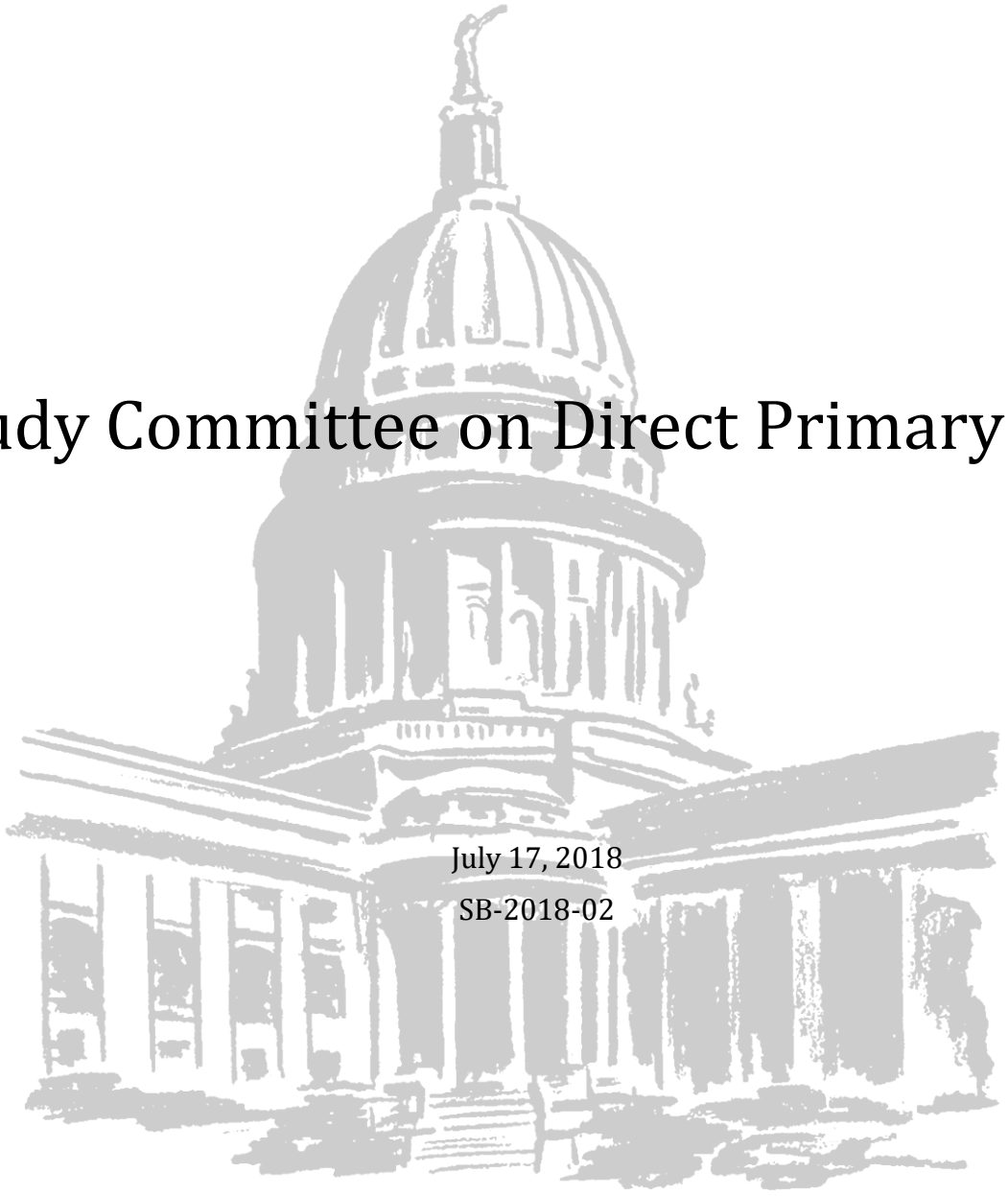
Legislative Council Staff Brief



Study Committee on Direct Primary Care

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INTRODUCTION

The Study Committee was formed to review the use of ***direct primary care (DPC)*** as a health care delivery option. Generally, DPC refers to an arrangement between a health care provider and a patient in which the provider agrees to provide an unlimited amount of primary care services for a monthly fee. State insurance laws do not apply, as the Office of the Commissioner of Insurance (OCI) does not recognize DPC as an insurance arrangement. Other states have similarly exempted DPC from insurance regulation, and some states have passed laws to create a regulatory framework for DPC practices. At the federal level, the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) has announced it will consider ways to incorporate DPC and other direct provider models into the Medical Assistance (MA) program. Several states' DPC laws include mechanisms to test or promote the use of DPC in the MA program. In Wisconsin, a DPC bill was considered during the 2017-18 Legislative Session that also included such a provision.

