Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan
FINAL REPORT

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University of Michigan
Institute for Healthcare Policy & Innovation

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EXECUTIVE SUMMARY

The University of Michigan Institute for Healthcare Policy and Innovation (IHPI) is conducting the evaluation required by the Centers for Medicare and Medicaid Services (CMS) of the Healthy Michigan Plan (HMP) under contract with the Michigan Department of Health and Human Services (MDHHS). The fourth aim of Domain IV of the evaluation is to describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

Methods

We conducted 19 semi-structured telephone interviews with primary care practitioners caring for Healthy Michigan Plan patients in five Michigan regions selected to include racial/ethnic diversity and a mix of urban and rural communities. Interviews informed survey items and measures and enhanced the interpretation of survey findings.

We then surveyed all primary care practitioners in Michigan with at least 12 assigned Healthy Michigan Plan patients about practice changes and innovations since April 2014 and their experiences caring for patients with the Healthy Michigan Plan.

Results

The final response rate was 56% resulting in 2,104 respondents.

Knowledge of Patient Insurance

- 53% report knowing a patient's insurance at the beginning of an appointment
- 91% report that it is easy to find out a patient's insurance status
- 35% report intentionally ignoring a patient's insurance status

Familiarity with HMP

- 71% very or somewhat familiar with how to complete a Health Risk Assessment
- 25% very/somewhat familiar with beneficiary cost-sharing
- 36% very/somewhat familiar with healthy behavior incentives for patients
- PCPs working in small, non-academic, non-hospital-based and FQHC practices and those with predominantly Medicaid or uninsured patients reported more familiarity with HMP

Acceptance of Medicaid and HMP

- 78% report accepting new Medicaid/HMP patients – more likely if:
  - Mental health co-location
  - FQHC, Rural practice
  - Salary payment
  - Medicaid/uninsured predominant payer mix
  - Not board certified
  - Younger age, female, non-physician PCPs
  - Detroit practice location
  - Previously provided care to underserved
  - Stronger commitment to caring for underserved
- 73% felt a responsibility to care for patients regardless of their ability to pay
- 72% agreed all providers should care for Medicaid/HMP patients

Changes in Practice

- 52% report an increase in new patients to a great or to some extent
- 57% report an increase in the number of new patients who hadn't seen a PCP in many years
- 51% report established patients who had been uninsured gained insurance
- Most practices hired clinicians (53%) and/or staff (58%) in the past year
- 56% report consulting with care coordinators, case managers and/or community health workers
- 41% said that almost all established patients who request a same or next day appointment can get one; 34% said the proportion getting those appointments had increased over the past year
- Large, academic, hospital-based, and FQHC practices were all more likely to have experienced practice changes and innovations in the prior year
- Practices with predominantly Medicaid or uninsured payer mixes were more likely to have had increased numbers of new patients, and were more likely to have hired new clinicians and/or co-located mental health care

Your working poor people who just were in between the cracks, didn't have anything, and now they've got something, which is great.

Experiences caring for HMP Beneficiaries - Health Risk Assessments

- 79% completed at least one HRA with a patient; most of those completed >10
- 65% don't know if they or their practice has received a bonus for completing HRAs
- PCPs reported completing more HRAs if they
  - Were located in Northern regions
  - Were paid by capitation or salary compared to fee-for-service
  - Reported receiving a financial incentive for completing HRAs
  - Were in a smaller practice (5 or fewer) size
- 58% reported that financial incentives for patients and 55% reported financial incentives for practices had at least a little influence on completing HRAs
- 52% said patients' interest in addressing health risks had at least as much influence
- Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals

What I've heard people say is "I just want to stay healthy or find out if I'm healthy."

ER Use and Decision Making

- 30% felt that they could influence non-urgent ER use by their patients a great deal (and 44% some)
- 88% accepted major or some responsibility as a PCP to decrease non-urgent ER use
- Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex problems
- PCPs identified care without an appointment, being the place patients are used to getting care and access to pain medicine as major influences for non-urgent ER use
- PCPs recommended PCP practice changes, ER practice changes, patient educational initiatives, and patient penalties/incentives when asked about strategies to reduce non-urgent ER use

People who work day shift…It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.

Access

- PCPs with HMP patients who were previously uninsured reported some or great impact on health, health behavior, health care and function for those patients. The greatest impact was for control of chronic conditions, early detection of serious illness, and improved medication adherence
- PCPs reported that HMP enrollees, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, treatment for substance use and counseling for behavior change

I learned a long time ago if the patient doesn't take the medicine, they don't get better…if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it.

It can still take up to six months to see a psychiatrist unless you get admitted to the hospital.

Discussing Costs with Patients

- 22% of PCPs reported discussing out-of-pocket costs with an HMP patient. The patient was the most likely one to bring up the topic
- 56% of the time, such a discussion resulted in a change of management plans

Impact and Suggestions to Improve the Healthy Michigan Plan

We provided PCPs open-ended opportunities in the survey to provide additional information. We asked about the impact of HMP:

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to care and compliance (especially medications), helped people engage in healthy behaviors like quitting smoking and saved lives

And also about suggestions to improve HMP:

- Educating patients about health insurance, health behaviors, when and where to get care, medication adherence and greater patient responsibility
- Improving accessibility to other providers, especially mental health and other specialists, and improve reimbursement
- Educating providers and providing up-to-date information about coverage, formularies, administrative processes and costs faced by patients
- Better coverage for some services (e.g., physical therapy)
- Formularies should be less limited, more transparent and streamlined across plans
- Decrease patient churn on/off insurance

Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

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The University of Michigan Institute for Healthcare Policy and Innovation (IHPI) is conducting the evaluation required by the Centers for Medicare and Medicaid Services (CMS) of the Healthy Michigan Plan (HMP) under contract with the Michigan Department of Health and Human Services (MDHHS). The fourth aim of Domain IV of the evaluation is to describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

METHODS

IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS

Sample: To develop PCP survey items and measures, and to enhance the interpretation of survey findings, we conducted 19 semi-structured interviews with primary care practitioners caring for Medicaid/Healthy Michigan Plan patients between December 2014 and April 2015. These interviews were conducted in five Michigan regions: Detroit, Kent County, Midland/Bay/Saginaw Counties, Alcona/Alpena/Oscoda Counties, and Marquette/Baraga/Iron Counties. These regions were purposefully selected to include racial/ethnic diversity and a mix of urban and rural communities. Interviewees were both physicians and non-physician practitioners who worked at small private practices, Federally Qualified Health Centers (FQHCs), free/low-cost clinics, hospital-based practices, or rural practices.

Interview Topics: Topics included: provider knowledge/awareness of patient insurance and experiences caring for HMP patients, including facilitators and challenges of accessing needed care; changes in practice, due to or to meet the needs of HMP patients; how decisions were made about whether to accept Medicaid/HMP patients and what might change PCPs' acceptance of new Medicaid/HMP patients in the future; provider and patient decision-making about ER use; experience with Health Risk Assessments (HRAs), and any knowledge or conversation with patients about out of pocket costs.

Analysis: Interviews were audio recorded, transcribed and coded iteratively using grounded theory and standard qualitative analysis techniques.[1,2] Quotations that illustrate key findings included in this report were drawn from these interviews.

SURVEY OF PRIMARY CARE PRACTITIONERS

To evaluate the impact of the Healthy Michigan Plan, we surveyed primary care practitioners about their experiences caring for Healthy Michigan Plan beneficiaries, new practice approaches and innovations, and future plans.

Sample: The sample was drawn from the 7,360 National Provider Identifier (NPI) numbers assigned in the MDHHS Data Warehouse as the primary care provider for at least one Healthy Michigan Plan managed care member as of April 2015. Eligible for the survey were those with at least 12 assigned members (an average of one per month); 2,813 practitioners were excluded based on <12 assigned members. Of the remaining 4,547 NPIs, 25 were excluded because the NPI entity code did not reflect an individual physician (20 were organizational NPIs, 4 were deactivated, and 1 was invalid). Also excluded were 161 physicians with only pediatric specialty; 4 University of Michigan physicians involved in the Healthy Michigan Plan evaluation; and 35 physicians with out-of-state addresses >30 miles from the Michigan border. After exclusions, 4,322 primary care practitioners (3686 physicians and 636 nurse practitioners/physician assistants) remained as the survey sampling frame.

Survey Design: The survey included measures of primary care practitioner and practice characteristics, and measures related to the Healthy Michigan Plan on a variety of topics, including:

- Plans to accept new Medicaid patients
- Perceptions of difficulty accessing care for Healthy Michigan Plan beneficiaries with parallel questions about difficulty accessing care for privately insured patients
- Experiences with Healthy Michigan Plan beneficiaries regarding decision making about emergency department use
- Perceptions of influences on non-urgent ER use by Healthy Michigan Plan beneficiaries
- Practice approaches in place to prevent non-urgent ER use
- Experiences of caring for newly insured Medicaid patients, including ability to access non-primary care (specialty care, equipment, medication, dental care, mental health care)
- New practice approaches adopted within the previous year
- Future plans regarding care of Medicaid patients

Drs. Goold, Campbell and Tipirneni developed the survey questions in collaboration with other members of the research team. The development process began by identifying the key survey domains through an iterative process with the members of the evaluation team. Then, literature searches identified survey items and scales measuring the domains of interest.[3-8] For domains without existing valid measures, items were developed from data collected from the 19 semi-structured individual interviews with PCPs. New items were cognitively pretested with two primary care practitioners who serve Healthy Michigan Plan patients, one MD from a low-cost clinic and one PA from a private practice. Both practitioners were asked about their understanding of each original survey item, their capacity to answer these questions, and how they would answer said items. The final survey itself was pretested with one PCP for timing and flow.

