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

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Evaluation team: Susan Dorr Goold, Renuka Tipirneni, Adrianne Haggins, Eric Campbell, Cengiz Salman, Edith Kieffer, Erica Solway, Lisa Szymecko, Sarah Clark, Sunghee Lee

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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

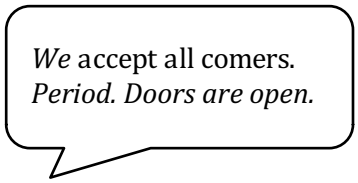
- 53% report knowing a patient's insurance at the beginning of an appointment
- 91% report that it is easy to find out a patient's insurance status
- 35% report intentionally ignoring a patient's insurance status

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 <u>new</u> Medicaid/HMP patients – more likely if:
    - Female, racial minorities or non-physician PCPs
    - Internal medicine specialty
    - Salary payment
    - Medicaid predominant payer mix
    - 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
- 56% 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
- FQHCs, those with predominantly uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominantly Medicaid payer mix, were more likely to report existing patients who had been uninsured gained insurance, and an increase in the number of patients who hadn't seen a PCP in many years.
- Large and FQHC practices were more likely to have hired new clinicians in the past year. Small, non-FQHC, academic and suburban practices and were less likely to report hiring additional staff.

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

- Large and FQHC practices and those with predominantly private or uninsured payer mixes were all more likely to report consulting with care coordinators, case managers and/or community health workers in the past year.
- MiPCT practices were more likely to have newly co-located mental health in the past year.

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 some influence on HRA completion
- 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

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.

- 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

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
- PCPs who were white, Hispanic/Latino, non-physician practitioners and with Medicaid or uninsured predominant payer mixes were more likely to have cost conversations with patients
- PCPs who were younger and in rural practices were more likely to report a change in management due to cost conversations with patients

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 improving 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

Conclusions

Our survey results, and the more detailed accounts from interviews, indicate that HMP has improved access to care and, especially for previously uninsured patients, led to new detection of serious conditions, adherence to medications, management of chronic conditions, and improved health behaviors.

PCPs in Michigan, as in other states, reported improved detection and management of chronic conditions such as diabetes and hypertension in patients who gained coverage due to Medicaid expansion, and better adherence to medical regimens. Most PCPs also reported that the Healthy Michigan Plan had a positive impact on improved health behaviors, better ability to work or attend school, improved emotional wellbeing and improved ability to live independently. In interviews, PCPs described previously uninsured patients for whom they had identified serious illness early; survey results confirmed these are frequent experiences reported by PCPs.

PCPs reported an increase in new patients, including some who had not sought primary care in many years. They reported hiring clinicians and staff; changing workflow for new patients; co-locating

mental health care in primary care; and consulting with care coordinators, case managers, and community health workers. Perhaps due to those changes, few reported that established patients' access to same- or next-day appointments worsened.

We found that PCP demographics, salary structure, history of caring for the underserved and perceived practice capacity were all associated with continued acceptance of new Medicaid patients. These results confirm several of the same factors considered important to PCPs in prior studies – practice capacity, specialist availability, medical and psychosocial needs of Medicaid patients. In addition, PCPs in our survey placed less emphasis on reimbursement, perhaps because many served in salaried positions, or because they instead emphasized professional commitment to caring for the poor and underserved.

Access to some services (e.g., specialty care, mental health care) remains challenging. Disparities in access have been noted for Medicaid patients before and after the ACA in other states. As one of our interviewed physicians said, "It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then."

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Susan Dorr Goold, MD, MHSA, MA
Professor of Internal Medicine and Health Management and Policy, University of Michigan
Renuka Tipirneni, MD, MSc
Clinical Lecturer in the Department of Internal Medicine, University of Michigan
Adrianne Haggins, MD
Clinical Lecturer in the Department of Emergency Medicine, University of Michigan
Eric Campbell, PhD
Professor of Medicine and Director of Research, Mongan Institute for Health Policy, Harvard Medical School
Cengiz Salman, MA
Research Associate at the Center for Bioethics & Social Sciences in Medicine (CBSSM), University of Michigan
Edith Kieffer, MPH, PhD
Professor of Social Work, University of Michigan
Erica Solway, PhD, MSW, MPH
Project Manager at the Institute for Healthcare Policy and Innovation, University of Michigan
Lisa Szymecko, PhD, JD
Project Manager and Research Area Specialist Intermediate at CBSSM, University of Michigan
Sarah Clark, MPH
Associate Research Scientist in the Department of Pediatrics, University of Michigan
Sunghee Lee, PhD
Assistant Research Scientist at the Institute for Social Research, University of Michigan

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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 (3,686 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

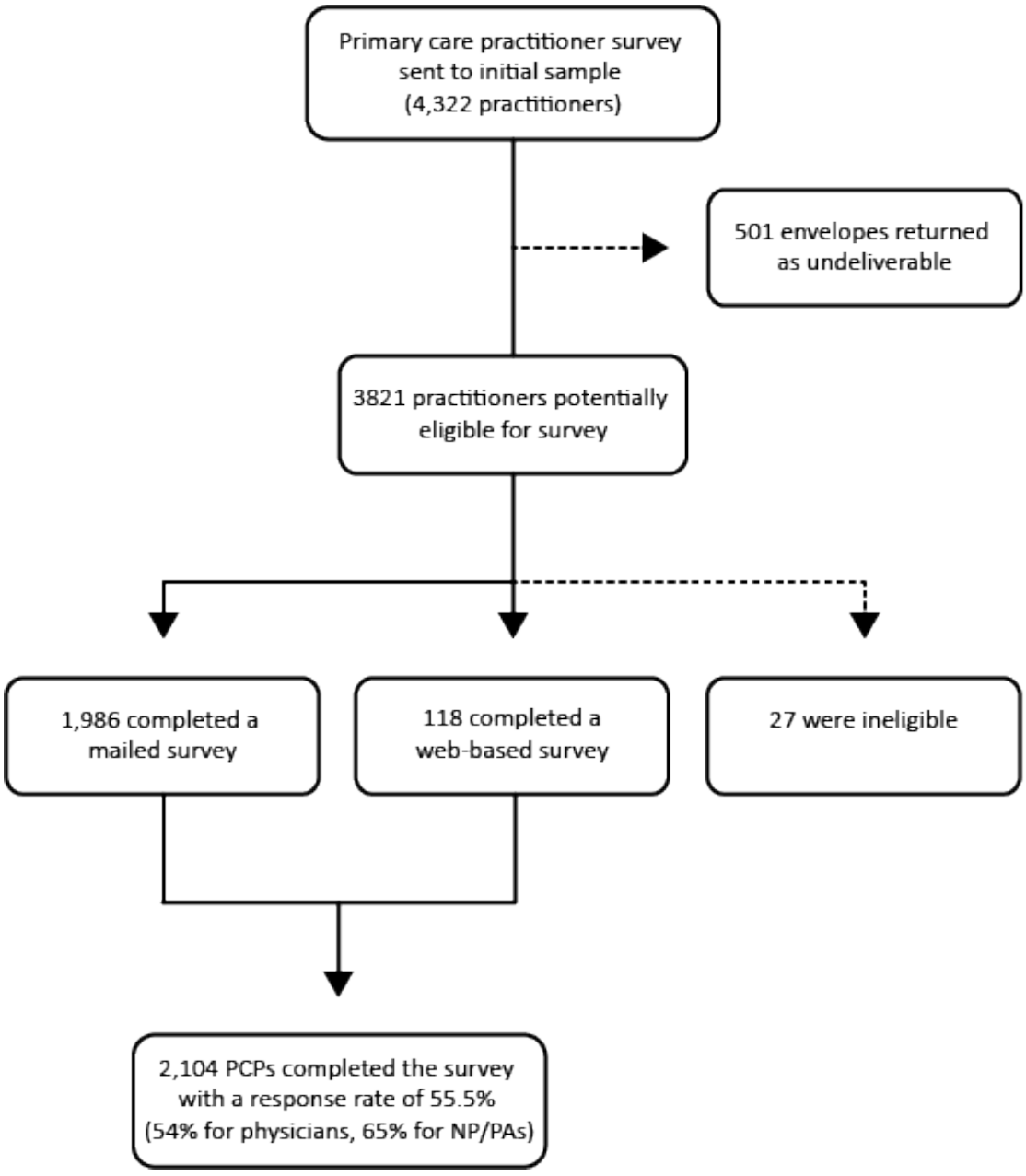
Drs. Goold, Campbell and Tipirneni developed the survey questions in collaboration with other members of the research team. The development process began by identifying the key survey domains through an iterative process with the members of the evaluation team. Then, literature searches identified survey 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) (Figure 1).

Figure 1. Flowchart of PCP Survey Response Rates



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 and practiced in urban areas (Table 1).