Against this backdrop, the Study Committee is directed to:

1. Assess the potential impact of DPC on the health care delivery system and health outcomes in the state.
2. Recommend legislation regarding requirements for DPC practices in the private market.
3. Assess the potential impact of DPC on the functionality, efficiency, and effectiveness of service delivery in the MA program, and health outcomes in the MA program.[1]
4. Recommend legislation regarding a DPC pilot in the MA program, including an evaluation of its impact on service delivery and health outcomes.

This Staff Brief provides background information, summarizes current law, and identifies considerations that may arise as the Study Committee carries out its assignment.

- **Part I** describes the emergence of DPC as a health care delivery option.
- **Part II** provides information relating to the use of a DPC model in the private market, including background information about the regulatory environment affecting health care and insurance.
- **Part III** provides information relating to the use of a DPC model in the MA program, including background information about relevant features of Wisconsin's MA program.

This Staff Brief was prepared by Brian Larson, Senior Staff Attorney, and Andrea Brauer, Staff Attorney.

[1] The phrase "potential impact" in this portion of the study assignment refers to both the fee-for-service (FFS) and managed care parts of the MA program.

PART I – DPC AS A HEALTH CARE DELIVERY MODEL

The DPC model has received attention as an alternative health care delivery option, in response to increasing complexity and financial pressures within the health insurance market. There are currently numerous DPC practices in Wisconsin, and approximately 25 states have enacted DPC legislation.

WHAT IS DPC?

In a DPC practice, physicians or other health care providers enter into a contract to directly charge patients for primary care services. Typically, the provider agrees to provide an unlimited amount of a list of primary care services for a monthly fee, and does not generally charge the patient any co-pays, deductibles, or other fees beyond the monthly fee for covered services. Generally, the provider also agrees not to charge an insurance company or other third party for services provided.

Proponents of the DPC model emphasize that DPC is not health insurance. The approximately 25 states that have enacted DPC legislation generally exempt DPC from regulation under state insurance laws. In Wisconsin, OCI does not recognize DPC as an insurance arrangement, in part because it does not involve risk distribution, as that term is used in s. 600.03 (25) (a) 1., Stats.[2] As a result, even though Wisconsin law does not define the term "direct primary care" or expressly exclude DPC from insurance, health care providers in Wisconsin can currently operate DPC practices, which are not subject to regulation under state insurance laws.

Each DPC practice operates according to the terms of the contract between the patient and the provider, or the DPC agreement. The DPC agreement identifies the fee amount, the frequency of payments, the primary care services that are covered under the fee, and any other terms that the parties wish to include, such as the duration of the agreement, conditions under which the agreement may be cancelled, medications that are covered under the fee, referral policies, or the provider's hours of operation. Currently, Wisconsin law does not specifically regulate the terms of DPC agreements.

[2] Section 600.03 (25) (a), Stats., provides that: (a) "Insurance" includes any of the following:

1. Risk distributing arrangements providing for compensation of damages or loss through the provision of services or benefits in kind rather than indemnity in money.

2. Contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction.

3. Plans established and operated under ss. 185.981 to 185.985.

4. Coverage, including stop-loss coverage, of an employer or plan sponsor relating to claims incurred under the employer's or plan sponsor's self-funded employee welfare benefit plan, as defined in 29 U.S.C. s. 1002 (1).

(b) "Insurance" does not include a continuing care contract, as defined in s. 647.01 (2).

DPC practices do not provide comprehensive health care coverage. A person who purchases a DPC plan would need to purchase a separate health insurance plan if he or she wanted to have coverage for items beyond primary care--or more specifically, items not included in the DPC agreement.

STATE DPC LEGISLATION

Wisconsin

DPC legislation was introduced in Wisconsin during the 2017-18 Legislative Session as companion bills 2017 Assembly Bill 798 and 2017 Senate Bill 670. An amended version of the Assembly bill passed in the Assembly, but the Senate did not concur. The bill as passed by the Assembly specifically excluded DPC from regulation under state insurance law, and defined it to mean "a contract in which a health care provider agrees to provide routine health care services for an agreed-upon fee and period of time." Routine health care services were defined to mean "screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and treatment for the purpose of promotion of health or the detection and management of disease or injury."