Survey Administration: Primary care provider addresses were identified from the MDHHS data warehouse Network Provider Location table, the MDHHS Provider Enrollment Location Address table, and the National Plan & Provider Enumeration System (NPPES) registry detail table linked to NPI. Research assistants reviewed situations where primary care practitioners had multiple addresses, and selected (a) the address with more detail (e.g., street address + suite number, rather than street alone), (b) the address that occurred in multiple databases, or (c) the address that matched an internet search for that physician.

The initial survey mailing occurred in June 2015 and included a personalized cover letter describing the project, a Fact Sheet about the Healthy Michigan Plan, a hard copy of the survey, a $20 bill, and a postage-paid return envelope. The cover letter gave information on how to complete the survey via Qualtrics, rather than hard copy. Two additional mailings were sent to nonrespondents in August and September 2015. Data from mail surveys returned by November 1, 2015, were entered in an excel spreadsheet, reviewed for accuracy, and subsequently merged with data from Qualtrics surveys.

Survey Response Characteristics: Of the original sample of 4,322 primary care practitioners in the initial sample, 501 envelopes were returned as undeliverable. Of the 2,131 primary care practitioners who responded, 1,986 completed a mailed survey, 118 completed a Qualtrics survey, and 27 were ineligible (e.g., retired, moved out of state). The final response rate was 56% (54% for physicians, 65% for nurse practitioners/physician assistants).

Comparison of the 2,104 eligible respondents and the 1,690 nonrespondents revealed no differences in gender, birth year, number of affiliated Medicaid managed care plans, and FQHC designation. More nonrespondents had internal medicine specialty.

Table 1. Comparison of Respondents to Nonrespondents

	Respondents N=2104	Nonrespondents N=1690	p
Gender			
Female	44.6	43.7	0.55
Male	55.4	56.3	
Birth Year			
1970 or earlier	71.0	69.5	0.32
1971 or later	29.0	30.5	
Medicaid Managed Care Plans			
1 plan	20.5	20.1	0.48
2 plans	27.2	25.7	
3 or more plans	52.3	54.2	
Practice setting			
FQHC	14.9	14.7	0.86
Not FQHC	85.1	85.3	
Specialty			
Family/general practice	54.5	51.0	
Internal medicine	27.3	36.3	<.0001
Nurse practitioner/physician assistant	17.0	11.3	
Ob-gyn/other	1.2	1.4	

Analysis: We calculated descriptive statistics such as proportion of primary care practitioners reporting difficulty accessing specialty care for Healthy Michigan Plan beneficiaries or experiences related to emergency department decision making. Examination of differences between primary care practitioners by rural vs. urban practice, gender, specialty, years in practice, size of practice, number of Healthy Michigan Plan beneficiaries and proportion of assigned beneficiaries with a primary care visit and/or emergency department visit in the preceding 12 months using χ^2 testing for dichotomous outcomes and *t*-test for continuous outcomes. For analyses adjusting for differences between groups, we used multivariable logistic regression for dichotomous outcomes and linear regression for continuous outcomes. Quotes from practitioner interviews have been used to expound upon some key findings from our analysis of survey data.

SURVEY OF PRIMARY CARE PRACTITIONERS
RESULTS

Survey results are presented in the following format:

Topic

Key findings
Illustrative quote(s) from PCP interviews
Tables of Results
Results of analysis of relationships (e.g., chi-square, multivariable logistic regression)

Respondents' Personal, Professional and Practice Characteristics

Just over half of respondents were men. About 80% self-identified as white. Eleven percent identified as Asian/Pacific Islander, with small numbers in other racial and ethnic groups. More than 80% of respondents were physicians, although nearly three-quarters had nonphysician providers in their practice. About half identified their specialty as family medicine and a quarter as internal medicine. More than half were in practices with 5 or fewer providers; 15% practiced in FQHCs. Three-quarters of PCP respondents practiced in urban settings, 31% in Detroit. Their self-reported payer mix varied; about one-third had Medicaid/HMP as the predominant payer.

Table 2. Personal, Professional and Practice Characteristics of PCP Respondents (N=2104)

Personal characteristics		
Gender	N	%
Male	1165	55
Female	939	45
Race[3]		
White	1583	79
Black/African-American	93	5
Asian/Pacific Islander	224	11
American Indian/Alaska Native	10	<1
Other	86	4
Ethnicity[3]		
Hispanic/Latino	46	2
Non-Hispanic/Latino	1978	98
Professional characteristics		
Provider type	N	%
Physician	1750	83
Non-Physician (NP/PA)	354	17
Specialty		
Family medicine	1123	53
Internal medicine	507	24
Medicine-Pediatrics	67	3
General practice (GP)	24	1
Obstetrics/Gynecology (OB/Gyn)	12	<1
Nurse practitioner (NP)	192	9
Physician's Assistant (PA)	165	8
Other	14	<1
Board/Specialty certification[4]	N	%
Yes	1695	82
No	383	18

Table 2 (continued). Personal, Professional and Practice Characteristics of PCP Respondents

Years in practice[5]		
<10 years	520	26
10-20 years	676	34
>20 years	810	40
Provider ownership of practice[6]		
Full-owner	446	22
Partner/part-owner	232	11
Employee	1352	1352
Practice characteristics		
Practice size (mean, median, SD)[4]	7.5, 5, 16.5	
Small (≤5 practitioners)[a]	1157	57.5
Large (≥6 practitioners)	855	42.5
Presence of non-physician practitioners in practice[b]	1275 (72%)	72
Federally qualified health center (FQHC)	311 (15%)	15
University/teaching hospital practice	276 (13%)	13
Hospital-based practice (non-teaching)	643 (31%)	31
Payer mix (current % of patients with insurance type)[5]	Mean %	SD
Private	32.8%	19.8
Medicaid	23.3%	18.3
Healthy Michigan Plan	10.9%	11.8
Medicare	30.2%	16.7
Uninsured	5.8%	7.1
Predominant payer mix[c]	N	%
Private	522	27
Medicaid/Healthy Michigan Plan	686	36
Medicare	645	34
Uninsured	15	<1
Mixed	37	2
Payment arrangement[7]		
Fee-for-service	784	38
Salary	946	45
Capitation	44	2
Mixed	275	13
Other	40	2
Urbanicity[d]		
Urban	1584	75
Suburban	193	9
Rural	327	16

[a] Dichotomized at sample median
[b] >5% missing
[c] Composite variable of all current payers: payer is considered predominant for the practice if >30% of physician's patients have this payer type and <30% of patients have any other payer type. "Mixed" includes practices with more than one payer representing >30% of patients, or practices with <30% of patients for each payer type.
[d] Zip codes and county codes were linked to the U.S. Department of Agriculture Economic Research Service 2013 Urban Influence Codes to classify regions into urban (codes 1-2), suburban (codes 3-7) and rural (codes 8-12) designations.

Knowledge of Patient Insurance

Because we relied on PCPs to report their experiences caring for patients with Healthy Michigan Plan coverage we asked them questions about their knowledge of patients' insurance status.

Key findings: About half report knowing what kind of insurance a patient has at the beginning of an encounter. Nearly all report that it is easy to find out a patient's insurance status. About a third report intentionally ignoring a patient's insurance status.

Table 3. Knowledge of Patients' Insurance Status

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
If I need to know a patient's insurance status it is easy to find out (n=2081)	904 (43.4%)	982 (47.2%)	131 (6.3%)	57 (2.7%)	7 (0.3%)
I know what kind of insurance a patient has at the beginning of an encounter (n=2081)	442 (21.2%)	671 (32.2%)	342 (16.4%)	427 (20.5%)	199 (9.6%)
I ignore a patient's insurance status on purpose so it doesn't affect my recommendations (n=2078)	294 (14.1%)	433 (20.8%)	549 (26.4%)	577 (27.8%)	225 (10.8%)
I only find out about a patient's insurance coverage if they have trouble getting something I recommend (n=2071)	281 (13.6%)	551 (26.6%)	393 (19.0%)	649 (31.3%)	197 (9.5%)

Familiarity with Healthy Michigan Plan

Key findings: PCPs report familiarity with how to complete and submit a Health Risk Assessment. They report less familiarity with beneficiary cost-sharing and rewards, and the availability of specialists and mental health services. PCPs working in small, non-academic, non-hospital-based and FQHC practices reported more familiarity with Healthy Michigan Plan.

