POLICY BRIEF:

INCREASING HEALTH CARE CHOICE AND COMPETITION IN WISCONSIN

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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:
  a) Offer enrollees adequate choice and access to providers.
  b) Allow health plans to meet the needs of heterogeneous populations and account for different program characteristics, degrees of rurality, and constraints with workforce supply.
  c) 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:
  a) 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.
  b) 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

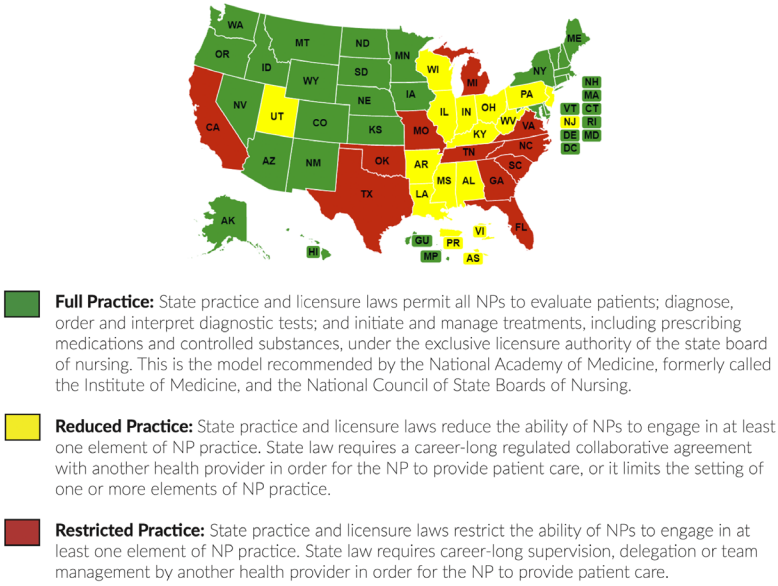
1.1 Background

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



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

During the COVID-19 pandemic, in order to address the health workforce shortage, a number of states temporarily expanded the SOP 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

[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

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.

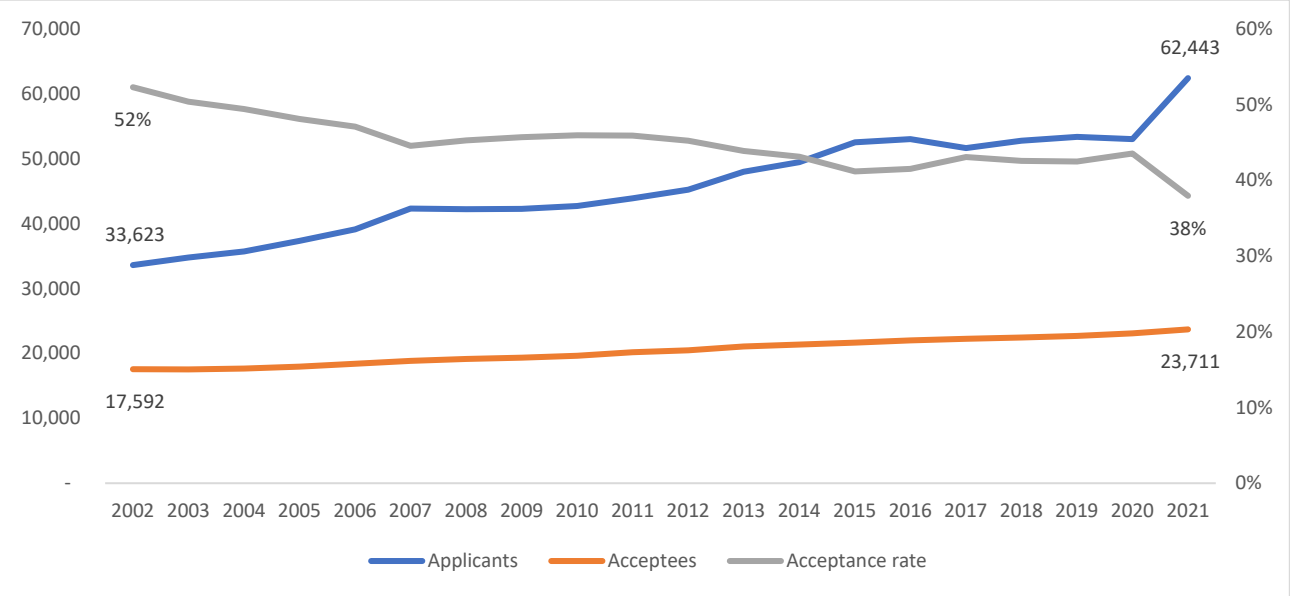
"Credentialing" functions within hospitals and health plans is another barrier that adds cost and time to the hiring process. Is this something to address, and is there any data on the issue?