Table 1. Comparison of Respondents to Nonrespondents

	Respondents (N=2,104)	Nonrespondents (N=1,690)	p
Gender			
Female	44.6	43.7	NS
Male	55.4	56.3	
Birth Year			
1970 or earlier	71.0	69.5	NS
1971 or later	29.0	30.5	
Medicaid Managed Care Plans			
1 plan	20.5	20.1	NS
2 plans	27.2	25.7	
3 or more plans	52.3	54.2	
Practice setting			
FQHC	14.9	14.7	NS
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	
Urbanicity			
Urban	75.8	83.1	<0.001
Suburban	8.8	7.3	<0.001
Rural	15.4	9.6	
Region			
Upper Peninsula/Northwest/Northeast	14.5	8.3	
West/East Central/East	32.9	31.6	<0.001
South Central/Southwest/Southeast	21.3	23.9	
Detroit Metro	31.3	36.3	

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. No survey weighting was necessary, as the sample included the full census of PCPs with ≥12 HMP patients. Bivariate and multivariate logistic regression analysis was used to assess the association of independent variables (personal, professional and practice characteristics) with dependent variables - practice changes reported since Medicaid expansion. Multivariate models were run with and without interaction variables (Ownership*Practice size and FQHC*predominant payer type), and chi-square goodness-of-fit tests calculated. All analyses were performed using STATA version 14 (Stata Corp, College Station, TX. Quotes from practitioner interviews have been used to expound upon some key findings from our analysis of survey data. To address practice-level clustering where more than one PCP from a practice completed the survey, sensitivity analyses were performed for each regression model, adding practice ID as a random intercept in the model. Results from these analyses did not represent any changes in significance or direction of associations, and full output from these analyses can be found in the appendix.

RESULTS FROM SURVEY OF PRIMARY CARE PRACTITIONERS

Survey results are presented in the following format:

Topic

Key findings

Illustrative quote(s) from PCP interviews

Tables of Results

Numeric endnotes in tables refer to citations for survey measures

NS indicates p≥.05

Results of analysis of relationships (e.g., chi-square, multivariate logistic regression) with reference to tables in Appendix A.

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 non-physician 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).

Table 2. Personal, Professional and Practice Characteristics of PCP Respondents (N=2,104)

Personal characteristics		
Gender	**N**	**%**
Male	1,165	55.4
Female	939	44.6
Race		
White	1,583	79.3
Black/African-American	93	4.7
Asian/Pacific Islander	224	11.2
American Indian/Alaska Native	10	0.5
Other	86	4.3
Ethnicity		
Hispanic/Latino	46	2.3
Non-Hispanic/Latino	1,978	97.7
Professional characteristics		
Provider type	**N**	**%**
Physician	1,750	83.2
Non-Physician (NP/PA)	357	16.8
Specialty		
Family medicine	1,123	53.4
Internal medicine	507	24.1
Medicine-Pediatrics	67	3.2
General practice (GP)	24	1.1
Obstetrics/Gynecology (OB/Gyn)	12	0.6
Nurse practitioner (NP)	192	9.1
Physician's Assistant (PA)	165	7.8
Other	14	0.7

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Board/Specialty certification		
Yes	1,695	81.6
No	383	18.4
Years in practice		
<10 years	520	25.9
10-20 years	676	33.7
>20 years	810	40.4
Provider ownership of practice		
Full-owner	446	22.0
Partner/part-owner	232	11.4
Employee	1,352	66.6
Practice characteristics		
Practice size (mean, median, SD)	7.5, 5, 16.5	
Small (≤5 practitioners)[a]	1,157	57.5
Large (≥6 practitioners)	855	42.5
Presence of non-physician practitioners in practice[b]	1,275	71.7
Federally qualified health center (FQHC)	311	14.9
University/teaching hospital practice	276	13.1
Hospital-based practice (non-teaching)	643	30.7
Payer mix (current % of patients with insurance type)	**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	27.4
Medicaid/Healthy Michigan Plan	686	36.0
Medicare	645	33.9
Uninsured	15	0.8
Mixed	37	1.9
Payment arrangement		
Fee-for-service	784	37.5
Salary	946	45.3
Capitation	44	2.1
Mixed	275	13.2
Other	40	1.9
Participation in MiPCT	511	24.3
Urbanicity[d]		
Urban	1,584	75.3
Suburban	193	9.2
Rural	327	15.5
Region		
Upper Peninsula/NW/NE	301	14.6
West/East Central/East	675	32.8
South Central/SW/SE	438	21.3
Detroit Metro	642	31.2

[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.

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).

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=2,081)	43.4%	47.2%	6.3%	2.7%	0.3%
I know what kind of insurance a patient has at the beginning of an encounter (n=2,081)	21.2%	32.2%	16.4%	20.5%	9.6%
I ignore a patient's insurance status on purpose so it doesn't affect my recommendations (n=2,078)	14.1%	20.8%	26.4%	27.8%	10.8%
I only find out about a patient's insurance coverage if they have trouble getting something I recommend (n=2,071)	13.6%	26.6%	19.0%	31.3%	9.5%

Familiarity with Healthy Michigan Plan

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 (Table 4).

We hypothesized that PCPs in different practice settings would differ in their familiarity with Healthy Michigan Plan.

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 (Appendix A, Table 1).

> *But I mean it's not reported to me. I don't know anything about their health accounts or MI Health account kind of thing.*
>
> - Rural physician; Small, private practice

Table 4. Familiarity with Healthy Michigan Plan

	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
In general, how familiar are you with the Healthy Michigan Plan? (n=2,031)	15.1%	38.2%	27.4%	19.3%
How familiar are you with the following:				
How to complete a Health Risk Assessment (n=2,028)	47.6%	23.3%	13.6%	15.5%
How to submit a Health Risk Assessment (n=2,025)	34.6%	23.2%	17.5%	24.7%
Healthy behavior incentives that Healthy Michigan Plan Patients can receive (n=2,032)	12.6%	23.7%	27.0%	36.7%
Specialists available for Healthy Michigan Plan patients (n=2,027)	9.3%	27.3%	26.3%	37.1%
Mental health services available for Healthy Michigan Plan patients (n=2,032)	7.7%	18.2%	27.8%	46.4%
Out-of-pocket expenses Healthy Michigan Plan Patients have to pay (n=2,031)	6.7%	18.6%	28.4%	46.3%
Dental coverage in the Healthy Michigan Plan (2,032)	4.4%	13.5%	20.4%	61.7%

Acceptance of Medicaid and Healthy Michigan Plan

About 4 in 5 survey respondents reported accepting <u>new</u> Medicaid/Healthy Michigan Plan patients (Table 5). 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 (Table 6). Of PCPs' <u>established patients</u>, an average of 11% had Healthy Michigan Plan and 23% had Medicaid as their primary source of coverage (Table 2).

> *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

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 (Table 7).

We hypothesized that acceptance of new Medicaid/Healthy Michigan Plan patients would vary by PCPs' personal, professional and practice characteristics.

In multivariate analyses, PCPs were more likely to accept new Medicaid/Healthy Michigan Plan patients if the PCP was female, a racial minority, a non-physician provider, specializing in internal

medicine, paid by salary vs. fee-for service, with prior history of care to the underserved, or working in practices with Medicaid predominant payer mixes. PCPs were less likely to accept new Medicaid/Healthy Michigan Plan patients if they considered their practice's overall capacity to accept new patients important (Table 8).

> *[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

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	%
Private (n=1,774)	87.0%
Medicaid* (n=1,517)	75.0%
Healthy Michigan Plan* (n=1,464)	72.8%
Medicare (n=1,717)	84.4%
No insurance (i.e., self-pay) (n=1,541)	76.4%

*Combined, 1,575 (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?[1]

The decision is entirely mine (n=459)	I have a lot of influence (n=275)	I have some influence (n=425)	I have no influence (n=866)
22.7%	13.6%	21.0%	42.8%

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 (n=2,049)	37.8%	31.1%	9.1%	8.6%	13.3%
Reimbursement amount (n=2,056)	25.9%	29.8%	13.3%	15.1%	15.9%
Availability of specialists who see Medicaid or Healthy Michigan Plan patients (n=2,052)	25.7%	30.1%	15.1%	13.8%	15.3%
Psychosocial needs of Medicaid or Healthy Michigan Plan patients (n=2,051)	19.7%	30.4%	18.3%	16.8%	14.8%
Illness burden of Medicaid or Healthy Michigan Plan patients (n=2,052)	18.0%	28.0%	21.5%	18.0%	14.4%

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 (n=2,073)	45.4%	26.8%	16.7%	7.2%	3.9%
It is my responsibility to provide care for patients regardless of their ability to pay (n=2,066)	42.3%	31.1%	13.6%	9.2%	3.8%
Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice (n=2,067)	20.2%	28.5%	36.1%	11.9%	3.2%
Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction (n=2,064)	18.4%	26.3%	38.5%	12.6%	4.3%

In the past three years, have you provided care in a setting that serves poor and underserved patients with no anticipation of being paid?

