually Cheyenne during the session) and Seattle.

Robert Kelley, Dean, University of Wyoming College of Health Sciences

Recommendation 33

The Hospital Delivery System: Amendment to Recommendation 29

The Wyoming Health Reform Commission recommends that the Recommendation 29: Office of Rural Health – Additional Functions, be amended to include the function of providing technical assistance upon request to hospitals.

No information available at time of report – Wyoming Hospital Association had no recollection of what this referred to, or why it was perceived to be needed.

Recommendation 34

The Hospital Delivery System: Federal Legislation for Medical Assistance Facilities

The Wyoming Health Reform Commission recommends that federal legislation be passed that would allow Medical Assistance Facilities to be reimbursed by the Health Care Financing Administration in states other than Montana. The Commission requests that the Governor contact the Congressional Delegation regarding this matter and that a joint resolution from the legislature be prepared.

About the time this was going on, Congress had authorized EACH-PEACH (not the true acronym, but close), which allowed for increased reimbursement in a hub-spoke system for hospitals. As such, even though we already had the Medical Assistance Facilities legislation on the books, and because the feds wanted to see how successful the EACH-PEACH program would be, the Health Care Finance Administration would not allow Wyoming a waiver to its Medicaid plan to allow for the reimbursement and Congress did not entertain a bill authorizing such a program. Congress later patterned the Critical Access Hospital program after the Medical Assistance Facilities program.

Dan Perdue, Wyoming Hospital Association

About half of Wyoming's hospitals have converted to or are examining the possibility of converting to Critical Access Hospital status. Critical Access Hospital status improves a hospital's ability to remain fiscally stable in a rural/frontier setting by getting better

reimbursement and shifting staff patterns, as well as reducing the number of type and beds available. Torrington, Wheatland, Worland, Thermopolis, Douglas, Basin, Lovell, Powell, Buffalo, and Newcastle hospitals have converted or are planning to convert to Critical Access Hospital status. Sheridan and Cody hospitals are exploring the possibility of becoming Critical Access Hospitals. Lusk is remodeling the closed Long Term Care facility that will become the new CAH hospital and Sublette County is exploring the possibility of building a new hospital that potentially could be a CAH. The Sundance hospital has also periodically considered the possibility of becoming a CAH. Wyoming receives close to $500,000 in Medicare Rural Hospital Flexibility (FLEX) program funds annually with which to assist hospitals seeking conversion to CAH status, to network CAH hospitals, and to support volunteer ambulance facilities supporting CAHs.

Wyoming Department of Health

Recommendation 35

The Wyoming Health Reform Commission recommends that life insurance companies selling policies in Wyoming be encouraged to offer, as an option, an accelerated benefit provision. Consumer education relating to this benefit should also be provided by insurers.

Life companies, as an industry practice, do offer an accelerated benefits option, generally when the insured has a terminal condition or in some cases to help with long-term care services.

Wyoming Insurance Department

Recommendation 36

Long-Term Care Insurance Reforms

The Wyoming Health Reform Commission recommends that long term care insurance reform, specifically public/private partnerships, standardized benefits packages and a broader range of benefit levels be priority items for further research by the ongoing health reform oversight commission.

An on-going health reform oversight commission did not evolve. That is a challenge for the new health care commission and the legislature.

Wyoming Insurance Department

There are a few more companies selling long-term care insurance than there were 10 years ago. There are competitors out there. Long-term care addresses assisted living and home health services. I don't think there has been a tremendous increase in the purchasing of it – 10 years ago there was something like less than a 2% interest in buying. But I really felt that the Wyoming Office on Aging needed to put some real emphasis on

education about long-term care financing and long-term care insurance. That was a recommendation that I had made both to the legislature and to the Commission 10 years ago: if the state of Wyoming could do anything, it saves them Medicaid dollars to cooperate with the AARP and the Office of Aging to do education programs on what is and is not covered in long term care. I still think that is a valuable service the state should be doing.

Dan Lex, Quality Health Care Foundation

Recommendation 37

Planning for Long-Term Care

The Wyoming Health Reform Commission recommends that the Wyoming Department of Health initiate planning immediately for assuring well-defined and integrated long-term home and community-based services throughout the state. The Commission believes that planning and pilot implementation should be completed within three years of initiation.