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).

[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.

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

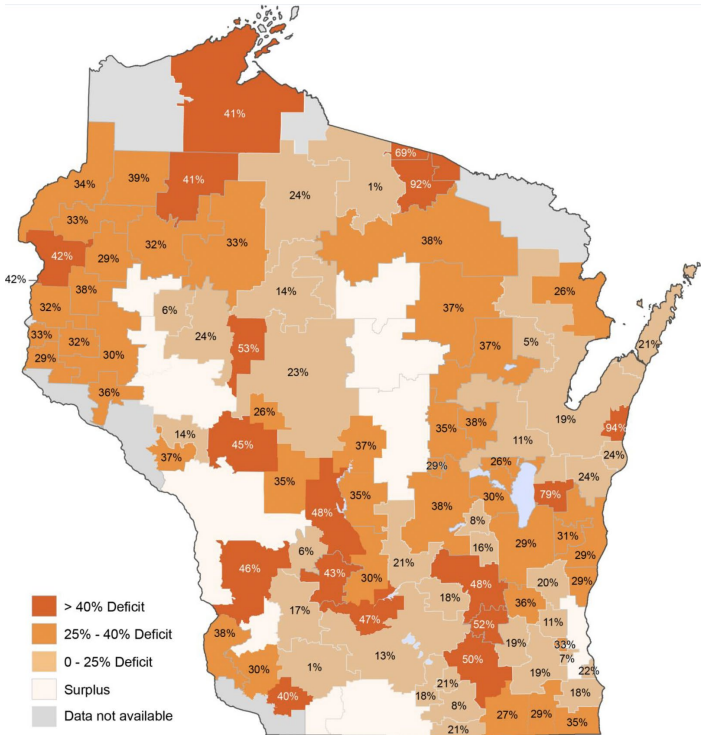
At the same time the amount of MD students is stagnant, due to aging, population growth, and a greater insured population following the Affordable Care Act (ACA), physician availability to patients has been recognized as one of the top barriers to meet the healthcare needs of patients in the US: the 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).

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 organizations[3] 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).

[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.

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:

a) Workforce Mobility

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).

b) 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).

c) 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 loweing 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):

a) 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.
b) 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).
c) 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.
d) 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 personal emergency response systems services will meet the standards for provider to member ratios, the

[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

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
  a) 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.

b) 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.

c) 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 waiver[5]. 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.

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

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 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

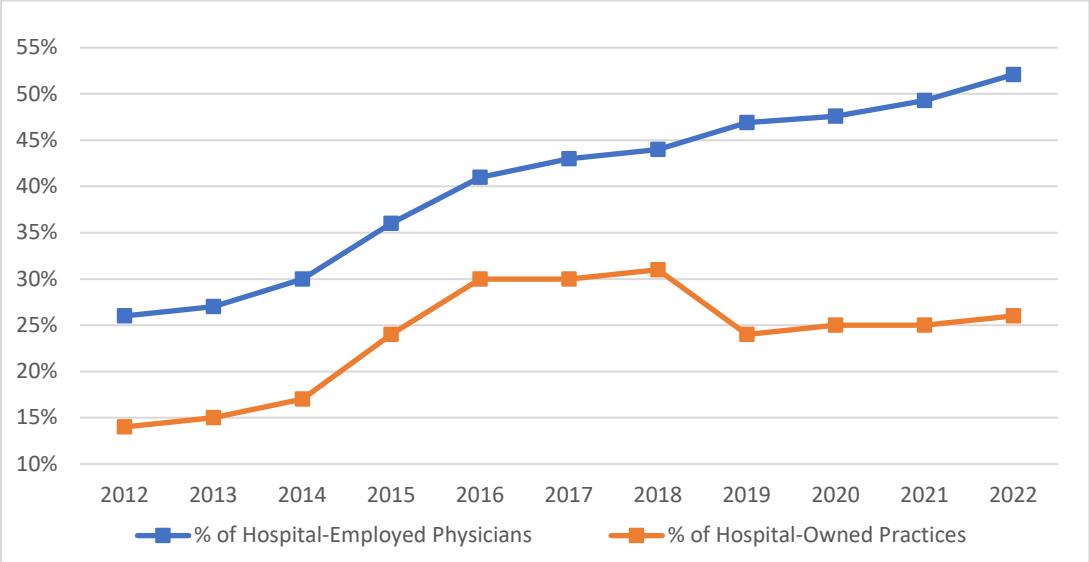
CMS implements the law providing general parameters for how each type of provider is paid and develops detailed elements of different payment systems. The core elements of the systems are generally the same: payment is based on a set rate payment, which is calculated from the average cost of providing 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 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