DPC Agreements in the Private Market

In the private market, the bill as passed by the Assembly authorized any health care provider, as that term is used in s. 146.81 (1) (a) to (p), Stats., to enter into a DPC agreement with an individual patient, or with a patient's legal representative or employer.[3]

The bill as passed by the Assembly also required the contract for the DPC agreement to disclose the following information: (a) the type and quantity of services covered under the agreement; (b) the fee for the DPC arrangement; (c) that the agreement is not health insurance and may not satisfy coverage requirements under federal law; (d) that the patient must pay for any services provided which are not included in the DPC agreement, or covered under a different insurance plan; (e) that the DPC provider may not bill an insurer or other third party on a FFS basis; (f) the circumstances under which the agreement may be terminated; and (g) that the patient is encouraged to consult with his or her health insurance carrier before entering into the

[3] More specifically, the following health care providers were authorized to enter into a DPC agreement:

- The following **individual licensees**: nurses, chiropractors, dentists, physicians, physician assistants, perfusionists, respiratory care practitioners, physical therapists, physical therapist assistants, podiatrists, dietitians, athletic trainers, occupational therapists, occupational therapy assistants, optometrists, pharmacists, acupuncturists, psychologists, social workers, marriage and family therapists, professional counselors, speech-language pathologists, audiologists, speech and language pathologists, massage therapists, and bodywork therapists. These licensees would still be subject to the scope of practice requirements associated with licensure.
- The following **organizations**: a partnership, corporation, or limited liability company of any of the provider types described above; a licensed hospice; a cooperative health care association that directly provides services through salaried employees in its own facility; an inpatient health care facility; a community-based residential facility; or a rural medical center.

agreement, since some services may already be covered under the insurance plan, and DPC fees may not be credited towards deductibles or out-of-pocket maximums under the insurance plan.

In addition, the bill as passed by the Assembly prohibited DPC providers from discriminating in selecting patients based on a list of factors including age, health status, and pre-existing conditions. It also stated that DPC providers may base their fees on age, but did not specifically state that fees may not be based on other factors.

Finally, the bill as passed by the Assembly specified that DPC providers who wish to be part of an insurance network must still comply with the insurance carrier's terms of participation.

DPC Medicaid Pilot Program

The companion bills as originally introduced required the Department of Health Services (DHS) to contract with one or more primary care providers to implement a DPC program within the state's Medicaid program. They also required DHS to enter participants into a DPC agreement to receive routine health services from one of these providers for a monthly fee, as specified in the agreement. After program implementation, DHS would be required to submit annual reports to the Legislature.

The bill as passed by the Assembly removed these provisions and instead required DHS to convene a work group to propose a DPC pilot program. DHS was required to introduce legislation following a hearing held on the proposal. The work group was also directed to submit a report regarding implementation of an "alternative payment model" for potentially preventable hospital readmissions of Medicaid recipients.

Other States

West Virginia was the first state to enact DPC legislation, through a pilot program that began on July 1, 2006. [W. Va. Code s. 16-2J-1, *et seq*. (2006).] Since then, about half of the states have enacted legislation exempting DPC practices from state insurance law and creating a separate framework for regulating DPC. While each of these states' laws speak to DPC agreements sold on the private market, only a smaller share have addressed the use of DPC in state Medicaid programs. Experiences in the States of Washington and Michigan aimed at testing or promoting the use of DPC in state Medicaid programs are described in more detail in Part III of this Staff Brief.

The Direct Primary Care Coalition, a national organization that seeks to expand the use of DPC, has created model legislation, which proposes regulations for the use of DPC on the private market, and bears some similarities to legislation that states have enacted.[4] Although there is variation between the specific provisions, other states' laws generally address the following factors:

- **Definition of primary care.** Each DPC practice covers only the primary care services that are identified in the agreement, but states can still delineate the scope of DPC agreements by defining the concept of primary care. Many states incorporate the definition recognized by HHS: "routine health care services, including screening,

[4] The model legislation is available at: https://www.dpcare.org/dpcc-model-legislation.

assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury." [76 Fed. Reg. 41900 (July 15, 2011).] Other states have adopted different definitions. Iowa and Texas define primary care to mean "general health care services of the type provided at the time a patient seeks preventive care or first seeks health care services for a specific health concern," including a list of services such as care that promotes health or prevents disease, treatment of acute conditions, or coordination of care. [Iowa Code, s. 135N.1.1.g.; Texas Occ. Code s. 162.251 (5).][5]

- **Who may enter into a DPC agreement?** States vary with regard to the range of health care professionals who may offer DPC services. Alabama's DPC law applies to physicians or dentists,[6] whereas some states allow any licensed health care provider to practice DPC. States also vary with regard to whether DPC agreements must be directly between an individual provider and an individual patient, or whether it can be between groups of individuals. In Washington, for example, providers or groups of providers may enter into a DPC agreement with individual patients only, and not with groups of subscribers. [Wash. Rev. Code, s. 48.150.110.] Other states' laws are more permissive.

- **"Anti-discrimination" provisions.** Many states prohibit DPC providers from declining to accept patients based on health status, or other factors that are deemed discriminatory. Washington's law provides that a DPC provider may only decline a patient based on his or her health status if the practice has reached its maximum capacity, or if the provider is unable to adequately care for the patient based on his or her health condition. [Wash. Rev. Code, s. 48.150.050 (1).] Some states also prohibit DPC providers from setting fee rates based on health status, although it appears that rates often vary by age group. In Wisconsin, it seems possible that DPC providers who choose patients or set rates based on health status could be viewed as engaging in risk assessment, in which case the practice may fall within the definition of insurance.