The Long Term Care Home and Community-Based Waiver (LTC/HCBS) was initiated July 1, 1993. It is a Medicaid funded program to provide care in the community for persons age 19 and up who meet the functional and financial criteria for Medicaid reimbursed nursing home care. Currently 1,000 people are being served. The "slots" are full and there is a 145-person waiting list. The number of "slots" and the appropriation to cover the program were set by the legislature. Over the 10-year period the waiver has served nearly 3,100 people at a cost of 50% of nursing home cost. During that time, the statewide nursing home occupancy rate has dropped over 5%.

The Assisted Living Facility Waiver started 7/1/01. It also covers persons age 19 and above that meet the functional and financial criteria for Medicaid reimbursed nursing facility care. This waiver covers the care portion of the assisted living facility costs (the room and board costs are the responsibility of the client.) 100 slots were allotted and they are full with a waiting list of 25 persons.

The Developmental Disabilities Division has three waivers that also provide care in the community. The Aging Division also has a mostly state funded Community Based In-Home Services program.

Wyoming Department of Health, Aging Division

Recommendation 38

Comprehensive School Health Education

The Wyoming Health Reform Commission recommends that all school districts in Wyoming implement a community-based comprehensive school health education programs in order to improve the health of Wyoming youth.

Health education standards have been adopted and are being implemented, but not all school districts in Wyoming have implemented community-based comprehensive school health education programs.

Wyoming Department of Education

Health education standards were approved by the State Board of Education in the summer of 2000. Wyoming's Health Education standards are based on the National Health Education standards and were slightly modified to become the Wyoming Standards. Wyoming schools now have a guide of what would need to be included in an effective curriculum, grades K - 12, with one of the standards relating to health education knowledge, while the remaining six focused on skill development related to high risk health behaviors. The Wyoming Department of Education was a partner with the Council of Chief State School Officers (CCSSO) to develop common assessment tools to be used in 4th, 8th, 11th grades for school health instruction. The tools were already available for teachers to use. The SCASS tools align with the National Health Education Standards, which gave school districts an advantage as the standards and assessments were parallel. This was a tremendous advantage over the other curricular areas, such and reading and math, because schools could implement programs without having to spend considerable time to develop curricula and accompanying assessments. Training for health education staff members were offered at regional levels to increase staff knowledge and skills to meet the new standards and assessment tools. This training was provided and funded by the Wyoming Department of Education, Health and Safety Unit.

Food Services Directors, School Nurses, Counselors, Coaches and Parents have all had opportunities to learn and engage strategies for Coordinated School Health Programs sponsored by multiple players in the health and education world. The nine components of a Coordinated School Health Program are:

- School environment
- Health education - instructional piece for K - 12th grade students
- School Meals and Nutrition
- Physical Education
- Health Services
- Counseling, Psychological and Mental Health Services
- Staff Wellness
- Parent and community involvement

The Governor's Youth Development Council was an initiative started by Gov. Geringer in 2000 to guide positive youth development efforts across a number of arenas in the state. The major partners at the council are the Departments of Health, Family Services, and Education, and community agencies and organizations; i.e. Wyoming Business Council, Wyoming Community Coalition for Health Education. Results of this governor's council include the combination of four streams from several State departments into a single stream of funding to communities to reach youth with best practices in drug prevention, after school programs, and tobacco prevention and cessation

(21st Century/SIG). This single stream of funding again provided a unique opportunity for all players within each community to work together at the same table for prevention dollars and programs.

The Wyoming Department of Education developed a collaboration for Coordinated School Health Programs three years ago. The statewide group of 30 working professionals represents a diverse group of health education staff and providers. This group has been active in setting the strategic plan for the state of Wyoming in support of CSHP. Resources to assist school districts and communities to implement CSHP have been developed from this group. Significant time and energy have been committed to a social marketing campaign for CSHP to increase the general population's understanding of the many benefits of a school/community health education partnership resulting in better health for the young people, their parents and other community members.

Wyoming Community Coalition for Comprehensive Health Education

Recommendation 39

Community Health Access Initiative

The Wyoming Health Reform Commission recommends that a Community Health Access Initiative be established within the Office of Rural health to provide technical assistance and funding to community health initiatives which are designed to improve health by increasing access to and utilization of primary and preventive health services. The Commission recommends that the initiative be funded at the level of $177,500 per year.

The Wyoming Office of Rural Health – in cooperation with Wyoming Health Resources Network, Inc., the Wyoming Department of Health Community and Family Health Division and Maternal and Child Health Program – began funding a Community Health Access Initiative in the late 1990s. The initiative was first housed within Wyoming Health Resources Network, Inc. and offered community health planning technical assistance across the state to promote community coalition building and data-based strategic planning to improve population health. The initiative is now housed in the Wyoming Office of Rural Health and has expanded to more broadly encompass health care access and poverty-related health status, and the hospital emergency room primary care delivery burden. No legislative appropriation has been made; funds have been contributed from the coffers of the Wyoming Department of Health Community and Family Health and Maternal and Child Health divisions and the Office of Rural Health.

