
# Wisconsin's Primary Care Shortage

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WISCONSIN POLICY PROJECT • April 2020, Volume 3, Number 5

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## Overview

Primary care physicians—those who practice under the specialties of general practice, family medicine, general internal medicine, pediatrics, or geriatrics—play a critical role in the health care system. They provide patient-centered, comprehensive, and coordinated care, frequently over the span of a patient's life.

Often referred to as the gatekeepers of the health care system, primary care physicians are frontline providers who conduct diagnostic tests and refer patients for specialty or hospital care as needed. When demand on the system is high—for instance, during the public health emergency that was declared under Executive Order #72 in March 2020—primary care physicians provide and coordinate expert medical care in an outpatient setting, reducing the burden on hospitals, emergency rooms, and urgent care clinics.

Despite the essential role that primary care providers play in the health care system, less than 40 percent of Wisconsin's physicians practice primary care specialties. Across the state, nearly 150 areas are currently facing shortages of primary care providers. Many of these areas are located in rural Wisconsin, where populations are aging rapidly and the demand for care is expected to rise exponentially in the years ahead.

Wisconsin's primary care provider shortage is a public health concern with repercussions that are already being felt as the state responds to the COVID-19 pandemic. In the coming years, expanding Wisconsin's primary care workforce and ensuring the strategic distribution of providers will be essential in meeting the health care needs of the aging population. Addressing the shortage will likely improve health outcomes, lower health care costs, and reduce the strain on the existing workforce.

This publication addresses the shortage of primary care providers in Wisconsin. Part one provides an overview of the state's existing shortage. Part two summarizes the efforts that are underway in Wisconsin to address the challenge. Part three examines the efforts other states are taking to build their primary care workforces. Part four lists several policy options that could mitigate the growing problem in Wisconsin. The publication concludes with a brief summary.

## I. Wisconsin's primary care provider shortage

Studies show that geographic areas with higher ratios of primary care providers to population have better health outcomes,[1] longer life expectancies,[2] and lower total health care costs,[3] yet Wisconsin's shortage of clinicians has been growing for years. Only 38 percent

1. Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly* 83, no. 3 (Sep. 2005), 457–502, 460.

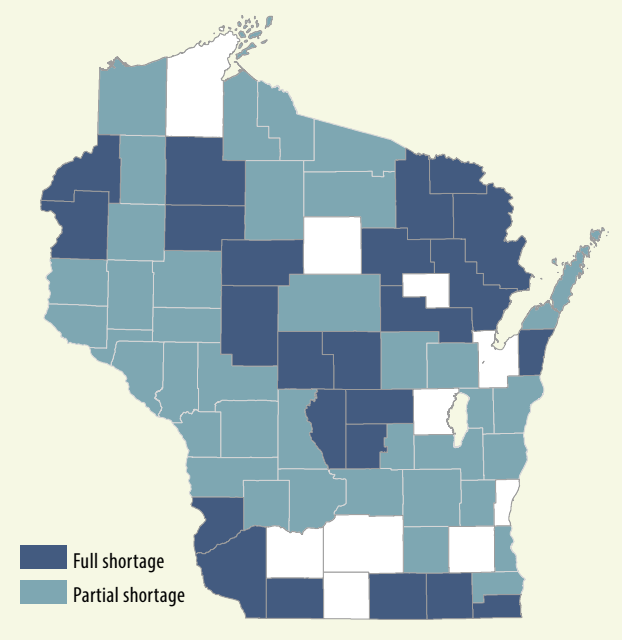
2. Sanjay Basu, Seth Berkowitz, and Robert Phillips, "Association of Primary Care Physician Supply with Population Mortality in the United States, 2005–2015," *JAMA Internal Medicine* 179, no. 4 (February 18, 2019), 506–514.

3. Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," 473.

of Wisconsin's physicians practice primary care,[4] and the average age of the state's existing primary care workforce is 50 or older.[5] By 2035, around 40 percent of Wisconsin's supply of primary care physicians is expected to retire.[6] However, due to the growing demand on the profession, many aging physicians will likely retire before that date. In studies that measure stress and exhaustion among physicians, over half of those surveyed say they are experiencing burnout,[7] due in large part to the administrative burden that accompanies the practice of primary care. Research has linked physician burnout to medical errors, unnecessary referrals, higher hospital admissions and readmissions, and early retirement, among other things.[8]

Across the state, 140 areas—both urban and rural—have been designated primary care health professional shortage areas (HPSAs) by the federal Health Resources and Services Administration.[9] In several counties in Wisconsin, the entire county has been designated a shortage area, while in other counties, the shortages are partial and are limited to certain areas. These shortage areas can be seen in Figure 1.

Figure 1. **Primary care health professional shortage**




Source: Wisconsin Department of Health Services, 2019

According to the Kaiser Family Foundation, 40 percent of Wisconsin's need for primary care providers is currently unmet, and the state's HPSAs would require an immediate influx of around 150 physicians to remove the existing shortage designations.[10] In ten years, Wisconsin will likely require more than 740 additional

4. Wisconsin Area Health Education Center, *Wisconsin AHEC Health Workforce Data Brief: Primary Care Physicians* (Madison, WI: Wisconsin Area Health Education Center, June 2015): 1, https://ahec.wisc.edu.

5. Wisconsin Hospital Association, *Wisconsin 2019 Health Care Workforce Report* (Madison, WI: Wisconsin Hospital Association, 2019): 4, https://wha.org.

6. Wisconsin Council on Medical Education & Workforce, *Mapping Our Way to Success: Wisconsin's Physician Workforce* (Madison, WI: Wisconsin Council on Medical Education & Workforce, 2018): 1, https://wcmew.org.

7. Agency for Healthcare Research and Quality, *Physician Burnout* (Rockville, MD: Agency for Healthcare Research and Quality, July 2017), 1, http://ahrq.gov.

8. John Noseworthy, James Madara, Delos Cosgrove, Mitchell Edgeworth, Ed Ellison, Sarah Krevans, Paul Rothman, Kevin Sowers, Steven Strongwater, David Torchiana, and Dean Harrison, "Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs," *Health Affairs* (March 28, 2017), http://healthaffairs.org.

9. "Data by Geography: Wisconsin," U.S. Health Resources and Services Administration, accessed January 28, 2020, https://data.hrsa.gov.

10. "Primary Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation, accessed January 29, 2020, https://kff.org.

primary care providers to meet the growing demand for care.[11] However, by 2035, the state's supply of primary care physicians is expected to grow by just 4 percent.[12]

## II. Statewide efforts to address the shortage

The statewide shortage of primary care providers has been well understood by Wisconsin's legislators and industry stakeholders for years. Several efforts to address it are currently underway. Strategies include the following: (1) providing financial assistance and incentives to primary care physicians; (2) supporting increased enrollment in medical schools and residency programs; (3) boosting or authorizing Medicaid reimbursements for certain services; (4) authorizing eligible out-of-state and foreign physicians to practice in the state; and (5) encouraging primary care providers and pharmacists to practice in more collaborative relationships.