> *[O]ne of our challenges…from an FQHC standpoint, when we have patients that do have Medicaid, we do get an increased reimbursement. So that number…being aware of that is, I think, very important for all of the providers in the clinic and probably all of the staff as well.*
>
> – Urban physician, FQHC

In general, how familiar are you with the Healthy Michigan Plan? (n=2031)

Very familiar	Somewhat familiar	A little familiar	Not at all familiar
307 (15.1%)	776 (38.2%)	557 (27.4%)	391 (19.3%)

Table 4. Familiarity with Healthy Michigan Plan

How familiar are you with the following:	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
How to complete a Health Risk Assessment	966 (47.6%)	472 (23.3%)	276 (13.6%)	314 (15.5%)
How to submit a Health Risk Assessment	700 (34.6%)	469 (23.2%)	355 (17.5%)	501 (24.7%)

Table 4 (continued). Familiarity with Healthy Michigan Plan

How familiar are you with the following:	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
Healthy behavior incentives that Healthy Michigan Plan Patients can receive	257 (12.6%)	481 (23.7%)	548 (27.0%)	746 (36.7%)
Specialists available for Healthy Michigan Plan patients	189 (9.3%)	553 (27.3%)	533 (26.3%)	752 (37.1%)
Mental health services available for Healthy Michigan Plan patients	156 (7.7%)	369 (18.2%)	564 (27.8%)	943 (46.4%)
Out-of-pocket expenses Healthy Michigan Plan Patients have to pay	137 (6.7%)	377 (18.6%)	577 (28.4%)	940 (46.3%)

We hypothesized that PCPs in different practice settings would differ in their familiarity with Healthy Michigan Plan. We found that PCPs working in **small**, **non-academic**, **non-hospital-based** and **FQHC** practices, as well as practices with **predominantly Medicaid or uninsured payer mixes**, reported greater familiarity with Healthy Michigan Plan. Differences in familiarity based on practice size, academic or hospital-based status were relatively modest.

Acceptance of Medicaid and Healthy Michigan Plan

Key findings:

About 4 in 5 survey respondents reported accepting <u>new</u> Medicaid/Healthy Michigan Plan patients. Most PCPs reported having at least some influence on that decision. Capacity to accept any new patients was rated as a very important factor in decisions to accept Medicaid/Healthy Michigan Plan patients.

> *We accept all comers. Period. Doors are open. Come on in. But I have to add a comment to that or a clarification…a qualification to that. My nurse manager…The site manager just came to me on Monday of this week and said, "You know, [name], if a person wants a new appointment with you, we're scheduling…It's like the end of April. There are so many patients now that are in the system that even for routine follow-up stuff, we can't get them in."*
>
> – Urban physician, FQHC

Mental health co-location, reimbursement/payment arrangements, and attitudes about caring for the underserved were associated with PCP acceptance of Medicaid/Healthy Michigan Plan patients in multivariable analyses. PCP respondents who were younger, female, non-physician practitioners, not board-certified, practicing in rural areas or FQHCs or in practices with predominantly Medicaid or uninsured payer mixes were all more likely to accept new Medicaid/Healthy Michigan Plan patients.

> *[A]s long as the rural health center plans still pay me adequately, I don't foresee making any changes. If they were to all of a sudden say, "Okay, we're only going to reimburse 40% or 50% of what we used to," that would be enough to put me out of business. So I would think twice about seeing those patients then, but as long as they continue the way they have been for the last six years that I've owned the clinic, I don't see making any changes. It works just fine.*
>
> – Rural nurse practitioner, Rural health center

PCPs in the Detroit area were more likely to accept new Medicaid/Healthy Michigan Plan patients than PCPs in other regions of the state. Of PCPs' <u>established patients</u>, an average of 11% had Healthy Michigan Plan and 23% had Medicaid as their primary source of coverage (see demographics table, pg. 4-5).

Most PCPs reported providing care in a setting that serves poor and underserved patients with no anticipation of being paid in the past three years, and nearly three-quarters felt a responsibility to care for patients regardless of their ability to pay. Nearly three-quarters agreed all practitioners should care for Medicaid/Healthy Michigan Plan patients.

We asked PCPs whether they were currently accepting new patients with Healthy Michigan Plan and other types of insurance:

Table 5. Acceptance of New Patients by Insurance Type[5]

Accepting *new* patients, by type of insurance	n (%)
Private	1774 (87%)
Medicaid*	1517 (75%)
Healthy Michigan Plan*	1461 (73%)
Medicare	1717 (84%)
No insurance (i.e., self-pay)	1541 (76%)
*Combined, 1575 (78%) of PCP respondents reported accepting new patients with either Healthy Michigan Plan or Medicaid.	

How much influence do you have in making the decision to accept or not accept Medicaid or Healthy Michigan Plan patients in your practice?[8]

The decision is entirely mine	I have a lot of influence	I have some influence	I have no influence
459 (23%)	275 (14%)	425 (21%)	866 (43%)

Table 6. Importance for Accepting New Medicaid or Healthy Michigan Plan Patients

Please indicate the importance of each of the following for your practice's decision to accept new Medicaid or Healthy Michigan Plan patients:	Very important	Moderately important	Not very important	Not at all important	Don't know
Capacity to accept new patients with any type of insurance	774 (38%)	638 (31%)	187 (9%)	177 (9%)	273 (13%)
Reimbursement amount	532 (26%)	613 (30%)	274 (13%)	310 (15%)	327 (16%)
Availability of specialists who see Medicaid or Healthy Michigan Plan patients	528 (26%)	617 (30%)	310 (15%)	284 (14%)	313 (15%)
Psychosocial needs of Medicaid or Healthy Michigan Plan patients	404 (20%)	623 (30%)	376 (18%)	344 (17%)	304 (15%)
Illness burden of Medicaid or Healthy Michigan Plan patients	370 (18%)	574 (28%)	442 (22%)	370 (18%)	296 (14%)

We asked PCPs about their prior experience and attitudes toward caring for poor or underserved patients. A majority reported providing care in a setting that serves poor and underserved patients with no anticipation of being paid.

Table 7. Attitudes About Caring for Poor or Underserved Patients

	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
All practitioners should care for some Medicaid/Healthy Michigan Plan patients	941 (45%)	555 (27%)	346 (17%)	150 (7%)	81 (4%)
It is my responsibility to provide care for patients regardless of their ability to pay	874 (42%)	642 (31%)	282 (14%)	190 (9%)	78 (4%)
Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice	418 (20%)	590 (29%)	746 (36%)	246 (12%)	67 (3%)
Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction	379 (18%)	543 (26%)	794 (39%)	260 (13%)	88 (4%)

We hypothesized that acceptance of new Medicaid/Healthy Michigan Plan patients would vary by PCPs' personal, professional and practice characteristics. In multivariable analyses, **we found that PCP respondents who were younger, female, non-physician practitioners (OR 3.38, p<0.001), not board-certified, practicing in rural areas or FQHCs or in practices with predominantly Medicaid or uninsured payer mixes were all more likely to accept new Medicaid/Healthy Michigan Plan patients.** The presence of non-physician practitioners in the practice was not statistically significantly associated with acceptance. PCPs in the **Detroit area** were more likely to accept new Medicaid/Healthy Michigan Plan patients than PCPs in other regions of the state.

PCPs were also more likely to accept new Medicaid/Healthy Michigan Plan patients if **paid by salary** vs. other payment arrangements (OR 2.08, p<0.001) or had **co-location of mental health** within primary care (OR 1.42, p=0.07; when not adjusted for predominant payer, OR 1.48, p=0.03). In addition, PCPs who had **previously provided care to poor and underserved patients** (OR 1.59, p<0.001) or who expressed **stronger commitment to caring for the underserved** (OR 1.15 for composite score, which may underestimate strength of association, p<0.001) were more likely to accept new Medicaid/Healthy Michigan Plan patients. They were less likely to accept new Healthy Michigan Plan/Medicaid patients if they deemed overall capacity to accept new patients very/moderately important (OR 0.51, p<0.001) or deemed reimbursement amounts very/moderately important (OR 0.75, p=0.02).

Changes in Practice

Key findings:

Most PCPs reported an increase in new patients and in the number of new patients who hadn't seen a PCP in many years.

> *Really the only thing I know about the expansion is in early 2014 we started getting a way lot more requests for a new patient visit than we've ever had before. I was just like, "what is going on? We don't get 25 requests for new patients/month." So when it started really climbing, that's when I figured out, "Okay. It's probably due to the Obamacare Medicaid expansion."*
>
> – Urban physician; Small, private practice

Most reported established patients who had been uninsured gained insurance. Fewer reported patients changing from other insurance to Healthy Michigan Plan.

Your working poor people who just were in between the cracks, didn't have anything, and now they've got something, which is great.

– Urban physician, FQHC

Most practices hired clinicians and/or staff in the past year. Most reported consulting with care coordinators, case managers and/or community health workers.

About a third of PCPs reported that the portion of established patients able to obtain a same- or next-day appointment had increased over the previous year.

Large, academic, hospital-based, and FQHC practices were all more likely to have experienced practice changes and innovations in the prior year. Practices with predominantly Medicaid or uninsured payer mixes were more likely to have had increased numbers of new patients, and were more likely to have hired new clinicians and/or co-located mental health care.

