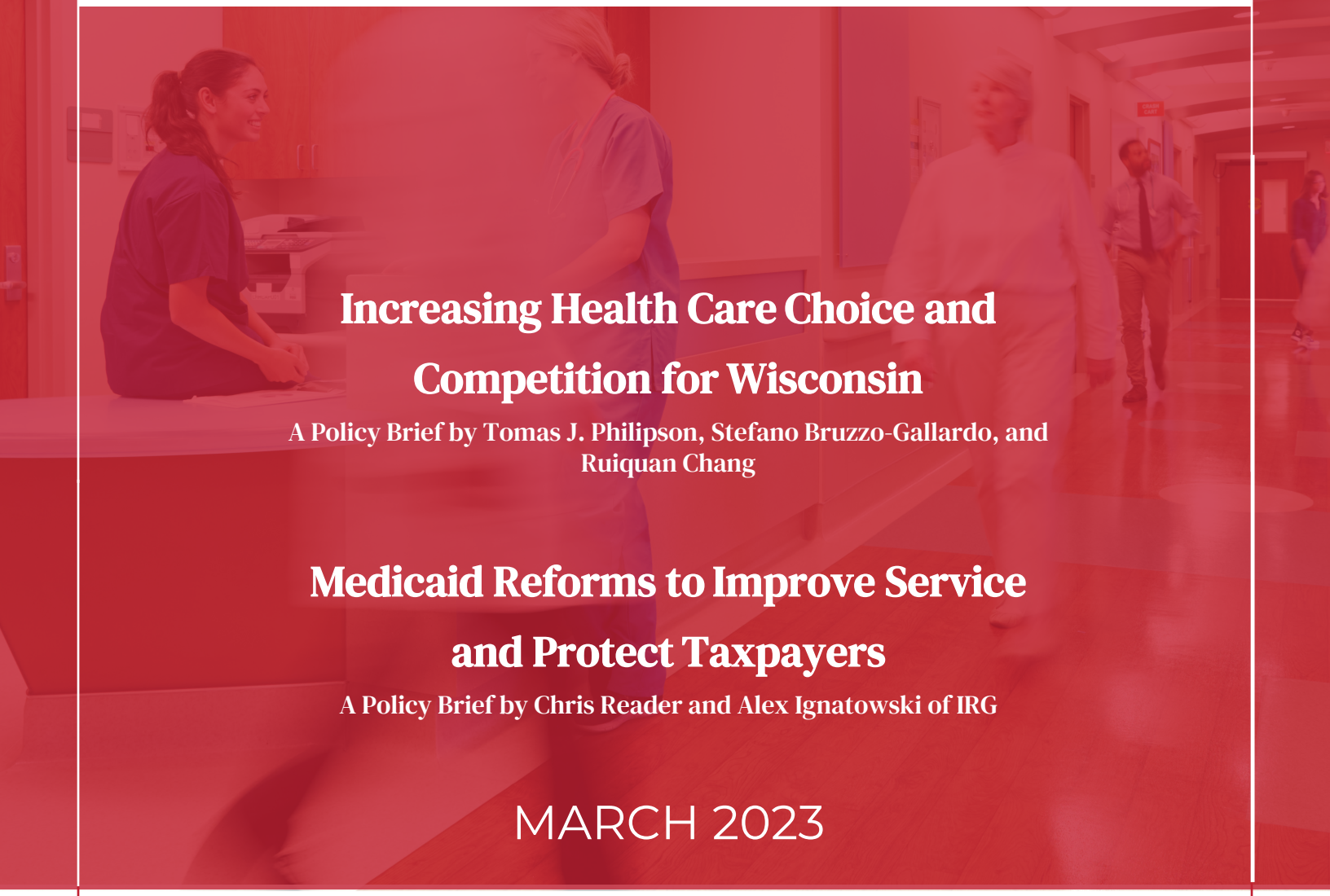
# COMMON SENSE HEALTH CARE REFORMS FOR WISCONSIN



## Increasing Health Care Choice and Competition for Wisconsin

A Policy Brief by Tomas J. Philipson, Stefano Bruzzo-Gallardo, and Ruiquan Chang

## Medicaid Reforms to Improve Service and Protect Taxpayers

A Policy Brief by Chris Reader and Alex Ignatowski of IRG

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# INTRODUCTION

The health care public policy debate has typically focused on the liberal agenda of greater government involvement and control over the health care system and expansion of government sponsored health coverage programs. While conservative perspectives regarding consumer choice, transparency in pricing, and tax policy mechanisms have been considered and partially enacted, the United States continues methodically down a path toward government-run health care and potentially a single payer system, as evidenced by the Affordable Care Act, various pandemic-related policies, and the so-called Inflation Reduction Act of 2022. Invariably, the conservative viewpoint has been on the defensive.

The reform recommendations outlined in this paper are designed to change this dynamic by presenting compelling reforms that enhance consumer options, increase the supply of health care, help address the severe health care workforce challenges, and apply conservative principles to Medicaid and the insurance exchange. They are presented under two parts.

## Part I: Increasing Health Care Choice and Competition in Wisconsin

Part one deals with increasing consumer choice and competition in health care and was written for the Institute for Reforming Government by **Tomas Philipson**, the Daniel Levin Professor of Public Policy Studies Emeritus at the University of Chicago Harris School of Public Policy.

### 1. Expand the Scope-of-Practice (SOP) of Nurse Practitioners (NPs) in Wisconsin

**Problem:** Rigid agreements on the range of services health professionals such as NPs are legally allowed to perform unnecessarily limits the overall supply of health care in Wisconsin.

**Policy recommendations:**

I. Broaden the SOP of NPs and other professionals to allow them to utilize their full skill set.
II. Eliminate requirements for rigid collaborative practices between different health professions.
III. Evaluate emerging healthcare occupations to increase their access and thereby drive down health care costs.

### 2. Grow the supply of Physicians (MDs) in Wisconsin

**Problem:** The state of Wisconsin is expected to face a shortage of 2,263 physicians by 2035, caused by an increase in the demand for health care, delays in increasing the

supply of health care, low acceptance rates at medical schools, and restrictions of practice for physicians.

**Policy recommendations:**

I. Increase the acceptance rates in medical schools to increase the total pool of active MDs in the state.
II. Ease state-based licensing requirements to improve workforce mobility across states.
III. Facilitate telehealth to improve patient access to health care.
IV. Ease restrictions on foreign-trained doctors.

### 3. Allow insurer networks in Wisconsin to be based on market needs

**Problem:** There are potential trade-offs between more flexible and rigid network adequacy requirements. The state should apply the types of standards that are most effective in the context of specific population and health needs.

**Policy recommendations:**

I. More flexible networks in terms to facilitate competition and innovation among providers and meet multiple needs for different populations and conditions.
II. More rigid networks in terms to reduce uninsured populations and generate savings for taxpayers.
III. Pair with state-based amendment to current 1332 waiver under certain requirements.

### 4. Allow site neutrality payments in the Medicaid Program in Wisconsin

**Problem:** The Medicaid program pays higher rates when procedures are performed in HOPDs (Hospital Outpatient Departments) rather than at physician's offices or ASCs (Ambulatory Surgical Centers). There is little reason for such payment differentials when the services offered are equivalent in the same office settings, and the patient's health status is similar, which could cause extra spendings to the government.

**Policy recommendations:**

I. Embrace site neutral payment reform for State Medicaid program with straightforward metrics.
II. Analyze financial benefits and health outcomes across different settings based on comparable data.
III. Prioritize patients to ensure they receive individualized assessments of specific care needs.

# Part II: Medicaid Reforms to Improve Service and Protect Taxpayers

Part two, authored by the Institute for Reforming Government policy staff and fellows, under the guidance of and including **Chris Reader**, Executive Vice President, and **Alex Ignatowski**, Director of State Budget and Government Reform, focuses on reforms to Medicaid that will improve service and protect taxpayers.

## 1. Transition Medicaid childless adult (CLA) population to the Exchange

**Problem:** Wisconsin's Medicaid program has seen an increasing number of CLAs added to the program over the course of the public health emergency (PHE), from approximately 158,000 in 2019-20, to 283,000 in August 2022.

**Policy Recommendation:**

I. Transition the CLAs to the Exchange. This requires a federal waiver or change in federal law.

## 2. Integrate Direct Primary Care (DPC) into the Medicaid Program

**Problem:** Wisconsin's Medicaid program utilizes managed care organizations (MCOs) or health maintenance organizations (HMOs) to maintain responsibility for the care provided to Medicaid members. Wisconsin contracts with 14 MCOs in the BadgerCare Plus program (children, parents and caregivers, pregnant women, childless adults), and supplemental security income (SSI) program, typically with 2-3 MCOs in each region. Without a financial incentive to choose a particular primary care provider, many members forgo their ability to choose a primary care provider from the allowed network, and MCOs then often assign members to primary care providers. That means the cost management benefit provided by DPC is not realized in the state system.

**Policy Recommendation:**

I. Require the Wisconsin Medicaid program to establish a pilot program to integrate a DPC model for a select population within the Medicaid program.

## 3. Reassess Nursing Home Bed Limit

**Problem:** Long term care, including nursing home services, accounts for $4 billion of Wisconsin's $9.7 billion Medicaid program (SFY 2020). Wisconsin has a statutorily imposed limit on the number of licensed nursing home beds, stifling competition and impacting the spectrum of care.

**Policy Recommendations:**

I. Evaluate the impact of raising or eliminating the bed limit towards increased competition, quality improvement, and balance in the continuum of care.

### 4. Increase Medicaid MCO Accountability, Quality, and Competition

**Problem:** Wisconsin's Medicaid program utilizes fourteen managed care organizations (MCOs) to ensure the care provided to Medicaid members, typically with 2-3 MCOs in each region, determined through a "certification" process, with limited competitive dynamics or new market entrants.

**Policy Recommendations:**

I. Wisconsin Medicaid should pursue more aggressive withhold and P4P strategies with HMOs/MCOs.
II. The State should explore a more aggressive certification system, with enhanced quality standards aimed at Wisconsin-specific health concerns.

### 5. Conduct 3rd Party Analysis of Wisconsin Medicaid Rx Purchasing Efficiency

**Problem:** Wisconsin's Medicaid program prescription drug expenditures have more than doubled from SFY18 to SFY20, from $302 million to $632 million (after Medicaid Drug Rebate Program dollars are included).

**Policy Recommendations:**

I. Require a third-party analysis of the Wisconsin Medicaid drug purchasing and rebate processes.
II. Request a SPA from the federal government to allow outcomes-based arrangements.
III. Evaluate the opportunities for value-based purchasing for "high cost" drugs and therapies.

### 6. Establish Consumer-Friendly Transparency

**Problem:** "Transparency" in health care and health insurance has been debated for decades. Multiple Wisconsin legislatures, the federal government, and private providers and insurers have attempted to bring clarity to the issue.

**Policy Recommendations:**

I. Adopt one or more models of more consumer actionable transparency, including models from other states.
II. Establish regulatory mechanisms in Wisconsin to enhance compliance with federal requirements.

The recommendations in part one and part two can be taken independently or in any combination by lawmakers. Some of the items have been proposed in Wisconsin but not yet enacted into law or implemented administratively. As demonstrated above, the list is comprehensive and tackles challenges from different angles. Once enacted, these reforms will set Wisconsin apart as a leading state in health care reform.

# ABOUT THE AUTHORS

**Tomas J. Philipson** is the Daniel Levin Professor of Public Policy Studies Emeritus at the University of Chicago Harris School of Public Policy and directs the Becker Friedman Institute's Program on Foundational Research in Health Care Markets and Policies within the Health Economics Initiative. He is also an associate member of the Department of Economics and a former senior lecturer at the Law School. His research focuses on health economics, and he teaches master's and PhD courses in microeconomics and health economics at the University. Tomas has advised a bipartisan collection of federal officials on health care matters, including serving as acting Director of the White House Counsel of Economic Advisors under President Trump and on the steering committee of Vice President Biden's Cancer Moon Shot Initiative.

**Chris Reader**, Executive Vice President at the Institute for Reforming Government, was previously the Senior Policy Director at Wisconsin Manufacturers and Commerce (WMC), the statewide chamber of commerce and manufacturers association. Chris directed health care policy for WMC for eight years, and represented employers on the Wisconsin Worker's Compensation Advisory Council

**Alex Ignatowski** is the Director of State Budget and Government Reform at the Institute for Reforming Government. Prior to IRG, Alex was the legislative policy advisor for Waukesha County and held multiple positions in Governor Scott Walker's administration, including serving as legislative advisor at the Department of Health Services, Assistant Deputy Secretary at the Department of Financial Institutions, and advisor to several Public Service Commission commissioners.

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# Part I

# Increasing Health Care Choice and Competition in Wisconsin

## A Policy Brief by:

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**March 2023**

# EXECUTIVE SUMMARY

This policy brief contains a set of recommendations for improving access and competition in the state of Wisconsin's health care system. These recommendations are based on how current state and federal reforms apply to Wisconsin. The brief is focused on four main problems, the evidence that effects them, and the recommendations that the evidence suggest.

## 1. Expand the Scope-of-Practice (SOP) of Nurse Practitioners (NPs) in Wisconsin

**Problem:** Rigid agreements on the range of services health professionals such as NPs are legally allowed to perform unnecessarily limits the overall supply of health care in Wisconsin.