### Providing financial incentives for primary care physicians

According to a nationwide survey of final-year residents and fellows, only 2 percent of respondents specializing in primary care said they would like to practice in a community with fewer than 10,000 residents, and another 2 percent said they hope to practice in a community with fewer than 25,000 residents.[13] In an effort to draw new primary care physicians to rural and other shortage areas, the State of Wisconsin currently offers a loan assistance program to medical students.

The Physician and Dentist Loan Assistance Program, which was enacted in 1990 by 1989 Wisconsin Act 317,[14] offers student loan repayment assistance of up to $50,000 to medical providers who commit to three years of practice in HPSAs, on American Indian reservations, or at free or charitable clinics.[15] The program was expanded in 2010 by 2009 Wisconsin Act 190[16] to include loan assistance of up to $100,000 to medical providers who commit to three years of practice in rural areas, defined by law as areas with populations below 20,000 that are at least 15 miles from cities, towns, or villages with populations of at least 20,000.[17] Under the program, eligible physicians must specialize in family practice, general internal medicine, general pediatrics, obstetrics and gynecology, or psychiatry.[18]

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11. Cynthia Haq, Melissa Lemke, Michelle Buelow, Marjorie Stearns, Christine Ripp, and Patrick McBride, "Training in Urban Medicine and Public Health: Preparing Physicians to Address Urban Health Care Needs," *Wisconsin Medical Journal* 115, no. 6 (Dec. 2016): 1, https://med.wisc.edu.

12. Wisconsin Council on Medical Education & Workforce, *Mapping Our Way to Success: Wisconsin's Physician Workforce*, 2.

13. Merritt Hawkins, 2019 Survey: Final-Year Medical Residents (Dallas, TX: Merritt Hawkins, 2019): 10, https://merritthawkins.com.

14. 1989 Wis. Act 317.

15. Wis. Stat. § 36.60 (3) (a).

16. 2009 Wis. Act 190.

17. Wis. Stat. § 36.63 (1) (c) 1.

18. Wis. Stat. § 36.60 (1) (b).

The Physician and Dentist Loan Assistance Program and a separate loan assistance program for nonphysician clinicians—the Health Care Provider Loan Assistance Program—receive approximately $1.5 million in combined state funding per biennium. The two programs split $488,700 annually from the Indian gaming receipts,[19] and in recent biennial budgets they have been appropriated an additional $500,000 per biennium.[20]

In addition to student loan assistance, in 2014, the state also created a grant program for providers who practice in Wisconsin's HPSAs. The Primary Care and Psychiatry Shortage Grant Program, enacted by 2013 Wisconsin Act 128,[21] awards grants to primary care physicians and psychiatrists who practice in the state's medically underserved areas.[22] Under the program, awardees may receive a minimum of $20,800 in financial assistance, and they may receive grants under the program no more than three times.[23] The grants may be used for any purpose, as the law does not stipulate how they must be spent.[24] This program received $1.5 million in funding when it was created in 2014,[25] but it has not received state funding since then.

These financial incentives draw primary care providers to rural and shortage areas, where it is significantly more difficult to recruit young physicians. Those who receive grants or loan assistance are likely to practice and remain in rural or shortage areas for several years.

### Supporting increased enrollment in medical schools and residency programs

In an effort to address the physician shortage, the state's two medical schools—the Medical College of Wisconsin and the University of Wisconsin–Madison School of Medicine and Public Health—have increased their enrollment numbers and have committed to prioritizing in-state applicants who are more likely to practice medicine in Wisconsin.[26]

The University of Wisconsin–Madison School of Medicine and Public Health has developed two specialized programs in response to physician shortages in urban and rural areas: the Training in Urban Medicine and Public Health (TRIUMPH) program and the Wisconsin Academy for Rural Medicine (WARM) program. Since the programs began accepting students around 2008, enrollment in the medical school has increased by 17 percent.[27] The TRIUMPH program is based in Milwaukee and trains physicians

19. Wis. Stat. § 20.505 (8) (hm) 6r.

20. 2019 Wis. Act 9.

21. 2013 Wis. Act 128.

22. Wis. Stat. § 39.385 (4) (a) 1.

23. State of Wisconsin Higher Educational Aids Board, *Primary Care and Psychiatry Shortage Grant* (Madison, WI: Health Educational Aids Board, February 2018): 1, https://heab.wi.gov.

24. State of Wisconsin Higher Educational Aids Board, *Primary Care and Psychiatry Shortage Grant*.

25. 2013 Wis. Act 128.

26. Wisconsin Hospital Association, *Wisconsin 2019 Health Care Workforce Report*, 2.

27. Wisconsin Hospital Association, *Wisconsin 2019 Health Care Workforce Report*, 2.

to provide care for medically underserved populations in urban areas. WARM enrollees split their training between Madison and various rural areas, where they receive training that is relevant to rural practice. According to the university, 61 percent of TRIUMPH graduates practice primary care and 50 percent practice medicine in Wisconsin's medically underserved urban areas.[28] Fifty-two percent of WARM graduates practice primary care and 91 percent go on to practice medicine in Wisconsin—28 percent of them in their hometowns.[29]

Additionally, in 2011, the Medical College of Wisconsin, based in Milwaukee, added 50 enrollment spots and opened two rural campuses located in northeastern and central Wisconsin in an attempt to draw physicians to Wisconsin's rural areas.[30] The new campuses offer accelerated three-year programs and encourage students to select specialties in primary care, general surgery, psychiatry, and other specialty shortage fields.[31]

To keep pace with increased enrollment numbers and to encourage new graduates to practice in shortage areas, the State of Wisconsin also supports rural residency programs.[32] The Rural Physician Residency Assistance Program was created in 2010 by 2009 Wisconsin Act 190.[33] The law directs the Department of Family Medicine at the University of Wisconsin School of Medicine and Public Health to establish and fund rural residencies in family medicine, pediatrics, psychiatry, general surgery, internal medicine, and other shortage specialties.[34] In the 2019 biennial budget, $1,718,400 in biennial funding was appropriated for the program.[35] Since 70 percent of Wisconsin's physicians graduated from in-state medical schools and completed in-state residencies,[36] the program prioritizes residencies that actively recruit graduates of Wisconsin's medical schools.[37]

#### Boosting or authorizing Medicaid reimbursements for certain services

The State of Wisconsin also offers Medicaid reimbursements that incentivize the practice of medicine in HPSAs or rural areas. All covered Medicaid procedures provided by primary care physicians, advanced practice nurse practitioners, or physician assistants in the state's HPSAs receive reimbursements set at 120 percent of the standard Medicaid re-

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28. "Training in Urban Medicine and Public Health," University of Wisconsin–Madison School of Medicine and Public Health, accessed March 10, 2020, https://med.wisc.edu.

29. University of Wisconsin–Madison School of Medicine and Public Health, *WARM: Wisconsin Academy for Rural Medicine* (Madison, WI: University of Wisconsin–Madison School of Medicine and Public Health), https://med.wisc.edu.

30. Wisconsin Hospital Association, *Wisconsin 2019 Health Care Workforce Report*, 2.

31. "Curriculum Schedule and Course Descriptions," Medical College of Wisconsin, accessed February 5, 2020, https://mcw.edu.

32. Wisconsin Hospital Association, *Wisconsin 2019 Health Care Workforce Report*, 2.

33. 2009 Wis. Act 190.