The Wyoming Department of Health and Wyoming Health Resources Network, Inc., partnered to create a Grants Clearinghouse that has made grants available for community health planning coalition coordination and health promotion intervention implementation for several years.

Wyoming Department of Health

Recommendation 40

Funding for Public Health

The Wyoming Health Reform Commission recommends that a formula be established by the Wyoming Department of Health by 12/31/95 and then considered by the legislature in 1995 which shall provide an adequate and sustained level of funding to address priority public health needs of the state.

This was not done. We did not develop a funding formula in the late 90's to bolster public health prevention (which were the priorities at the time). Most of this was due to flat budgets due to funding shortfalls and therefore no ability to garner new funds. No policy makers back then wanted to rob Peter to pay Paul.

Wyoming Department of Health

Recommendation 41

Emergency Medical Services/Wyoming Trauma Plan Funding

The Wyoming Health Reform Commission recommends that funding for the Wyoming Trauma Plan, prepared by the Wyoming Trauma coalition, be funded at the level of $225,000, so that the plan can be implemented in 1995.

The trauma program was funded by the legislature; $117,000 general fund appropriation was made beginning in July of 1996. Funding has remained unchanged. A trauma program coordinator was hired and a part-time physician is under contract to oversee the program's activities. The bulk of the state funding appropriated is used to secure these positions. The trauma nurse position is a full-time state position. Computers and trauma registry software placed in all hospitals. On-going training is provided to local trauma nurse coordinators, along with yearly training by the software vendor. All yearly site licenses, technical support, and software upgrades are provided by the trauma program and original software vendor -- at no cost to any hospital. Various grants have been secured to provide these for the hospitals. In-house IT is provided by the EMS program.

The Trauma Coalition meets yearly with most of its expenses paid from the Wyoming Department of Health EMS budget. Recently, federal reauthorization of trauma programs yielded $40,000 for trauma system development activities in Wyoming. The new funded pays for a lot of the travel and meetings of trauma coordinators. EMS also uses the State Office of Rural Health Medicare Rural Hospital Flexibility Program Grant (FLEX) for trauma system-related training and travel.

Trauma site designation and verification of hospitals began two years ago. Presently all facilities have received initial reviews with 19 of 25 facilities designated. Contact Maggie Cleveland, RN trauma program coordinator for more specifics on this. In December 2001, mandatory submission of trauma registry data began. Participation in

the trauma system and submission of trauma registry data are now tied into facilities' licensing requirements. A statewide trauma quality review committee was formed and is now functioning as the Trauma Advisory Board. The Governor's EMS Advisory Committee remains the driving force behind the trauma system development. Once fully implemented, Wyoming will have the only mandatory, statutorily-identified, funded, and inclusive rural/frontier trauma system. The system development has been slow but deliberate and reflects a collaborative effort of many agencies -- both governmental and public.

Wyoming Department of Health

Recommendation 42

Youth Physical Fitness

The Wyoming Health Reform commission recommends that every school district in Wyoming require students to participate in daily physical fitness activities. The Commission is well aware of the issue of local control in Wyoming in managing our schools. However, the Commission strongly supports the benefits of daily physical activity for our students. The Commission believes that the benefits of daily physical activity are so great that school districts should consider this as a priority and should be creative in devising low-cost appropriate means for keeping Wyoming youth in the best possible physical condition throughout their school years.

The Commission recommends that each school district report annually to the Superintendent of Public Instruction, beginning December 31, 1995, their intentions regarding the implementation of this recommendation. The Superintendent of Public Instruction will be responsible for assembling such reports and integrating the results into an annual statewide report for distribution to the legislature and other interested parties.

This has not been enacted – not every school district in Wyoming requires students to participate in daily physical fitness activities.

Wyoming Department of Education

Recommendation 43

Exchange of Health and Human Service Personnel between the University of Wyoming and State Agencies

The Wyoming Health Reform Commission recommends that State personnel policies and procedures be streamlined and/or formal exchange programs established to encourage the exchange of health and human service related personnel, between the University of Wyoming and state agencies and between state agencies for the purposes of program and/or professional development.