Yes (n=1,153)	No (n=871)
57.0%	43.0%

Table 8. Multivariate Analysis of Association of PCP and Practice Characteristics with Medicaid Acceptance

	Unadjusted Odds of Medicaid Acceptance OR [95% CI]	Adjusted[a] Odds of Medicaid Acceptance aOR [95% CI]
Personal and professional characteristics		
Female	1.59 [1.28, 1.98]**	1.32 [1.01, 1.72]*
Race		
White	[ref]	[ref]
Black/African American	3.93 [1.80, 8.57]*	3.46 [1.45, 8.25]*
Asian/Pacific Islander	1.76 [1.20, 2.58]*	1.84 [1.21, 2.80]*
Other	1.94 [1.04, 3.62]*	1.79 [0.84, 3.80]
Ethnicity, Hispanic	1.88 [0.79, 4.48]	1.54 [0.56, 4.22]
Years in practice		
<10 years	[ref]	[ref]
10-20 years	0.69 [0.51, 0.93]*	0.87 [0.62, 1.22]
>20 years	0.51 [0.38, 0.68]**	0.82 [0.58, 1.15]
Non-physician provider (vs. physician provider)	4.78 [3.09, 7.40]**	2.21 [1.32, 3.71]*
Specialty		
Family medicine	[ref]	[ref]
Internal medicine	1.43 [1.12, 1.83]*	1.47 [1.09, 1.97]*
Nurse practitioner (NP)	7.81 [3.95, 15.45]**	3.53 [1.64, 7.61]*
Physician Assistant (PA)	4.07 [2.32, 7.16]**	1.83 [0.94, 3.56]
Other	2.86 [1.21, 6.79]*	2.02 [0.75, 5.45]
Board Certified	0.57 [0.42, 0.77]**	0.92 [0.64, 1.32]

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Personal and professional characteristics		
Payment arrangement		
Fee-for-service	[ref]	[ref]
Salary predominant	3.02 [2.36, 3.85]**	2.09 [1.58, 2.77]**
Mixed payment	1.34 [0.98, 1.84]	1.43 [0.99, 2.07]
Other payment arrangements	2.44 [1.01, 5.93]*	1.33 [0.51, 3.49]
PCP attitudes		
Capacity very/moderately important	0.53 [0.41, 0.68]**	0.59 [0.44, 0.79]**
Reimbursement very/moderately important	0.64 [0.51, 0.79]**	0.86 [0.67, 1.10]
Specialist availability very/moderately important	0.95 [0.76, 1.17]	1.11 [0.86, 1.42]
Illness burden of patients very/moderately important	1.02 [0.83, 1.27]	1.03 [0.81, 1.32]
Psychosocial needs of patients very/moderately important	1.10 [0.89, 1.37]	1.14 [0.89, 1.45]
Provided care to the underserved in past 3 years	1.64 [1.33, 2.03]**	1.35 [1.05, 1.73]*
Expressed commitment to caring for underserved	1.16 [1.13, 1.19]**	1.14 [1.11, 1.18]**
Practice characteristics		
Small practice with ≤5 providers (vs. large practice)	1.18 [0.95, 1.47]	1.27 [0.99, 1.63]
Urban (vs. rural/suburban)	0.69 [0.53, 0.89]*	0.97 [0.72, 1.31]
Federally qualified health center (FQHC)	2.40 [1.66, 3.47]**	1.08 [0.70, 1.65]
Mental health co-location	1.99 [1.42, 2.79]**	1.16 [0.79, 1.71]
Predominant payer mix		
Private insurance	[ref]	[ref]
Medicaid/HMP	9.04 [6.33, 12.91]**	7.31 [5.05, 10.57]**
Medicare	1.66 [1.30, 2.13]**	2.04 [1.52, 2.73]**
Mixed	6.88 [2.09, 22.72]*	3.76 [2.24, 6.30]**

[a] Logistic regression model with odds ratios, adjusted for covariates of gender, years in training, physician vs. non-physician provider, and all listed covariates.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Changes in Practice

Most PCPs reported an increase in new patients and in the number of new patients who hadn't seen a PCP in many years (Table 9).

> *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 (Table 9).

> *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 in the past year. A substantial

minority had newly co-located mental health within primary care within the past year (Table 10).

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 (Table 11).

Large and FQHC practices were more likely to have hired new clinicians in the past year. Small, non-FQHC, academic and suburban practices and were less likely to report hiring additional staff (Table 12).

Large, MiPCT, and FQHC practices and those with predominantly private or uninsured payer mixes were all more likely to report consulting with care coordinators, case managers and/or community health workers in the past year (Table 12).

In multivariate analyses, FQHCs, those with predominantly uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominantly Medicaid payer mix, were more likely to report existing patients who had been uninsured gained insurance, and an increase in the number of patients who hadn't seen a PCP in many years (Table 13 below, and Appendix A, Tables 15).

Large, FQHC, MiPCT, and rural practices, and those with predominantly Medicaid or uninsured patients, were more likely to have co-located mental health within the past year (Table 12).

Table 9. 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=2,020)	24.6%	31.6%	20.1%	6.4%	17.3%
Increase in number of new patients (n=2,021)	17.4%	34.9%	19.2%	9.6%	18.8%
Existing patients who had been uninsured or self-pay gained insurance (n=2,019)	15.9%	34.7%	24.9%	5.3%	19.2%
Existing patients changed from other insurance to Healthy Michigan Plan (n=2,019)	5.4%	26.2%	28.5%	8.7%	31.1%

Table 10. 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 (n=2,104)	53.2%	46.8%
Hired additional office staff (n=2,104)	57.5%	42.5%
Consulted with care coordinators, case managers, community health workers (n=2,104)	55.8%	44.2%
Changed workflow processes for new patients (n=2,104)	41.7%	58.3%
Co-located mental health within primary care (n=2,104)	15.4%	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.

Table 11. Availability of Urgent Appointments

What proportion of your established patients who request a same- or next-day appointment at your primary practice can get one? (n=2,033)[7]

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

Over the past year, this proportion has:

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

Table 12. Multivariate Analysis of Association of Practice Characteristics with Changes Made in PCP Practices Within the Past Year

Has your practice made the following changes in the past year?	Hired additional clinicians	Hired additional office staff	Consulted with care coordinator, case manager, or community health worker	Changed workflow processes for new patients	Co-located mental health within primary care
Practice size					
Large (ref)	71.8%	67.8%	68.2%	49.0%	18.3%
Small	40.0%***	52.6%***	51.9%***	38.5%***	12.2%**
Practice type					
FQHC (ref)	62.4%	70.0%	72.6%	44.2%	29.9%***
Non-FQHC	52.1%**	57.1%**	56.1%***	42.8%	11.8%
Academic (ref)	49.2%	51.6%	52.1%	39.6%	13.9%
Non-academic	54.3%	60.1%	59.3%	43.5%	15.6%
Hospital-based (ref)	51.6%	59.3%	55.1%	42.8%	11.2%**
Not hospital-based	54.6%	58.8%	59.9%	43.1%	17.8%
Predominant payer mix					
Private (ref)	54.8%	60.0%	62.3%	40.7%	11.0%
Medicare	50.9%	58.8%	55.8%*	48.5%*	13.1%
Medicaid	53.2%	60.1%	55.5%*	44.0%	19.7%***
Uninsured	40.9%	34.5%	68.3%	40.5%	29.1%*
Mixed	57.6%	51.6%	59.9%	35.1%	15.3%
MiPCT					
Yes	52.8%	60.0%	78.0%***	44.4%	22.0%
No	53.8%	58.6%	52.3%	42.5%	13.1%
Urbanicity					
Urban (ref)	53.6%	60.0%	58.1%	41.5%	13.6%
Suburban	52.6%	50.5%*	53.3%	45.5%	14.8%
Rural	53.9%	58.9%	62.2%	48.3%	23.6%***

*Proportions are the predictive margins from logistic regression models adjusted for each practice characteristic in the table, as well as PCP gender, specialty, ownership of practice, and years in practice. All p-values are based on logistic regression analysis

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 13. Multivariate Analysis of Association of Practice Characteristics with Experiences of Practices Since April 2014

To what extent has your practice experienced the following since the Healthy Michigan Plan began in April 2014?[1]	Increase number of new patients	Existing patients who had been uninsured or self-pay gained insurance	Existing patients changed from other insurance to Healthy Michigan Plan	Increase in the number of new patients who have not seen a primary care practitioner in many years
All	52.3%	50.6%	31.6%	56.2%
Practice size				
Large (ref)	51.4%	50.0%	28.9%	54.0%
Small	51.7%	51.2%	31.9%	57.8%
Practice type				
FQHC (ref)	58.8%	64.9%	32.6%	63.7%
Non-FQHC	50.5%*	48.5%***	30.3%	55.1%*
Academic (ref)	52.9%	53.5%	29.9%	59.2%
Non-academic	51.3%	50.2%	30.8%	55.7%
Hospital-based (ref)	51.5%	49.5%	28.3%	56.9%
Not hospital-based	51.6%	51.3%	31.7%	55.8%
Predominant payer mix				
Private (ref)	39.4%	41.5%	22.4%	46.2%
Medicare	43.8%	44.8%	25.0%	50.5%
Medicaid	69.7%***	64.7%***	43.0%***	72.4%***
Uninsured	79.4%*	59.1%	14.4%	61.5%
Mixed	49.9%*	50.4%	29.2%	49.7%
Urbanicity				
Urban (ref)	51.0%	49.5%	28.6%	56.7%
Suburban	59.8%*	55.6%	33.1%	60.3%
Rural	49.1%	53.7%	38.8%**	51.3%

Proportions are the predictive margins from logistic regression models adjusted for each practice characteristic in the table, as well as PCP gender, specialty, ownership of practice, and years in practice.
[1]Analyses based on sum of those who responded "to a great extent" or "to some extent" for the items below.
All p-values are based on logistic regression analysis
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Experiences Caring for Healthy Michigan Plan Beneficiaries

Health Risk Assessment

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 (Table 14).