34. Wis. Stat. § 36.63.

35. 2019 Wis. Act 9.

36. Wisconsin Council on Medical Education & Workforce, *Mapping Our Way to Success: Wisconsin's Physician Workforce*, 9.

37. Wis. Stat. § 36.63 (2) (b).

imbursement rate.[38] These HPSA bonus payments incentivize the treatment of Medicaid beneficiaries, over 65,000 of whom are elderly Wisconsinites who may be receiving costly long-term care.[39] The number of elderly Wisconsinites enrolled in the Medicaid program is expected to grow significantly in the years ahead as the population continues to age. Providing financial incentives such as bonus payments to providers who treat Medicaid beneficiaries in HPSAs improves access to care in shortage areas.

In addition to HPSA bonus payments, Wisconsin's Medicaid program will soon begin expanding the reimbursement of telehealth services, which are medical services that are provided remotely, through the use of telecommunications technologies. Under 2019 Wisconsin Act 56, which was signed into law in November 2019, the program will begin reimbursing additional telehealth services on or before January 1, 2021.[40] The law defines "telehealth" as "a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient."[41] The law specifically excludes services delivered by audio-only telephone, e-mail, or fax, but it allows the Wisconsin Department of Health Services to develop rules regarding those delivery methods.[42]

Act 56 requires the three most common types of telehealth services to be reimbursed by the Medicaid program: real-time and interactive communications between patients and providers; store-and-forward services that transmit medical data to providers without interactive communication; and remote patient monitoring, which occurs when medical data are transmitted to providers for monitoring and providers respond when necessary.[43] The original bill would have required telehealth services to be reimbursed by Medicaid at the same rate as equivalent services delivered in-person,[44] but it was later amended to exclude the payment parity requirement.[45] Regardless, the current policy of the Wisconsin Department of Health Services is to reimburse telehealth services at the same rate as equivalent services that are provided face-to-face.[46]

Importantly, the law requires the Medicaid program to reimburse covered telehealth services regardless of the Medicaid beneficiary's originating site or location, allowing pa-

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38. ForwardHealth, Topic #648: Health Professional Shortage Areas (Madison, WI: Wisconsin Department of Health Services), https://forwardealth.wi.gov.

39. Wisconsin Legislative Fiscal Bureau, *Medical Assistance and Related Programs: Informational Paper 41* (Madison, WI: Wisconsin Legislative Fiscal Bureau, January 2019); 7, https://docs.legis.wisconsin.gov.

40. 2019 Wis. Act 56.

41. Wis. Stat. § 49.45 (61) (a) 4.

42. Wis. Stat. § 49.45 (61) (a) 4.

43. 2019 Wis. Act 56.

44. 2019 Wis. SB 380.

45. Senate Amendment 2 to 2019 Wis. SB 380.

46. ForwardHealth, Topic #510: Telehealth (Madison, WI: Wisconsin Department of Health Services), https://forwardhealth.wi.gov.

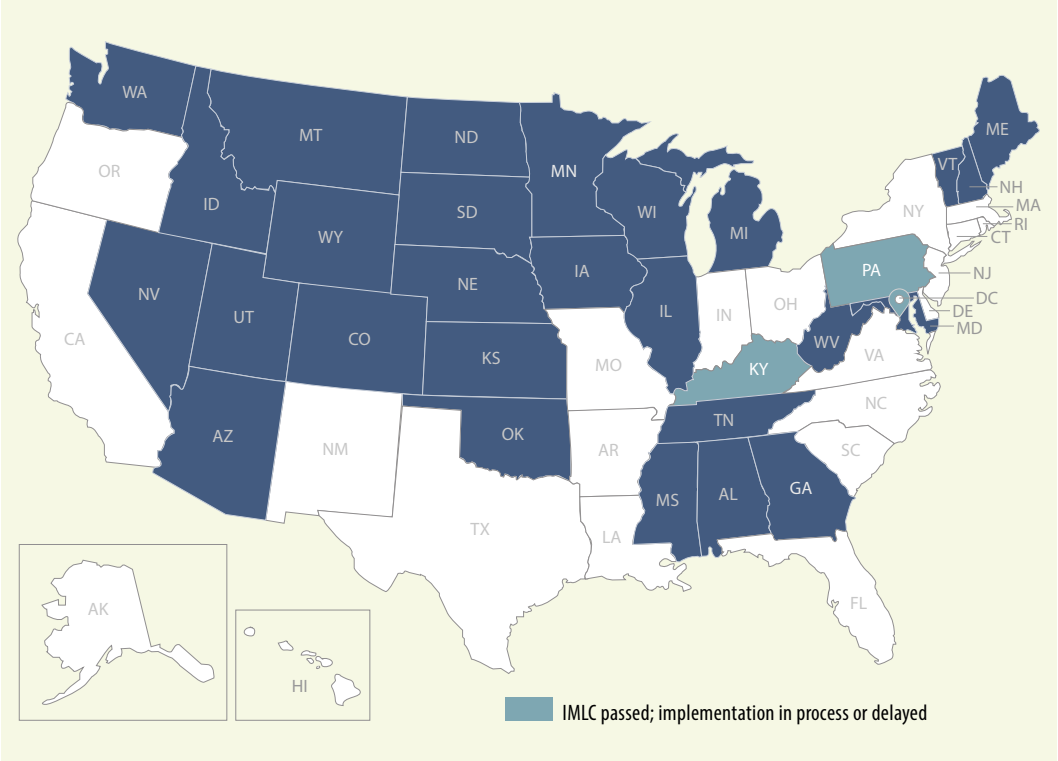
tients to receive care in their homes.[47] This enables the state's existing supply of primary care providers to more efficiently reach Medicaid beneficiaries who lack access to care because of physician shortages, geographic barriers, or physical limitations.

### Authorizing certain out-of-state or foreign physicians to practice in the state

In shortage areas facing severe provider deficits, eligible out-of-state or foreign physicians who are authorized to practice in Wisconsin provide valuable care to underserved populations. In 2015, Wisconsin joined the Interstate Medical Licensure Compact (IMLC)—an agreement among 29 states that created a streamlined process for physicians to become licensed in multiple states—following the bipartisan passage of 2015 Wisconsin Act 116.[48] A map highlighting IMLC member states can be seen in Figure 2.

The mission of the IMLC is to increase access to health care in rural and shortage areas, primarily through the use of telehealth services.[49] According to the American Medical Association, Wisconsin has issued 418 licenses through the compact—more than any other state—and applicants most commonly practice primary care specialties

Figure 2. **Interstate Medical Licensure Compact (IMLC) member states**




Source: Interstate Medical Licensure Compact, 2020

47. Wis. Stat. § 49.45 (61) (e) 3.

48. 2015 Wis. Act 116.

49. "The IMLC," Interstate Medical Licensure Compact, accessed February 12, 2020, https://imlcc.org.

such as internal medicine (30.7 percent of applicants) or family medicine (11.5 percent of applicants).[50] Through the IMLC, Wisconsinites in shortage areas have gained access to hundreds of primary care physicians who reside in other states.