The recommendation seems like common sense to me, and I don't know that anyone at the university was formally charged with implementing exchange of professional personnel between the university and state agencies. I'm working as closely as possible with the director of the state health department to effect programs common to both agencies (e.g. WYSAC, etc.) but, beyond this, I'm not aware of any formal mechanism to exchange personnel.

Dean Robert Kelley, UW College of Health Sciences

Recommendation 44

Funding for New and Expanded Degree Programs in the Health Care Disciplines

The Wyoming Health Reform Commission recommends that, subject to University approval, the following new or expanded degree programs receive priority for funding at a total estimated annual cost of $1,126,630;

Master of Science, Nurse Practitioner – estimated cost $200,000/year;

Masters in Social Work - $512,880/year; and

BS/MS in Occupational Therapy - $413,750/year.

The Commission recommends that the funds required to institute these programs be added to the University block grant. In addition, the Commission endorses the continued study and planning of Physician Assistant programs at the University of Wyoming.

The College of Health Sciences administers a Master's degree program in Family Nurse Practice through the School of Nursing. This program produces Family Nurse Practitioners at a variable annual rate, depending upon enrollments and rate of program completion.

Also, in 1998, the Division of Social Work instituted the Master's in Social Work degree and received full accreditation for the program from the Council on Social Work Education. That program continues to be productive on both the Laramie and Casper campuses of the university.

Although I understand that some planning discussions on developing an OT/PT program preceded the 1999-2004 academic plan for the university (before I came to UW in 1999), these conversations have not continued to the best of my knowledge. Nor have discussions of planning a PA program.

Finally, inquiring about funding placed in the university block grant in the amount of $1,126,630, the present administration is unaware that these funds were received during 1993-1994. Do you know whether these funds were actually authorized and allocated by the legislature, or just recommended by the Health Reform Commission?

Dean Robert Kelley, University of Wyoming College of Health Sciences

Recommendation 45

Access to High Quality Mental Health Services

The Wyoming Health Reform Commission recommends review and revision of licensing and certification requirements for professional practitioners providing mental health (MH) services in the State of Wyoming. The Commission also recommends installing systems of organizational accountability for services rendered by state supported or partially supported mental health organizations/institutions. These provisions will be considered by the Wyoming Mental Health Policy Board.

Recommendation #45 addresses issues of licensing and certification. In Wyoming the following licensing structure is maintained: the Psychology Board, the Board of Nursing, the Board of Medicine, and the Mental Health Professions Licensing Board (social workers, family and marriage counselors, substance abuse counselors). These boards have specific regulations regarding the credentialing of each of the disciplines. This also includes, but is not limited to, the necessity for continuing education.

We have developed a network of integrated systems of care throughout Wyoming, utilizing the strong partnership of public and private organizations. Within the private organizations in each area of the State in which we conduct business we do so through the community mental health centers. There are 16 community mental health centers designated in the State and they are composed of private citizen boards within a non-profit organization. We contract for specific functions and we define those functions and services to be provided under the definition of a community mental health center. There are clear expectations of performance measurements and accountabilities that are maintained in the execution of the contracts, as well as the accountability to the outcomes of those contracts. These facilities are well organized and planned and are established in each county of the state. The problem that we have had in years past, and not until the new resolution of the lawsuit that we have undergone (Chris S.--which has been settled in two separate settlement documents with the Wyoming Alliance for the Mentally Ill and Protection and Advocacy), is that the whole system was extremely under funded. So now we can say that we have a much better funded system of care. But the system is not yet completed. We have excellent programs; now we need to further enhance our system of care.

We have developed great opportunities and services for the adults with mental illness, not only the serious, persistent mentally ill, but also those with serious mental illness and the general population. Children and adolescents' services still have a long way to go, as do services for older adults.

The mission, vision, goals and objectives are being manifested in each of the programs, not just within the Mental Health Division which encompasses the community-based programs and the Wyoming State Hospital. The Wyoming State Hospital has a very

detailed accountability process of its service functions and they are monitored by several licensing and certification processes including HCFA, Medicaid and CARF.

Pablo Hernandez, Wyoming Department of Health, Mental Health Division

Recommendation 46

Availability of Mental Health Professionals

The Wyoming Health Reform Commission recommends that recruitment and continuing education of psychiatrists and other mental health and developmental disability practitioners for the statewide mental health/developmental disability system should be a high priority.