Most PCPs reported their practice has a process in place for submitting HRAs, but not for identifying patients who needed HRAs completed. Some PCPs 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 (Table 15, Figure 2).

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 (Table 16, Figure 3).

> *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 very or somewhat useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals. About half found them very or somewhat useful for getting patients to change behavior (Table 17, Figure 4).

> *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

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 (Appendix A, Table 22).

Table 14. Health Risk Assessment Completion

Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients? (n=2,032)

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

How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit? (n=1,923)

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

Table 15. 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=2,041)	61.2%	8.6%	30.1%
My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA. (n=2,042)	34.1%	25.2%	40.7%
I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA. (n=2,040)	33.2%	21.5%	45.3%
I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs. (n=2,033)	18.1%	16.7%	65.3%

Figure 2. Experience with Health Risk Assessments

Please report your experience with the following:

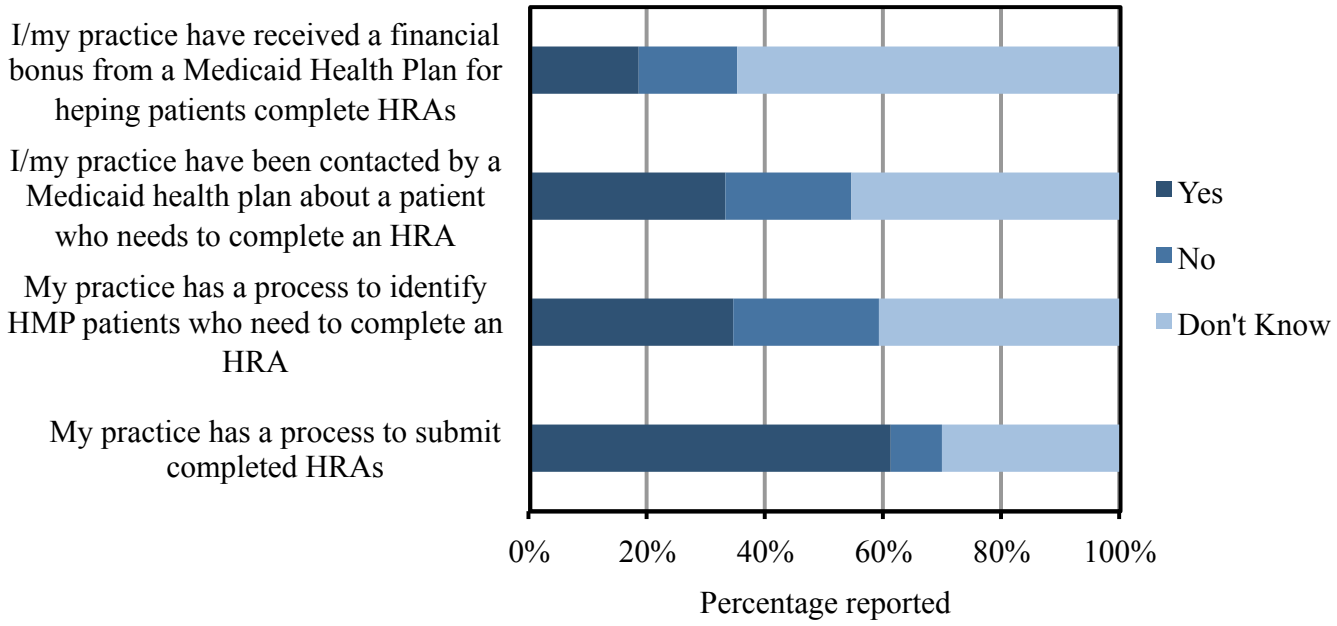


Table 16. Influence on Completing HRA

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=2,046)	26.8%	23.8%	7.6%	14.4%	27.5%
Patients' interest in addressing health risks (n=2,046)	21.4%	30.2%	18.3%	8.8%	21.3%
Financial incentives for practices (n=2,044)	18.3%	24.6%	12.6%	17.3%	27.3%

Figure 3. Influence on Completing HRA

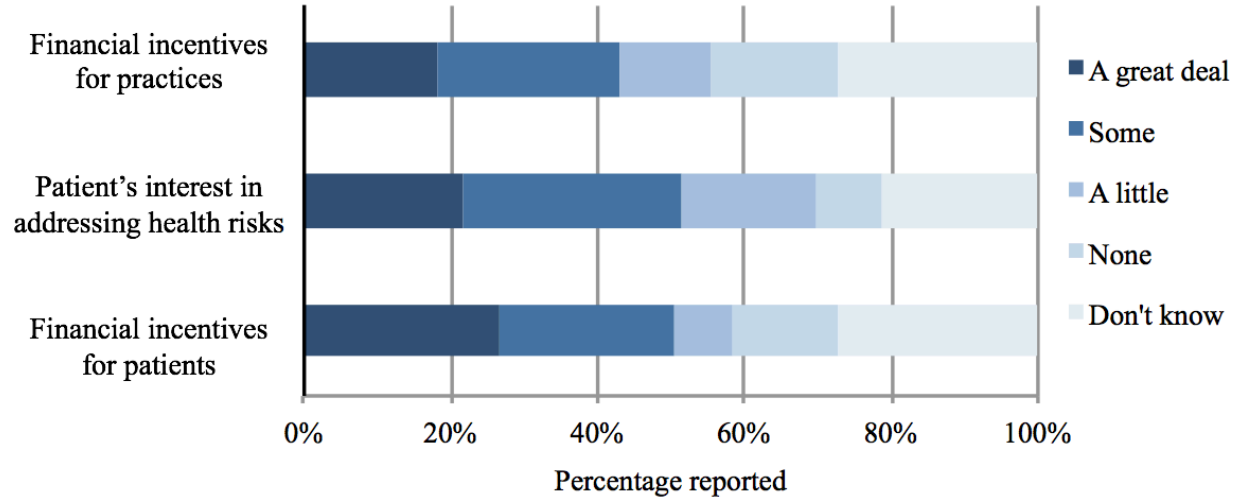
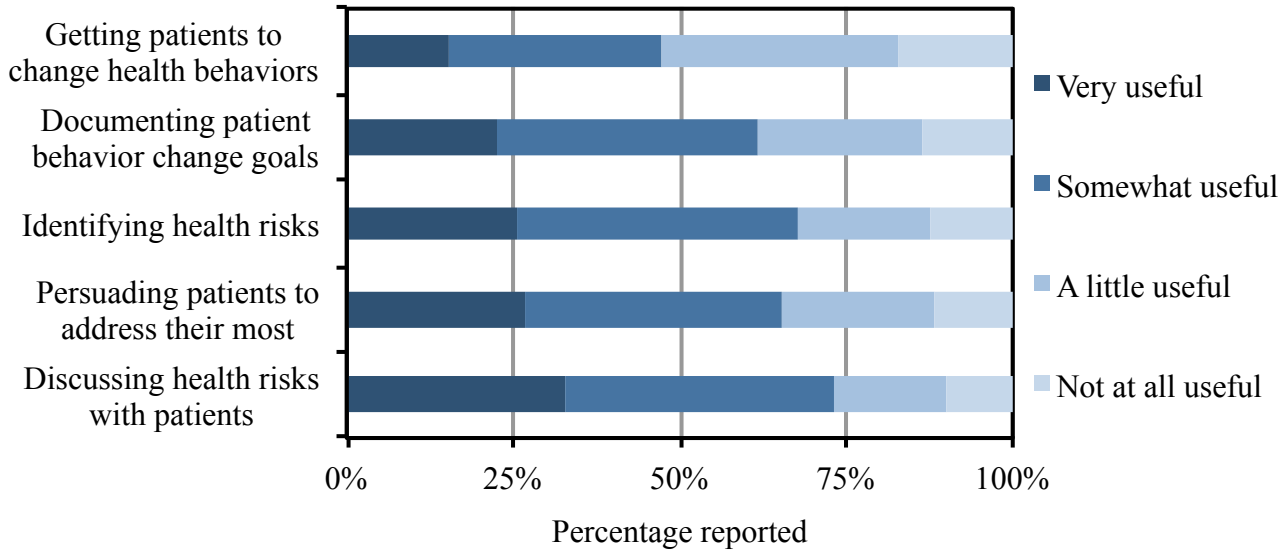