During the public health emergency that was declared in March 2020, Governor Evers suspended, on a temporary basis, the requirement that physicians using telehealth services to treat patients in Wisconsin be licensed by the Medical Examining Board.[51] Emergency Order #16, issued by Governor Evers on March 27, suspended Wis. Admin. Code MED §§ 24.04 and 24.07 (1) (a), allowing physicians with valid and current licenses issued by other states or Canada to treat Wisconsinites through telemedicine. Emergency Order #16 also authorized interstate reciprocity so that providers licensed outside Wisconsin could practice in the state under certain conditions without first obtaining a temporary or permanent license from the Wisconsin Department of Safety and Professional Services.[52] Under the emergency order, out-of-state physicians are required to apply for a temporary or permanent Wisconsin license within 30 days of first practicing in the state.[53]

This emergency order was made with the intent of improving access to medical care at a time when the state's health system was experiencing an unprecedented demand for care. It created a temporary influx of health care providers in Wisconsin, improving the state's ability to respond to the public health emergency and exposing many out-of-state physicians to Wisconsin's health care system for the first time.

In addition to participation in the IMLC and the temporary authorizations that were made in Emergency Order #16, the state participates in the federal Conrad 30 Waiver Program, which allows eligible foreign physicians to practice in the state's HPSAs. Under current federal law, J-1 visas are granted to foreign medical school graduates so they may complete residency or fellowship training programs in the United States; however, following the completion of the training program, J-1 visa holders must return to their home countries for two years.[54] The Conrad 30 Waiver Program waives this requirement for applicants who commit to practicing primary care or mental health care in HPSAs for three years.[55] Employers of physicians who are granted waivers must provide evidence that they attempted for at least six months to recruit providers with U.S. citizenship to fill the position.[56] The Wisconsin Department of Health Services is authorized to request

50. "Interstate Medical Licensure by the Numbers," American Medical Association, accessed February 12, 2020, https://ama-assn.org.

51. Emergency Order #16.

52. Emergency Order #16.

53. Emergency Order #20.

54. "Wisconsin Conrad 30 Waiver Program: General Information," Wisconsin Department of Health Services, accessed February 12, 2020, https://dhs.wisconsin.gov.

55. "Wisconsin Conrad 30 Waiver Program: General Information," Wisconsin Department of Health Services.

56. "Wisconsin Conrad 30 Waiver Program—Program Description," Wisconsin Department of Health Services, accessed February 12, 2020, https://dhs.wisconsin.gov.

waivers for 30 foreign J-1 visa physicians each year; since 2005, over 200 foreign physicians have been recruited to practice in Wisconsin, expanding access to care in shortage areas.[57]

Together, these actions have increased the primary care provider workforce in Wisconsin, improving access to care in areas that are currently facing shortages.

#### Encouraging providers and pharmacists to practice in more collaborative relationships

In an effort to reduce the demand on physicians and create a more collaborative primary care workforce, the State of Wisconsin enacted bipartisan legislation in 2014 that expanded the ability of licensed physicians to delegate certain patient care services to licensed pharmacists.[58] The law is broadly written and leaves "patient care services" undefined in statute, simply stating: "A pharmacist may perform any patient care service delegated to the pharmacist by a physician."[59]

This allows Wisconsin's 5,500 pharmacists[60] to perform a variety of services beyond those that they traditionally provide, such as dispensing prescription drugs and administering certain vaccines. When delegated by physicians, pharmacists in Wisconsin may provide a number of primary care services, including chronic disease management, drug therapy management, and preventive screenings. In rural and shortage areas, collaborative relationships between primary care providers and pharmacists can reduce the demand on the physician workforce and fill significant gaps in care.

## III. Policy initiatives in other states

Like Wisconsin, several other states are facing shortages of primary care providers and increased demand for care driven by aging populations. Many have enacted similar policies that provide financial incentives to physicians, boost Medicaid reimbursements, support medical education and training, authorize out-of-state or foreign physicians to practice in their states, and encourage more collaborative relationships between providers and pharmacists.

Several states have also enacted laws that aim to fill gaps in primary care shortage areas by increasing the capacity of the existing workforce. Three strategies have gained widespread support in other states: (1) expanding the scope of practice of nonphysician advanced practice clinicians; (2) regulating the coverage of telehealth services; and (3) supporting emerging payment models in the primary care field.

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57. "Wisconsin Conrad 30 Waiver Program: General Information," Wisconsin Department of Health Services.

58. 2013 Wis. Act 294.

59. Wis. Stat. § 450.033.

60. "Pharmacists Provide Care," American Pharmacists Association, accessed March 26, 2020, https://pharmacistsprovidecare.com.

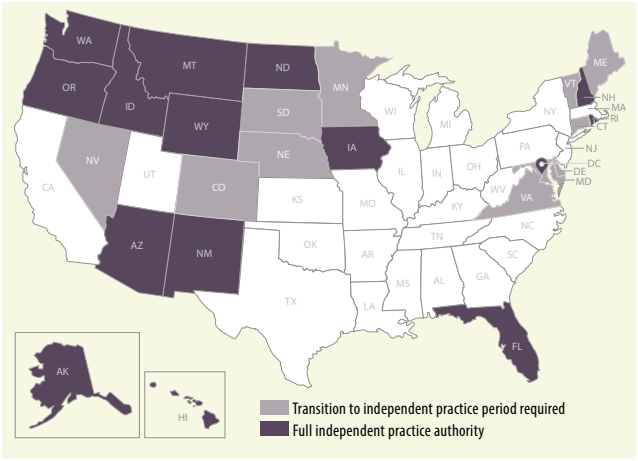
### Expanding the scope of practice of nonphysician advanced practice clinicians

Nurse practitioners (NPs) and physician assistants (PAs) are nonphysician advanced practice clinicians who regularly practice in primary care settings. Approximately 73 percent of the nation's NPs[61] and 26 percent of PAs[62] deliver primary care services, often in collaboration with or under the supervision of licensed physicians. However, several states facing shortages of primary care providers have authorized these advanced practice clinicians to practice with greater autonomy.

Thirteen states and the District of Columbia grant NPs full independent practice authority.[63] In these states—which are highlighted in Figure 3a—NPs may provide care within their scope of practice with no physician oversight. Eleven additional states, also highlighted in Figure 3a, allow NPs to practice independently after completing a transition period in which the NP maintains a regulated relationship with a physician, NP, or other health care provider.[64] Such transition periods range from 1,000 hours of practice (Colorado)[65] to five years of practice (Virginia).[66]

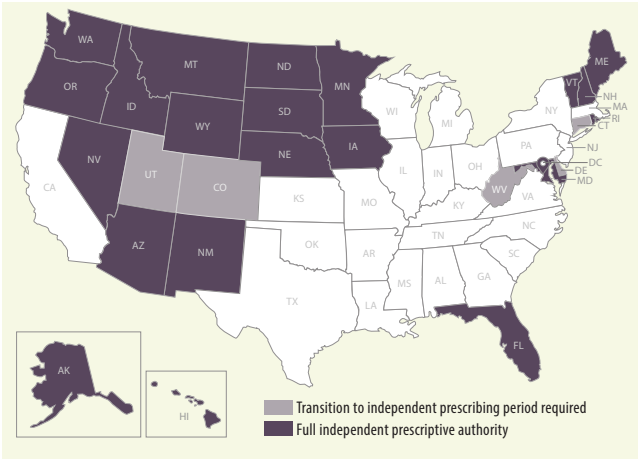
State policies also differ in the prescribing authority granted to NPs. At least twenty states, highlighted in Figure 3b, grant NPs the full independent authority to prescribe

Figure 3a. **Nurse practitioner practice authority**




Source: Scope of Practice Policy, 2020

Figure 3b. **Nurse practitioner prescriptive authority**




Source: Scope of Practice Policy, 2020

61. "NP Fact Sheet," American Association of Nurse Practitioners, accessed February 12, 2020, https://aanp.org.