### Evidence:

- Several states temporarily expanded the SOP for NPs during the COVID-19 pandemic, reducing the number of COVID-related deaths due to the increase in the supply and services of NPs.
- NPs typically expand access to primary care for vulnerable groups and underserved areas.
- The expansion of other health care professionals' SOP typically increases the overall supply of health care services in the state.

### Policy recommendations:

I. Broaden the SOP of NPs and other professionals to allow them to utilize their full skill set.
II. Eliminate requirements for rigid collaborative practices between different health professions.
III. Evaluate emerging healthcare occupations to increase their access and thereby drive down health care costs.

## 2. Grow the supply of Doctors of Medicine (MD) in Wisconsin

**Problem:** The state of Wisconsin is expected to face a shortage of 2,263 physicians by 2035, caused by an increase in the demand for health care, delays in increasing the supply of health care, low acceptance rates at medical schools, and restrictions of practice for physicians.

### Evidence:

- The current unmet demand for health care is driven by the shortage of primary care physicians, the slow growth of new professionals in the area, and the retirement of the current workforce.
- Increasing the supply of primary care physicians and MDs can reduce mortality, deconcentrate the health care market and potentially lower the prices of health care in Wisconsin.

- Increasing the availability of physicians and MDs can be achieved by increasing acceptance rates in medical schools and by removing barriers of practice in the state.

**Policy recommendations:**

I. Increase the acceptance rates in medical schools to increase the total pool of active MDs in the state.
II. Ease state-based licensing requirements to improve workforce mobility across states.
III. Facilitate telehealth to improve patient access to health care.
IV. Ease restrictions on foreign-trained doctors.

## 3. Allow insurer networks in Wisconsin to be based on market needs

**Problem:** There are potential trade-offs between more flexible and rigid network adequacy requirements. The state should apply the types of standards that are most effective in the context of specific population and health needs.

**Evidence:**

- Rigid network adequacy requirements lower the costs for enrollees, where the monthly premium of a health plan with narrow networks is 6.7% less than a plan with broad networks.
- Flexible network adequacy requirements will:
  - Offer enrollees adequate choice and access to providers.
  - Allow health plans to meet the needs of heterogeneous populations and account for different program characteristics, degrees of rurality, and constraints with workforce supply.
  - Encourage providers from competing on price and quality to attract patients.

**Policy recommendations:**

I. More flexible networks in terms to facilitate competition and innovation among providers and meet multiple needs for different populations and conditions.
II. More rigid networks in terms to reduce uninsured populations and generate savings for taxpayers.
III. Pair with state-based amendment to current 1332 waiver under certain requirements.

## 4. Allow site neutrality in the Medicaid Program in Wisconsin

**Problem:** The Medicaid program pays higher rates when procedures are performed in HOPDs (Hospital Outpatient Departments) rather than at physician's offices or ASCs (Ambulatory Surgical Centers). There is little reason for such payment differentials when the services offered are equivalent in the same office settings, and the patient's health status is similar, which could cause extra spendings to the government.

## Evidence:

- At the national level, HOPD services are projected to grow 8.3 times higher than physician fee schedule through 2032.
- Midwest region has the highest share of physicians employed by hospitals and physician practices owned by hospitals, where payment rate disparities are more serious.
- For Wisconsin, site neutrality in the Medicaid program can reduce cost-sharing burden to a large extent:
    - The fee-for-service spending for outpatient services in Wisconsin's Medicaid program is 7.6 times higher than the spending for physicians' offices in 2021.
    - Wisconsin is the top 10 states with highest state share of Medicaid spending (38.4%).

## Policy recommendations:

I. Embrace site neutral payment reform for State Medicaid program with straightforward metrics.
II. Analyze financial benefits and health outcomes across different settings based on comparable data.
III. Prioritize patients to ensure them to receive individualized assessments of specific care needs.

# 1. Expand the Scope-of-practice (SOP) of Nurse Practitioners (NP) in Wisconsin

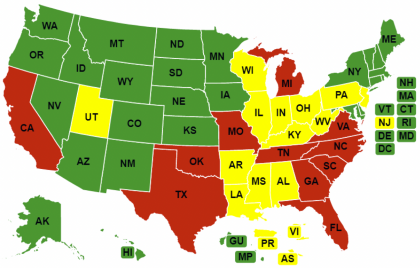
## 1.1 Background

According to the American Association of Nurse Practitioners (AANP), Nurse Practitioners (NPs) with full autonomy are authorized to "evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments" (AANP, 2022).

In each state, scope-of-practice (SOP) regulations primarily define the services a health professional is legally allowed to perform. While 22 states and the District of Columbia currently support NP full SOP, the remaining stares either reduce or restrict NP SOP by requiring NPs to have collaborative or supervisory relationships with physicians to practice. Such restrictions are, for example, that NPs are not allowed to practice independently or prescribe medications without a physician's cosignature (Barton Associates, 2017). An additional 11 states do not allow advanced practice registered nurses (APRN) full practice authority but impose fewer restrictions than Wisconsin.

These inconsistent patterns in NP regulations lead to wide variations in the independent practice of NPs across the states and potentially affect the ability of this workforce to help the country to meet the growing need for health-care services, by limiting the supply of NPs in needed areas (Poghosyan & Carthon, 2017).

Figure 1: Nurse Practitioners practice level by state




**Full Practice:** State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

**Reduced Practice:** State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

**Restricted Practice:** State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

*Source: American Association of Nurse Practitioners (AANP), State Practice Environment, 2022.*

The pandemic-related changes also provide an opportunity to alter the assumption that SOP cannot be expanded without extensive evidence of safety. Given the COVD waivers (Chung, 2020), however, the presumption should be that regulatory changes should remain unless there is evidence of harm (Weiner, 2021).

## 1.2 Problem

These regulations in the NP's SOP may impose unnecessary restrictions on provider supply and, therefore, competition. Oftentimes, SOP restrictions limit provider entry and ability to practice in ways that do not address demonstrable or substantial risks to consumer health and safety (U.S. Department of Treasury, 2015; Cox and Foster, 1990, FTC, 2014). When this happens, these undue restrictions are likely to reduce healthcare competition, the overall supply, and harm consumers (FTC, 2014; Xue et al., 2019).

Recently, Wisconsin's Governor Tony Evers has vetoed a bill that would have granted APRNs the legal ability to practice independently. The governor's action was supported by the American Medical Association (AMA) and the Wisconsin Medical Society[1], and revokes Senate Bill 394, which would have removed physician supervision or collaboration requirements for nurse practitioners, nurse anesthetists and clinical nurse specialists after 3,840 clinical care hours in their respective APRN role with a physician or dentist.

Extremely rigid collaborative practice agreements and other burdensome forms of physician and dentist supervision are generally not justified by legitimate health and safety concerns (FTC, 2014; Xue et al., 2019). For example, restrictive physician supervision protocols for APRNs impede fully collaborative care because they limit what health care professionals and providers can do to adapt to varied health care demands and constrain provider innovation in team-based care, while increasing healthcare costs and constraining innovation in health care delivery models (FTC, 2014).

Thus, many states have granted full practice authority to Advanced Practice Registered Nurses, but there is significant room for improvement in other states and for other professions, given that only 22 states grant full practice authority to them (AANP, 2022). Emerging healthcare occupations, such as dental therapy, can increase access and drive down costs for consumers, while still ensuring safe care.

## 1.3 Evidence

Current evidence shows that expanding the SOP can have a positive impact in the overall supply of NPs, equity, and access to healthcare services in the state of Wisconsin.

### Reduction of COVID-19 deaths

[1] Wisconsin's Governor Evers vetoes APRN independent-practice bill. https://www.ama-assn.org/practice-management/scope-practice/wisconsin-s-gov-evers-vetoes-aprn-independent-practice-bill

During the COVID-19 pandemic, in order to address the health workforce shortage, a number of states temporarily expanded the SOP of highly trained personnel, such as nurse practitioners (NP). It is shown that in the Midwest states that adopted this measure, COVID related deaths were potentially reduced by 10 cases per day between March and April of 2020 (Chung, 2020). At the same time, if Illinois (one of the only two Midwest states which did not expand the SOP for NP, along with Ohio) had expanded the SOP, it is estimated that 8% fewer COVID-19 deaths would have occurred in the Cook County, the most affected area in the state (Chung, 2020) (data not available for Wisconsin).

### Equity and access to healthcare services

The expansion of the services NPs are allowed to perform has the potential to expand the access to primary care for vulnerable groups. Since NP workforce is well distributed and growing in low-income and rural areas, this measure would counterbalance the maldistribution of the physicians supply, benefiting many racial and minority patients who live in geographically underserved areas (Gaskin, et al., 2012; Xue et al., 2019).

At the same time, there's evidence that states with less restrictive NP SOP regulations had a 2.5-fold greater likelihood of patients receiving primary care from NPs than states with restrictive SOP laws (Kuo et al., 2013). Thus, evidence is supportive of removing the regulatory restrictions on NP SOP to enhance access to high-quality primary care.

### Expansion of other specialists' SOP

Advanced Practice Registered Nurses (Institute of Medicine, 2011), physician assistants (U.S. Congress, 1986), pharmacists, optometrists (Bureau of Consumer Protection, 1977), and other highly trained professionals can safely and effectively provide some of the same healthcare services as physicians, in addition to providing complementary services. Similarly, dental therapists and dental hygienists can safely and effectively provide some services offered by dentists, as well as complementary services (FTC, 2013).

For example, evidence from 10 years of experience in Alaska shows that dental therapists have made a positive difference, for both children and adults, with the same quality of care as dentists, improving outcomes like more preventive care, fewer teeth removed, and fewer dental emergency visits (Chi et al., 2018). Analogously, for physical therapists, for which all states allow direct access, but insurers require a physician referral, there's evidence that attending to a physical therapy first instead reduces the risk of subsequent opioid use in patients (Sun et al., 2018).

## 1.4 Policy Recommendations

According to the presented evidence, the suggested measures to expand the scope-of-practice in order to increase the availability of Nurse Practitioners are as follows:

I. The state of Wisconsin should consider changes to broaden their scope-of-practice for Nurse Practitioners (NP) and other profession's statutes to allow

all healthcare providers to practice to the top of their license, utilizing their full skill set.

II. Similarly, Wisconsin should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and dentists and their care extenders (e.g., physician assistants, hygienists) that are not justified by legitimate health and safety concerns.

III. Furthermore, Wisconsin should evaluate emerging healthcare occupations, such as dental therapy, and consider ways in which their licensure and scope of practice can increase access and drive down consumer costs while still ensuring safe, effective care.

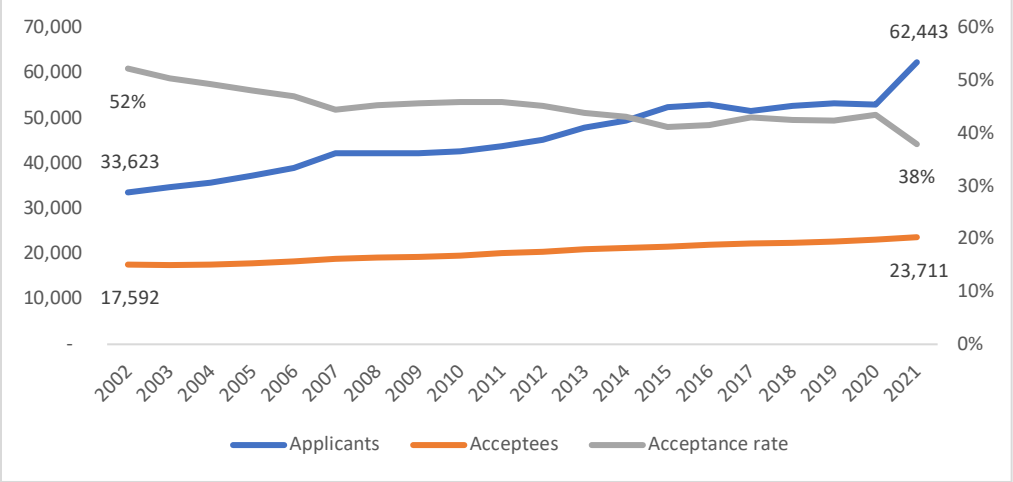
"Credentialing" functions within hospitals and health plans is another barrier that adds cost and time to the hiring process. Is this something to address, and is there any data on the issue?

# 2. Grow the supply of Doctors of Medicine (MD) in Wisconsin

## 2.1 Background

While Medical Schools applications in the USA have been steadily increasing in the last 20 years, the number of acceptees has been stagnant, dropping the national acceptance rate from 52% in 2002 to 38% in 2021 (Association of American Medical Colleges, 2021). As Figure 2 shows, after the 2020 pandemic, the number of applications spiked, yet the number of acceptees did not increase proportionally, drastically lowering the acceptance rate in medical schools despite the rise in applicants.

Figure 2: U.S. Medical School Total Applications and Acceptees, 2002-2021




*Source: Association of American Medical Colleges, 2021.*

Currently, in the state of Wisconsin, the Medical College of Wisconsin has an acceptance rate of 7.0% (353 admitted and 271 matriculants for 2022) for the Doctor of Medicine (MD) program, while the University of Wisconsin-Madison has a rate of 5.2% (287 admitted and 175 matriculants for 2022).