Table 8. Experiences of Practices Since April 2014

To what extent has your practice experienced the following since Healthy Michigan Plan began in April 2014?	To a great extent	To some extent	To a little extent	Not at all	Don't know
Increase in the number of new patients who haven't seen a primary care practitioner in many years (n=2020)	496 (24.6%)	638 (31.6%)	407 (20.1%)	130 (6.4%)	349 (17.3%)
Increase in number of new patients (n=2021)	351 (17.4%)	706 (34.9%)	389 (19.2%)	195 (9.6%)	380 (18.8%)
Existing patients who had been uninsured or self-pay gained insurance (n=2019)	321 (15.9%)	701 (34.7%)	502 (24.9%)	108 (5.3%)	387 (19.2%)
Existing patients changed from other insurance to Healthy Michigan Plan (n=2019)	110 (5.4%)	529 (26.2%)	576 (28.5%)	176 (8.7%)	628 (31.1%)

Table 9. Changes Made to PCP Practices Within the Past Year

Has your practice made any of the following changes in the past year? (check all that apply)	Checked	Not Checked‡
Hired additional clinicians	1120 (53.2%)	984 (46.8%)
Hired additional office staff	1209 (57.5%)	895 (42.5%)
Consulted with care coordinators, case managers, community health workers	1174 (55.8%)	930 (44.2%)
Changed workflow processes for new patients	878 (41.7%)	1226 (58.3%)
Co-located mental health within primary care	325 (15.4%)	1779 (84.6%)
‡288 (13.7%) participants did not check any boxes indicating that their practice had made changes in the previous year. This data was factored into the "Not Checked" category for each potential response.		

What proportion of your established patients who request a same- or next-day appointment at your primary practice can get one? (n=2033)[7]

Almost all (>80%)	Most (60-80%)	About half (~50%)	Some (20-40%)	Few (<20%)	Don't know
826 (40.6%)	527 (25.9%)	237 (11.7%)	287 (14.1%)	122 (6.0%)	34 (1.7%)

Over the past year, this proportion has:

Increased	Decreased	Stayed the same	Don't know
682 (34.0%)	316 (15.8%)	883 (44.1%)	123 (6.1%)

We anticipated that practice characteristics could be associated with the likelihood of changes in practice and adoption of new processes for Healthy Michigan Plan patients. We found that **large**, **academic**, **hospital-based**, and **FQHC** practices were all more likely to have experienced practice changes and innovations in the prior year. In addition, practices with **predominantly Medicaid or uninsured payer mixes** were more likely to have had increased numbers of new patients, and correspondingly were more likely to have hired new clinicians or co-located mental health care.

Experiences Caring for Healthy Michigan Plan Beneficiaries

Health Risk Assessments

Key findings:

About four-fifths of PCPs who responded to the survey have completed at least one HRA with a patient; over half of those have completed more than 10.

Most PCPs reported their practice has a process in place for submitting HRAs, but not for identifying patients who needed HRAs completed. Some PCPSs reported having been contacted by a health plan about a patient who needed to complete an HRA. Most don't know whether they or their practice has received a financial incentive for completing HRAs. PCPs reported completing more HRAs if they were located in Northern regions, reported a Medicaid or uninsured predominant payer mix, payment by capitation or salary, compared to fee-for-service, receiving a financial incentive for completing HRAs, smaller practice size, and co-location of mental health in primary care.

Most PCPs reported that financial incentives for patients and practices had at least a little influence on completing HRAs. According to PCPs, patients' interest in addressing health risks had at least as much influence.

> *We finally get the chance to do prevention because if someone doesn't have insurance and doesn't see a doctor, then there's no way we can do any kind of prevention. We're just kind of dealing with the end-stage results of whatever's been going on and hasn't been treated. So I mean what I've heard people say is "I just want to stay healthy or find out if I'm healthy," and to me that says a lot. We can at least find out where they stand in terms of chronic illness or if they have any or if they are healthy, how can we make sure that they stay that way?*
>
> – Urban physician; Large, hospital-based practice

Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals. Most found them at least a little useful for getting patients to change behavior.

> *I recently… In the last month, I've signed up two people [for Weight Watchers…two or three people to that, and one of them is really sticking to it. She's already lost 10 pounds.*
>
> – Urban physician; Small, private practice

Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients? (n=2032)

None	1-2	3-10	More than 10
420 (20.7%)	235 (11. 6%)	503 (24.8%)	874 (43.0%)

How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit? (n=1923)

Almost always	Often	Sometimes	Rarely/never
215 (11.2%)	416 (21.6%)	720 (37.4%)	572 (29.7%)

Table 10. Experience with Health Risk Assessments

Please report your experience with the following:	Yes	No	Don't know
My practice has a process to submit completed HRAs to the patient's Medicaid Health Plan. (n=2041)	1250 (61.2%)	176 (8.6%)	615 (30.1%)
My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA. (n=2042)	697 (34.1%)	514 (25.2%)	831 (40.7%)
I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA. (n=2040)	678 (33.2%)	438 (21.5%)	924 (45.3%)
I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs. (n=2033)	367 (18.1%)	339 (16.7%)	1327 (65.3%)

Table 11. Influence on Completing HRA

How much influence do the following have on completion and submission of the Health Risk Assessment?	A great deal	Some	A little	No	Don't know
Financial incentives for patients (n=2046)	549 (26.8%)	486 (23.8%)	155 (7.6%)	294 (14.4%)	562 (27.5%)
Patients' interest in addressing health risks (n=2046)	437 (21.4%)	618 (30.2%)	374 (18.3%)	181 (8.8%)	436 (21.3%)
Financial incentives for practices (n=2044)	374 (18.3%)	502 (24.6%)	258 (12.6%)	353 (17.3%)	557 (27.3%)

Table 12. Usefulness of HRA

For Healthy Michigan Plan patients who have completed their HRA, how useful has this been for each of the following?	Very useful	Somewhat useful	A little useful	Not at all useful
Discussing health risks with patients (n=1828)	601 (32.9%)	733 (40.1%)	311 (17.0%)	183 (10.0%)
Persuading patients to address their most important health risks (n=1828)	484 (26.5%)	712 (38.9%)	415 (22.7%)	217 (11.9%)
Identifying health risks (n=1833)	471 (25.7%)	769 (42.0%)	369 (20.1%)	224 (12.2%)
Documenting patient behavior change goals (n=1826)	409 (22.4%)	716 (39.2%)	449 (24.6%)	252 (13.8%)
Getting patients to change health behaviors (n=1821)	277 (15.2%)	582 (32.0%)	652 (35.8%)	310 (17.0%)

We hypothesized that PCPs who identify a process in place at their practice for identifying patients who need to complete an HRA, and a process in place for submitting an HRA, would report completing more HRAs and that was confirmed. PCPs reporting greater familiarity with healthy behavior incentives and out of pocket expenses faced by patients also reported completing more HRAs.

PCPs were more likely to report their practice had a process for submitting HRAs if they reported:

- Smaller practice size
- They or their practice consulted with care coordinators, case managers, or community health workers
- They or their practice changed workflow processes for new patients
- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern, Mid-state, or Detroit regions, compared with the Southern region

PCPs were more likely to report a practice to identify patients who needed to complete an HRA if they reported:

- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern, Mid-state, or Detroit regions, compared with the Southern region

PCPs reported completing more HRAs if they reported:

- Smaller practice size
- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- Payment by capitation or salary, compared with fee-for-service
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern regions of the state compared with other regions

ER Use and Decision Making

Key findings:

The majority of PCPs surveyed felt that they could influence ER utilization trends for their Medicaid patient population and nearly all accepted responsibility for playing a role in reducing non-urgent ER use. Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex problems, but were less likely to offer transportation services.

PCPs reported that accessibility to pain medication and evaluations without appointments are major drivers of ER use, along with patients' comfort with accessing ER services.

> *People who work day shift… It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.*
>
> – Rural physician; Small, private practice

> *I think that a lot of it is cultural. I don't mean ethnic culture. I mean just culture… There are some people who that is just what they understand, and that is how they operate. They've seen people do it for years, and they've done it and they just feel comfortable with that.*
>
> – Urban physician assistant, FQHC

PCPs recommended PCP practice changes, ER practice changes, patient educational initiatives, and patient penalties/incentives when asked about strategies to reduce non-urgent ER use.

How much can PCPs influence non-urgent ER use by their patients?

A great deal	Some	A little	Not at all
608 (29.9%)	886(43.6%)	460(22.6%)	80(3.9%)

To what extent do you think it is your responsibility as a PCP to decrease non-urgent ER use?

Major Responsibility	Some Responsibility	Minimal responsibility	No responsibility
740 (36.5%)	1035 (51.0%)	212 (10.4%)	43 (2.1%)

Table 13. PCP Practice Offerings to Avoid Non-Urgent ER Use

Does your practice offer any of the following to help Healthy Michigan Plan patients avoid non-urgent ER use?	Yes	No	Don't know
Walk-in appointments	1336 (66.5%)	607 (30.2%)	67 (3.3%)
Assistance with arranging transportation to appointments	615(30.6%)	1144 (57.0%)	249 (12.4%)
24-hour telephone triage	1492 (74.0%)	438 (21.7%)	85 (4.2%)
Appointments during evenings and weekends	1122(55.8%)	819(40.7%)	71 (3.5%)
Care coordination/social work assistance for patients with complex problems	1134 (56.5%)	672 (33.5%)	202(10.1%)

Table 14. Influence on Non-Urgent ER Use

In your opinion, to what extent do the following factors influence non-urgent ER use?	Major influence	Minor influence	Little or no influence
The ER will provide care without an appointment	1679 (82.7%)	273 (13.4%)	78 (3.8%)
Patients believe the ER provides better quality of care	341 (16.8%)	798 (39.4%)	887 (43.8%)
The ER offers quicker access to specialists	614 (30.3%)	723 (35.7%)	691 (34.1%)
Hospitals encourage use of the ER	377 (18.7%)	577 (28.7%)	1058 (52.6%)
The ER offers access to medications for patients with chronic pain	1030 (50.7%)	646 (31.8%)	355 17.5%)
The ER is where patients are used to getting care	1204 (59.5%)	633 (31.3%)	186 (9.2%)

Nearly three-quarters of PCPs felt that they could have "a great deal/some" influence on non-urgent ER use. This finding was associated with **fewer years in practice** and an **increased number of practice changes,** of which **changing workflow for new patients** and **care coordination or social work assistance** for complex problems seemed to be the more significant drivers of that trend.