62. National Commission on Certification of Physician Assistants, *2018 Statistical Profile of Certified Physician Assistants by State* (Johns Creek, GA: National Commission on Certification of Physician Assistants, 2019): 5, https://nccpa.net.

63. "Nurse Practitioners Overview," Scope of Practice Policy: A Collaboration between the National Conference of State Legislatures and the Association of State and Territorial Health Officials, accessed February 12, 2020, https://scopeofpracticepolicy.org.

64. "Nurse Practitioners Overview," Scope of Practice Policy.

65. "Colorado Scope of Practice Policy: State Profile," Scope of Practice Policy: A Collaboration between the National Conference of State Legislatures and the Association of State and Territorial Health Officials, accessed February 12, 2020, https://scopeofpracticepolicy.org.

66. "Virginia Scope of Practice Policy: State Profile," Scope of Practice Policy: A Collaboration between the National Conference of State Legislatures and the Association of State and Territorial Health Officials, accessed February 12, 2020, https://scopeofpracticepolicy.org.

medications.[67] Five additional states, also highlighted in Figure 3b, require NPs to complete transition periods before they are granted their full independent prescriptive authority.[68]

States that grant NPs the authority to practice and prescribe independently generally identify NPs as primary care providers in statute. For instance, Minnesota law states that the practice "includes functioning as a primary care provider,"[69] and Iowa law lists advanced registered nurse practitioners as one of four categories of certified professionals who may be considered primary care providers.[70] Other laws explicitly state that advanced practice nurses such as NPs have the expertise that is needed to provide high-quality medical care independently. For instance, North Dakota law states: "The health care needs of citizens in North Dakota require that nurses in advanced practice roles provide care to the fullest extent of their scope of practice."[71]

In addition to granting NPs the authority to practice without physician oversight, several states grant PAs the ability to practice with some independence. Most states do this by allowing medical practices—not state law—to determine the level of supervision and scope of practice of PAs. Thirty states currently allow medical practices to establish supervision requirements, while 37 states allow practices to set the scope of practice of PAs. Figures 4a and 4b provide an overview of these state policies.

States that grant PAs greater independence allow PAs and their supervising physicians to establish the necessary level of supervision. Many states do not require supervising or collaborating physicians to be physically present at the site where the PA is providing care. For instance, Illinois law states: "The relationship under a written collaborative agreement shall not be construed to require the personal presence of a physician at the place where services are rendered."[72] Wyoming law states: "Contact with the supervising physician by telecommunications is sufficient to show ready availability, if the board finds that such contact is sufficient to provide quality medical care."[73] In states that do not require supervising physicians to be physically present, experienced PAs often serve as primary care providers in rural or shortage areas, while physicians provide telehealth services or in-person care as needed.[74] Such collaborative agreements between PAs and physicians improve access to care by increasing the number of practicing providers in rural and shortage areas.

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67. "Nurse Practitioners Overview," Scope of Practice Policy.

68. "Nurse Practitioners Overview," Scope of Practice Policy.

69. Minn. Stat. § 148.171 (13) (a).

70. Iowa Stat. § 135.157 9. b.

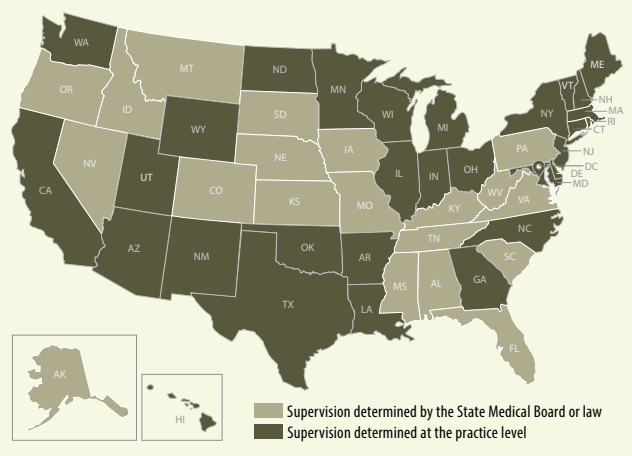
71. N.Dak. Stat. § 54-05-03.1-01.

72. Ill. Stat. § 225.95/7.5 (a) (1).

73. Wyo. Stat. § 33-26-501-vi.

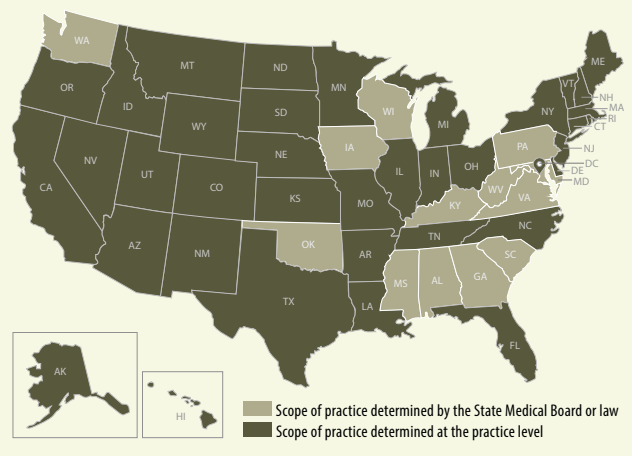
74. "Physician Assistants Overview," Scope of Practice Policy: A Collaboration between the National Conference of State Legislatures and the Association of State and Territorial Health Officials, accessed February 13, 2020, https://scopeofpracticepolicy.org.

Figure 4a. **Physician assistant supervision requirements**




Source: Scope of Practice Policy, 2020

Figure 4b. **Physician assistant scope of practice requirements**




Source: Scope of Practice Policy, 2020

**Summary of current Wisconsin law.** Wisconsin law requires certified advanced practice nurses such as NPs to practice in documented collaborative relationships with physicians or dentists.[75] While NPs may not practice independently under Wisconsin law, collaboration may occur through "modern communication techniques" and is not required to occur in person.[76]

Under the law, advanced practice nurses who work in collaborative relationships with physicians and wish to prescribe medications may apply to be certified as advanced practice nurse prescribers.[77] Certain limitations on the prescribing authority of these NPs apply. They may not issue prescriptions for Schedule I controlled substances, and they may issue prescriptions for Schedule II controlled substances only to patients with certain medical conditions.[78] Those who are certified may prescribe under the supervision or delegation of a physician, or they may prescribe independently if they maintain malpractice insurance in accordance with the law.[79]

In response to the public health emergency that was declared in March 2020, Wisconsin's NPs were granted the authority to practice with greater independence on a temporary basis in an attempt to meet the unprecedented demand for medical care. Emergency Order #16, issued by Governor Evers on March 27, suspended Wis. Admin. Code N § 8.10 (2) and (7) to eliminate the requirement that advanced practice nurse prescribers work in collaborative relationships with at least one physician or dentist.[80] Under the

75. Wis. Admin. Code N § 8.10 (7).
76. Wis. Admin. Code N § 8.10 (2).
77. Wis. Stat. § 441.16 (2).
78. Wis. Admin. Code N § 8.06.
79. Wis. Admin. Code N § 8.08.
80. Emergency Order #16.

order, NPs in Wisconsin have the temporary ability to practice independently, without physician oversight, during the declared emergency.