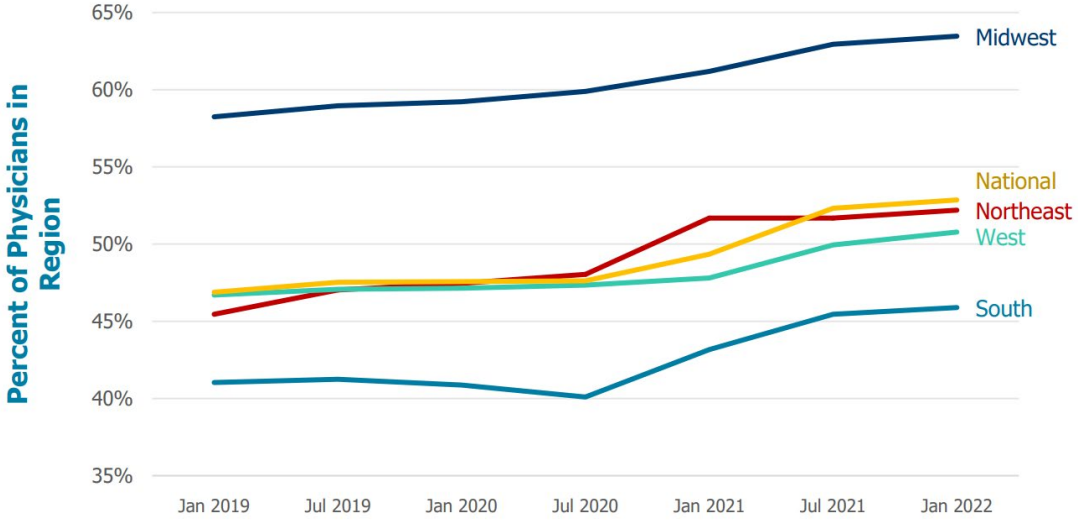
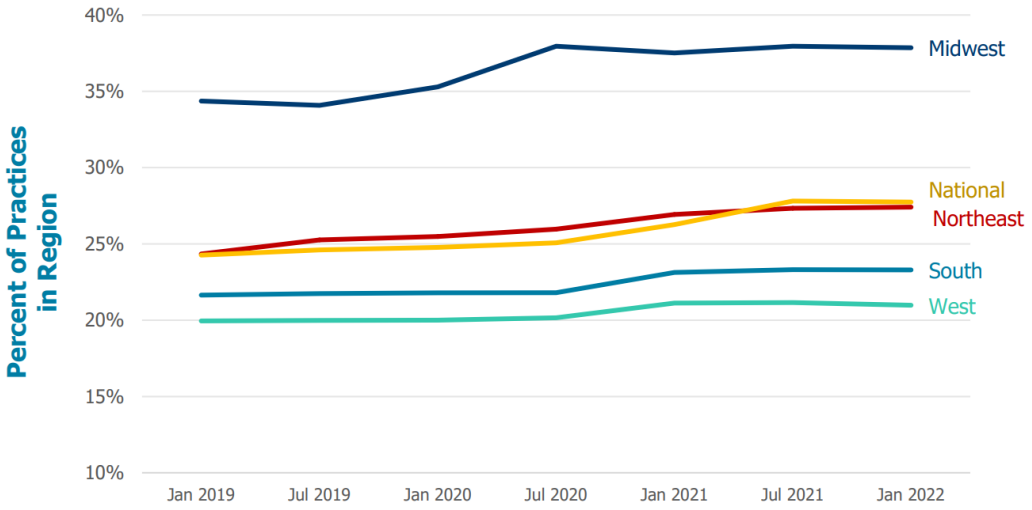


Figure 2b: Percent Hospital-Owned Practices by Region: Midwest vs. Other Regions



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'

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

Category	Sub-category	FY 2021
Acute Care	Inpatient Hospital	$ 471.2
	Physician	$ 60.4

[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 x

Category	Sub-category	FY 2021	
	Outpatient Services	$	459.4
	Prescribed Drugs	$	540.9
	Other Services	$	1,005.1
	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.

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