Nearly nine-tenths of PCPs surveyed felt that they had "a major/some" responsibility to decrease non-urgent ER use. This sense of responsibility was associated with **fewer years in practice**, and a **greater number of practice changes**. More specifically, **having care coordinators/case managers/community health workers** seemed to drive that trend. **Increasing familiarity with specialists or mental health services available for Healthy Michigan Plan patients** was also associated with increased responsibility to decrease non-urgent ER use.

When asked how to reduce non-urgent ER use (open-ended, write-in question), many respondent suggestions addressed **PCP availability** (e.g., increases in the workforce) and changes in **PCP practice** (e.g., extended hours, same-day appointments, improved follow-up). They also recommended gatekeeper

strategies, non-primary care options (e.g., urgent care clinics) and greater use of care coordinators and case managers.

Some PCPs suggested **modifications to ER practice**, such as diversion to PCPs, nearby urgent care sites or reducing payment to hospitals/ER practitioners. Others recommended **limiting pain medication** prescriptions in the ER. A few PCPs suggested that the Emergency Medical Treatment and Labor Act (EMTALA) be changed to allow ER practitioners to more readily divert patients to other settings, along with altering the "litigation culture."

Patient educational initiatives were also recommended, for example to clarify "when to seek care," awareness of available alternative services, enhancing patient "coping" and self-management skills, as well as increased transparency on the costs associated with ER care.

Most commonly, PCPs recommended **patient penalties**. Financial penalties were overwhelmingly co-pays, or point-of care payment for ER visits, particularly for visits that do not result in a hospital admission or for patients deemed "high utilizers." Non-financial penalties included having the patient dismissed from the practice panel, or by the insurer.

Others suggested instituting **financial incentives to encourage patients to contact their PCP** prior to seeking ER care, or suggested both increasing out of pocket costs for ER visits while lowering or eliminating costs for visits to primary or urgent care.

Access

Key findings:

PCPs with Healthy Michigan Plan patients who were previously uninsured reported some or great impact on health, health behavior, health care and function for those patients. The greatest impact was reported for control of chronic conditions, early detection of serious illness, and improved medication adherence.

> *One patient…a 64-year-old gentleman who has lived in Michigan or at least lived in the United States for 40 years and had never pursued primary care. Upon receiving health insurance and upon his daughter's recommendation, he pursued care and that was his first…according to him, his first physical evaluation of any sort in 40 years, and he has just....It wasn't a full health maintenance exam. It was a new patient evaluation, and in the time in that initial evaluation he was found to be hypertensive. Upon subsequent labs, you know, ordered on that visit, he was found to be diabetic and upon routine referral at that initial visit for an eye exam, given his hypertension, he was found to have had…hemianopia, which later was determined to be caused by a prior stroke.*
>
> – Urban physician assistant, FQHC

> *Well, I learned a long time ago if the patient doesn't take the medicine, they don't get better. There are a lot of different reasons they don't take it, but the easy one is that if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it….if they have financial barriers to getting that done, they're not going to get it done. So I'd say it has a humungous effect.*
>
> – Rural physician, FQHC

PCPs reported that Healthy Michigan Plan patients, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, treatment for substance use and counseling for behavior change (all, p<.001).

> *It can still take up to six months to see a psychiatrist unless you get admitted to the hospital… the ones that work for the hospital that don't take Medicaid or Medicare. And then at discharge, you*

really aren't going to see the other psychiatrist any quicker. It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then.

– Urban physician; Small, private practice

He has a job that I think he gets paid $9/hour to work, and he's like a super hard-working guy….I think his son has like…is 14 years old with…mental disabilities,….So now we're talking about a man that needs to get a super expensive medication….Although I feel like I'm a great primary care doc, sometimes, you know, those medications and the follow-up need to probably…There needs to be a team….some teamwork between the rheumatologist and the primary care doctor, and we couldn't get him back in.

– Urban physician, FQHC

Table 15. Impact of Healthy Michigan Plan on Previously Uninsured Patients

Please think about what has changed for your patients who were previously uninsured and are now covered by the Healthy Michigan Plan. Rate the extent to which you think the Healthy Michigan Plan has had an impact on each of the following for these patients:	Great impact	Some impact	Little impact	No impact	Don't know
Better control of chronic conditions	701 (35%)	789 (39.4%)	139 (6.9%)	30 (1.5%)	346 (17.3%)
Early detection of serious illness	674 (33.7%)	748 (37.4%)	153 (7.6%)	40 (2%)	387 (19.3%)
Improved medication adherence	568 (28.3%)	817 (40.8%)	215 (10.7%)	54 (2.7%)	350 (17.5%)
Improved health behaviors	323 (16.1%)	811 (40.4%)	378 (18.9%)	106 (5.3%)	387 (19.3%)
Better ability to work or attend school	263 (13.1%)	661 (33%)	399 (19.9%)	114 (5.7%)	566 (28.3%)
Improved emotional wellbeing	328 (16.4%)	813 (40.6%)	348 (17.4%)	76 (3.8%)	439 (21.9%)
Improved ability to live independently	239 (11.9%)	593 (29.6%)	438 (21.9%)	141 (7%)	591 (29.5%)

Table 16. Reported Frequency of Access Difficulty – Healthy Michigan Plan Patients

How often do Healthy Michigan Plan patients have difficulty accessing the following?[7]	Often	Sometimes	Rarely	Never	Don't know
Specialists	644 (31.3%)	729 (35.4%)	137 (6.7%)	19 (.9%)	530 (25.7%)
Medications	322 (15.6%)	886 (43.1%)	330 (16.0%)	37 (1.8%)	483 (23.5%)
Mental Health Care	711 (34.5%)	523 (25.4%)	193 (9.4%)	35 (1.7%)	597 (29.0%)
Dental/Oral Health Care	623 (30.2%)	361 (17.5%)	131 (6.4%)	23 (1.1%)	923 (44.8%)
Treatment for substance use disorder	594 (28.9%)	446 (21.7%)	151 (7.3%)	31 (1.5%)	836 (40.6%)
Counseling and support for health behavior change	536 (26.0%)	543 (26.4)	218 (10.6%)	55 (2.7%)	708 (34.4%)

Table 17. Reported Access Difficulty – Privately Insured Patients

How often do your privately insured patients have difficulty accessing the following?[7]	Often	Sometimes	Rarely	Never	Don't know
Specialists	71 (3.4%)	650 (31.3%)	1009 (48.6%)	273 (13.2%)	71 (3.4%)
Medications	137 (6.6%)	1053 (50.8%)	719 (34.7%)	97 (4.6%)	68 (3.3%)
Mental Health Care	367 (17.7%)	893 (43.1%)	551 (26.6%)	125 (6.0%)	136 (6.6%)
Dental/Oral Health Care	156 (7.5%)	632 (30.5%)	624 (30.1%)	132 (6.4%)	528 (25.5%)
Treatment for substance use disorder	305 (14.7%)	799 (38.6%)	525 (25.4%)	98 (4.7%)	344 (16.6%)
Counseling and support for health behavior change	256 (12.45)	802 (38.7%)	649 (31.3%)	144 (6.9%)	221 (10.7%)

Discussing Costs with Patients

Given the cost-sharing features of Healthy Michigan Plan, we asked PCPs about conversations they may have had with patients about out-of-pocket costs.

Key findings:

About one-fifth of PCPs reported discussing out-of-pocket costs with a Healthy Michigan Plan patient. The patient was more likely than the PCP to bring up the topic. About half the time the discussion resulted in a change of management plans.

> *They don't have that stigma any longer of not being insured and there's not that barrier between us about them worrying about the money, even though we really never made a big deal of it, but they could feel that. I don't know. I think they feel more worth.*
>
> – Rural physician; Small, private practice

Have you ever discussed out-of-pocket medical costs with a Healthy Michigan Plan patient? (n=1988)

Yes	No
445(22.4%)	1543 (77.6%)

Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, who brought up the topic? (n=440)

The Patient	Me	Somebody Else in the Practice	Other
247 (56.1%)	171 (38.9%)	16 (3.6%)	6 (1.4%)

Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, did the conversation result in a change in the management plan for the patient? (n=440)

Yes	No	Don't remember	Blank
248 (55.7)(56.4%)	131 (29.4)(29.8%)	61 (13.7)(13.9%)	5 (1.1)

Suggestions for Improvement and Impact of the Healthy Michigan Plan

We provided PCPs open-ended opportunities in the survey to provide additional information, including asking them for suggestions to improve and impact of the Healthy Michigan Plan.