PAs in Wisconsin are required to practice under the supervision of one or more physicians, and their scope of practice is limited by the Medical Examining Board.[81] PAs may issue prescription orders if their prescriptive practices are reviewed annually by supervising physicians.[82] Under the law, no physician may supervise more than four on-duty PAs at any time unless the Medical Examining Board approves a plan to do so.[83] While supervision need not occur in person, the law does require supervising physicians to be "within 15 minutes of contact by telecommunication or other means."[84]

An effort to grant PAs greater autonomy has received bipartisan support in the current legislative session. Companion proposals[85] 2019 Assembly Bill 575 and 2019 Senate Bill 515 create a Physician Assistant Examining Board, tasked with licensing and regulating the PA profession.[86] The bills also propose eliminating the requirement that PAs practice under the supervision of physicians; instead, they allow PAs and physicians to maintain written collaborative agreements.[87] The bills explicitly state that PAs may serve as patients' primary or specialty care providers, and they propose making PAs—not their supervising physicians—"individually and independently responsible for the quality of the care they deliver."[88] Assembly Bill 575 was passed by the Assembly in February 2020, but it was not taken up by the Senate.

In response to the public health emergency, Governor Evers suspended several rules affecting the practice authority of the state's PAs. They, like NPs, were temporarily granted during the public health emergency greater independence from oversight in an attempt to meet the demands on the health care system. Emergency Order #16 suspended Wis. Admin. Code MED § 8.07 (3), temporarily eliminating the requirement that PAs be able to readily identify supervising physicians and podiatrists.[89] The order also authorized PAs to delegate tasks to other health care providers, and it modified the limitation that prohibits physicians from supervising more than four on-duty PAs at any time.[90] Under the order, physicians are granted the authority to supervise eight on-duty PAs in Wisconsin during the declared emergency.[91]

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81. Wis. Admin. Code Med § 8.07 (1).
82. Wis. Admin. Code Med § 8.07 (2) (i).
83. Wis. Admin. Code Med § 8.10 (1).
84. Wis. Admin. Code Med § 8.10 (2).
85. Companion proposals are identical bills introduced in both houses for simultaneous consideration.
86. 2019 Wis. AB 575.
87. 2019 Wis. AB 575.
88. 2019 Wis. AB 575.
89. Emergency Order #16.
90. Emergency Order #16.
91. Emergency Order #16.

### Regulating the coverage of telehealth services

A second strategy that has been effective at improving access to primary care in many states is supporting the increased use of telehealth services. States have accomplished this by requiring health insurers—both Medicaid programs and private insurance companies—to reimburse a variety of telehealth services, including live communications, store-and-forward services, and remote patient monitoring.

All 50 states require their Medicaid programs to reimburse certain telehealth services.[92] In addition, 41 states—highlighted in Figure 5—have enacted laws that require private health insurers to cover certain telehealth services.[93] For instance, Michigan law states that private insurers "shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine."[94] Similarly, in Indiana, the law states that private health insurance policies "must provide coverage for telemedicine services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person."[95] These telehealth laws improve access to care for those who are privately insured and are unable to receive in-person care for any number of reasons.

Most states that have enacted laws governing the coverage of telehealth services by private insurers do not require payment parity between services delivered in person and via telehealth. However, six states, highlighted in Figure 5, have enacted laws that do require payment parity.[96] In Minnesota, the law states that health insurers must reimburse services "delivered via telemedicine on the same basis and at the same rate" as those services delivered in person.[97] The law is similar in Georgia where health care providers must be reimbursed for telehealth services "on the same basis and at least at the rate that the insurer is responsible for coverage for the provision of the same service through in-person consultation or contact."[98] Georgia's law, which took effect on January 1, 2020, states that it was enacted with the intent to "mitigate geographic discrimination in the delivery of health care."[99] Such laws that require payment parity for private health insurers incentivize the delivery of telehealth services, potentially increasing access to care for those who reside in rural and shortage areas.

**Summary of current Wisconsin law.** Like most other states, Wisconsin law requires

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92. Center for Connected Health Policy: The National Telehealth Policy Resource Center, *State Telehealth Laws & Reimbursement Policies* (Sacramento, CA: Center for Connected Health Policy, 2019): 2, https://cchpca.org.

93. Center for Connected Health Policy: The National Telehealth Policy Resource Center, *State Telehealth Laws & Reimbursement Policies*, 9.

94. Mich. Stat. § 500.3476 (1).

95. Ind. Stat. § IC 27-8-34-6.

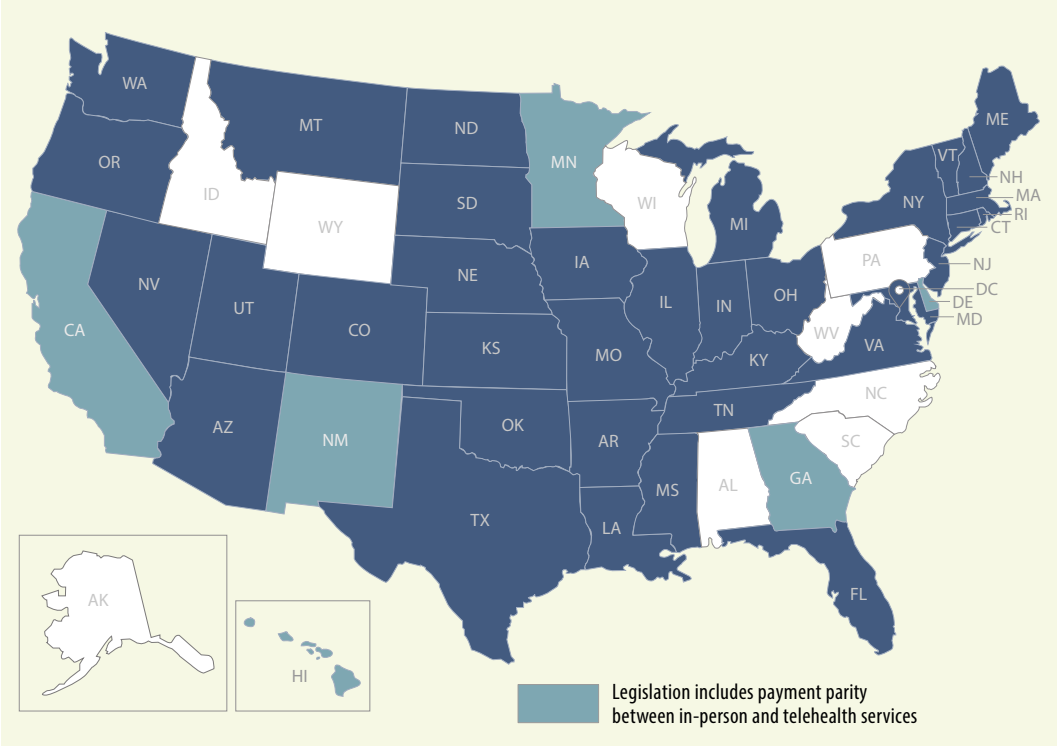
96. Center for Connected Health Policy: The National Telehealth Policy Resource Center, *State Telehealth Laws & Reimbursement Policies*, 12, 13.