Table 1: Acceptance rates and matriculants in MD programs in the state of Wisconsin, 2021

| | Acceptance Rate | Applicants | Admitted | Matriculants | Rate of matriculants/admitted[2] |
|---|---|---|---|---|---|
| Medical College of Wisconsin | 7.0% | 5,041 | 353 | 271 | 76.8% |
| University of Wisconsin-Madison | 5.2% | 5,474 | 287 | 175 | 61.0% |

*Source: University of Wisconsin School of Medicine and Public Health, Medical College of Wisconsin websites (retrieved in August 2022).*

Due to this low acceptance rate, as of 2021, Wisconsin had 1,796 students enrolled in MD granting schools, for a rate of 30.8 MD students per 100,000 habitants, below the national median (38.6 students) and positioning the state on number 33 in a national states rank (Association of American Medical College, 2021) (see Table 2).

Table 2: Wisconsin's current state of students enrolled in MD granting schools with current acceptance rate (2021)

| Year | State Population | Students Enrolled in MD granting schools per year | Rate per 100,000 | National Rank | National Median |
|---|---|---|---|---|---|
| 2020 | 5,822,434 | 1,796 | 30.8 | 32 | 38.6 |
| 2018 | 5,813,568 | 1,770 | 30.4 | 32 | 32.7 |
| 2016 | 5,778,708 | 1,703 | 29.5 | 28 | 32.7 |
| 2014 | 5,757,564 | 1,602 | 27.8 | 31 | 30.4 |
| 2012 | 5,726,398 | 1,594 | 27.8 | - | 29.1 |

At the same time the amount of MD students is stagnant, due to aging, population growth, and a greater insured population following the Affordable Care Act (ACA), physician availability to patients has been recognized as one of the top barriers to meet the healthcare needs of patients in the US: the Bureau of Labor Statistics predicts that 91,400 physician jobs will be needed nationally; this is a 13% increase from 2016 to 2026 (Bureau of Labor Statistics, 2019). It is expected that by 2030, 36 states will have a shortage of physician workforce (Zhang et al., 2020), and in a recent study, the Association of American Medical Colleges (AAMC) predicted that by 2030, the demand for doctors will outstrip the supply and that the United States of America will experience a shortage of up to 121,000 physicians (Association of American Medical Colleges, 2018).

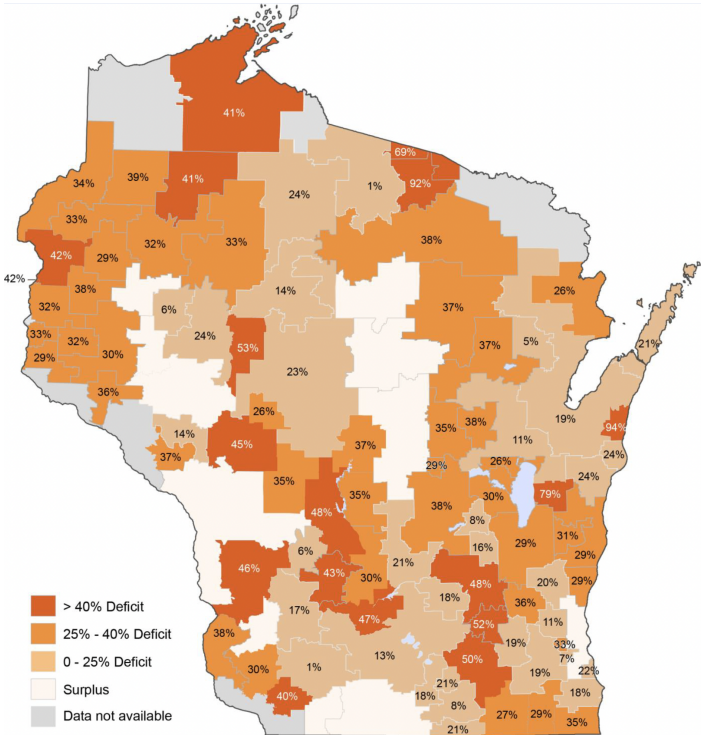
[2] This rate is presented because it is used for later calculations (see Table 3), but there is no specific rationale for the difference in this rate between the two schools.

Additionally, according the AAMC, as of 2020 45% of practicing physicians are over 55. This means more than 2 of every 5 active physicians will be over 65 in the next decade, suggesting that nearly half of all physicians who are currently practicing will be retired by 2030 (Association of American Medical Colleges, 2020). Moreover, 30% of physicians retire between the ages of 60 and 65 and 12% retire before the age of 60 (AMA Insurance, 2018).

## 2.2 Problem

Wisconsin is expected to face a shortage of 2,263 physicians by 2035 (Zhang et al., 2020), and 745 primary care physicians (PCP) by 2030, which is equivalent to 16% of the overall supply predicted by that year (Wisconsin Council on Medical Education and Workforce, 2021). The unmet need, however, was previously identified to potentially range from a surplus of 24.4% to a deficit of 93.7% depending on the Hospital Service Area (Wisconsin Council on Medical Education and Workforce, 2018) (data not available for 2021), as indicated in Figure 1.

Figure 1: Projected Primary Care Physician Deficits, percent of all unmet need (predicted for year 2035)




*Source: Wisconsin Council on Medical Education and Workforce, 2018.*

This forecast considers that while the population is expected to increase 12% statewide, demand is expected to increase by over 20%, with the supply of PCPs projected to increase by approximately 4%, and around 40% of Wisconsin's supply of PCP is expected to retire by 2035 (Wisconsin Council on Medical Education and Workforce, 2018).

Furthermore, in the last decade, hospital and physician organization markets became increasingly concentrated in the US, where concentration among primary care physicians increased the most, partially because hospitals and health care systems acquired primary care physician organizations and workforce (Fulton, 2017; Health Care Cost Institute, 2019). This means that healthcare services in the US are served by few providers, which concentrate a large share of the market, a concentration that is accentuated by the shorter supply of physicians and doctors. These high levels of market concentration are usually associated with higher prices in healthcare (Schneider et al., 2008; Gaynor et al., 2015; Gaynor et al., 2012).

Still, the current and projected shortage of primary care physicians and specialists in the US and in the state of Wisconsin is driven by the present bottleneck in physician supply and training at the level of graduate medical education, caused by medical school enrollment caps (average acceptance rates of 5% nationwide and 6.1% in Wisconsin in 2022) and a large portion of the physician workforce nearing traditional retirement age (Association of American Medical Colleges, 2021).

Altogether, it is expected for the country and Wisconsin to face a considerable shortage of physicians, led by an unmet increasing demand, the slow growth of new professionals in the area and the retirement of the current workforce. This shortage is expected to cause both a decrease in the amount of healthcare services provided and an increase in the concentration of providers, with a consequent increase in healthcare prices and, therefore, lower chances for the population to access quality services in the state.

## 2.3 Evidence

In order to meet the increasing demand of healthcare services, current evidence points towards 2 directions: (i) Increasing the supply of primary care physicians and MDs; and (ii) removing barriers of practice for physicians. These measures are associated with increasing the overall supply of healthcare services in the states and deconcentrating the healthcare market, which can potentially lower the prices of healthcare.

### Increasing the supply of primary care physicians and MDs

It has been documented that increasing the primary care physician supply is associated with improved efficacy in healthcare (Starfield, 2012) and health outcomes, including all-cause, cancer, heart disease, stroke and infant mortality; low birth weight; life expectancy; and self-rated health (Gulliford, 2002; Macinko et al., 2005, 2011; Starfield and Shi, 2002; Starfield, 2012). Particularly in the US, other findings suggest that the increase of one primary care physician per 10,000 population can be associated with an average mortality reduction of 5.3 percent, or equivalently, 49 less deaths per 100,000 people per year (Macinko et al., 2007).

Additionally, as described in the previous section, high levels of market concentration are usually associated with higher prices in healthcare (Schneider et al., 2008; Gaynor et al., 2015; Gaynor et al., 2012). Moreover, higher concentration in health care markets are also associated with higher physician prices: It has been found that an increase in 10% in the market concentration of physicians

organizations3 is associated with 1% to 4% higher physician prices (Schneider et al., 2008), suggesting that increasing the supply and competition, and thus lowering the market power concentration, could lower the prices of healthcare in the states.

Table 3 shows a simulation based on the data provided in Table 2, considering a slightly higher acceptance rate of 15% for each school (currently 7.0% and 5.24% for the Medical College of Wisconsin and the University of Wisconsin-Madison, respectively). Under these conditions, the state of Wisconsin could potentially increase the total students enrolled in MD programs, and consequently increasing the rate of MDs per 100,000 habitants, positioning them above the national median, and in a higher rank at national level (a higher ranking position -lower number- indicates a higher rate of enrolled students per 100,000 habitants).

Table 3: Wisconsin's MD students estimation with 15% acceptance rate for both schools

| | New Acceptance Rate (15% for both schools) | | |
|---|---|---|---|
| Year | Students Enrolled in MD granting schools per year | New Rate per 100,000 habitants | New National Rank |
| 2020 | 2,432 | 41.8 | 21 |
| 2018 | 2,406 | 41.4 | 20 |
| 2016 | 2,339 | 40.5 | 19 |
| 2014 | 2,238 | 38.9 | 17 |
| 2012 | 2,230 | 38.9 | - |

*Source: State Physician Workforce Data Report (2021, 2019, 2017, 2015), Association of American Medical Colleges.*

This estimation considers a constant rate of 76.8% and 61.0% of matriculants over admitted students respectively for both schools and constant amount applicants over time (see Table 1), so we can estimate the increase in total students enrolled in MD programs.

Under this estimation 636 additional students could potentially be enrolled in Wisconsin's medical schools each year, showing a glance of how the state could potentially increase their MD supply by increasing the acceptance rate of their medical schools.

## Increasing availability of MDs by removing barriers of practice

The "Reforming America's Healthcare System Through Choice and Competition analysis" (U.S. Department of Health and Human services, Department of the Treasury, and Department of Labor, 2017) document has also identified 3 critical dimensions which can increase the supply of Medical Doctors in the states:

### Workforce Mobility

[3] Measured as the Herfindahl-Hirscham index (HHI) of concentration, a standard method for measuring market concentration (Viscusi et al., 1996), that goes from 0 to 10,000, where an HHI of 10,000 indicates an industry or market consists of a single seller.

State-based licensing requirements, by their nature, inhibit provider mobility. Licensing rules are in most cases state-based, establishing licensure requirements and enforcement standards of practice for health providers, including physicians, nurses, pharmacists and other types of practitioners (U.S. Department of Health and Human Services, 2010). These requirements add time and expense when healthcare providers seek to move or work across state lines, whether or not appropriate standards of care do not differ from state to state.

Consequently, markets cannot be as responsive to economic change when workers cannot easily move to meet the demand for their services (FTC, 2017), a phenomenon that is created by the difficulty for qualified healthcare professionals licensed in one state to work in another state, even while having same education background, training programs and certifications (U.S. Department of Health and Human Services, 2010).

### Telehealth services

Telehealth, the use of telecommunications to provide healthcare services, has been hailed as a significant innovation in healthcare delivery (Lustig, 2012). Examples of healthcare services that have been proved to effectively provided by telehealth include mental health services (Hilty et al., 2013), dermatology (Coates et al., 2015), ophthalmology (Fierson et al., 2015) specialist-to-provider consultations in neurology and pathology (Schwamm et al., 2009) and direct-to-consumer services for minor conditions (Mehrotra et al., 2013).

In particular, telehealth was proved to be particularly efficient during the COVID-19 pandemic. The advantages of having a non-in-person service rely on the feasibility of preventing, diagnosing, treating, and controlling diseases without physically visiting a physician, a key element to prevent spreading during COVID-19 outbreak (Abraham et al., 2020; Monaghesh & Hajizadeh, 2020). Beyond that, since the pandemic changed the landscape of health care delivery, many health care providers have shifted to virtual care delivery in order to maintain the continuity of care during this time (Haque, 2021).

Moreover, telehealth often increases the virtual supply of providers and extends their reach to new locations, promoting beneficial competition. By doing so, telehealth healthcare services can enhance price and non-price competition, reduce transportation expenditures, and improve access to quality care in underserved locations (Committee on Pediatric Workforce, 2015, Haque 2021).

### Restrictions on Foreign-trained Doctors

Currently, any physician trained outside the United States or Canada must obtain an Educational Commission for Foreign Medical Graduates (ECFMG) certification, complete a United States residency program, and apply for a state license, which is an extensive process. This burden varies across physicians but represents an unduly entry barrier into the profession that lowers entry for physicians on the margin.

Yet, international medical graduates (IMGs) have already helped meet the growing need—over 25% of current physicians in the US were trained abroad (Carroll, 2017); and a high percentage of them cover densely populated, low-income communities

with sicker residents and low physician density (Kaushal et al., 2022). Moreover, existing evidence suggests that the quality of patient care provided by IMGs is at least as good as that provided by US medical graduates (Mick & Comfort, 1997; Tsugawa et al., 2017), suggesting that excessive concerns that IMGs presence compromises the quality of medical care are unwarranted (Desbiens & Vidaillet, 2010; Norcini et al., 2010).