Table 17. Perceived Usefulness of HRA

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=1,828)	32.9%	40.1%	17.0%	10.0%
Persuading patients to address their most important health risks (n=1,828)	26.5%	38.9%	22.7%	11.9%
Identifying health risks (n=1,833)	25.7%	42.0%	20.1%	12.2%
Documenting patient behavior change goals (n=1,826)	22.4%	39.2%	24.6%	13.8%
Getting patients to change health behaviors (n=1,821)	15.2%	32.0%	35.8%	17.0%

Figure 4. Perceived Usefulness of HRA



PCPs were more likely to report a process to identify patients who needed to complete an HRA if they reported (Appendix A, Table 2):

- 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 (Appendix A, Table 22):

- Smaller practice size
- Co-location of mental health within primary care in the past year
- 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

We hypothesized that PCPs who identify a process in place at their practice for identifying patients who need to complete an HRA would report completing more HRAs and that was confirmed (Appendix A, Table 22). PCPs reporting greater familiarity with healthy behavior incentives and out of pocket expenses faced by patients also reported completing more HRAs.

Estimates of HRA completion rates by PCPs

It is not possible to link PCP surveys directly to HRA records, since the HRAs are linked to patients, and the PCP listed on the HRA does not have to be the assigned PCP (it could be any PCP within the plan). As a proxy, in July 2016 we retrieved the count of all HMP enrollees for whom the PCP respondent was the PCP of record, and the number of those enrollees who had a complete HRA on record (which may or may not have been completed by the PCP respondent) from the data warehouse,. Since these data reflected the number of enrollees per PCP and the number of HRAs completed about one year after the survey, we cannot draw firm conclusions based on the relationship between survey responses and this data.

HRA completion rates by PCP are not quite normally distributed (Appendix A, Figure 1).

	Mean (SE)	Median	Interquartile range (IQR)
HMP member count	94 (2.6)	53	27-111
HRA completions	18 (0.62)	9	4-20
Rate of HRA completions (HRA completions/HMP members)	19.6% (0.003)	15.8%	9.5-25.9%

We examined the relationship between HRA completion, as documented (attested) in the Data Warehouse, and provider characteristics, practice characteristics and PCP views of the HRA**.**

PCP familiarity with the HRA was the only consistent predictor of HRA completion, particularly after sensitivity analyses adjusting for practice ID (Appendix A, Tables 20, 21).

ER Use and Decision Making

The majority of PCPs surveyed reported 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 (Table 18).

PCPs who reported a greater sense of influence on ER use (Appendix Table 4):

- **Reported fewer years in practice**
- **Reported larger practice size**
- **Reported hiring new staff or clinicians in the past year**
- **Reported offering care coordination or social work assistance for patients with complex problems**

PCPs who reported a greater sense of responsibility for decreasing ER use (Appendix Table 4):

- **Reported fewer years in practice**
- **Were more likely to be non-physicians**
- **Reported larger practice size**
- **Reported practice changes in the past year including hiring new clinicians, consulting with care coordinators, case managers, or community health workers, changes in workflow, and newly co-locating mental health.**

- **Were more likely to report the availability of urgent appointments had increased**
- **Were more likely to report the availability of walk-in appointments and weekend and evening appointments at their practice**
- **Were more likely to report offering transportation assistance and care coordination or social work assistance**

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 (Table 19).

> *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

PCP views about other factors that affect ER use also influenced their sense of influence and responsibility (Appendix Table 4).

In multivariate analyses (Appendix Table 5), years in practice, Asian/Pacific Islander race and suburban location were associated with PCPs' sense of influence over ER use.

In multivariate analyses (Appendix Table 5), years in practice, non-physician status, practice size and changes in workflow in the past year and suburban location were associated with PCPs' sense of responsibility for 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.

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

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

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

Major Responsibility (n=740)	Some Responsibility (n=1,035)	Minimal responsibility (n=212)	No responsibility (n=43)
36.5%	51.0%	10.4%	2.1%

Table 18. 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 (n=2,010)	66.5%	30.2%	3.3%
Assistance with arranging transportation to appointments (n=2,008)	30.6%	57.0%	12.4%
24-hour telephone triage (n=2,015)	74.0%	21.7%	4.2%
Appointments during evenings and weekends (n=2,012)	55.8%	40.7%	3.5%
Care coordination/social work assistance for patients with complex problems (n=2,008)	56.5%	33.5%	10.1%

Table 19. 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 (n=2,030)	82.7%	13.4%	3.8%
Patients believe the ER provides better quality of care (2,026)	16.8%	39.4%	43.8%
The ER offers quicker access to specialists (n=2,028)	30.3%	35.7%	34.1%
Hospitals encourage use of the ER (n=2,012)	18.7%	28.7%	52.6%
The ER offers access to medications for patients with chronic pain (n=2,031)	50.7%	31.8%	17.5%
The ER is where patients are used to getting care (n=2,023)	59.5%	31.3%	9.2%

Access

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 (Table 20).

> *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 (Table 21).

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 20. Impact of Healthy Michigan Plan on Previously Uninsured Patients

Please think about what has changed for your patients <u>who were previously uninsured</u> and are now covered by the Healthy Michigan Plan. Rate the extent to which you think HMP 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 (n=2,005)	35.0%	39.4%	6.9%	1.5%	17.3%
Early detection of serious illness (n=2,002)	33.7%	37.4%	7.6%	2.0%	19.3%
Improved medication adherence (n=2,004)	28.3%	40.8%	10.7%	2.7%	17.5%
Improved health behaviors (n=2,005)	16.1%	40.4%	18.9%	5.3%	19.3%
Better ability to work or attend school (n=2,003)	13.1%	33.0%	19.9%	5.7%	28.3%
Improved emotional wellbeing (n=2,004)	16.4%	40.6%	17.4%	3.8%	21.9%
Improved ability to live independently (n=2,002)	11.9%	29.6%	21.9%	7.0%	29.5%

Table 21. Reported Frequency of Access Difficulty – Healthy Michigan Plan Patients

	Often	Sometimes	Rarely	Never	Don't know
How often do Healthy Michigan Plan patients have difficulty accessing the following?[7]					
Specialists **+ (n=2,059)	31.3%	35.4%	6.7%	0.9%	25.7%
Medications **+ (n=2,058)	15.6%	43.1%	16.0%	1.8%	23.5%
Mental Health Care **+ (n=2,059)	34.5%	25.4%	9.4%	1.7%	29.0%
Dental/Oral Health Care **+ (n=2,061)	30.2%	17.5%	6.4%	1.1%	44.8%
Treatment for substance use disorder **+ (n=2,058)	28.9%	21.7%	7.3%	1.5%	40.6%
Counseling and support for health behavior change **+ (n=2,060)	26.0%	26.4%	10.6%	2.7%	34.4%
How often do your privately insured patients have difficulty accessing the following?[7]					
Specialists **+ (n=2,074)	3.4%	31.3%	48.6%	13.2%	3.4%
Medications **+ (n=2,074)	6.6%	50.8%	34.7%	4.7%	3.3%
Mental Health Care **+ (n=2,072)	17.7%	43.1%	26.6%	6.0%	6.6%
Dental/Oral Health Care **+ (n=2,072)	7.5%	30.5%	30.1%	6.4%	25.5%
Treatment for substance use disorder **+ (n=2,071)	14.7%	38.6%	25.4%	4.7%	16.6%
Counseling and support for health behavior change **+ (n=2,072)	12.4%	38.7%	31.3%	6.9%	10.7%

**p<.001 paired t-test comparing don't know responses for HMP and privately insured patients
+p<.001 Wilcoxon signed-rank test comparing responses for HMP and privately insured patients

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.

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

We hypothesized that PCPs' likelihood of having cost conversations would vary by their PCPs' personal, professional and practice characteristics.

In multivariate analyses, we found that PCPs who were white, Hispanic/Latino, non-physician practitioners and with Medicaid or uninsured predominant payer mixes were more likely to have cost conversations with patients. PCPs with fewer years in practice and in rural practices were

more likely to report a change in management due to cost conversations with patients (Tables 22, 23).