- **Required Disclosures.** States generally specify a list of disclosures that must be included in the DPC agreement. The required disclosures are often similar to those required in 2017 Assembly Bill 798, as passed by the Assembly. Some states require fewer disclosures, and some require more. Iowa requires each DPC agreement to include the following language:

> NOTICE. This direct primary care agreement is not health insurance and is not a plan that provides health coverage for purposes of any federal mandates. This direct primary care agreement only covers the primary care health services described in this agreement. It is recommended that you obtain health insurance to cover health care

[5] As a point of comparison, DHS's contract with managed care providers in the MA program describes primary care as "both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions," and states that "the primary care provider is a person formally designated as primarily responsible for coordinating the services accessed by the member." [BadgerCare Plus and Medicaid SSI Contract for Jan. 1, 2018 – Dec. 31, 2019, effective Jan. 1, 2018, p. 25.]

[6] Alabama Physicians and Dentists Direct Pay Act, 2017 Al. SB 94.

services not covered under this direct primary care agreement. You are personally responsible for the payment of any additional health care expenses you may incur. [Iowa Code, s. 135N.1.2.a.(11).]

- **Charges to third parties.** Some states prohibit DPC providers from charging insurance companies or other third parties for services performed under the DPC agreement, although they may generally charge for services provided outside the scope of the agreement. In Iowa, DPC providers may accept payment either directly or indirectly from a third party, including an employer. [Iowa Code, s. 135.N.1.7.]
- **Terminating the agreement.** States vary with regard to the conditions under which a DPC agreement may be terminated. Indiana allows the contract to be terminated at will by either party. [Ind. Code, s. 25-1-10-5 (3).] The model legislation proposed by the Direct Primary Care Coalition suggests that states prohibit DPC practices from discontinuing patients solely because of the patient's health status.

PART II – DPC AND THE PRIVATE MARKET

This Part of the Staff Brief provides background information about the regulatory environment affecting health care and insurance to inform the Study Committee's discussion of how the DPC model interacts with the health insurance market.

STATE REGULATION OF HEALTH INSURANCE PROVIDERS

Because DPC agreements are not considered health insurance, they are exempt from oversight by OCI as well as state insurance law under chs. 600 to 655, Stats. Health insurance providers must typically be licensed by OCI and meet requirements related to financial stability and consumer protection. OCI regulates all rate and form filings, performs financial and market conduct examinations, and responds to consumer complaints. Examples of consumer protections built into state insurance laws include access standards, quality assurance standards, guaranteed acceptance of certain classes of individuals, standards for portability of insurance, requirements regarding referrals to specialists, provider disclosures, and standards relating to termination of coverage and continuity of care. State insurance laws also include certain mandated benefits that insurance plans often must cover.[7] None of these laws apply in the context of a DPC practice. Instead, currently DPC practices are largely guided by providers' professional licensing standards and the terms of a DPC agreement.

COMBINING DPC AGREEMENTS WITH WRAP-AROUND INSURANCE

DPC agreements are not comprehensive health care coverage, and DPC providers often encourage patients to purchase a wrap-around insurance plan that covers services not included in the DPC agreement. If DPC is provided through an employer on the large group market, or as a self-insured plan, it may be possible for the employer to design or purchase wrap-around coverage of services not included in the DPC agreement to offer combined coverage that is comprehensive without duplication.[8] In other contexts, there may be few or no options to combine DPC agreements with seamless wrap-around coverage. A health insurance plan purchased through an exchange created under the federal Affordable Care Act (ACA)--referred to as a "qualified health plan" (QHP) under federal law--provides essential health benefits and cost-sharing for preventative services, and may come with premium tax credits and cost-sharing subsidies. However, as explained below, it is not currently possible in Wisconsin to purchase a QHP in conjunction with a DPC agreement without having duplication in coverage.

[7] Many of these requirements are in ch. 632, subch. VI. For more information regarding state mandated benefits, see *Fact Sheet on Mandated Benefits in Health Insurance Policies*, OCI, PI-019 (Rev. 06/2017), available at https://oci.wi.gov/Documents/Consumers/PI-019.pdf.

[8] Grandfathered plans, plans sold on the large-group market, and self-insured plans are not required to be ACA qualified (unless they are sold on the exchange). On the large-group market, individuals obtain health insurance under a group plan maintained by a large employer, which has at least 51 employees. [s. 632.745 (17), Stats.] In the case of a self-insured plan, an employer is the insurer and takes on the risk of providing health care services to its employees. The employer may contract with a third party to administer the plan.