Suggestions from PCPs included the following:

- Ways to increase patient responsibility
- Need for increased patient education about health insurance, health behaviors, primary care, appropriate ER use, and medication adherence
- Improve accessibility to and availability of other practitioners (especially specialists including mental health and addiction providers)
- Increase reimbursement to encourage practitioners to participate
- Need for increased provider education and up-to-date information about what is/is not covered, program features, administrative processes, billing for HRA completion, and costs faced by patients
- Need for better coverage for some specific services (e.g., behavioral health, physical therapy)
- Formularies are too limited, lack transparency, and require too much paperwork to obtain authorization for necessary prescription drugs
- Suggested streamlining formularies between Medicaid plans, keeping an updated list of preferred medications and more transparency around medication rejections
- Reduce the complexity of paperwork
- HRA had mixed responses; some saw it as more paperwork or redundant with existing primary care practice, others saw it as worthwhile
- Patient churn on and off and between types of coverage is challenging, especially because patients are often unaware of the change

Impact of the Healthy Michigan Plan:

- Many respondents reported that Healthy Michigan Plan had a positive impact by allowing patients to get much needed care, improving financial stability, providing a sense of dignity, improving mental health, increasing accessibility to care and compliance (especially with medications), helping people to engage in healthy behaviors like quitting smoking, and saving lives
- Some reported a negative impact, saying that it has "opened a flood gate" and there are not enough practitioners, that too many new patients are seeking [pain] medications, and that it even influenced their decision to change careers or retire

IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS
RESULTS

The results section begins with a brief description and summary table of the characteristics of 19 primary care providers who care for Medicaid/HMP patients, and who participated in in-depth semi-structured telephone interviews between December 2014 and April 2015. The next section provides key findings from those interviews. The main topics appear in boxes, followed by key findings in bold font, a brief summary explanation in regular font, if indicated, and illustrative quotations, in italics.

Characteristics of Primary Care Practitioners Interviewed

Between December 2014 and April 2015, we conducted 19 semi-structured telephone interviews with sixteen physicians (84%) and three non-physician (16%) primary care practitioners. Of the sixteen physicians interviewed, fourteen specialized in family medicine (88%) and two in internal medicine (12%). Five of these providers practiced in the City of Detroit (26%); four practiced in Marquette, Baraga, or Iron County (21%); four practiced in Kent County (21%); three in Midland, Bay, or Saginaw County (16%); and three in Alcona, Alpena, or Oscoda County (16%). PCPs interviewed came from both urban and rural settings, had a range of years in practice, included private practices, hospital-based practices, Federally Qualified Health Centers, rural clinics and free/low-cost clinics.

Table 18. Personal, Professional and Practice Characteristics of PCP Interviewees (N=19)

Personal characteristics		
Gender	N	%
Male	12	63
Female	7	37
Professional characteristics		
Provider type		
Physician	16	84
Non-Physician (NP/PA)	3	16
Specialty		
Family medicine	14	74
Internal medicine	2	11
Nurse practitioner (NP)	1	5
Physician's Assistant (PA)	2	11
Years in practice		
<10 years	5	26
10-20 years	6	32
>20 years	8	42
Practice characteristics		
Presence of non-physician providers in practice		
Yes	16	84
No	3	16
Practice type		
Federally qualified health center (FQHC)	5	26
Large/hospital-based practice	3	16
Free/low-cost clinic	2	11

Table 18 (continued).Personal, Professional and Practice Characteristics of PCP Interviewees

Practice type	N	%
Small, private practice	7	37
Rural health clinic	2	11
Urbanicity	12	63
Urban	7	37
Rural	5	26

Interview results are presented in the following format:
Key Findings
Representative quote(s)

PCP Understanding of Healthy Michigan Plan and its Features

There was significant variation among the PCPs in their understanding of the Healthy Michigan Plan and its features, and therefore their ability to navigate or help patients obtain services.

> *I had a ton of exposure during the development and the implementation of Healthy Michigan because we were trying to get all of our thousands of enrollees [on the county health plan] onto Healthy Michigan. So that would be back when I first heard about it.*
>
> – Urban physician, FQHC

> *Really the only thing I know about the expansion is in early 2014 we started getting a way lot more requests for a new patient visit than we've ever had before. I was just like, "what is going on? We don't get 25 requests for new patients/month." So when it started really climbing, that's when I figured out, "Okay. It's probably due to the Obamacare Medicaid expansion."*
>
> – Urban physician; Small, private practice

> *I'm not aware of a change in how patients can get access to care with regards to transportation since Healthy Michigan has begun. Is there…I don't know…Is there some additional payment available for patients to get to doctors and dentists with Healthy Michigan?*
>
> – Rural physician; Large, hospital-based practice

Many PCPs perceived that the Healthy Michigan Plan cost-sharing requirements may create some misunderstandings among patients but were supportive of patients making financial contributions to their care.

> *The only significant difficulty that I foresee is with the copay issue. I have a concern that patients see this as free for the first six months, and now all of a sudden are confronted with a bill that they don't understand how they got.*
>
> – Urban physician, Free/low-cost clinic

> *We've got it posted in the front where people exit, and I looked at the amounts and thought, "Well, it's pretty fair actually." You know, it's not break the bank copays, but it gets people to think, "Well, yeah, you know, that's less than the cost of a pack of cigarettes."*
>
> – Rural physician, Rural health clinic

> *For the most part, the patients have it all filled out ahead of time … And then the nurse puts in their vitals, their last cholesterol and things like that on that sheet. We look that over and answer a couple of questions on the back.*
>
> – Rural physician, FQHC

The health risk assessments. So, part of my selling point is, "Okay, you're going to get half off on your copays. We've done it. You're set," you know, kind of thing. While that doesn't totally engage them in the process (LAUGHTER), you know, we continue to work on that.

– Urban physician, FQHC

Some of the plans, and I think these might be the Medicare/Medicaid plans, have offered patients like a gift card or something, and that has prompted a lot of patients to really make sure that we fill those forms out, but I don't recall patients really telling me, "Well, I have to pay a low copay because you fill out this form for me."

– Urban physician; Large, hospital-based practice

PCPs found the Healthy Michigan Plan's Health Risk Assessment useful for identifying health risks, disease detection, discussing risks with patients, and setting health goals.

…In the last month, I've signed up two people [for Weight Watchers]…two or three people to that, and one of them is really sticking to it. She's already lost 10 pounds. She really likes it. She's hoping that she can get an extension on it. The other two I haven't really heard back from yet. They just started it, but I personally think that's a great benefit because a lot of people need education on how to properly eat and what a good diet actually is instead of just Popeye's chicken.

– Urban physician; Small, private practice

There were some people that came in with the Healthy Michigan plan and their health risk assessment, although I don't remember anybody that said, "Hey, you have no issues." It was at least, "You need to stop smoking," or "work on your diet or exercise," and "get a flu shot," if not needing management for diabetes or asthma or other things like that.

– Rural physician, FQHC

Overall Impact of Healthy Michigan Plan on Beneficiaries

Many of the PCPs interviewed had favorable views of the Healthy Michigan Plan and its overall benefits for patients and health systems.

I think…I hate to tell you, but so far everything has been easier. I don't know that I've had anything that's worse. There might be something with drugs as far as ordering stuff, but across the board that's not just Healthy Michigan. I mean they want us to use generics. We're happy to do that. Once in a while, a generic is not going to do it, but I don't think I've had…I can't think of anything that is really negative about it. It's like…People just…I think they're just…They're thankful for it. People aren't overly demanding. They're not coming in acting like, "I deserve this. I want an MRI of my entire body. Nobody's like that, you know? They just…It's like, you know…It's really…It's kind of a nice working together partnership. It's like I usually tell people, "Let's get you caught up." It has become my motto for that. It's like, "We're gonna get you caught up."

– Rural physician assistant, Free/low-cost clinic

Yes. [E]very single day this law has changed my patients' lives…So I get to be in this special niche where I feel like I have a front row seat to the good things that happen as a result of Healthy Michigan….So for example, half the patients I would see pre-Healthy Michigan had essentially nothing in terms of health insurance, right?...I could almost do no labs. I could do very limited health maintenance. I certainly could do no referrals and had a really difficult time getting any type of imaging or substantive workup apart from a physical exam and some in-house kind of labs because people were petrified of the bills that would accumulate.

– Urban physician, FQHC

You know, the Healthy Michigan part has made a big difference…The idea of more people having insurance is good for everyone. Now we'll see long-term in terms of the cost and everything. I know that's a big challenge, but there's no doubt…Like the reimbursement of specifically the hospitals in the city, they're doing much better knowing that a lot of the patients that never had insurance before, do have insurance and that they can get some reimbursement instead of having to, you know, worry about some of the challenges of, you know, unnecessary care.

– Urban physician, FQHC

This program is helping people. It's helping working people, not the totally indigent people who are on disability who are already getting things. These are people…like a parent, a relative of yours that's been working and can't afford the insurance which is ridiculous.

– Urban physician; Small, private practice

PCPs noted that their patients were relieved of the stigma and worry associated with not being able to pay for needed care, and able to get needed services they could not previously afford.

They don't have that stigma any longer of not being insured and there's not that barrier between us about them worrying about the money, even though we really never made a big deal of it, but they could feel that. I don't know. I think they feel more worth.

– Rural physician; Small, private practice

Well, I learned a long time ago if the patient doesn't take the medicine, they don't get better. There are a lot of different reasons they don't take it, but the easy one is that if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it. So I mean I think it plays into every decision where we're ordering a test or recommending a treatment or medication or a referral because if they have financial barriers to getting that done, they're not going to get it done. So I'd say it has a humungous effect.

– Rural physician, FQHC

People are definitely more receptive to the idea of talking about healthcare maintenance items now as opposed to just wanting to deal with the acute issue. It may be because they feel less stressed about the ability to actually be able to get the test done because they understand that it's a…It's a benefit covered under the insurance.