Have you ever discussed out-of-pocket medical costs with a Healthy Michigan Plan patient? (n=1,988)

Yes (n=445)	No (n=1,543)
22.4%	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 (n=247)	Me (n=171)	Somebody else in the practice (n=16)	Other (n=6)
56.1%	38.9%	3.6%	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 (n=248)	No (n=131)	Don't remember (n=61)
56.4%	29.8%	13.9%

Table 22. Unadjusted Association of PCP Personal, Professional and Practice Characteristics with Frequency of Cost Conversations and Change in Clinical Management due to Cost Conversations

	%	
	Cost Conversations†	Change in Management due to Cost Conversation‡
Personal characteristics		
Gender		
Male (n=345)	20.5%*	52.7%
Female (n=348)	24.7%	60.2%
Race		
White (n=571)	24.3%**	56.0%
Black/African American (n=22)	15.4%	57.1%
Asian/Pacific Islander (n=39)	12.3%	60.9%
Other/More than one (n=28)	17.5%	55.6%
Ethnicity		
Hispanic/Latino (n=23)	33.3%	53.3%
Not Hispanic/Latino (n=650)	22.0%	56.9%
Professional characteristics		
Provider type		
Physician (n=517)	20.4%**	54.1%
Non-physician (NP or PA) (n=176)	32.2%	63.6%
Specialty		
Family medicine (n=349)	21.6%**	52.2%*
Internal medicine (n=154)	17.8%	61.7%
Other physician specialty (n=14)	21.6%	27.3%
Non-physician (NP or PA) (n=176)	32.2%	63.6%
Years in practice		
<10 years (n=213)	25.1%	69.6%*
10-20 years (n=206)	20.8%	54.1%
>20 years (n=256)	22.8%	49.7%

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Prior care for underserved patients		
Yes (n=445)	25.8%**	57.1%
No (n=233)	18.1%	55.4%
Practice characteristics		
Practice size		
Small (≤5 providers) (n=393)	23.2%	56.4%
Large (>5 providers) (n=284)	22.1%	57.9%
FQHC practice		
Yes (n=152)	31.4%**	61.7%
No (n=535)	20.8%	54.8%
University/teaching hospital practice		
Yes (n=75)	18.3%	57.5%
No (n=605)	23.0%	56.5%
Hospital-based practice (non-teaching)		
Yes (n=216)	22.0%	62.1%
No (n=464)	22.5%	54.2%
Payer mix		
Medicaid/Uninsured predominant (n=281)	26.4%*	58.8%
Private/Medicare/Other predominant (n=360)	20.0%	55.7%
Practice characteristics		
Urbanicity		
Urban (n=480)	20.9%*	54.4%*
Suburban (n=62)	22.7%	47.6%
Rural (n=151)	29.3%	67.4%
Total	22.4%	56.4%

†Percent among total respondents

‡Percent among those respondents who had a cost conversation

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 23. Multivariate Association of PCP Personal, Professional and Practice Characteristics with Likelihood of Cost Conversations, and Likelihood of Change in Clinical Management due to Cost Conversations

	Adjusted Odds Ratio† [95% CI]	
	Odds of Cost Conversation	Odds of Change in Management due to Cost Conversation
Personal characteristics		
Male	0.82 [0.63, 1.05]	0.91 [0.58, 1.41]
Race		
White	[ref]	[ref]
Black/African American	0.52 [0.28, 0.96]*	0.92 [0.29, 2.93]
Asian/Pacific Islander	0.43 [0.27, 0.70]*	1.37 [0.54, 3.46]
Other/More than one	0.65 [0.36, 1.17]	1.60 [0.52, 4.94]
Ethnicity, Hispanic/Latino	2.11 [1.08, 4.12]*	0.93 [0.31, 2.77]

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Professional characteristics		
Provider type, physician (ref=non-physician)	0.71 [0.51, 0.99]*	0.96 [0.54, 1.73]
Years in practice		
<10 years	[ref]	[ref]
10-20 years	0.81 [0.60, 1.09]	0.52 [0.30, 0.89]*
>20 years	1.04 [0.77, 1.42]	0.47 [0.27, 0.82]*
Practice characteristics		
Payer mix		
Medicaid/Uninsured predominant	1.31 [1.02, 1.69]*	0.95 [0.60, 1.51]
Private/Medicare/Other predominant	[ref]	[ref]
Urbanicity		
Urban	0.82 [0.60, 1.11]	0.62 [0.35, 1.11]
Suburban	0.70 [0.45, 1.11]	0.41 [0.18, 0.95]*
Rural	[ref]	[ref]

Logistic regression models with adjusted odds ratios. Models are adjusted for all listed variables.
†Each column represents a different multivariate model
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

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

RESULTS FROM IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS

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. Additional excerpts can be found in Appendix B.

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 24. 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
Practice type		
Small, private practice	7	37
Rural health clinic	2	11

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Practice characteristics	N	%
Urbanicity		
Urban	12	63
Rural	7	37

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 <u>Health Risk Assessment</u> 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

PCP Decision Making on Acceptance of Medicaid/Healthy Michigan Plan Patients

PCPs described influences on the Medicaid acceptance decision at the provider level (illness burden and psychosocial needs of Medicaid patients), practice level (capacity to see both new and established patients), health system level (availability of specialists and administrative structures), and the policy environment level (reimbursement).

There are days when we'll look at each other and it's like, "I think we've got enough people like that." It's like the person who takes the energy of dealing with six ordinary people.

– Rural physician assistant, Rural health clinic

It has to do with what our capacity is. So looking at schedules, looking at next appointments, are we able to adequately care for the patients that we're currently responsible for.

– Urban physician, Free/low-cost clinic

I think the actual decision as to whether to accept Healthy Michigan patients … is made ... at a higher level... It's at the health system level... I wouldn't really be involved in making that decision, nor would most of my clinic leadership.

– Urban physician; Large, hospital-based practice

I've been hearing about [the Medicaid/Medicare primary care rate bump], but I don't feel like I've paid attention to details.

–Urban physician; Large, hospital-based practice

For our clinic, [reimbursement amount] plays no role in whether we accept more Medicaid patients … we're gonna serve that population and take care of them ... We'll do whatever reasonably we can do to get paid for that, but that doesn't make or break the decision whether we're going to do that.

– Urban physician, Free/low-cost clinic

[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 clinic

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

Many of these people are working and so they're going to be able to continue working and paying taxes and contributing to society, where if you ignore your diabetes and you ignore your blood

pressure, eventually you might end up losing limbs, losing your kidneys. Now you're on disability and, oh look, now you qualify for Medicaid.

– 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

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) that were often diagnosed after enrolling in Healthy Michigan Plan.

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

*She's only 33 and I had five diagnoses at the end….. it's even double that if you're 70. They waited all this time. They haven't had a doctor; you have to, at least, touch on everything the first time you see them… you have to know what's wrong with them***.**

-Urban physician; Small, private practice

So yesterday I had a patient… The guy's got totally uncontrolled diabetes…. He's like 53. He hadn't been to a doctor, he thinks, since his twenties. The only reason he came in . . .because he got this new insurance. He had his little health risk assessment. He's like, "Alright. I'm going in."

-Urban physician, FQHC

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

We're taking care of the comorbidities before they happen. In the long run, the program is going to pay for itself. We're identifying diabetics. Hypertension is rampant.

-Urban physician; Small, private 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. Some PCPs also reported that their patients had difficulty accessing counseling services for healthy behavior change.

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

We have a Medicaid dental clinic here, but it's a long wait to get in. …up here no one accepts Medicaid … They kind of just pull people's teeth out and not do the usual restorative work.

-Rural physician; Small, private-practice

We do have. . . a smoking cessation program in our health system, but they don't take Medicaid patients. ... we do have a weight management program, but they don't take Medicaid.

-Urban physician; Large, hospital-based practice

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 MiPCT, and I guess with the start of MiPCT, 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

That [co-location] has been very helpful especially to our Medicaid patients …we can get those people in quickly and get treatment, which was otherwise very difficult. …now it's less of a barrier for them to get behavioral health services.

-Rural physician; Small, private practice

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

We're going to be able to hire a full-time social worker…. if we didn't have Medicaid expansion, there's no way we'd have the dollars to do that.