Essential Health Benefits

Under the ACA, issuers that offer a QHP on an exchange must include coverage of the following 10 categories of essential health benefits: (a) ambulatory patient services (or outpatient care); (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance abuse disorder services; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care. Under each of these categories, the plan must offer coverage that is substantially equal to the coverage under the state's benchmark plan. Also, QHPs must limit cost-sharing requirements for essential health benefits. As defined under the ACA, "cost-sharing requirements" include deductibles, coinsurance, co-pays, and other similar charges. [42 U.S.C. s. 18022 (b) (1) and (c) (3); 45 C.F.R. s. 156.110 (a).][9]

Because the essential health benefits will inevitably include some aspects of primary care, it is not currently possible in Wisconsin to purchase an ACA QHP in conjunction with a DPC agreement without duplication in coverage.

Cost-Sharing for Preventive Services

The ACA requires non-grandfathered group health plans to provide coverage of preventive health services without any patient cost-sharing requirements. HHS defines **preventive services** to mean: (a) evidence-based screenings and counseling that have an "A" or "B" rating by the U.S. Preventive Services Task Force; (b) routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (c) preventive services for children and youth as recommended by the Health Resources and Services Administration (HRSA); and (d) preventive services for women as recommended by HRSA. [ACA s. 2713; 45 C.F.R. s. 147.130.] In effect, it is likely that health insurance plans would already be required to offer some of the services provided under a DPC agreement at no additional cost to those covered by the insurance.

Premiums Tax Credits and Cost-Sharing Subsidies

Individuals and families who purchase a QHP through an ACA-created exchange may qualify for **premium tax credits** to offset the costs of purchasing the QHP. Premium tax credits are available to households with incomes between 100% and 400% FPL. The amount of the credit is based on a formula limiting premium contributions to a certain percentage of household income, ranging from 2% at 100% FPL to 9.5% at 400% FPL.

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[9] Note that only ACA qualified health insurance plans are required to cover the 10 essential health benefits. ACA qualified plans are plans sold on the small-group and individual markets, and plans sold on the ACA exchange. On the individual market, individuals purchase health insurance directly from an insurance company, rather than obtaining insurance through an employer. On the small-group market, individuals obtain health insurance under a group plan maintained by a small employer, which has at least two but not more than 50 employees. [s. 632.745 (26), Stats.]

In addition to premium tax subsidies, a QHP purchased through an ACA-created exchange may be eligible for subsidies that reduce cost-sharing requirements. The subsidies are available for plans with a 70% actuarial value (AV) purchased by individuals or households with incomes between 100% and 250% FPL. The amount of these **cost-sharing subsidies** are based on a statutory formula that both expands coverage requirements (effectively increasing the plan's AV) and that lowers the overall cap on out-of-pocket costs that would otherwise apply under the ACA.

DPC Medical Home Plans Under the ACA

The ACA does include a mechanism that allows a DPC practice to be integrated into a health insurance plan that offers **full coverage without duplication** through a "**direct primary care medical home plan**." In this model, an insurance provider may contract with a DPC provider to offer a QHP on an ACA–created exchange, as long as all applicable criteria under the ACA are satisfied, such as coverage of essential health benefits and cost-sharing limitations. [42 U.S.C. s. 18021 (3); and 45 C.F.R. s. 156.245.]. There are not, however, currently any DPC medical home plans offered in Wisconsin.

Washington State Model

HHS directs states to look to the State of Washington as a model for DPC medical home plans. Washington enacted legislation in 2013 to allow the sale of DPC medical home plans on its state exchange beginning on January 1, 2015. [RCW s. 43.71.065 (3).] In the Washington model, the consumer purchases one plan, which includes a DPC practice combined with a wrap-around insurance plan. HHS places the responsibility on the issuer to "promote a seamless consumer experience" and ensure that enrollees understand which services are covered by the DPC provider, and how to access specialists. [76 Fed. Reg. 41900 (July 15, 2011), finalized without modification in 77 Fed. Reg. 18423 (Mar. 27, 2012).][10]

Coordination With Plan

There are certain benefits to consumers who purchase QHPs through ACA-created exchanges, including limits on cost-sharing for essential health benefits, and limits on overall out-of-pocket expenses. However, consumers who purchase a DPC agreement with a QHP that is duplicative because it is not a wrap-around insurance plan--just like those who purchase a DPC agreement and a wrap-around insurance plan **outside of the exchange**--should be aware that their monthly DPC payment will likely not count towards any cost-sharing requirements for the insurance plan. This concern should not apply to consumers who purchase a DPC medical home plan, since benefits are coordinated up-front.

[10] HHS has stated that it chose to support this model rather than allowing individuals to choose a DPC agreement and wrap-around coverage separately for two reasons. First, the enrollee only has to make one payment rather than two. Second, HHS does not consider DPC providers to be insurance providers, and therefore chose not to require the DPC provider to be separately accredited in order to participate on the exchange.