97. Minn. Stat. § 62A.672 3. (a).

98. Ga. Stat. § 33-24-56.4-f.

99. Ga. Stat. § 33-24-56.4-c.

Figure 5. **Telehealth coverage legislation for private health insurers**




Source: Center for Connected Health Policy, 2019

reimbursements for any covered Medicaid benefits that are delivered by certified Medicaid providers through interactive telehealth.[100] However, Wisconsin law does not regulate telehealth reimbursements for private health insurers, and payment parity between in-person and telehealth services in the private sector is not required. Under the status quo, telehealth reimbursement policies vary among the private health insurance companies that are operating in the state.

### Supporting emerging payment models in the primary care field

In addition to incentivizing the use of telehealth services and expanding the role that NPs and PAs play in the health care system, many states are attempting to address primary care provider shortages by supporting emerging payment models that could attract new and veteran physicians to the primary care field. One such model is direct primary care (DPC), in which physicians contract directly with patients to provide care outside the traditional insurance-based system. DPC providers charge their patients a monthly subscription fee, typically ranging from $25 to $125 per person, in exchange for unlimited primary care services.

DPC has emerged as an alternative to the standard fee-for-service model, in which physicians are reimbursed, typically by health insurers, for each service they provide.

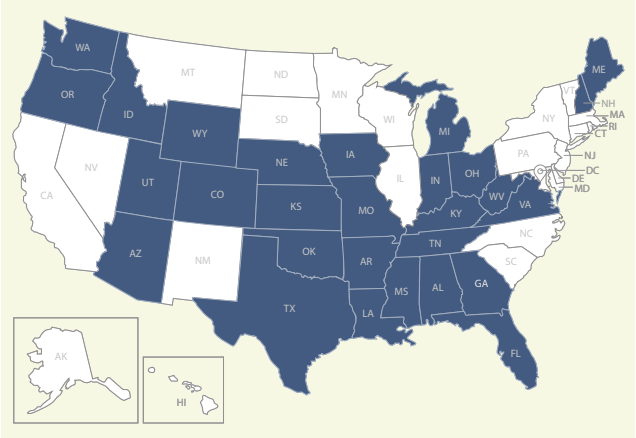
100. Wis. Stat. § 49.45 (61) (b).

Many physicians using this standard payment model cite the administrative burden of billing health insurers—combined with the large patient panels and limited patient interaction that typically occurs in a fee-for-service setting—as a driver of job dissatisfaction, burnout, and early retirement.

Proponents of DPC believe its widespread adoption could improve job satisfaction, revitalize the primary care field, and improve access to care in geographic areas facing physician shortages. While it is too soon to tell whether emerging payment models like DPC will draw more physicians to primary care, many states have enacted laws that support its adoption. At least 28 states—including the midwestern states of Michigan, Iowa, and Indiana—have enacted laws that define DPC in statute and exempt DPC practices from state insurance laws.[101] These states are highlighted in Figure 6.

**Summary of current Wisconsin law**. In Wisconsin, around 25 DPC providers are currently operating lawfully and are not regulated by state insurance law.[102] However, the Wisconsin Office of the Commissioner of Insurance has the authority to decide on a case-by-case basis whether DPC providers are practicing unlawfully.[103] The only statutory requirement under current state law, which applies to all practicing physicians regardless of the payment model they use, is that physicians practice within the scope of their professional licenses, granted by the Wisconsin Medical Examining Board.[104]

Figure 6. **Direct Primary Care legislation enacted**




Source: Legislative Reference Bureau, 2020

In the current session, the Wisconsin State Legislature passed legislation defining DPC in statute and exempting DPC practices from state insurance law.[105] However, this legislation was vetoed in February 2020. Under the status quo, providers may continue to use the DPC payment model in Wisconsin, but no legal protections for physicians or patients exist in state law.

101. For more information regarding DPC, read volume 3, number 2, of the Legislative Reference Bureau's *Wisconsin Policy Project*, titled "Direct Primary Care: State Approaches to Regulating Subscription-Based Medicine."

102. "DPC Frontier Mapper," Direct Primary Care Frontier, accessed October 2, 2019, http://mapper.dpcfrontier.com.

103. Wis. Legis. Council Study Committee on Direct Primary Care, Meeting Materials, Presentation by Elizabeth Hizmi and Zach Bemis, Office of the Commissioner of Insurance: Direct Primary Care and Insurance (July 24, 2018), https://docs.legis.wisconsin.gov.

104. Wis. Stat. § 448.03 (1).

105. Such legislation—Assembly Bill 26—was passed by the Assembly in January 2020 and the bill was concurred in by the Senate in February 2020.

## IV. Policy options for Wisconsin

Countless policy options could reduce the primary care provider shortage in Wisconsin. However, the following seven would build upon existing programs in Wisconsin and other states.

### Support innovative physician payment models

Nationwide, emerging payment models that serve as alternatives to the traditional fee-for-service model, including DPC, are attracting many physicians to the primary care field. According to DPC Frontier, an organization that maps these providers across the country, around 25 DPC providers are currently operating in Wisconsin.[106] Enactment of legislation such as 2019 Assembly Bill 26, which provides statutory protections for providers and subscribers who use the payment model, could lead to increased use of DPC. Such legislation could draw new physicians to primary care across the state. Because DPC providers typically practice outside the traditional insurance-based health care system, an influx of DPC physicians in the state's rural areas—where insurance networks can limit access to care—could be particularly effective.

### Require private health insurers to cover certain telehealth services

More than 80 percent of states across the country regulate or require telehealth reimbursements for certain services covered by private health insurance companies, but Wisconsin does not. Under the status quo, telehealth reimbursement policies vary among the private health insurance companies that are operating in Wisconsin. Companies may opt not to cover care provided via telehealth, even when services could effectively be delivered in that manner and patients with geographic or physical barriers would benefit. Enactment of legislation that requires private insurers to cover certain telehealth services could improve access to care in Wisconsin's rural and shortage areas. Additionally, increasing the use of telehealth services—in both the public and the private sectors—will likely improve the quality of the service over time, increase efficiency in the health care system, and maximize the capacity of the existing provider workforce.

### Improve access to high-speed Internet in rural Wisconsin

Nationwide, approximately 30 percent of rural residents lack access to high-speed Internet or broadband in their homes.[107] In Wisconsin, that number is significantly higher. Forty-three percent of rural residents, or around 748,000 Wisconsinites, lack access to

106. "DPC Frontier Mapper," Direct Primary Care Frontier, accessed March 18, 2020, http://mapper.dpcfrontier.com.