## 2.4 Policy Recommendations

According with the evidence presented, our recommendation for the state of Wisconsin are the following:

I. Increasing Acceptance Rate in Medical Schools to increase the total pool of active Medical Doctors (MD) in the state: A higher supply of MDs would increase the overall supply of physicians in the state along with reducing the market concentration of healthcare services by expanding the total available supply of healthcare providers. This can be achieved by increasing the number of accepted applications by Medical Schools in the state and has the potential of increasing competition between providers and lowering the overall prices of healthcare services in the state.
II. Improve Workforce Mobility: The state of Wisconsin should consider adopting interstate compacts and model laws that improve license portability, either by granting practitioners licensed in one state a privilege to practice elsewhere, or by expediting the process for obtaining licensure in multiple states.
III. Facilitate Telehealth to improve Patient Access: Facilitate and promote telehealth consultations, by increasing the virtual supply of providers and primary care services, extending their reach to new and underserved locations and promoting competition between providers.
IV. Ease restrictions on Foreign-trained Doctors: The state of Wisconsin should create an expedited pathway for highly qualified, foreign- trained doctors seeking licensure who have completed a residency program equivalent to an American Graduate Medical Education (GME) program.

# 3. Allow insurer networks in Wisconsin to be based on market needs

## 3.1 Background

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract (National Conference of State Legislatures, 2018). Starting with the 2018 plan year, the Trump Administration ended direct federal oversight of qualified health plan (QHPs) networks and deferred them to state oversight. Though states have enacted laws to ensure that provider networks are of adequate size, federal oversight is scheduled to resume for the 2023 plan year. In place of previous

mandatory time and distance standards, CMS suggests several alternative quantitative standards that states may elect to use (KFF, 2022; CMS, 2022):

- Time and distance standard: this standard is used to determine whether participating providers are geographically accessible to plan enrollees. Beginning in 2023, CMS has proposed time/distance standards for various types of providers and facilities, where at least 90 percent of enrollees must live within the maximum distance to at least one provider of each type.

- Provider-to-enrollee ratio standard: this standard establishes minimum provider-to-enrollee ratios. Under Medicare Advantage plans (Part C), plans must contract with at least 1.67 primary care physicians per 1,000 beneficiaries. Under the Medicaid program, CMS does not require minimum ratios. For example, the minimum ratio of primary care providers to enrollees in Wisconsin 1:1500 (State of Wisconsin Department of Health Services, 2020).

- Appointment wait time standard: this standard sets maximum wait times for certain types of services. CMS conducts compliance reviews in response to complaints and random audits, where issuers would attest that 90% of contracted providers meet the wait-time standard. Medicare Advantage plans currently are not required to meet appointment wait time standards; Wisconsin's Medicaid program varies standards based on times and services.

- Other standards: qualified health plans (QHPs) are required to contract with a minimum number of available essential community providers (ECPs). Beginning in 2018, the Trump Administration reduced the percentage of available ECPs from 30% to 20%. For 2023, CMS has proposed to increase the threshold to 35%. In addition, other standards are under consideration. CMS proposes to seek comment in 2023 on whether and how telehealth availability might be incorporated into network adequacy standards.

## 3.2 Problem

While most states (89.7%) report time and distance standards for network adequacy that considers local populations and geographies (Zhu et al, 2022), there remains considerable variation in access standards across health insurance. For example, since the CMS loosened requirements for Medicaid managed care final rules in 2020, more states are using alternative quantitative standards above in conjunction with the traditional time and distance standards.

Currently, the state of Wisconsin applies multiple network adequacy requirements for different service types of Medicaid[4]. Providers for services such as AODA services, mental health services, and adult day care and habilitation services, etc. shall meet the standards for both time and distance and provider to member ratios. Providers for community support programs, personal care, skilled nursing services, and

[4] Wisconsin Department of Health Services, Division of Medicaid Services (2020). Managed Care Organization (MCO) Provider Network Adequacy. https://www.dhs.wisconsin.gov/publications/p02542.pdf

personal emergency response systems services will meet the standards for provider to member ratios, the wait time to recipient, or both. However, there are potential trade-offs between flexible and rigid network adequacy requirements. More investigation is needed to understand the types of standards that are most effective in the context of specific population and health needs.

## 3.3 Evidence

### Benefits of rigid network adequacy requirements

Greater rigidity in network adequacy requirements can lower the premiums for enrollees, reduce the number of uninsured people, and generate savings for taxpayers. Health plans with a narrow network had a monthly premium that was 6.7 percent less than a plan with a broad network (Polsky et al, 2016). Another study shows premiums for narrow network plans are 13 to 17 percent lower on average than those with broad networks (Ginsburg, 2014). This could be achieved through several mechanisms. First, a narrow network can reduce health care costs of beneficiaries by removing high-cost providers from the network (Ho, 2005). Second, a narrow network could reduce costs by negotiating lower reimbursement rates with providers in exchange for greater volume of patients to them (Polsky et al, 2004). Third, by removing high-cost providers, the plan could establish favorable risk selection because healthier and lower-cost beneficiaries would be more likely to select it (Shepard, 2022).

In addition, narrower provider networks are a feasible tool to contain costs and foster improved quality when Any Willing Provider Laws (AWP) are present. Including Wisconsin, a total of 27 states now have AWP statutes. Specifically, the law in Wisconsin applies to health care professionals, services, facilities, and organizations (Medtrade, 2020). According to Ginsburg (2014), AWP laws lead to higher state healthcare spending and interfere with meeting consumer and employer demand for lower-priced plans. Healthcare providers are spurring great efforts to pass such laws in order to protect themselves from further competition, which will become more disruptive to financing such that the costs to consumers, employers and taxpayers could be even larger than in the past. Rigid network adequacy requirements can offset the potential negative impacts of the AWP laws by simply excluding providers who do not meet the quality standards.

A narrow network is particularly beneficial to lower-income consumers who tend to be price sensitive and are more interested in the size of the premium relative to the breadth of the network (Finkelstein, 207). This is much less of an issue for Medicaid beneficiaries due to the heavy federal subsidies under the recent Inflation Reduction Act. As part of the Inflation Reduction Act, the Senate passed a three-year extension of enhanced subsidies for people buying their own health coverage on the Affordable Care Act Marketplaces, which are estimated to reach $64 billion through 2025 (CRFB, 2022).

### Benefits of flexible network adequacy requirements

### Offer enrollees adequate choice and access to providers.

A narrow network may have insufficient capacity to serve all enrollees within a health plan because the providers may be too geographically dispersed to be reasonably accessible, leading some enrollees with only the option of more expensive health care from out-of-network providers (Hall et al, 2017). These issues pertain to private insurance as well as Medicaid managed care and Medicare Advantage plans, where insurers generally contract with a limited number of providers. The economic burden of receiving out-of-network care is substantial. This is especially true for lower-income populations because the cost-sharing reductions that the ACA provides are not available out-of-network. Therefore, flexible requirements can give enrollees more choices and access to providers by ensuring that provider networks are adequate in size and scope of coverage.

### Allow health plans to meet the needs of heterogeneous populations and account for different program characteristics, degrees of rurality, and constraints with workforce supply.

According to Zhu et al (2022), current standards largely rely on single travel time or distance dimensions of access, without adequately reflecting availability and acceptability. For example, Medicaid managed care allows each state to determine the criteria to be applied to telehealth providers and how such providers would be considered when evaluating network adequacy beginning in 2020 (CMS, 2020). In this context, the traditional time and distance standards may not be an appropriate criterion, particularly if telehealth access occurs at the expense of necessary in-person care or if telehealth has inequitable uptake across communities. Therefore, broader network adequacy requirements allow states to consider new modalities for which traditional time and distance standards do not apply.

### Encourage competition in price and quality to attract patients.

Narrow networks give insurers leverage in their negotiations with providers over lower reimbursement rates that are detrimental for enrollees. In addition, narrow measures used to determine network adequacy may discourage innovative ways to meet enrollee's preferences. For example, only using proximity measures may discourage insurers from developing telemedicine capabilities and utilizing regional or national care centers outside the residency area (Urban Institute, 2016). Moreover, network adequacy requirements forcing insurers to contract with outside providers will undermine the vertically integrated health systems that promote delivery-system innovation and care coordination (Howard, 2014). To bolster more competition and innovation, network adequacy standards should place greater emphasis on network outcomes while giving states flexibility to meet their specific needs (U.S. Department of Health and Human Services, 2020).

## 3.4 Policy Recommendations

On the basis of boons and banes for flexible or rigid network adequacy requirements, the government should establish policies which benefit more consumers and protect the interests of providers based on actual market needs.

I. To facilitate competition and innovation among providers, meet heterogenous needs for different populations, and provide more choices for

enrollees, Wisconsin should consider loosening network adequacy standards and avoid stringent requirements that are not conducive to innovation and modern medicine.

II. To reduce the number of uninsured people, lower the economic burdens for low-income populations, and generate savings for taxpayers and state spending, Wisconsin should restrict network adequacy requirements to control health care costs.

III. It is also plausible to pair the state-based amendment to the current 1332 waiver5. While the ACA provides states with flexibility to alter certain provisions using 1332 waiver authority, it establishes guardrails that limit the extent of the changes states may make. The current law requires state waiver applications to demonstrate that coverage that is at least as comprehensive in covered benefits; at least as affordable; cover at least a comparable number of state residents; and not increase the federal deficit. The Kaiser Family Foundation (2020) provides the status of 1332 waivers requested by states.

# 4. Allow site neutrality in the Medicaid Program in Wisconsin

## 4.1 Background

Health insurance beneficiaries can receive services in different settings and from different type of providers under the fee-for-service reimbursement, and the same services can be offered in more than one setting in some cases (Health Affairs, 2014). For example, a beneficiary could receive chemotherapy in either a physician's office or a hospital outpatient department. Over the past decade, for the same medical services that are equally safe and effective, the Medicare and Medicaid program pay higher rates when they are performed in Hospital Outpatient Departments (HOPDs) than at physician's offices or Ambulatory Surgical Centers (ASCs) (Health Savers Initiative, 2021). Conceptually, physician reimbursement for ambulatory services has two components: the professional component, which covers the physician time, and the technical component, which covers the cost of the office, equipment, and auxiliary staff's time. For the Medicare program, though the professional part is paid under the physicians fee schedule (PFS) regardless of site of services, the technical part is much higher in the HOPD than in a physician's office or ambulatory surgical center (U.S. Department of Health and Human Services, 2018).

Site neutral payment is the concept of paying the same amount for rehabilitation regardless of whether the patient is treated in an inpatient rehabilitation hospital or nursing home (Center for Medicare Advocacy, 2021). Proposed by President Trump, this policy has bipartisan support and has been recommended by the Medicare Payment Advisory Commission to eliminate differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) for selected conditions (MedPAC, 2015). Aiming to address payment differences

[5] CMS (2021). Section 1332: State Innovation Waivers. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

between sites of service, the reform allows patients to choose the setting that best meets their needs among safe and clinically appropriate options and generates large savings in Medicare and Medicaid premiums and cost-sharing for clinic visits provided at an off-campus hospital outpatient department (CMS, 2018).

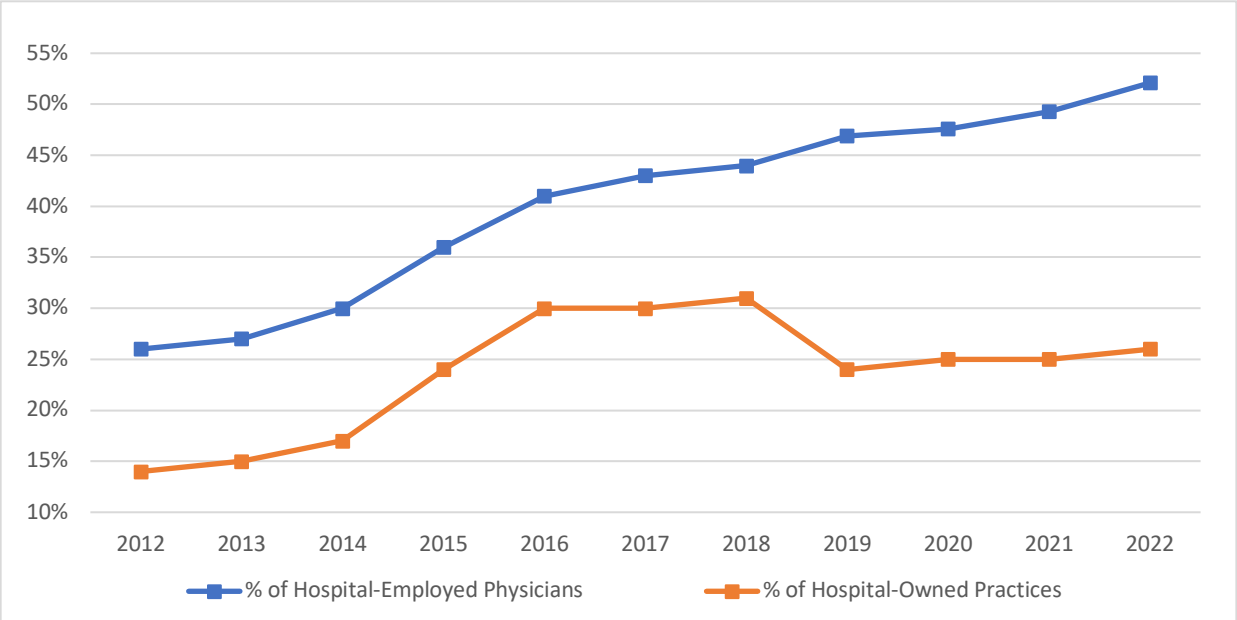
## 4.2 Problem

CMS implements the law providing general parameters for how each type of provider is paid and develops detailed elements of different payment systems. The core elements of the systems are generally the same: payment is based on a set rate payment, which is calculated from the average cost of providing a unit of service across providers; and updated annually through an inflation rate that has specific features for different system (i.e., hospital market basket index under outpatient prospective payment system for hospital outpatient, medical economic index under physician fee schedule for physicians' offices, and consumer price index under ambulatory surgical center payment system for ambulatory surgical centers).