ADDITIONAL ACA CONCEPTS AS THEY RELATE TO DPC

Health Savings Accounts

DPC proponents often point to high deductible health plans as a natural fit for the DPC model. Under the ACA, individuals who have a high-deductible plan generally qualify for a tax-favored health savings account (HSA). Contributions into an HSA are tax deductible, and interest on the assets in the account are tax free. [I.R.C. s. 223 (e).] However, the Internal Revenue Service (IRS) has not allowed the use of HSA funds to pay for DPC agreements purchased outside of the exchange for two reasons.

First, the IRS considers DPC agreements to be a form of gap insurance.[11] HSAs are not available to individuals who have overlapping coverage of services under a non-high deductible health insurance plan, subject to a few narrow exceptions.[12] [I.R.C. s. 223 (c).] Second, HSA funds may only be used to purchase qualified medical expenses, which generally include only expenses that would qualify for a medical expense deduction or prescription drugs. It is not clear whether the IRS would consider DPC payments to be a qualifying medical expense.

Individual Mandate

The individual mandate responsibility provision of the ACA generally requires every individual to purchase minimum essential coverage. As of 2019, there will no longer be a penalty for failing to purchase health insurance, but the individual mandate has not been repealed.[13] DPC agreements, which only provide primary care services, do not qualify as health insurance, and do not satisfy the individual mandate. [26 U.S.C. s. 5000A.]

Open Enrollment Periods

Individuals may generally only purchase an ACA plan during a yearly open enrollment period. For example, the open enrollment period for plans issuing coverage beginning on January 1, 2018 ran from November 1 to December 15, 2017. An individual may qualify for a special enrollment period, during which time he or she could enroll in an ACA plan, if he or she had a "triggering event." Examples of triggering events include losing health insurance due to a change in jobs, getting married or divorced, or having a baby. Since DPC is not health insurance, it is not

[11] As noted earlier, this is in contrast to state DPC laws and HHS's approach regarding DPC medical homes, both of which consider DPC providers to not be health insurance providers.

[12] IRS allows duplication of coverage if the plan is solely for "preventive care," as defined by the IRS, or is otherwise disregarded coverage. Both of these exceptions are narrow. The IRS defines preventive care to include periodic health evaluations, prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and certain screening services, but it "does not generally include any service or benefit intended to treat an existing illness, injury, or condition." [IRS Notice 2004-23.]

[13] The Tax Cuts and Jobs Act of 2017 repealed the penalty associated with the individual mandate. In response, 19 states, including Wisconsin, filed a lawsuit in February 2018 in a federal district court in Texas. The U.S. Supreme Court previously concluded that the individual mandate falls within the federal government's taxing power, since the associated penalty could be viewed as a tax penalty. The states argue that since the penalty has been eliminated, all that remains is an unconstitutional mandate which the federal government has no authority to carry out. The U.S. Department of Justice has stated that it also believes the individual mandate is no longer constitutional.

clear that cancellation of a DPC agreement would be a triggering event under the ACA. [42 U.S.C. s. 1395p; and 45 C.F.R. Part 155, Subpart E.]

PART III – DPC AND MEDICAID

This Part of the Staff Brief provides an overview of the MA program, and discusses some considerations for creating a DPC pilot program.

OVERVIEW OF MA

MA--also known as "Medicaid"--is a public health care program administered by CMS in partnership with the states. MA is authorized under the federal Social Security Act (SSA). Its costs are paid from a combination of state and federal funds. Each state administers its own unique version of the program, providing health care and long-term care services to eligible individuals within parameters established by CMS.

Program Participation

Participation in MA is voluntary for states. However, all states, U.S. territories, and the District of Columbia choose to participate. Medicaid is a significant participant in the health care sector. The program accounts for about 15% of all health spending in the United States, in a given year. For certain services related to children's and women's health, the percentage is much higher. Medicaid pays for about half of the births in the United States in most years.

Benefits

The law requires states to offer coverage for certain **mandatory** benefits and allows them to choose to offer coverage for **optional** benefits if desired. States have general authority to determine the scope of services covered in connection with both mandatory and optional benefits, including the amount and duration of the services. Mandatory benefits include physician services, hospital services, nursing facility services, home health services, and others. Optional benefits include case management services, prescription drug coverage, physical therapy, and occupational therapy.

Eligibility

Individuals may receive Medicaid services by meeting eligibility criteria set by the states, subject to the minimum standards under federal law. Individuals must meet both a **categorical** requirement and a **financial** requirement in order to become eligible for a state's program. Categorical eligibility requirements are satisfied by individuals who are elderly, blind, disabled, pregnant, a parent of dependent children, or qualifying childless adults. Financial eligibility requirements are satisfied by individuals who meet certain income limits and, in certain cases, asset limits. Individuals must also meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship to qualify for the program.