– Urban physician, FQHC

The positive impact of the Healthy Michigan Plan has had a ripple effect in encouraging people to get covered and seek needed care.

Not only are they maybe talking to other people who are then applying and have applied and have gotten the insurance coverage…It just seems like more people are coming, both uninsured and insured because they maybe heard good things about the ease with which they've been able to get care or they've seen how maybe other peoples' circumstances have seemingly changed. I just feel like there's been kind of…a positive ripple effect of people just pursuing care, whether insured or not.

– Urban physician, FQHC

I know a lot of people that didn't have access to healthcare before are getting it now. The ones who were able to get Medicaid that weren't otherwise qualified for it before are starting to get help now, and we're able to find the conditions that they have never been able to get tested for before and treat them for it.

– Urban physician; Small, private practice

Healthy Michigan Plan is Meeting Many Unmet Health Needs

PCPs reported many examples of patients with unmet health care needs, whose health and well-being greatly improved after enrolling in Healthy Michigan Plan. This was particularly true for patients who were previously uninsured and for those with chronic illness (e.g., diabetes, asthma, hypertension).

> *Upon receiving health insurance and upon his daughter's recommendation, he [patient in his early 60s] pursued care and that was his first …according to him, his first physical evaluation of any sort in 40 years, and he has just…It wasn't a full health maintenance exam. It was a new patient evaluation, and in the time in that initial evaluation he was found to be hypertensive. Upon subsequent labs, you know, ordered on that visit, he was found to be diabetic and upon routine referral at that initial visit for an eye exam, given his hypertension, he was found to have had…hemianopia, which later was determined to be caused by a prior stroke.*
>
> – Urban physician, FQHC

> *A lot of neglected… A lot of chronic diseases that have been neglected. Because before, what would suddenly make that person decide to come in and see the doctor and pay out of pocket if they hadn't been doing that for three years? There's nothing to make them come in and take care of it. They wanted to, but they couldn't afford it. They weren't even seeing anybody. Now suddenly, there's this opportunity to get health insurance or to get Medicaid, and so now they are coming to the doctor because they know that they need to get their diabetes under control.*
>
> – Urban physician; Small, private practice

PCPs reported an increased ability to provide preventive services and tests that had previously been an unmet need.

> *I know a lot of people that didn't have access to healthcare before are getting it now. The ones who were able to get Medicaid that weren't otherwise qualified for it before are starting to get help now, and we're able to find the conditions that they have never been able to get tested for before and treat them for it.*
>
> - Urban physician; Small, private practice

> *I think on one level, it's a sense of relief that they don't have to go to the ER for urgent things, that they can come to us first if it's something that we can handle, and then just having a chance to confirm that either they're healthy or that there are issues that they need to work on. I guess from my perspective is that we finally get the chance to do prevention because if someone doesn't have insurance and doesn't see a doctor, then there's no way we can do any kind of prevention. We're just kind of dealing with the end-stage results of whatever's been going on and hasn't been treated. So I mean what I've heard people say is "I just want to stay healthy or find out if I'm healthy," and to me that says a lot.*
>
> – Urban physician; Large, hospital-based practice

Coverage for dental services, prescription drugs, and mental health services were specifically noted as unmet needs being addressed by the Healthy Michigan Plan. Access to these services were described "as a lifesaver." PCPs reported increased ability to connect people to needed services, though challenges remain, especially in the area of mental health.

> *I refer a lot for mental health services and counseling, and a lot of these people just don't know about the services out there. So being able to connect people with the appropriate care that they need or could use in the future, I think, has been really valuable.*
>
> – Urban physician; Large, hospital-based practice

For thirteen years, getting dental has been like pulling teeth… It's been very difficult for our patient population. Dental is a huge issue. I would say well over half of our folks have significant dental problems that haven't been cared for in years.

– Urban physician; Free/low-cost clinic

[W]*hile it doesn't allow them to access say whatever specialist they want, by all means, they have access to things that I think are appropriate for them, i.e. this particular study, that particular lab, this particular workup…In addition to that, they also now have access to a pharmaceutical formulary which is, you know, light years better than what they had when they were looking at, "Okay, what's the $4 Wal-Mart offer me?"*

– Urban physician; FQHC

PCPs reported challenges finding local specialists for referrals. In some cases, this was because of a general shortage of specialists in the area, but often it was noted that there are too few practitioners willing to accept patients with Healthy Michigan Plan/Medicaid coverage.

For the most part. It can still take up to six months to see a psychiatrist unless you get admitted to the hospital. But then if you get admitted to the hospital, the private psychiatrist will see you…the ones that work for the hospital that don't take Medicaid or Medicare. And then at discharge, you really aren't going to see the other psychiatrist any quicker. It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then.

– Urban physician; Small, private practice

Dermatology is a huge issue…Yeah, in this county…In this county we have a huge problem because we have no place to send our Medicaid patients. And obviously they can't afford to do it out of pocket.

– Rural nurse practitioner; Rural health center

The specialty offices that don't accept Medicaid, don't accept Healthy Michigan plan Medicaid either…So, I mean, I don't think that's changed with the Healthy Michigan plan.

– Urban physician; Free/low-cost clinic

[I]in terms of referral and specialty care, it is still tricky. So while our ability to care for them has dramatically expanded, our ability to tap into our disjointed healthcare system in terms of specialty care, I think, maybe hasn't changed a whole lot. I think if I lived closer to [medical center] or closer to some other big training centers, that would probably be different. But like private specialists don't really care if they're uninsured or if they have Healthy Michigan.

– Urban physician; FQHC

PCPs noted that connecting patients to mental health services remains particularly challenging.

[W]e've got community mental health services available but they don't have enough money and they're too busy, and the patients suffer because of that. And Medicaid helps that to a modest degree, but there's still not enough providers and still not enough, I guess, reimbursement from Medicaid.

– Urban physician; Free/low-cost clinic

In our area, due to the limited resources, I think it is difficult that there's not enough psychiatrists and counselors around....and there doesn't seem to be any stability with respect to who is a practicing psychiatrist within the community, meaning individuals might have a psychiatrist for a couple of months, and then somebody else new comes on board. So I do think it's an area that is not being handled well.

– Rural physician; Small, private practice

PCPs noted that barriers to care, such as transportation, are reduced but remain.

You've solved the insurance problem, but then there are certain other parts of their life that makes it hard for them to deal with the healthcare system, and that is they may not follow up with appointments, they may not go to appointments, they may not be so good at communicating their history, they may not follow through with getting medications even if they have insurance. It's kind of like a whole host of behavioral parts to it. So, solving the insurance issue is a really important part, but then really many of these people almost like need a case manager to help make sure all the other little pieces come together because just leaving them on their own, they won't necessarily get the care.

– Urban physician; Small, private practice

Transportation has always been an issue with our patients. We've provided transportation for our uninsured patients, and we know that about one-third of our patients wouldn't have been able to get here or to their specialty appointments without that. Now fortunately [Healthy Michigan Plan health plan] does provide transportation. There's two barriers to their transportation. One is the amount of time patients have to call ahead to get it, which is understandable. But for our patients, sometimes difficult. And the fact that it tends to run late. In some circumstances, it's not a real predictable timeframe. So that's been a challenge. I know I've had one patient who's been so frustrated. We referred her to counseling. She made two counselling appointments, and transportation didn't pick her up for either.

– Urban physician; Free/low-cost clinic

That's a great question. That's a great question. Transportation is huge. That's a huge, huge issue that sort of is under the radar for most people. That's a huge issue for my patients. People just don't have cars, and they don't have family or friends with cars. If you don't have insurance, you are stuck. I just had a guy…I had two guys yesterday who I hadn't seen in, I don't know, maybe six months. Both of them. "I just can't get in to see you, doc." "I can't get in to see you." I said to them yesterday, "Well how did you get in to see me today?" "Oh, I just called my insurance." Fantastic!

– Rural physician; FQHC

ER Use

PCPs discussed a number of factors influencing high rates of ER use including culture or habit, sense of urgency for care and need for afterhours care. Some PCPs noted that some Healthy Michigan Plan beneficiaries use the ER because it's convenient. Even for those practices with extended hours, their office may not be open at convenient time for patients, and their schedules may not coincide with when health issues arise.

I mean those people who use the ER…sometimes it's just the culture. That's just how they've been …they…I don't want to say "conditioned," but maybe long-term circumstances or habit or what have you…They just tend to utilize the ER as a means of…almost like a secondary or a primary care clinic.

– Urban physician assistant, FQHC

You know, to some degree, it is convenience. You know, we have a few days where we're open to 6:00 or 7:00, but not every day, and we're not open on Saturdays or Sundays…People who work day shift… It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.

– Rural physician; Small, private practice

Yeah, I know what you mean. The question is it somehow more convenient or timely or something to go to the ER or come to the office? And I think sometimes people have that perception, but they always wait for 3 hours in the ER. They're never in and out in 20 minutes, you know.

– Urban physician, FQHC

The families up here that I know have always done that do it because…Like the one lady, for example, might be sitting and watching television at 6:00, and she gets a little twinge in her abdomen. Because she has an anxiety condition, she talks herself into the fact that she's got colon cancer, and she goes to the ER in about a 20-minute time frame.