Wyoming is designated as a mental health professional manpower shortage area as a whole. We have made great progress at the Wyoming State Hospital in our retention and recruitment of essentially needed professionals, but this has not come about without major effort. This has come about specifically by the multitude of service systems that includes, but is not limited to, programs of internships, clerkships, and relationships with schools of higher learning that have fermented the growth in these areas. Likewise, having a process that brings about camaraderie instead of isolation fosters the ability for recruitment and retention. That collegial process is absent in many areas of the state where many practitioners are in solo practice. So the collegial relationship and the support may not be truly manifested. Again, the problem here is the distance and geographical layout of Wyoming, which can be addressed by solving the component around the continuing education needs and opportunities by the utilization of telehealth (telemedicine, telepsychiatry, etc.) that will help us build the bridges.

Pablo Hernandez, Wyoming Department of Health, Mental Health Division

Recommendation 47

Statewide Mental Health Policy Board

The Wyoming Health Reform Commission recommends the establishment of a permanent statewide Mental Health Policy Board, appointed by the Governor, to be responsible and have authority for the development of a comprehensives system of mental health services in Wyoming. This group must set priorities for funding, establish and review accountability requirements, and generally foster high quality services in the state. This policy board should be appointed in early 1995 and be funded at an estimated annual cost of $10,000.

This has been addressed by the Mental Health Planning Council that is composed of multiple stakeholders, with representation from families, consumers, providers, legislators and mental health administration. It is a very functional council which is appointed by the Governor.

Pablo Hernandez, Wyoming Department of Health, Mental Health Division

Recommendation 48

Taxes on Tobacco Products and alcohol

The Wyoming Health Reform Commission recommends that taxes on cigarettes, other tobacco products and alcohol must be increased to finance health care reform recommendations.

The 2003 Legislature passed a 48-cent tax increase, with all revenues to go to the general fund. The increase took Wyoming from 12 cents per pack to 60 cents per pack (as of July 1, 2003). This places Wyoming at about the middle of all states. This should raise about $20 million per year of new revenue. There is no earmarking for these funds.

Wyoming's smokeless tobacco rate is 20% of wholesale price. This was first instituted in 1999. A bill was sponsored during the 2003 legislative session that would have provided for an increase in taxes on cigars, snuff and other non-cigarette tobacco products by 10% (to equal a total rate of 30%) of the wholesale purchase price, or by 5% (total of 15%) of the retail price if the wholesale tax had not been paid. The revenue from the tax would be haven deposited into the Wyoming tobacco settlement trust fund account and continuously appropriated to the substance abuse control plan (killed by House Committee).

Another bill that died would have created a corporation with directors as a state instrumentality to securitize specified tobacco settlement proceeds, authorize the sale of future tobacco receipts, provide for redistribution of funds, create an account within the permanent mineral trust fund in which to put the tobacco settlement funds and repeal the tobacco settlement trust account, allowing the use of tobacco settlement funds for capital construction.

A bill was introduced that would have increased the malt beverage excise tax by 1 ½ per liter, with the increase in collections continuously appropriated to the Department of Health to establish and implement programs to prevent, intervene in, and limit alcohol and substance abuse (died in Committee).

Wyoming Department of Health/Wyoming Primary Care Association

Recommendation 49

Miner's Hospital Fund

The Wyoming Health Reform Commission recommends that the earnings of the Miner's Hospital Fund be utilized for health care reform in Wyoming, and to that end, that a joint resolution requesting Congress to amend the act of Admission be passed by the Wyoming

legislature. It is further recommended that a sum, to be determined by the Legislature, be regularly directed to support the Sweetwater County Memorial Hospital.

Since the Wyoming Health Reform Commission recommendation, litigation was pursued to clarify a number of issues related to the Miners Hospital Land Grant. Those issues remain unresolved. The lawsuit ended when the court determined that the Memorial Hospital of Sweetwater County was not the appropriate party to bring the suit.

As a result of legislation approved by the Wyoming Legislature in 2001, A "Miners' Hospital Board" was formed. Operating expenses are borne by the Miners' Land Grant fund. And, Memorial Hospital receives funding through this group for its Miners' Clinic.

Prior to the formation of the Miners' Hospital Board", Memorial Hospital of Sweetwater County received approximately $500,000 annually for the operations of the Miners' Clinic within the hospital facility in Rock Springs. The amount of money received from the Miners' Hospital Board has declined to approximately $250,000 annually. With funding for the Miners' clinic declining, the Board of Trustees of the Memorial Hospital of Sweetwater County are reviewing the appropriateness of the continued operations of the Miners' Clinic.

John Ferry, CEO, Sweetwater County Memorial Hospital