Some individuals belong to **mandatory** coverage groups, meaning that all states with a Medicaid program must provide them with Medicaid coverage. Mandatory coverage groups include the following:

- Pregnant women with income up to 138% FPL.
- Children under 19 with family income up to 138% FPL.
- Children in an adoption assistance or foster care program identified under federal law, and certain youth who have aged out of foster care.
- Parents/caretakers of dependent children with family income up to the state's eligibility limit in 1996 for Aid to Families with Dependent Children (ADFC) cash assistance.
- Elderly, blind, and disabled individuals receiving cash benefits under the federal Supplemental Security Income (SSI) program.

States may also establish criteria offering Medicaid eligibility to individuals in groups for which coverage is **optional** under the federal law. Optional coverage groups include the following:

- Pregnant women, children, and parents/caretakers of dependent children with income above the federal minimum level.
- Medically needy individuals who are categorically eligible but have income that exceed the applicable requirements.
- Childless adults, not otherwise eligible, with income up to 138% FPL.

Wisconsin's Medicaid program extends eligibility beyond the federally mandated coverage requirements in various categories of eligibility. For example, children and pregnant women are eligible at income levels up to 305% FPL. The adult group (which includes parents/caretakers and childless adults) are eligible up to 100% FPL. Wisconsin also provides coverage for elderly, blind, and disabled individuals who qualify under certain criteria not specified in the federal law, in addition to those who qualify through SSI determinations as provided above.[14]

Dual Eligible Population

Under federal law, individuals may qualify for Medicare either because they are age 65 or older or because they are under the age of 65, have a disability, and receiving SSDI. Many of those Medicare-eligible individuals may also meet categorical and eligibility requirements under the Medicaid program, as described above. This population of **dual-eligible** beneficiaries tend to be sicker and poorer than the Medicaid population as a whole; however, not all dual-eligible beneficiaries are in poor health.

The ACA established the Medicare-Medicaid Coordination Office (MMCO) within CMS to improve care coordination for dual-eligible beneficiaries. CMS is funding demonstration projects

[14] For more detailed information on Wisconsin's eligibility criteria, see Section II of the Legislative Fiscal Bureau document entitled, "Medical Assistance and Related Programs – Informational Paper 41 (January 2017)" available at: http://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2017.

to develop approaches to coordinate care for dual eligible individuals and to integrate Medicare and Medicaid financing for these individuals.

Provider Certification and Reimbursement

DHS must certify health care providers for participation in the MA program. Providers may include individual health care practitioners, hospitals, nursing homes, managed care organizations, local governmental entities, and school districts. The certification of a provider allows Medicaid recipients to receive covered, medically necessary health care and long-term care services furnished by the provider. Certification also authorizes the provider to submit claims to DHS for reimbursement for the services.

Service Delivery Models

In general, benefits are available to Medicaid recipients through one of two service delivery systems. Under the traditional FFS delivery system, the state Medicaid program pays health care providers for each service they have provided to a Medicaid recipient. Under the more recent "managed care" alternative, benefits are delivered through contracted arrangements with managed care organizations (MCOs) in exchange for payment to the MCO of an actuarially based per-member, per-month fee.

In addition to the two main service delivery models, states have fashioned alternative payment and service delivery models to promote policy objectives, in certain cases, involving complex physical and mental health. Some of the alternative models have arisen through a state plan option to enroll a group of qualifying recipients in a "health home" for delivery of Medicaid services. States may use health homes to create payment structures to incentivize case management, care coordination, and access to community supports, according to the needs of individual recipients. [ACA s. 2703.]

Wisconsin Program Components

Wisconsin's Medicaid program is broadly divided into two parts. The first part is **BadgerCare Plus**, which is a managed-care program authorized by federal waiver. BadgerCare Plus provides low-income children, their parents, and childless adults with health care services, such as physician services, inpatient and outpatient hospital care services, and vision and dental care. The relationship between the BadgerCare Plus program and the managed care organizations (MCOs) who administer the program is governed by the contracts entered into between DHS and the MCOs. The current model contract sets forth in detail the delegation of service delivery requirements to the MCO and clarifies duties regarding the adequacy and accessibility of health care services, payment procedures, billing, enrollment, and grievances and appeals.[15]

The second component of Wisconsin's program is **Elderly, Blind, and Disabled (EBD) Medicaid**. EBD Medicaid provides elderly, blind, and disabled individuals with primary, acute, and long-term care health care services, and includes numerous subprograms targeted to individuals within this group. EBD Medicaid has also been referred to as "traditional Medicaid" because it has

[15] See generally, BadgerCare Plus and Medicaid SSI Contract for Jan. 1, 2018 – Dec. 31, 2019, effective Jan. 1, 2018.

been delivered on a FFS basis. However, DHS has also offered nontraditional services to EDB Medicaid recipients under options referred to as "home and community-based programs" which have allowed recipients of EBD Medicaid to receive self-directed long-term care services on a managed-care basis.[16] In January 2018, DHS launched an even bigger transition away from traditional Medicaid by requiring many individuals eligible for EBD Medicaid to enroll in managed care. Those EBD Medicaid recipients who are affected by the change will be required, or in some cases may choose, to enroll in the SSI Managed Care Program, which is structured similarly to the BadgerCare Plus program, described above.[17]

The Study Committee could recommend a pilot to test the use of DPC in either or both of those models. Similarly, a pilot could target one or any combination of the MA populations described above.