- Urban physician, FQHC

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

Appendix A: Results from Multivariate Analyses

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Table 1. Bivariate associations between familiarity with HMP by practice types and predominant payer mix

Familiarity with Healthy Michigan Plan	A little/not at all familiar	Very/somewhat familiar	*p*-value
	N (Row %)	N (Row %)	
Practice size			0.047
Large practice	409 (49.4%)	419 (50.6%)	
Small practice	500 (44.8%)	615 (55.2%)	
Practice type			< 0.001
FHQC	101 (33.2%)	203 (66.8%)	
Non-FQHC	833 (48.8%)	874 (51.2%)	
University/teaching hospital			< 0.001
Academic	158 (58.5%)	112 (41.5%)	
Non-academic	771 (44.8%)	951 (55.2%)	
Hospital-based practice			0.043
Hospital-based	310 (50.0%)	310 (50.0%)	
Not hospital-based	619 (45.1%)	753 (54.8%)	
Predominant payer mix			< 0.001
Private	371 (56.5%)	286 (43.5%)	
Medicaid	206 (30.5%)	469 (69.5%)	
Medicare	236 (56.3%)	183 (43.7%)	
Uninsured	3 (25.0%)	9 (75.0%)	
Mixed	67 (47.5%)	74 (52.5%)	
Participating in MiPCT			0.023
Yes	254 (51.1%)	243 (48.9%)	
No	694 (45.2%)	840 (54.8%)	

p-values were calculated using Pearson's chi-square

Table 2. Bivariate associations between practice having a process to identify HMP patients who need HRA completed by practice characteristics

Practice has process to identify HMP patients who need HRA completed	Yes	No/don't know	
	Row %	Row %	*p*-value
Region			< 0.001
Upper Peninsula/Northwest/Northeast (n=296)	38.9	61.1	
West/East Central/East (n=656)	36.6	63.4	
South Central/Southwest/Southeast (n=422)	23.2	76.8	
Detroit Metro (n=623)	37.4	62.6	
Urbanicity			NS
Urban (n=1,530)	32.9	67.1	
Suburban (n=190)	35.8	64.2	
Rural (n=322)	38.8	61.2	
Practice size			NS
Large practice (6+) (n=837)	31.9	68.1	
Small practice (0-5) (n=1,118)	36.0	64.0	
New clinicians hired in past year?			NS
No/Not checked (n=953)	34.4	65.6	
Yes (n=1,089)	33.9	66.1	
New office staff hired in past year?			NS
No/Not checked (n=863)	31.9	68.1	
Yes (n=1,179)	35.8	64.2	
Consulted with care coordinators, case managers, community health workers in past year?			NS
No/Not checked (n=897)	32.7	67.3	
Yes (n=1,145)	35.3	64.7	
Changed workflow in past year?			NS
No/Not checked (n=1,185)	32.6	67.4	
Yes (n=857)	36.3	63.7	
Co-located Mental Health w/in Primary Care in past year?			< 0.001
No/Not checked (n=1,720)	31.6	68.4	
Yes (n=322)	47.5	52.5	
Payment arrangement			NS
FFS-predominant (n=758)	31.1	68.9	
Capitation-predominant (n=44)	40.9	59.1	
Salary-predominant (n=921)	36.2	63.8	
Mixed payment (n=266)	34.2	65.8	
Other payment arrangement (n=40)	42.5	57.5	
Predominant payer mix			< 0.001
Private (n=639)	22.5	77.5	
Medicaid (n=666)	47.4	52.6	
Medicare (n=407)	30.7	69.3	
Uninsured (n=11)	72.7	27.3	
Mixed (n=136)	33.1	66.9	
Received financial bonus for HRA completion			< 0.001
No/Don't know (n=1,664)	26.4	73.6	
Yes (n=365)	69.3	30.7	

p-values were calculated using Pearson's chi-square

Table 3. Bivariate associations between number of self-reported HRAs completed by practice characteristics

Number of HRAs completed (self-reported)	None	1-2	3-10	>10	
	Row %	Row %	Row %	Row %	*p*-value
Region					< 0.001
Upper Peninsula/Northwest/ Northeast (n=293)	13.7	5.5	24.2	56.7	
West/East Central/East (n=654)	18.5	10.6	23.9	47.1	
South Central/Southwest/Southeast (n=416)	31.0	16.1	22.8	30.0	
Detroit Metro (n=624)	19.1	12.2	27.6	41.2	
Urbanicity					< 0.001
Urban (n=1,527)	23.1	13.1	25.7	38.0	
Suburban (n=186)	11.8	9.1	18.8	60.2	
Rural (n=319)	14.1	5.6	23.5	56.7	
Practice size					< 0.001
Large practice (6+) (n=823)	23.9	13.4	25.3	37.4	
Small practice (0-5) (n=1,121)	17.8	10.4	24.8	47.0	
New clinicians hired in past year?					NS
No/Not checked (n=954)	19.7	10.4	26.1	43.8	
Yes (n=1,078)	21.5	12.6	23.6	42.3	
New office staff hired in past year?					NS
No/Not checked (n=863)	21.7	10.4	26.9	41.0	
Yes (n=1,169)	19.9	12.4	23.2	44.5	
Consulted with care coordinators, case managers, community health workers in past year?					NS
No/Not checked (n=899)	22.7	10.3	25.1	41.8	
Yes (n=1,133)	19.1	12.5	24.4	44.0	
Changed workflow in past year?					NS
No/Not checked (n=1,182)	21.3	10.9	26.3	41.5	
Yes (n=850)	19.8	12.5	22.6	45.2	
Co-located Mental Health w/in Primary Care in past year?					< 0.001
No/Not checked (n=1,714)	22.3	12.0	26.0	39.8	
Yes (n=318)	11.9	9.4	18.2	60.4	
Payment arrangement					0.008
FFS-predominant (n=754)	24.0	12.9	26.4	36.7	
Capitation-predominant (n=42)	19.0	9.5	21.4	50.0	
Salary-predominant (n=915)	18.0	10.9	23.1	48.0	
Mixed payment (n=268)	20.5	11.6	26.9	41.0	
Other payment arrangement (n=39)	20.5	5.1	20.5	53.8	
Predominant payer mix					< 0.001
Private (n=635)	27.6	14.3	26.8	31.3	
Medicaid (n=668)	9.7	8.1	17.1	65.1	
Medicare (n=409)	29.3	13.0	31.8	25.9	
Uninsured (n=12)	8.3	8.3	8.3	75.0	
Mixed (n=134)	15.7	15.7	30.6	38.1	

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Practice has process to identify HMP patients who need HRA completed					< 0.001
No/Don't know (n=1,312)	28.5	15.1	26.2	30.2	
Yes (n=694)	3.9	5.2	22.5	68.4	
Practice has process to submit completed HRAs					< 0.001
No/Don't know (n=764)	47.3	18.6	20.7	13.5	
Yes (n=1,243)	3.1	7.3	27.6	61.9	
Received financial incentive for HRA completion					< 0.001
No/Don't know (n=1,636)	23.8	12.8	25.7	37.7	
Yes (n=365)	2.7	6.6	21.1	69.6	
Familiarity with out-of-pocket HMP expenses					< 0.001
Very familiar (n=136)	2.2	1.5	16.9	79.4	
Somewhat familiar (n=371)	8.4	9.4	25.1	57.1	
A little familiar (n=560)	11.4	13.8	26.6	48.2	
Not at all familiar (n=904)	34.5	12.5	23.9	29.1	

p-values were calculated using Pearson's chi-square

Table 4. Bivariate analysis of demographic and practice characteristics and PCP influence and responsibility for decreasing ER use

		PCP influence on ER use			PCP responsibility for decreasing ER use		
	Total (%)	A little/ not at all (%)	Some/ a great deal (%)		Minimal/no (%)	Major/some (%)	
Years in practice (mean, [95%CI])		20.3 [19.3, 21.4]	18.2 [17.6, 18.8]	.001[a]	22.2 [20.7, 23.7]	18.3 [17.7, 18.9]	<.001[b]
				p[c]			p[c]
Race				.005			NS
White (n=1,553)	79.5	83.5	78.1		84.1	78.9	
Black/African American (n=92)	4.7	5.6	4.4		3.8	4.9	
Asian/Pacific Islander (n=215)	11.0	7.0	12.5		8.8	11.3	
American Indian/Alaska Native (n=10)	0.5	0.2	0.6		0.0	0.6	
Other (n=83)	4.2	3.7	4.5		3.3	4.3	
Hispanic/Latino				NS			NS
Yes (n=45)	2.3	1.9	2.4		1.2	2.4	
No (n=1,934)	97.7	98.1	97.6		98.8	97.6	
MD/Non-MD				NS			0.001
MD/DO (n= 1,692)	83.2	83.9	82.9		90.2	82.2	
Non-physicians (n= 342)	16.8	16.1	17.1		9.8	16.8	
Specialty				NS			.008
FM (n=1,088)	53.5	55.7	52.7		63.1	52.1	
GP (n=23)	1.1	1.3	1.1		2.0	1.0	
IM (n=487)	23.9	21.9	24.7		22	24.2	
Med-Peds (n=66)	3.2	3.1	3.3		2.4	3.4	
NP (n=186)	9.1	9.3	9.1		4.7	9.7	
OB/GYN (n=12)	0.6	1.1	0.4		0.8	0.6	
Other (n=13)	0.6	0.6	0.7		0.0	0.7	
PA (n=159)	7.8	7.0	8.1		5.1	8.2	
Urbanicity				.05			NS
Urban (n=1,530)	75.2	72.6	76.2		73.3	75.5	
Suburban (n=188)	9.2	11.9	8.3		9.4	9.2	
Rural (n=316)	15.5	15.6	15.5		17.3	15.2	