107. Public Service Commission of Wisconsin, "Frequently Asked Questions Regarding the Broadband Expansion Grant, FY 2019," 1, https://psc.wi.gov/.

broadband services.[108] This technological barrier prohibits many rural residents from using telehealth services—particularly those that require live video communications—despite the fact that this population would benefit considerably from their increased use. Through the Broadband Expansion Grant Program, the Wisconsin Public Service Commission is working with Internet providers and underserved communities to expand access to high-speed Internet.[109] When evaluating grant applications, the commission must consider whether proposed projects would enhance "the ability of individuals to access health care services from home."[110] Priority is also given to grant applications that propose public-private partnerships and include matching funds.[111] Since the program was created in 2013, it has awarded over $20 million in grants.[112] Ensuring adequate funding for the program and modifying provisions that make it difficult for some communities to qualify—such as the requirement that the commission prioritize applicants with the ability to contribute matching funds—could improve access to broadband, and subsequently to telehealth services, in rural Wisconsin.[113]

#### Authorize NPs and PAs to practice with greater independence

More than 4,300 advanced practice registered nurses[114] and 2,600 PAs[115] are currently practicing in Wisconsin. Many of these professionals specialize in the delivery of primary care services, either under the supervision of or in collaboration with the state's licensed physicians. Authorizing these nonphysician clinicians to practice with greater autonomy, as many other states have done and as Wisconsin temporarily did during the public health emergency, would likely have an immediate positive impact on the number of primary care providers in the state. Policy options include granting NPs the independent authority to practice within the scope of their licenses without physician oversight; limiting their authority to practice independently to the state's HPSAs; authorizing PAs to practice in less restrictive collaborative relationships with physicians; and identifying NPs and PAs as primary or secondary care providers in statute. Additionally, providing financial incentives for NPs and PAs to provide primary care services in HPSAs and rural areas would likely draw many of them to the state's shortage areas and improve access to care.

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108. Public Service Commission of Wisconsin, "Frequently Asked Questions Regarding the Broadband Expansion Grant, FY 2019," 1.

109. Wis. Stat. § 196.504.

110. Wis. Stat. § 196.504 (2) (c).

111. Wis. Stat. § 196.504 (2) (c).

112. Jillian Slaight, "Connecting the Countryside: Understanding Rural Broadband Expansion in Wisconsin," *Wisconsin Policy Project* 2, no. 10 (Madison, WI: Legislative Reference Bureau, 2019), 12.

113. For more information regarding broadband access in Wisconsin, read volume 2, number 10, of the Legislative Reference Bureau's *Wisconsin Policy Project*, titled "Connecting the Countryside: Understanding Rural Broadband Expansion in Wisconsin."

114. "Wisconsin APRN Coalition," Wisconsin Nurses Association, accessed March 19, 2020, https://wisconsinnurses.org.

115. "Wisconsin Academy of PAs (WAPA)," Wisconsin Academy of Physician Assistants, accessed March 19, 2020, https://wapa.org.

### Fund additional rural residency programs

According to the Wisconsin Collaborative for Rural Graduate Medical Education (GME), 75 medical students per year graduate from Wisconsin medical schools with an interest in rural practice, but only around ten rural training slots are available to them each year.[116] Residencies and training opportunities expose physicians to rural hospitals, clinics, and communities, increasing the likelihood that they will later practice in those areas.[117] Since the Rural Physician Residency Assistance Program was created in 2009, state funding has remained relatively flat, increasing from $1.5 million in biennial appropriations in 2010[118] to $1,718,400 in 2019.[119] Boosting appropriations for the program by a significant amount would fund additional rural residency positions and expose new providers to the state's rural and shortage areas, where they are most needed.

### Increase or create new bonus payments for Medicaid providers

Under current law, primary care physicians, advanced practice nurse prescribers, and PAs receive bonus payments when they treat Medicaid beneficiaries in the state's HPSAs. This financial incentive encourages primary care providers to treat Medicaid beneficiaries in shortage areas. As the population ages and the number of elderly Medicaid beneficiaries grows in the years ahead, ensuring access to care for this population will become increasingly important. Enhancing or creating new Medicaid bonus payments for providers in HPSAs could further incentivize the practice of primary care. Policy options include boosting the current bonus payment rate beyond 120 percent of the standard Medicaid reimbursement; creating a new Medicaid bonus payment for primary care providers who treat patients over age 65 or 85; or creating a new Medicaid bonus payment for primary care providers who deliver services to patients in HPSAs via telehealth. Bonus payments such as these could draw more providers to the primary care field and to the state's rural and shortage areas.

### Fund and expand financial incentives for primary care providers

Several other programs that provide financial incentives to primary care providers under current law could also be expanded in an attempt to mitigate the shortage. For instance, the student loan repayment assistance award for the Physician and Dentist Loan Assistance Program could be increased—temporarily or permanently—from $50,000 to $100,000. Similarly, the award for the Rural Physician Loan Assistance Program could

116. "Become a Rural Training Site," Wisconsin Collaborative for Rural GME, accessed March 19, 2020, https://wcrgme.org.

117. "Become a Rural Training Site," Wisconsin Collaborative for Rural GME.

118. 2009 Wis. Act 190.

119. 2019 Wis. Act 9.

be modified by boosting the award amount beyond $100,000, by decreasing the amount of time that physicians must commit to practicing in rural areas from three years to two years, or by appropriating additional funds so that more awards may be granted each year. Finally, the Primary Care and Psychiatry Shortage Grant Program, which has not received state funding since it was enacted in 2014, could also be modified. Funding the program at the $1.5 million level—the same amount it received in 2014—would allow the program to award grants to 12 primary care physicians and 12 psychiatrists. Increasing funding beyond that amount could allow 15 or 20 grants to be awarded each year. As an additional incentive, the provision that limits awardees to receiving the grant only three times could be eliminated. Adjusting these programs to address the provider shortage, either temporarily or permanently, could draw more physicians to the state's rural and shortage areas.

## V. Moving forward

Wisconsin's primary care provider shortage has been well understood for years, and recent legislative action has incentivized the profession, boosted reimbursements in HPSAs, and encouraged the use of telehealth services, among other things. However, without further legislative action, the state's shortage of primary care providers will likely grow more severe as the baby boomers age and the demand for medical care increases.

To mitigate the shortage, Wisconsin can build upon existing programs and look to other states as models. To date, other states have expanded their primary care workforces or increased their capacity to treat more patients by authorizing nonphysician clinicians to practice with greater independence, by maximizing their use of telehealth services, and by supporting emerging payment models that could draw new providers to primary care specialties.

Several states, including Wisconsin, also temporarily expanded their health care workforces in response to the COVID-19 pandemic. With the enactment of 2019 Act 185 on April 15, 2020, Wisconsin waived the requirement that out-of-state health care providers be licensed in this state, granted temporary credentials to former health care providers, extended the duration of temporary licenses, and waived credential fees for a variety of health professions.[120] These and other measures included in Act 185 improved the ability of the state's health workforce to respond to the public health emergency.

Meeting the health care needs of the rapidly aging population is a public health challenge that can be addressed in large part by simply building upon existing programs and incentives in this state and others. Reducing the primary care provider shortage in the coming years will improve health outcomes, lower costs, and reduce the strain on Wisconsin's health care workforce. ■

120. 2019 Wisconsin Act 185