In some cases, the payment differential between HOPDs and ASCs are quite large. According to MedPAC's report to the Congress (2022), Medicare payment rates for surgical services performed in HOPDs are almost twice as high as in ASCs. The rationale for higher payments to HOPDs is based on differences relative to freestanding physician offices and ASCs in regulatory requirements, comprehensive licensing, and the complexity of services provided (AHA, 2021a). However, the truth is that many outpatient departments now are located off-campus, where hospitals purchase previously independent physicians' offices and change their designation in order to take advantage of the higher rate available. In this case, the exact same services can be delivered but with a higher cost for the payers, only because they are hospital owned. As reported by MedPAC (2022), the shifts in billing from freestanding physician offices to HOPDs raises the total Medicare payment amount by over 105%, from $92 to $189.

Evidence has shown the growing trend of hospital-employed physicians and hospital-owned physician practices. Due to the COVID-19 pandemic in the last half of 2020 and throughout 2021, this trend has even accelerated. According to the Physician Practice Acquisition Study (PAI, 2019; 2022), the share of hospital-owned physicians continues to increase between 2012 and 2022. Nationwide, over 52% of physicians are now employed by hospitals. Besides, the share of hospital-owned physician practices has doubled from 2013 to 2018, and still maintains a relatively high level of 26% although the situation got better after CMS empowered and ensured site-neutral payment in proposed rules for the Medicare program in 2018 (CMS, 2018). The increase in hospital-employed physicians and hospital-owned practices will no doubt accelerate the shifts in payment from physician offices to hospitals, and thereby raise the total program payment due to the higher payment rates to HOPDs.

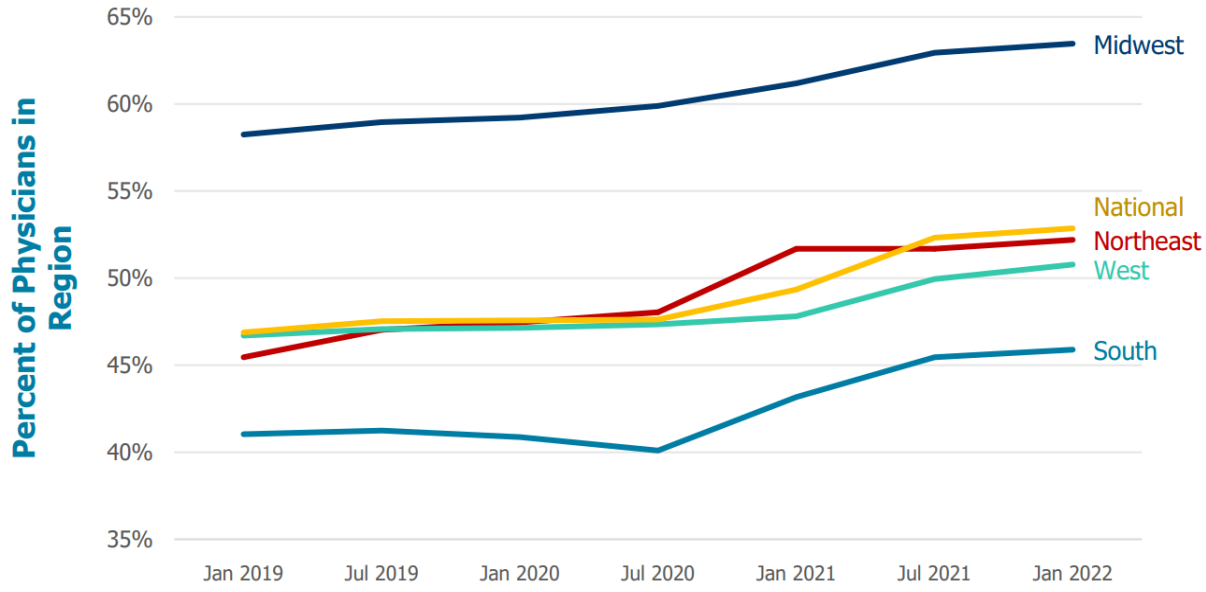
Figure 1: Growth of Hospital Employment of Physicians and Ownership of Physician Practices, 2012-2022




*Source: Physicians Advocacy Institute, 2022*

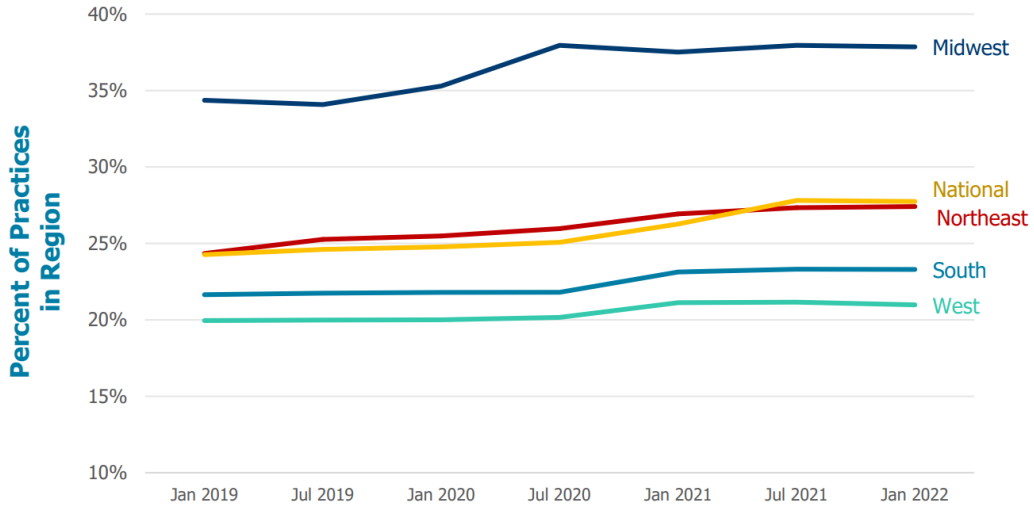
Situations are even worse in the Midwest region including Wisconsin. As of January 2022, 63.5% of all physicians in the Midwest are employed by hospitals with a 9% growth rate between 2019 and 2022, which is far above the national average level (52%). Besides, the Midwest has the largest percentage of hospital-owned practices with 37.9%, far exceeding other regions and national average (26%), as shown in Figure 2a and 2b (PAI, 2022).

Figure 2a: Percent Hospital-Employed Physicians by Region: Midwest vs. Other Regions




*Source: Physicians Advocacy Institute, 2022*

Figure 2b: Percent Hospital-Owned Practices by Region: Midwest vs. Other Regions




*Source: Physicians Academy Institute, 2022*[6].

In addition, evidence shows that the actual and projected payments for HOPDs are significantly higher than for ASCs or physicians' offices. At the national level, it has been projected that fee-for-service payments to HOPDs will grow much faster than to physicians' offices and ASCs over the next decade in the Medicare program (CBO, 2022a), as shown in Table 1. HOPD services will grow by 115.6% through 2032, which is the second fastest growing factor after Part D prescription drugs; by comparison, physician fee schedule will only increase by 13.9%. At the state level, the payment disparity could still exist in the Medicaid program as the fee-for-service section accounts for nearly 30% of the total care benefits (CBO, 2022b). Specifically, the fee-for-service including acute care and long-term care accounts for 43.2% of the overall Medicaid spending in Wisconsin in FY 2021 (KFF, 2022), where the FFS spending for outpatient services is 7.6 times higher than the spending for physicians' offices, as shown in Table 2.

Table 1: Growth in Fee-For-Service Payments in Medicare by Sector, US, 2022, $ Billions

| Components of Benefits Payments (Billion) | 2022 | 2032 | Percent Increase |
|---|---|---|---|
| Part D Prescription Drugs | $ 119 | $ 258 | 116.8% |
| Hospital Outpatient Services | $ 64 | $ 138 | 115.6% |
| Other Services | $ 108 | $ 196 | 81.5% |
| Hospital Inpatient Services | $ 145 | $ 200 | 37.9% |
| Home Health Agencies | $ 17 | $ 23 | 35.3% |
| Skilled Nursing Facilities | $ 28 | $ 32 | 14.3% |

*Source: CBO Baseline Projections, 2022*
*Note: Spending on ASCs is included in 'Other Services'*

[6] Physicians Academy Institute (2022). http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

Table 2: Distribution of Medicare Spending by Service, Wisconsin, 2021, $ Million

| Category | Sub-category | FY 2021 | |
|---|---|---|---|
| | Inpatient Hospital | $ | 471.2 |
| | Physician | $ | 60.4 |
| | Outpatient Services | $ | 459.4 |
| | Prescribed Drugs | $ | 540.9 |
| | Other Services | $ | 1,005.1 |
| Acute Care | Total | $ | 2,536.9 |
| Long-Term Care | Total | $ | 1,947.1 |
| Managed Care & Health Plans | Total | $ | 5,384.8 |
| Payments to Medicare | Total | $ | 384.1 |
| DSH Payments | Total | $ | 138.1 |
| Grand Total | | $ | 10,391.0 |

*Source: Urban Institute estimates based on data from CMS (Form 64), as of August 2022*

In conclusion, there is little reason for significant payment differentials between HOPDs and ASCs or physicians' offices when the services offered are equivalent in the same office settings, and the patient's health status is similar (Health Savers Initiative, 2021). What's more, it is especially urgent for Midwest states including Wisconsin to establish reforms to reduce the disparity of fees between HOPD services and physician office services as these states continue to have the highest percentage of physicians employed and physician practices owned by hospitals.

## 4.3 Evidence

Site neutral payment reform can address the disparity by lowering premiums and out-of-pocket costs for beneficiaries, and generate federal-level and state-level savings. Beginning from 2018, CMS has empowered and ensured site-neutral payment in proposed Medicare rules (CMS, 2018). According to Health Savers Initiative (2021), assuming different levels of private sector spillover savings, site-neutral policy in Medicare could reduce total national health expenditures (NHE) by a range of $436 to $672 billion, and reduce projected federal budget deficits by $217 to $279 billion over the next decade (2021-2030), as shown in Table 3. Among these, a total of $10 billion could be saved for the Medicaid program through 2030, including $6 billion in federal Medicaid spending and $4 billion in state Medicaid spending.

Table 3: Estimated Savings from Adopting Site-Neutral Payments in Medicare, 2021-2030, $ Billion

| | Savings (2021-2030) |
|---|---|
| Federal Spending | $175 |
| Federal Revenue | $31 - $90 |
| State Medicaid Spending | $4 |
| Private Sector | $140 - $466 |
| Medicare Beneficiaries | $137 |
| National Health Expenditure | $346 - $672 |
| Total Federal Budget Deficit Reduction | $217 - $279 |

*Source: Committee for a Responsible Federal Budget, Health Savers Initiative, 2021*
*Note: Total Federal Budget Deficit Reduction = Revenue + Spending + Interest Savings*

The difference between Medicare and Medicaid fee-for-service reimbursement is that each state controls its own Medicaid program, making it more difficult to compare Medicaid FFS payments to hospitals and nursing facilities due to the variation in how states pay these providers (MACPAC, 2021). Research comparing Medicaid FFS hospital payments across states and to Medicare find that Medicaid has paid a greater percentage of costs than Medicare once supplemental payments are considered (MACPAC, 2017; AHA, 2016). In addition, according to CMS and Urban Institute estimates (KFF, 2022), Wisconsin is the top 10 states with the highest state share of Medicaid spending, having an average percentage of 38.4% over recent five years, as shown in Table 4. Therefore, Wisconsin could reduce premiums and cost-sharing burden to a greater extent by embracing site neutrality in the Medicaid program. Furthermore, there would be less incentive for hospitals to purchase physician practices to convert to HOPDs, which will lead to a much lower private sector prices for beneficiaries.

Table 4: Federal and State Share of Medicaid Spending, Wisconsin, 2017-2021, $ Billion

| Year | Federal | State | Total | State Share |
|---|---|---|---|---|
| 2017 | $ 4.8 | $ 3.4 | $ 8.2 | 41.2% |
| 2018 | $ 5.2 | $ 3.6 | $ 8.8 | 40.9% |
| 2019 | $ 5.5 | $ 3.7 | $ 9.2 | 40.3% |
| 2020 | $ 6.2 | $ 3.3 | $ 9.4 | 34.6% |
| 2021 | $ 6.8 | $ 3.6 | $ 10.4 | 35.0% |

*Source: Urban Institute estimates based on data from CMS (Form 64), as of August 2022*

However, there are also potential issues for site neutral payment. According to American Hospital Association (AHA, 2021b), Medicare beneficiaries treated in hospital off-campus provider-based departments are more likely to be poorer and have more severe chronic conditions than those who receive care in independent physician offices (IPOs). Specifically, patients who received care in HOPDs are 31% more likely to be non-White, and have a median household income of $3,000 lower than beneficiaries treated in IPOs. However, site-neutral reimbursement may threaten access to health cares in HOPDs for the most at-risk patients. Vulnerable

beneficiaries may risk being diverted into a less intensive and less appropriate rehabilitation setting simply because it is less expensive (Revcycle Intelligence, 2021).