CONSIDERATIONS FOR A DPC PILOT

DPC in Other State MA Programs

DPC has attracted the interest of practitioners, patients, and policy experts for its potential to strengthen the role of primary care in the treatment of patients, with the ultimate goal of improving health outcomes and care coordination among providers. While the bulk of the efforts to promote DPC have focused on the enactment of private market legislation, as described in Part I, states have also searched for ways to incorporate DPC into MA, given the potential DPC may have to improve outcomes and potentially create cost-savings.

Washington

In the State of Washington, the experiences of the state's largest DPC provider, Qliance, are notable with regard to testing the use of DPC in MA. In 2007, Washington became the second state to enact DPC legislation. Although Qliance is no longer operating, by 2014, it had expanded its business model to include monthly fee agreements with a managed-care company under contract with the Washington State Medicaid program.[18]

Michigan

The State of Michigan has enacted statutory language directing its Department of Health & Human Services to implement a DPC pilot in Michigan's Medicaid program, with a recent

[16] The home and community-based services available under EBD Medicaid are: the Community Integration Program (CIP), Community Options Program (COP), Family Care, Family Care Partnership, IRIS (Include, Respect, I Self-Direct), or Program of All-Inclusive Care for the Elderly (PACE).

[17] DHS, "HMO Enrollment Changes for Medicaid Supplemental Security Income Members" February 21, 2018, at: www.dhs.wisconsin.gov/medicaid/hmo-2018chng.htm; see also, BadgerCare Plus and Medicaid SSI Contract for Jan. 1, 2018 – Dec. 31, 2019, effective Jan. 1, 2018.

[18] "DPC Leadership Response To Washington State OIC Report: 'Outlook for DPC is bright throughout U.S.,'" Direct Primary Care Journal, December 19, 2014.

subsequent enactment requiring the department to begin making quarterly reports to the Legislature regarding the status of the pilot.[19] Michigan's pilot has not yet been implemented.

Nebraska

Recently, the State of Nebraska enacted legislation creating a DPC pilot program for its state employee health plan. While this is not a Medicaid pilot, it may provide insight into how a similar pilot could be structured in that program. Nebraska's pilot project will experiment with at least two different plan designs: one in which a DPC agreement is matched with a high-deductible wrap-around plan, and one in which a DPC agreement is matched with a low-deductible wrap-around plan. Many of the remaining details of Nebraska's DPC pilot project have not yet been determined.[20]

Federal Approval Process

An effort to test or promote the use of the DPC model in a state Medicaid program presents a series of choices that a state must make regarding how to specifically incorporate DPC into the program. If a state seeks to implement a pilot project, and if it is determined that federal approval is required, there are essentially two options available to the state for seeking such approval. A state's first option is to seek federal approval through an amendment to the **Medicaid State Plan** (or simply the **State Plan**). As a condition of federal funding, DHS is required to publish and maintain the State Plan, which DHS describes as "the officially recognized statement describing the nature and scope of Wisconsin's Medicaid program."[21] Any change to the State Plan document must be submitted to CMS for a response, and is deemed approved unless a denial is received within 90 days.

On the other hand, if the proposed pilot or law change is more significant or part of a broader package, states are permitted to apply to CMS for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute. Section 1115 of the SSA gives the Secretary of HHS the authority to approve demonstration projects that allow states flexibility in the operation of their state Medicaid programs. An approved demonstration project is referred to as a "waiver," because it waives certain requirements under federal law that would otherwise apply. In return, a state must implement alternative provisions that, in the view of the Secretary, promote the objectives of the MA program. States seeking approval of a demonstration project, or an amendment of an existing one, must negotiate terms with CMS.

[19] Michigan Department of Health & Human Services, "Implementation of the Direct Primary Care Pilot Program--Quarterly Report 1 (FY2018 Appropriation Act--Public Act 158 of 2017), dated January 19, 2018.

[20] Nebraska Legislative Bill 1119, approved by the Governor April 13, 2018, available at: https://nebraskalegislature.gov/FloorDocs/105/PDF/Slip/LB1119.pdf.

[21] A copy of the Medicaid State Plan is available on DHS's website, at: www.dhs.wisconsin.gov.