– Rural nurse practitioner, Rural health clinic

PCPs also discussed ways to reduce ER use such as educating patients on appropriate use, providing other sources of afterhours care (e.g., urgent care), and imposing a financial penalization or higher cost sharing for inappropriate ER use.

You know, I mean I think it still comes to education and availability…continuing to try to educate patients on, you know, why it is important to kind of…appropriately pursue care. So, you know, kind of having a conversation with patients about…why it's in their best interest to come to their primary care office, though it may take a little longer to do so than to go to the ER, and also making sure that we have available appointments so a patient doesn't feel, you know, as if they have no other alternative. So, you know, having office hours that…evening office hours…having a fair amount of those and getting appropriate…appropriately trained triage staff to be able to adequately address patients' acute care needs and questions when they call in.

– Urban Physician Assistant, FQHC

If you go to the ER and you're not admitted to the hospital, you're charged a significant amount…That tends to deter people, and I think that's the only way things are going to change and whether the ER's have a triage person that can determine this is an ER-appropriate problem and send people elsewhere, but I think it…There has to be some financial consequences …Even if it's a small amount. I know you're dealing with economically disadvantaged people, but even a small amount of money tends to sometimes affect behaviors.

– Rural physician; Small, private practice

I think certainly accessibility because I'm sure part of it has to do with accessibility. So possibly providing extended hours, weekend hours…Clearly the health system does have access, extended hours, weekend hours…They're not really well-located for MY patients in the sense that my patients live in downtown [city], are in the [city] area specifically, and they don't necessarily have access to some of these facilities which tend to be near [city], but not necessarily in [city]. So I think that maybe setting up that kind of an urgent care close to the hospital, right here. If it means co-locating it next to the ER so we can send the urgent care-type patients there; that would be certainly something that we can do.

– Urban physician; Large, hospital-based practice

PCPs noted that the hospitals play a role in rates of ER use.

The hospital is not incentivized to send those people away because they're paying customers. They want to support having a busy ER. There are some places that actively deter people from going to the emergency room where they'll do a medical screen and exam and say, "No. Your problem is not acute. You don't need to be seen in the emergency room today. Go back and make an appointment with your primary care doctor."

– Rural physician, FQHC

Actually I think it's 29 [minutes] right now, and then in mid and Northern Michigan, there are… billboards that tell you exactly what your wait time is right now in their ER. So it will say 8 minutes or 10 minutes or whatever their wait time is.

– Urban physician, Free/low-cost clinic

Impact of Healthy Michigan Plan on PCP Practice

PCPs reported utilizing a variety of practice innovations including co-locating mental health care, case management, community health workers, same-day appointments, extended hours and use of midlevel practitioners.

At our office, we have two behavioral health specialists. I think they're both MSWs. So they do counseling and group therapy and so our clinic is kind of special. We're able to route a lot of people to them.

– Rural physician, FQHC

I think our office has become much more accommodating with phone calls for same-day appointments. So we've done a better job at looking at schedules, at planning for this… for these kinds of patients that fall into the acute care category. So we're able to do that a lot more readily. We're a large clinic than we used to be. We've got more providers, and that certainly makes a difference also. So there's multiple reasons for it.

– Rural physician; Large, hospital-based practice

Yeah. We have a number of people working as caseworkers now. That's been a big change in the last year. I should probably mention that…We're part of MIPIC, and I guess with the start of My Pick, we got financial support for a number of caseworkers, and then we sort of steal their time for basically any insurance that needs some management. We're having a lot of…We're getting a lot of help with case managers for people coming out of hospitals to coordinate care there.

– Rural physician, FQHC

So, one of the pieces that we are developing now is using our navigator to reach out to those patients. As we see new people assigned to us and we don't see an appointment on the schedule, reaching out to them, helping them get into care.

– Urban physician, Free/low-cost clinic

PCPs noted an increase in administrative burden as a result of the Healthy Michigan Plan because of increased paperwork and need for more communication. PCPs reported that pre-authorizations, multiple formularies, patient churn in and out of insurance and (sometimes) HRAs presented challenges for their practice.

Yes. Much more work for the staff. Not much more, but, of course, it's [HRA] more work for the staff because of the long requirements and things have to be dated the same day as this thing or that thing. Yeah, it's much more of a pain in the neck for them. And I understand that we get some $25…some malarkey for doing it, and the patient gets some discount on something.

– Urban physician, Free/low-cost clinic

But this insurance wouldn't let us order a stress test. They felt that we needed to do a separate stress ECG and then order a separate 2D echo. So that was one scenario where, you know, I actually had to do a physician-to-physician contact because I didn't think it made sense, but that was the only way they would cover it. So I had to order two separate tests where one could have probably given me the answer I was seeking.

– Urban physician; Large, hospital-based practice

For me, the bigger issue, I think, for us is that, you know, there are certain insurances that we do accept even in the Healthy Michigan plan, and some we do and some we don't. So what will end up happening is maybe they had an appointment to see me, and they come in and then, of course, we don't accept that one. So then they…I would say for the most part they're not too happy about that. Then they'll get sent to talk with one of the insurance people, and they'll find a way to fix it if it is fixable.

– Urban physician, FQHC

So we've also had an influx of or an increase in the number of medical prior authorizations that have created basically a headache for us because there's no standardization amongst the Medicaid plans…Yeah, and they're flip-flopping fairly regularly with respect to…This drug might be covered for a period of time, and then a short while later, they don't cover that drug. So we've got to go through the process for another medication. That requires more staff time. It doesn't necessarily benefit patient care.

– Rural physician; Small, private practice

PCPs noted their practices were considerably busier since implementation of the Healthy Michigan Plan.

So our plan is to continue accepting more…We're open to those three Medicaids right now… straight Medicaid, Meridian and Priority. So we see new patients every day with those, and that's…That's what our game plan is at least for the time being. We're not…We're not overwhelmed enough with the patients that we can't do that.

– Urban physician, Free/low-cost clinic

Some PCPs hired new staff to increase their capacity to handle the increase in demand.

So we had to hire…create a position for somebody to basically find out who takes Medicaid and arrange for those referrals, as well as process those prior authorizations for various tests. So it did require us to hire somebody or create a position for somebody to handle that…So, nonetheless that's an increase cost to us.

– Rural physician; Small, private practice

For some PCPs, wait times also increased.

We accept all comers. Period. Doors are open. Come on in. But I have to add a comment to that or a clarification…a qualification to that…There are so many patients now that are in the system that even for routine follow-up stuff, we can't get them in." So what's happened is…The results of this great expansion and people now trying to come get primary care…She [site manager] *said to me this week, "We'll probably have to close your panel, although I don't think we're allowed to close your panel per FQHC guidelines."*

– Urban physician, FQHC

Some PCPs noted that the Healthy Michigan Plan has an impact on their relationships with patients.

So I do think by requiring one to come in…it [an initial appointment] helps to facilitate the beginning, hopefully in most cases, of a relationship between the provider and the patient. It helps assign…It helps align them together hopefully with some mutual goals in the interest of the patient. So, yes, I do think bringing them in and kind of making that a requirement is helpful. I think it's just helpful because it works to establish that relationship.

– Urban physician, FQHC

Part of my concern is it's going to decrease trust. From the standpoint that before our patients were getting free care, [so] they knew that our only incentive for caring for them was their best interest. That incentive hasn't changed. The revenue that we get from Healthy Michigan is great, but…it's not even enough to pay our staff. It's not going to change what the providers have in any way, but that may not be the perception our patients have. Especially as people talk about, you know, "Well, if your doctor says no to this, it's because they get more money if they don't refer." And before when we didn't refer, patients understood it was either we couldn't get it or it wasn't in their best interest or whatever.

– Urban physician, Free/low-cost clinic

Some PCPs noted that reimbursement rates are an important consideration depending on the type/structure of their practice.

Well, we're a rural health clinic. So that means we're reimbursed for Medicaid patients. We get a flat amount for them irrespective of the complexity of the visit, and it's more favorable than if we were just taking straight Medicaid. So right now we can afford to see Medicaid patients as being part of the rural health clinic initiative, but if we weren't and the reimbursement for primary care reverted back to the old way of doing things with Medicaid, we would probably have to change how we handle things with respect to taking new Medicaid patients and how many Medicaid patients we take. So I know the current Medicaid reimbursement scheme is par with Medicare in Michigan.

– Rural physician; Rural health clinic

You're talking about government reimbursing at the Medicare rates. That was 2013 and 2014 that did that…So far they haven't approved to do that in 2015 or 2016, and the rates that they pay for…the plans pay for Medicaid patients are substandard…you know, are markedly below any other insurances in this country. So they definitely are underpaying primary care providers. There's no two ways about that.

– Urban physician; Small, private practice

So, it hasn't affected our practice because as an FQHC we're reimbursed differently than . . . Medicaid reimburses a hospital practice or a private practice. Because we have to see all comers including all uninsured, and we can't cherry pick…I shouldn't say "cherry pick." We can't self-select what patients we see and won't see…We get "x" dollars for every Medicaid visits. We get "x" dollars for every whatever, with the assumption that we'll see everybody.

– Urban physician, FQHC

It's not affected our practice directly, but it seems that especially in a couple of the counties around us, that the number of private providers who are accepting Medicaid has actually, if anything, gone down, and so what we're finding are patients coming out of other practices, especially private practices with no cost base reimbursement, coming to us or asking to get in line to be with us.

– Rural physician, FQHC

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