## 4.4 Policy Recommendations

Based on our analysis, we therefore recommend Wisconsin to reform the state's Medicaid Program that reimburse hospital outpatient departments at the same rate as physician-owned medical practices for all equivalent outpatient services and ensure patients are notified when hospitals acquire physician-owned medical practices, in order to protect the taxpayers from paying substantially higher rates for equivalent outpatient health services.

I. Wisconsin should embrace site neutrality in the Medicaid program as a goal and reform their payment systems to pay for the value delivered where value is defined according to a relatively limited, straightforward, and non-gameable set of metrics. Additionally, metrics should not be designed and proposed solely by the entities to which they will ultimately apply.
II. Policies should be evidence-based with comparable data. Detailed data for Medicaid program is needed in order to make policies not only based on costs, but on patient care and health outcomes, such as projected state savings due to the reform, and the total economic value of health outcomes for Medicaid enrollees. However, typically Medicaid program data do not contain substantial health outcomes data but is mainly focused on costs.

**Supporting Materials May Be Found in the Document's Appendix**

# Part II

# Medicaid Reforms to Improve Service and Protect Taxpayers

## A Policy Brief by:

**The Institute for Reforming Government Policy Team**

**Chris Reader, Executive Vice President**

**Alex Ignatowski, Director of State Budget and Government Reform**

# EXECUTIVE SUMMARY

The health care public policy debate has typically focused on the liberal agenda of greater government involvement and control over the health care system and expansion of government sponsored health coverage programs. While conservative perspectives regarding consumer choice, transparency in pricing, and tax policy mechanisms have been considered and partially enacted, the United States continues methodically down a path toward government-run health care and potentially a single payer system, as evidenced by ObamaCare, various pandemic-related policies, and the so-called Inflation Reduction Act. The conservative viewpoint has been on the defensive.

The Medicaid and market reform recommendations outlined below are designed to change this dynamic by presenting compelling reforms that reduce dependence on government programs, enhance consumer choice, increase transparency, manage costs, and apply conservative principles to health care broadly. The reforms presented in this report consist of:

1. **Transitioning Medicaid childless adult (CLA) population to the Exchange**
2. **Integrating Direct Primary Care into Medicaid (DPC)**
3. **Reassessing the nursing home bed limit**
4. **Increasing Medicaid MCO accountability, quality, and competition**
5. **Conducting third Party analysis of Wisconsin Medicaid Rx purchasing efficiency**
6. **Establishing consumer-friendly cost transparency**

# 1. Transitioning Medicaid childless adult (CLA) population to the Exchange

## 1.1 Background

Since 2013, Wisconsin has operated its Medicaid program under waiver authority articulated in s. 1115 of the Social Security Act, authorizing the Secretary of the federal Department of Health and Human Services (DHHS) to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's' Health Insurance Programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states extra flexibility to design and improve their programs (WI Department of Health Services, DHS).
Under this waiver, Wisconsin provides Medicaid coverage for individuals and families earning up to 100% of the federal poverty level (FPL), which translates to $13,590 for an individual, and $27,750 for a family of four.

While Medicaid provides coverage for a variety of populations, from low-income pregnant women to severely disabled individuals, it also provides coverage for individuals with no dependents and no apparent health-related barriers to obtaining employment. This is the so-called "childless adult" population (CLAs). The federal Affordable Care Act ("ObamaCare") included provisions for states to expand Medicaid to this population, but only if that coverage extended to such individuals earning up to 138% of the FPL. As noted, Wisconsin requested, and received, a waiver allowing the income threshold to be established at a maximum of 100% FPL. This population also often "churns" in and out of Medicaid as income fluctuates.

The waiver was initially approved for five years (through 2018), followed by a five-year renewal, extending the program through the end of calendar 2022. Governor Evers, while repeatedly calling for full Medicaid expansion per the Affordable Care Act (repeatedly rejected by the Legislature), recently submitted a formal request to DHHS to once again extend the program an additional five years, through 2028. The Governor's request includes no substantive modifications to the waiver as first requested by Governor Walker nearly a decade ago.

## 1.2 Problem

The table below illustrates the growth of Medicaid enrollment for Wisconsin's childless adult population. As illustrated, there was a more than threefold increase resulting from the waiver, and a nearly doubling of this population over the course of the public health emergency (PHE), formally declared in March 2020:

| 2013-14 (Pre-waiver) | 2018-19 (Pre-PHE) | 2021-22 (November 2022) |
|---|---|---|
| 39,000 | 149,000 | 291,000 |

This population, as mentioned earlier, is generally considered able to gain employment, even if such employment does not reach the 100% FPL threshold. During the PHE and this extended period of historically low unemployment, there is even less rationale for such a large population to remain on Medicaid. Moreover, the transition to the Exchange does not need to disrupt coverage, as most Medicaid managed care organizations also offer plans on the Exchange. In fact, exchange offerings have been expanding since Wisconsin launched its 1332 waiver, the WI Healthcare Stability Plan. This plan has been referred to by the current Wisconsin Insurance Commissioner, Nathan Houdek, as "a bipartisan success story for providing more affordable health care coverage options for Wisconsin residents across the state," (Office of the Commissioner of Insurance Press Release, December 5, 2022).

It is anticipated that Medicaid enrollment will fall nationwide by between 5.3 million and 14.2 million when the PHE ends and continuous enrollment ends. In Wisconsin, this is expected to translate to "hundreds of thousands" (Milwaukee Journal Sentinel, March 15, 2022). Further information regarding specific categories of eligibility and enrollment impacts are expected in coming months. However, many experts expect the most vulnerable Medicaid populations, such as long-term care patients, pregnant women, and severely disabled, will not see dramatic disenrollment.

## 1.3 Evidence

This population generates the second-highest annual cost for the State ($7,500 per 2021 LFB info paper 43; funded approximately 60% by the federal government and 40% by the State) and the State would see a large reduction in Medicaid enrollment as well as a significant state cost savings by shifting them to the Exchange, where coverage resembles the commercial market – which is where this group would generally be covered when "churning" off of public assistance.

The average premium cost on the Exchange for the lowest cost Silver Plan" (largely paid for by the federal government for this group under this initiative) is $5,040 (Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tiers, 2018-2022").

In addition, the federal "Inflation Reduction Act" enacted earlier this year includes a three-year extension of generous federal subsidies (initially enacted in the "American Rescue Plan Act") for many individuals and families purchasing coverage on the Exchange. These subsidies apply to populations earning up to FOUR times the FPL.

## 1.4 Policy Recommendations

Transition the CLA category to the Exchange. This is unlikely to substantively impact the cost of coverage for individuals in this group, as federal subsidies for the lowest cost silver plan may result in zero monthly premiums and only minor cost

sharing. Such cost sharing could be offset by State assistance, although this would be a policy and fiscal choice of the Governor and Legislature. However, a more thorough actuarial and financial analysis should be conducted to provide an accurate assessment.

As Governor Walker expressed, public assistance is meant to be a trampoline rather than a hammock. This initiative applies this philosophy while still ensuring excellent coverage for CLAs and maintaining the current benefits and programmatic structure provided for other, more vulnerable, Medicaid populations.

It should be noted that this initiative likely requires an amendment to the current 1115 waiver (after it is presumably extended by DHHS). However, a change in federal law may be required, particularly given the unlikelihood of the Biden Administration approving a waiver that reduces the dependance on government programs.

# 2. Integrate Direct Primary Care into the Medicaid Program

## 2.1 Background

Wisconsin's Medicaid program utilizes managed care organizations (MCOs) or health maintenance organizations (HMOs) to maintain responsibility for the care provided to Medicaid members. Wisconsin contracts with 14 MCOs in the BadgerCare Plus program (children, parents and caregivers, pregnant women, childless adults), and supplemental security income (SSI) program, typically with 2-3 MCOs in each region.

In turn, these MCOs establish networks of providers, pursuant to contractual and regulatory requirements (federal and state). As referenced above, Medicaid members have a choice of two or three MCOs within their region. However, many members – anecdotally reaching two-thirds in some years – do NOT make a choice. These members are then assigned to a particular MCO through an algorithmic program within Medicaid (in other words, a computer chooses for them, based on certain criteria).

## 2.2 Problem

This dynamic of members foregoing their opportunity to choose often extends to selection of a primary care provider (PCP). In these cases, MCOs will typically (and often are contractually required) assign members to a PCP. While this addresses the question of, "who is my provider"?, it does not directly address patient choice and appropriate engagement of a PCP for general health concerns and management of a specialist, if needed.

The importance of primary care is paramount. The Institute of Medicine defines primary care as "[t]he provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the

context of family and community." (Defining Primary Care: An Interim Report, 1994, 1.)

Therefore, a lack of engagement with a PCP can lead to poor management of chronic conditions and more common health care issues. In turn, this can drive preventable utilization of health care services, avoidable emergency department visits, and the corresponding costs of delayed care for manageable conditions. According to the Bipartisan Policy Center (Advancing Comprehensive Primary Care in Medicaid, July 2020), *"...a number of federal policy barriers limit the spread and scale of effective primary care. Effective primary care services have the potential to result in better healthcare outcomes and cost-savings, while reducing disparities. Medicaid is the primary source of coverage for millions of low-income and vulnerable Americans, yet many beneficiaries still lack a relationship with a primary care doctor. When low-income adults have both health insurance and access to a regular care provider they are "less likely to report cost-related access problems, more likely to be up-to-date with preventive screenings, and report greater satisfaction with the quality of their care."*

## 2.3 Evidence

On the private side, many commercially insured families (and the businesses paying a large portion of the insurance premium) utilize direct primary care. According to the American Academy of Family Physicians, *"the Direct Primary Care (DPC) model is a practice and payment model where patients/consumers pay their physician or practice directly in the form of periodic payments for a defined set of primary care services. DPC practices typically charge patients a flat monthly or annual fee...in exchange for access to a broad range of primary care and medical administrative services. The DPC practice framework includes any practice model structured around direct contracting with patients/consumers for monthly or annual fees which serve to replace the traditional system of third party insurance coverage for primary care services...Such services may include real time access via advanced communication technology to their personal physician, extended visits, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration."*

In other words, DPC is designed to address general health needs and provide prompt access for patients in exchange for a monthly or annual fee. Generally, DPC providers will limit the number of patients to ensure reasonable, prompt access. From a provider perspective, DPC arrangements are alternatives to the often administratively burdensome fee-for-service or insurance environment.

DPC models have demonstrated improved clinical care and management of costs. According to the American Journal of Lifestyle Medicine, Direct Primary Care: A Successful Financial Model for the Clinical Practice of Lifestyle Medicine (April 2021), DPC *"...has been shown to be economically and financially sustainable. Furthermore, it has the potential to fulfill the Quadruple Aim of health care in the United States. LM practiced in a DPC model has the potential to transform health care delivery."*


Interestingly, Johns Hopkins Health System includes DPC as part of its benefit structure for its own employees. The results? According to Steve Kravet, president of Johns Hopkins Community Physicians, the organization responsible for the practice, this structure continuously receives among the highest patient experience scores of all primary care practices in the nation.

"Our vision was to fundamentally change the way we deliver primary care," Kravet says. "Further, through enhanced patient-provider relationships, DPC has decreased unnecessary urgent care, emergency care and specialty visits. During COVID-19, DPC was readily able to adapt to the increased reliance on telemedicine, as this was already a fundamental part of the program." (Direct Primary Care at Johns Hopkins Medicine).

In Wisconsin, the DPC model has had a challenging legislative path. In the 2017-18 session, Representative Joe Sanfelipo introduced AB 798 (17-1619/1) (legis.wisconsin.gov) to require the Medicaid program to integrate a DPC model on a pilot basis. This legislation received bipartisan support and favorable committee action but was never sent to then-Governor Walker by the full Legislature. At the time, the state Medicaid program was pursuing multiple initiatives to transition Medicaid towards a more consumer-based, commercial insurance program. This may have complicated the DPC issue.

During the 2021-22 session, the Legislature passed Assembly Bill 26 to authorize the DPC model in the commercial sector (without the previous Medicaid provisions). However, Governor Evers vetoed the legislation, in part due to concerns regarding hypothetical patient discrimination by some practitioners. However, commercial insurers expressed additional concerns that the consumer protections within the DPC model may be insufficient, while also arguing it doesn't make financial sense for those who have coverage.

"For many individuals the math just isn't going to work. If you purchase both a direct primary care arrangement and a comprehensive insurance plan, you're going to be paying twice for a broad swatch of services," said Tim Lundquist, director of government and public affairs for the Wisconsin Association of Health Plans. Wisconsin Public Radio, (Direct Primary Care Arrangements Offer New Way To Pay For Routine Health Care, November 23, 2018)

## 2.4 Policy Recommendations

The Legislature should require the Wisconsin Medicaid program to establish a pilot program to integrate a DPC model for a select population within the Medicaid program. This pilot program could provide resources for a subset of Medicaid members to engage with direct primary care providers and establish metrics to indicate the impacts of the pilot, as well as direct the Medicaid program to address the "paying twice" dynamic described above. Integrating a DPC model within Medicaid may require federal approval through the Center for Medicare and Medicaid Services.

# 3. Reassess Wisconsin's Nursing Home Bed Limit

## 3.1 Background

The State of Wisconsin imposes a "Nursing Home Bed Limit" across the health care field, regardless of the payers (Medicaid, Medicare, Commercial, self, pay, etc.). This limit was apparently established in the 1980s, due to concerns regarding the "institutionalization" of patients when many could be better served in the community. This philosophy has grown in the decades since, as the goal of many home and community based services (HCBS) and long term care (LTC) programs has been to address patient and family needs in the home and community, to the degree possible. Wisconsin's FamilyCare and IRIS ("I Respect I Self-direct") programs are constructed around this philosophy.

This bed limit is governed by ch. 150.31 Wisconsin Statutes. This chapter articulates how the limit is determined and governed. This section, originally created in 1983, has been amended over the decades to address very narrow situations, such as the closures of various types of facilities, or conversions of facilities from one type of service provider to another.

The bed limit is further governed by substantive administrative rules promulgated and enforced by two divisions within the Department of Health Services (DHS): the Division of Medicaid Services and the Division of Quality Assurance (DQA). This regulatory structure is complex and leaves the industry and stakeholders with uncertainty regarding the bed limit and possible adjustments. For example, DMS

administers the actual bed limit, deciding on the reallocation of beds and formally managing the count of such beds in the state. However, DQA manages the licensing side of nursing homes. As such, when a potential buyer of a nursing home is working with DMS to manage the allocation of beds, that same buyer must work with DQA on licensing issues.

## 3.2 Problem

Long term care, which includes nursing home services, accounts for $4 billion of Wisconsin's $9.7 billion Medicaid program (SFY 2020). The elderly, blind disabled (EBD) population has a per member annual cost of $26,000 (2021 LFB info paper 43), the highest in the program. As noted above, the State has a statutorily imposed limit on the number of nursing home beds permitted to be licensed.

The data above is limited to the Medicaid program; it does not include the additional billion spent by the private/commercial sector.

The last two biennial state budgets have pumped over $325 million into nursing home reimbursement increases, under the guise of addressing staffing shortages and raising reimbursements that – allegedly - fail to cover costs. The pandemic has enhanced workforce pressures, and there is no end in sight to the financial demands. Simultaneously, there is a lack of accountability regarding the use of such funds: are these funds really solving the problems cited by the industry, and are these funds contributing to maintaining (increasing) the quality of care.

Even if the funds referenced above are being used appropriately, they do not address overall capacity of the nursing home system. This is a related but different problem discussed below.

## 3.3 Evidence

Moreover, from a clinical perspective, a shortage of nursing home space results in patients remaining in often higher cost facilities, such as outpatient hospitals, longer than is clinically – and financially - appropriate. This phenomenon has downstream effects on overall system capacity, filtering right down to individual patients facing a double whammy: lengthy delays in clinically necessary procedures, and potentially nowhere to be discharged to after hospital care has been completed (longer lengths of stay). These problems are only exacerbated by the Public Health Emergency and the various "waves" of Covid-19.

This is due in part to the capacity problem within the nursing home industry. As capacity has fallen, patients in hospitals needing additional care, but in a more appropriate setting, are forced to stay in the hospital. They can't be discharged without an open nursing home bed to accept them. In turn, hospitals are seeing longer lengths of stay, a key metric indicating quality of care and financial health of hospitals.

Nursing home bed capacity was a problem before the pandemic. However, the pandemic has clearly worsened this dynamic: over 400,000 health care workers

have left the field since February 2020 (Bureau of Labor Statistics), making the problem even more acute (pun intended).

According to Erik Swanson, senior vice president of data analytics at Kaufman Hall, a leading national health care consulting firm, "We've seen continual growth in length of stay since the beginning of the pandemic up to now." Large, nonprofit hospital and health care systems are reporting higher lengths of stay and lower discharges. These systems include such brand names as Providence, Intermountain, Sutter, Mass General Brigham and Advocate Aurora. For-profit systems are reporting similar results, including HCA Healthcare and UHS. (Healthcare Dive, "*How tight nursing home capacity is bottlenecking hospital operations*", October 4, 2022)

These longer lengths of stay impact the bottom line, as Medicare and many commercial insurance policies are paying a flat rate or bundled payment for certain conditions and procedures, regardless of the length of stay or the reasons for it. This eventually translates into "deteriorating" financial ratings for these large systems (Healthcare Dive, "*Outlook for nonprofit hospitals is 'deteriorating,' Fitch says*", August 17, 2022), which increases the costs of borrowing. All of these impacts bring a similar result for the consumer: higher costs.

## 3.4 Policy Recommendations

Revisit the rationale and continued relevance of the bed limit. Evaluate the impact of raising or eliminating the bed limit to foster competition, quality improvement, and balance in the continuum of care.

While it is not clear that such a policy initiative would quickly alleviate the very real labor shortages in the health care field broadly and nursing homes specifically, this recommendation could provide greater flexibility for hospitals to address the problem in different ways. This includes building and staffing their own facilities, partnering with other healthcare stakeholders, or modifying the relationship with the nursing home industry.

Such a solution may not have been considered just a few years ago. However, there is a critical need to allow market forces and competition to constructively disrupt the field and allow new approaches. This can only occur if state laws and regulation are modernized to recognize the need for new solutions.

# 4. Increase Medicaid MCO Accountability, Quality and Competition

## 4.1 Background

Wisconsin's Medicaid program utilizes managed care organizations (MCOs) or health maintenance organizations (HMOs) to maintain responsibility for the care provided

to Medicaid members. Wisconsin contracts with 14 MCOs in the BadgerCare Plus program (children, parents and caregivers, pregnant women, childless adults), and supplemental security income (SSI) program, typically with 2-3 MCOs in each region. This is done through a "certification" process, rather than an RFP process common in other states.

These MCOs are held to quality standards in six major areas (four for SSI, as indicated), per the Wisconsin Department of Health Services HMO Report Card:

- Staying Healthy: reflects immunization for children, breast cancer screening for women;
- Living with Illness: reflects controlling blood pressure, and testing and controlling HbA1c levels for diabetic patients;
- Mental Health Care: reflects care for depression, alcohol and other drug dependence, tobacco counseling, and follow-up care provided after discharge from hospital for mental health;
- Pregnancy & Birth-related Care (BC+ only): reflects timely care provided to women before and after birth;
- Emergency Department Visits: reflects visits members made to the ER (fewer visits are better);
- Dental Care (BC+ only): reflects dental care for children and adults provided through HMOs in southeastern Wisconsin.

DHS includes a "Pay-For-Performance (P4P) Withholds in its Medicaid program. This means each HMO faces a potential loss of up to 2.5% of premium revenue from the State if it fails to achieve various quality benchmarks. However, the BadgerCare Plus HMOs have earned back "at least 74% of the P4P withhold from 2011 to 2019 in aggregate," (WI DHS, *Calendar Year 2022 Capitation Rate Development*, December 15, 2021). This same document indicates that the State actuary, Milliman, believes "the P4P withholds are reasonably achievable by the HMOS during the 2022 contract period."

In addition, DHS implemented a "potentially preventable readmission" (PPR) incentive payment program in 2018 that continued in 2022, offering a maximum of 5% of the capitation rate for achieving certain standards. This mechanism is designed to foster collaboration with providers and the HMOs. As such, for any incentive earned by an HMO, 85% must be shared with providers.

Each HMO is then assigned a "star rating" from one to five stars, with five being the best. Below is a screenshot of the 2019 version (latest available on DHS website):

2 of 6

**Wisconsin Department of Health Services**

**2019 HMO Report Card**

***BadgerCare Plus HMO Ratings***

| BadgerCare Plus HMO | Staying Healthy | Living with Illness | Mental Health | Pregnancy & Birth | Emergency Department | Overall (out of 5) |
|---|---|---|---|---|---|---|
| Anthem Blue Cross Blue Shield | ★★★★ | ★★★ | ★★★★ | ★ | ★★ | 2.8 |
| Children's Community Health Plan | ★★★★ | ★★★ | ★★★★★ | ★★★★ | ★★ | 3.8 |
| Dean Health Plan | ★★★ | ★★★★ | ★★★★ | ★★★★★ | ★★★★★ | 3.8 |
| GHC - Eau Claire | ★★★★ | ★★★ | ★★★★★ | ★★ | ★★★★ | 3.5 |
| GHC - South Central | ★★★★★ | ★★★ | ★★★★★ | ★★★★ | ★★★★★ | 4.2 |
| Independent Care Health Plan | ★★★★ | ★★★ | ★★★★ | ★★★★ | ★ | 3.3 |
| MercyCare Insurance Company | ★★★ | ★★★★ | ★★★ | ★★★★★ | ★★ | 3.4 |
| MHS Health Wisconsin | ★★★ | ★★ | ★★★★★ | ★ | ★ | 2.8 |
| Molina Healthcare | ★★ | ★★★ | ★★★ | ★★★ | ★ | 2.7 |
| My Choice Wisconsin Health Plan[2] | ★★ | ★ | ★★ | ★ | ★ | 1.5 |
| Network Health Plan | ★★★ | ★★★ | ★★★★★ | ★★ | ★★ | 3.1 |
| Quartz | ★★★★ | ★★★★★ | ★★★★ | ★★★★★ | ★★★★★ | 4.5 |
| Security Health Plan | ★★★★ | ★★★★★ | ★★★★ | ★★★★★ | ★★★★★ | 4.3 |
| United Health Care Community Plan | ★★★★ | ★★★★★ | ★★★★★ | ★★★★ | ★★★ | 4.3 |
| **All Wisconsin BC+ HMOs [1]** | ★★★★ | ★★★ | ★★★★ | ★★★ | ★★★ | 3.6 |

*1=Wisconsin state-wide average compared to applicable national benchmark.*
*2=MyChoice Wisconsin Health Plan for BadgerCare Plus was previously named Trilogy Health Insurance.*

September 9, 2021

## 4.2 Problem

The MCOs typically remain constant, with few, if any, new entrants into the market. It is unclear if the current withhold and quality standards are driving improved performance or greater market competition.

## 4.3 Evidence

Market consolidation through mergers and acquisitions and partnerships have increased the difficulty of entering the market while fostering an environment where the providers and insurers are often owned by the same entity. These factors have reduced competition and contribute to an environment of limited quality improvement and increasing costs.

## 4.4 Policy Recommendations

Wisconsin Medicaid should pursue more aggressive withhold and P4P strategies with HMOs/MCOs. While there are actuarial limitations to such strategies, the State should explore greater mechanisms for holding HMOs/MCOs accountable for improved patient care and population health. This could be achieved through greater "downside" risk combined with further incentives. However, such programs should be structured to achieve a "zero sum" competition among MCOs/HMOs,

particularly if the State intends to continue the certification system currently employed.

In addition, the State should explore a more aggressive certification system, with enhanced quality standards aimed at Wisconsin-specific health concerns, such as diabetes, children's and adult mental health, substance use disorder, health equity, and potentially Social Determinants of Health Care.

This mechanism could be utilized to reduce the number of HMOs/MCOs in the Medicaid program. However, simply reducing the number of HMOs/MCOs is unlikely to improve quality and/or reduce costs unless it is coupled with specific, targeted quality improvement and financial strategies.

While a full procurement with a formal request for proposals (RFP) process could be pursued to similarly reduce the number of MCOs/HMOs, such processes can be lengthy and costly. In addition, the "losers" in such procurements often file appeals – and occasionally legal challenges. These factors add uncertainty regarding implementation and program direction.

# 5. Conduct 3rd Party Analysis of Wisconsin Medicaid Rx Purchasing Efficiency, and adopt Outcomes-Based Purchasing for Gene Therapies and Other High Cost Drugs and Therapies

## 5.1 Background

Prescription drugs are an optional benefit under Medicaid, meaning states can choose NOT to include prescription drugs in the Medicaid benefit package. However, all states provide such coverage for a number of largely obvious reasons. Medicaid programs also receive the "best price" from manufacturers, administered through the Medicaid Drug Rebate Program (MDRP). In turn, every drug approved for use by the federal Food and Drug Administration (FDA) is covered by Medicaid.

While prescription drug expenditures receive significant media and stakeholder attention, under the assumption that prices and expenditures are steadily rising.

The table below indicates NET expenditures growing at a significant rate in a short time, from state fiscal year 2018 (SFY18) to SFY20:

| | Gross Expenditures | Manufacturer Rebates | NET EXPENDITURES |
|---|---|---|---|
| SFY18 | $1,139 million | $837 million | $302 million |
| SFY20 | $1,355 million | $723 million | $632 million |

This increase can be driven by new drugs coming to market. For example, antidiabetics spending (before rebates) grew by 53% from 2015 to 2019, driven by spending on newer, non-insulin antidiabetic drugs (Kaiser Family Foundation, Utilization and Spending Trends in Medicaid Outpatient Prescription Drugs, 2015-2019. Similarly, per the same study, Opioid prescriptions used to treat pain declined 41% over the same period, while prescriptions to treat opioid addiction and overdose increased.

State Medicaid programs utilize varying mechanisms to purchase prescription drugs (National Council of state Legislatures, "*Medicaid Prescription Drug Laws and Strategies*", August 2021). These include:

- "carve-in", where the managed care organizations (MCOs) purchase the drugs and the cost is addressed in the per-member-per month (PMPM) rate-setting structure (most states);

- "carve-out", where such purchases are managed by the State rather than the MCOs (**WI**, MO, TN, WV);

- "carve-in" with exceptions, where states generally utilize the MCOs, but carve out certain drugs or categories of drugs (IN, MI, SC, WA, MD).

The Wisconsin "carve-out" system has been sustained over decades and across administrations of both parties. Given the shifting foundation of drug and therapy development and overall cost pressures that are likely to become more acute, it should no longer be assumed that Wisconsin is getting the most out of its prescription drug/therapies dollars.

Simultaneously, new gene therapies are being developed and approved for the market for certain rare conditions, including hemophilia, spinal muscular atrophy, and certain cases of vision loss. However, such treatments can cost in the millions of dollars, even as they replace traditional drugs and offer revolutionary patient improvements. Such clinical advancements need corresponding financial and analytical methodologies.

To maximize value both for the patient and for taxpayers supporting Medicaid programs, some states are pursuing "outcomes-based arrangements" (OBAs) or value-based purchasing for higher cost drugs and therapies. However, such arrangements are complicated by federal regulations. According to the Campaign for Transformative Therapies (CTT), "*Oucomes-Based Arrangements: A Sustainable Financing Option for Transformative Therapies and a Review of State Activity*" (March 2022), 11 states have addressed this challenge by requesting permission from the federal Centers for Medicare and Medicaid Services (CMS) to enter into such arrangements with manufacturers through Medicaid State Plan Amendments (SPAs). These SPAs are less complicated than federal rules regarding VBC. However, it should be noted that both the Trump and Biden Administrations have

implemented regulatory changes to ease the process, even as more states pursue SPAs.

## 5.2 Problem

Prescription drug prices continue to climb. One-half of all drugs covered by Medicare in 2020 had price increases above the rate of inflation. More specifically, 33% of those drugs saw price increases of up to 7.5%, while 17% of those drugs saw price increases exceeding 7.5% (Kaiser Family Foundation, Prices Increased Faster Than Inflation for Half of all Drugs Covered by Medicare in 2020, February 25, 2022).

However, federal policy in general has been to impose price controls, including recent changes to Medicare enacted in the so-called Inflation Recovery Act (The White House, *Inflation Reduction Act Fact Sheet*, October 14, 2022):

- $35 monthly maximum per monthly insulin prescription;
- $2,000 maximum out-of-pocket for prescription drugs; and
- Additional mandatory rebates from drug manufacturers that raise prices more than inflation.

Such measures fail to address the costs of research and development of new drugs and treatments. According to The Hill, US Drug Prices Higher Than Rest of the World, Here's Why (January 19, 2018), "only 1 out of every 12.5 potential drugs ever reach patients, the average drug takes 11-14 years to develop, and the costs of bringing a drug to market range from $1 to $2.6 billion".

Further, several studies (including the National Library of Medicine, National Center for Biotechnology Information, "US Pharmaceutical Policy in a Global Marketplace") suggest that the benefit of lower prices today is offset by the forgone value created by drugs that never reach the market. According to one estimate, if the U.S. were to adopt European-level price controls, the reductions in U.S. prices today would result in 0.7 years lower longevity for future cohorts of Americans and Europeans due to fewer new drugs.

Notwithstanding the market dynamics, Medicaid programs must confront the challenges of numerous new drugs and gene therapies coming to market in the next few years, some with prices in the millions. Wisconsin's Medicaid program has not yet addressed these high-cost situations, choosing be default to manage such serious situations on a case-by-case basis. This is sustainable in the short term only.

## 5.3 Evidence

As referenced, Wisconsin is one of four states that largely "carve out" the prescription drug benefit from its managed care program, preferring to purchase prescription drugs "on its own", with the advice of pharmacy management consultants and some pooling arrangements. This might be effective, but it is a dated model with little transparency, particularly as more expensive genetic and other therapies are

brought to market, and as value-based purchasing gains acceptance by manufacturers, the federal government, and Medicaid programs nationally.

In addition, while complex, federal rules regarding value-based care are evolving, the issue has become largely bipartisan. This is encouraging, as it demonstrates the federal government recognizes at least some of the scientific and market dynamics in play on such issues. In fact, the federal Centers for Medicare and Medicaid Services (CMS), has indicated it plans to take a "…'hands off' approach to the VBP arrangements between states and manufacturers…" (Government Contractors Navigator, *The Medicaid Drug Rebate Program and Value-Based Purchasing*", March 29, 2022).

## 5.4 Policy Recommendations

Require a third-party analysis of the Wisconsin Medicaid drug purchasing and rebate processes, and evaluate the opportunities for value-based purchasing for "high cost" drugs and therapies. While it is possible the current processes are performing well, a third-party review will, at a minimum, apply up-to-date processes and techniques while providing transparency that may encourage manufacturers to come to the table in different ways.

In addition, Wisconsin should submit a SPA to CMS to enable outcomes-based arrangements for unusually expensive drugs and therapies, as well as more traditional therapies where other states and manufacturers have already demonstrated constructive collaboration.

# 6. Establish Consumer-Friendly Transparency

## 6.1 Background

For decades, the liberal political philosophy has been the expansion of government-sponsored health care coverage, such as Medicaid and Medicare. In recent years, political initiatives such as "ObamaCare" and "Medicare for All" have dominated the health care debate. More extreme versions of such initiatives are focused on a "single-payer" system: essentially, the federal government managing all of our care, determining coverages, paying providers, and determining prices.

Over those same decades, the conservative philosophy has been centered on consumer choice, transparency of pricing and costs, tax mechanisms to encourage the purchase of coverage (health savings accounts), and opposing the expansion of government coverage programs.

From a practical perspective, government programs continue to dominate the market, as coverage and payment trends in the commercial market generally follow Medicare policy. This applies to new clinical services, drug pricing, and the facilities where procedures are performed.

"Transparency" in health care and health insurance has been discussed and debated for literally decades. Multiple Wisconsin legislatures have attempted to bring clarity to the issue, such as 2009 Wisconsin Act 146, requiring reporting by insurers and providers regarding certain charges. In addition, various federal initiatives have also been debated and, on occasion, enacted through legislation or rule. This includes new rules under the Trump Administration: the Calendar Year 2020 Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule, and the Transparency in Coverage Rule (similar to the rule for providers but applicable to insurers). Alternatively, providers, insurers, and related state associations have established their own versions, such as the Wisconsin Hospital Association's PricePoint.

The Wisconsin Institute for Law and Liberty (WILL), published a report in October 2022, "Empowering Patients: How Price Transparency Will Lower Healthcare Costs". This report included references to measures passed in other states. These include items requiring insurers to provide out-of-pocket cost estimates upon request within 7 days (Florida), or through a public website (Tennessee). Similarly, Nebraska requires providers to provide cost estimates for uninsured and self-pay patients.

## 6.2 Problem

Despite these efforts, consumers remain frustrated with health care costs, and numerous polls in advance of the Fall 2022 election indicate such perspectives. For example, a Gallup poll indicated 87% of Americans rate a candidate's plan for reducing health care prices as "very" or "somewhat" important. The same poll indicated this issue can potentially drive voters to cross party lines, as 39% indicated it is very or somewhat likely they would cross party lines on this issue.

Regardless of polling and politics, most consumers simply are unable to "shop around". Their coverage is determined by their employers, and their "choice" of providers is limited to their health plan "options", if any. For example, if an employer selects a health plan for its employees, those employees can only see the providers that are "in network" for that health plan, or face massive and unrealistic "retail" costs for an out-of-network provider driven by consumer preference.

This limits the value of current transparency mechanisms and initiatives, even those that are well-intended.

## 6.3 Evidence

These laws, rules, regulations, and private sector initiatives have at least partially pulled back the curtain on provider and insurer pricing. However, these initiatives have not succeeded in fostering enhanced competition among such entities, nor are they truly allowing consumers (patients) to "shop around" as they do for groceries, clothing, auto mechanic services, home repair, etc. While there are areas where consumers can apply basic economic principles to their health care, they are typically limited to non-urgent procedures and services, or items generally not

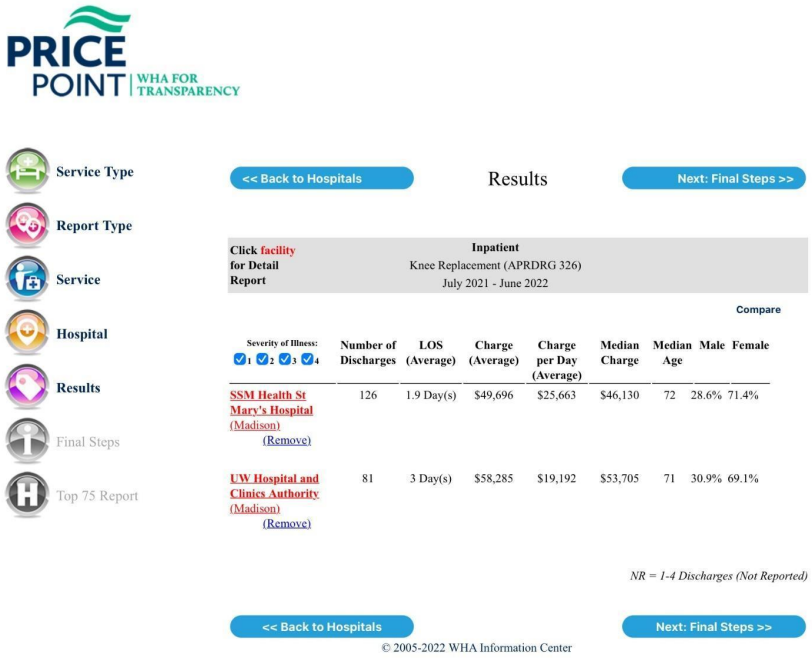
covered by insurance (high-end vision correction procedures, cosmetic procedures, some high-level imaging services). Moreover, hospital and insurer compliance with federal requirements has been low (Health Affairs, September 12, 2022).

For example, 2009 Wisconsin Act 146, according to the Wisconsin Department of Health Services (DHS), "specifies requirements for hospitals, insurance plans, health care providers, and the Department of Health Services (DHS) related to disclosure of information about the cost and quality of health care services" 2009 Wisconsin Act 146 | Wisconsin Department of Health Services. However, this legislation focuses on "billed charges", exclusive of discounts typically applied when a person's health insurance is applied. Therefore, it is of limited value to a consumer on a day-to-day basis. Notwithstanding this challenge, the legislation has helped foster an improved culture of transparency and consumer empowerment in the health care field.

At the federal level, the Trump Administration rules referenced above were considered groundbreaking by some, as these rules were designed to truly pull back the curtain on hospital and insurer prices, and various contracting policies. These rules, ironically, built upon an often-forgotten requirement of the ACA that hospitals, "make public a list of the hospital's charges".

According to the American Legislative Exchange Council's (ALEC) Brooklyn Roberts (July 12, 2021), the Trump rules went a significant step further to define such information as, "charges and information based on negotiated rates and for common or shoppable items and services." Further, such information must be reported, "in an easy-to-understand, consumer-friendly, and machine-readable format using…standards that will meaningfully inform patients' decision-making and allow patients to compare process across hospitals." However, provider and insurer compliance has been low: by April 2021, 32% of hospitals had not posted any of the required data. Further, a Health Affairs study from March 2021 found 65 of the largest 100 hospitals were "unambiguously non-compliant". Regardless, the Biden Administration has kept these rules in place.

Even the WHA PricePoint tool, which contains insightful and useful information regarding prices as well as relatively simple methods of comparison, provides consumers with limited data upon which to make decisions. Here is a screenshot of the website illustrating a comparison for knee replacement at UW Hospital and at St. Mary's Hospital, both in Madison. While the data is fascinating and shows identifiable and useful differences, very few consumers will utilize this tool if their health plan only provides access to one provider, or the other.




# 6.4 Policy Recommendations

Adopt one or more models of more consumer actionable transparency, including models from other states. In addition, establish regulatory mechanisms in Wisconsin to enhance compliance with federal requirements. This could include penalties on hospitals and insurers that are failing to comply with the Trump/Biden rules. Such penalties could be financial (and severe). Additional or alternative penalties could include ineligibility to participate in Medicaid, the Exchange, and/or state employee health programs.

Laws and regulations requiring hospitals and providers to offer out-of-pocket cost estimates are valuable, and many insurers are already providing such tools for their members. While such information does not directly lower the costs of health care and correspondingly the cost of purchasing coverage, it does give consumers more information and, therefore, more reason and motivation to discuss both the necessary care, and cost of such care, with their providers and insurers.

# APPENDIX

## Section 1: Expand the Scope-of-practice (SOP) of Nurse Practitioners (NP) in Wisconsin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