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Practice size				.01			<.001
Large practice (6+) (n=832)	42.6	38.0	44.3		30.9	44.2	
Small practice (0-5) (n=1,120)	57.4	62.0	55.7		69.1	55.8	
New clinicians hired in past year?				.04			.002
No/Not checked (n=946)	46.5	50.4	45.1		55.7	45.3	
Yes (n=1,088)	53.5	49.6	54.9		44.3	54.7	
New office staff hired in past year?				.03			NS
No/Not checked (n=859)	42.2	46.1	40.8		47.1	41.5	
Yes (n=1,175)	57.8	53.9	59.2		52.9	58.5	
Consulted with care coordinators, case managers, community health workers in past year?				NS			.01
No/Not checked (n=896)	44.1	44.3	44.0		51.4	43.0	
Yes (n=1,138)	55.9	55.7	56.0		48.6	57.0	
Changed workflow in past year?				NS			.001
No/Not checked (n=1,182)	58.1	60.6	57.2		67.5	56.7	
Yes (n=852)	41.9	39.4	42.8		32.5	43.3	
Co-located Mental Health w/in Primary Care in past year?				NS			.001
No/Not checked (n=1,720)	84.6	86.5	83.9		91.4	83.6	
Yes (n=314)	15.4	13.5	16.1		8.6	16.4	
Practice ownership				NS			.02
Full owner (n=431)	21.9	22.6	21.7		28.6	21.0	
Partner/part-owner (n=228)	11.6	9.9	12.2		12.5	11.4	
Employee (n=1,305)	66.4	67.5	66.1		58.9	67.5	
Underserved care within 3y				NS			NS
No (n=854)	43.2	45.3	42.4		45.2	42.8	
Yes (n=1,125)	56.8	54.7	57.6		54.8	57.2	

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Proportion of established patients who can get same-day/next-day appointment				NS			NS
Almost all (>80%) (n=807)	40.6	42.7	39.8		46.8	39.6	
Most (60-80%) (n=514)	25.9	24.2	26.4		20.0	26.8	
About half (~50%) (n=234)	11.8	12.6	11.5		13.2	11.6	
Some (20-40%) (n=280)	14.1	12.8	14.6		10.8	14.6	
Few (<20%) (n=121)	6.1	5.8	6.2		7.2	5.9	
Don't know (n=32)	1.6	1.9	1.5		2.0	1.6	
Proportion of established patients who can get same-day/next-day appointment has: _				NS			.02
Increased (n=671)	34.2	30.5	35.6		28.3	35.0	
Decreased (n=309)	15.8	17.0	15.3		17.4	15.6	
Stayed the same (n=862)	44	46.6	43.0		51.0	42.9	
Don’t know (n=119)	6.1	5.9	6.1				
Predominant payer mix				NS			.009
Private (n=653)	34.9	33.7	35.3		40.1	34.1	
Medicaid (n=663)	35.4	36.9	34.9		30.8	36.0	
Medicare (n=409)	21.8	21.7	21.9		17.7	22.4	
Uninsured (n=12)	0.6	0.2	0.8		0.0	0.7	
Mixed (n=136)	7.3	7.6	7.1		11.4	6.7	
Specialists available for HMP patients				NS			.009
Very familiar (n=185)	9.3	8.4	9.6		8.0	9.4	
Somewhat familiar (n=541)	27.2	25.3	27.9		19.1	28.4	
A little familiar (n=523)	26.3	26.5	26.3		31.1	25.7	
Not at all familiar (n=739)	37.2	39.8	36.2		41.8	36.5	
Mental health services available for HMP patients				NS			.02
Very familiar (n=153)	7.7	7.9	7.6		5.6	8.1	
Somewhat familiar (n=357)	17.9	16.9	18.3		13.1	18.5	
A little familiar (n=554)	27.8	25.7	28.6		25.9	28.1	
Not at all familiar (n=927)	46.6	49.6	45.4		55.4	45.3	

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Dental coverage in HMP				NS			.06
Very familiar (n=86)	4.3	4.7	4.2		2.4	4.6	
Somewhat familiar (n=269)	13.5	12.4	13.9		10.8	13.8	
A little familiar (n=402)	20.2	19.7	20.4		17.5	20.7	
Not at all familiar (n=1,234)	62.0	63.3	61.5		69.3	60.9	
Difficulty accessing specialists				NS			.03
Often (n=627)	31.3	32.5	30.9		37.4	30.5	
Sometimes (n=701)	35.0	33.8	35.5		27.6	36.1	
Rarely (n=133)	6.6	6.4	6.8		4.7	6.9	
Never (n=18)	0.9	1.1	0.8		0.8	0.9	
Don't know (n=522)	26.1	26.2	26.1		29.5	25.5	
Difficulty accessing medications				NS			.02
Often (n=310)	15.5	15.7	15.4		20.9	14.8	
Sometimes (n=857)	42.9	44.8	42.2		38.2	43.6	
Rarely (n=320)	16	14.2	16.7		11.8	16.7	
Never (n=36)	1.8	2.4	1.6		1.6	1.8	
Don't know (n=476)	23.8	22.8	24.2		27.6	23.2	
Difficulty accessing mental health care				NS			NS
Often (n=690)	34.5	33.8	34.7		35.0	34.4	
Sometimes (n=508)	25.4	25.4	25.4		21.3	26.0	
Rarely (n=183)	9.1	9.3	9.1		7.5	9.4	
Never (n=34)	1.7	3.0	1.2		2.0	1.7	
Don't know (n=586)	29.3	28.4	29.6		34.3	28.5	
Difficulty accessing dental care				NS			.05
Often (n=599)	29.9	33.0	28.8		34.6	29.2	
Sometimes (n=348)	17.4	14.8	18.3		11.4	18.2	
Rarely (n=128)	6.4	5.6	6.7		5.1	6.6	
Never (n=23)	1.1	1.7	1.0		0.8	1.2	
Don't know (n=904)	45.2	44.9	45.2		48.0	44.7	

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Difficulty accessing substance abuse treatment				.02			.03
Often (n=576)	28.8	29.8	28.5		31.9	28.4	
Sometimes (n=431)	21.6	18.4	22.7		13.8	22.6	
Rarely (n=145)	7.3	7.1	7.3		7.9	7.2	
Never (n=28)	1.4	2.6	1.0		2.0	1.3	
Don't know (n=819)	41.0	42.1	40.5		44.5	40.4	
Walk-in appointments available in practice				NS			.03
No/Don't know (n=673)	33.6	34.8	33.2		39.7	32.8	
Yes (n=1,331)	66.4	65.2	66.8		60.3	67.2	
Transportation assistance by practice				NS			.002
No/Don't know (n=1,389)	69.4	71.5	68.6		78.1	68.2	
Yes (n=613)	30.6	28.5	31.4		21.9	31.8	
24h telephone triage in practice				NS			NS
No/Don't know (n=521)	25.9	25.8	26.0		26.5	25.9	
Yes (n=1,488)	74.1	74.2	74.0		73.5	74.1	
Weekend/Evening appts in practice				NS			.005
No/Don't know (n=888)	44.3	47.4	43.1		52.6	43.1	
Yes (n=1,118)	55.7	52.6	56.9		47.4	56.9	
Care coordination/ social work for patients w/complex problems in practice				.03			<.001
No/Don't know (n=870)	43.4	47.4	42.0		57.2	41.5	
Yes (n=1,133)	56.6	52.6	58.0		42.8	58.5	
ER will provide care without appt				.01			NS
Major influence (n=1,677)	82.8	86.5	81.4		82.4	82.9	
Minor influence (n=272)	13.4	9.6	14.8		13.7	13.4	
Little or no influence (n=77)	3.8	3.9	3.8		3.9	3.8	
Patients believe ER provides better quality of care				.01			NS
Major influence (n=341)	16.9	17.2	16.7		19.4	16.5	
Minor influence (n=797)	39.4	34.2	41.3		33.2	40.2	
Little or no influence (n=884)	43.7	48.6	42.0		47.4	43.2	

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ER offers quicker access to specialists				NS			NS
Major influence (n=613)	30.3	28.9	30.8		32.7	29.9	
Minor influence (n=722)	35.7	34.5	36.1		31.5	36.3	
Little or no influence (n=689)	34.0	36.7	33.1		35.8	33.8	
Hospitals encourage use of ER				.01			<.001
Major influence (n=377)	18.8	22.9	17.3		32.5	16.8	
Minor influence (n=577)	28.7	25.5	29.9		22.2	29.7	
Little or no influence (n=1,054)	52.5	51.6	52.8		45.2	53.5	
ER offers access to meds for chronic pain				.001			.01
Major influence (n=1,029)	50.8	57.7	48.3		58.7	49.6	
Minor influence (n=644)	31.8	27.3	33.4		24.4	32.9	
Little or no influence (n=354)	17.5	15.0	18.3		16.9	17.5	
ER is where patients are used to getting care				<.001			<.001
Major influence (n=1,202)	59.6	70.1	55.7		72.0	57.7	
Minor influence (n=631)	31.3	24.4	33.7		22.0	32.7	
Little or no influence (n=185)	9.2	5.4	10.5		5.9	9.6	

Data in the table are shown as column percentages

"Predominant payer mix" is the 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.

[a] Years in practice did not violate Levene's test for equality of variances, df(1,1939)= .057, p= .811; therefore students t-test was used, t(1939)= 4.866, p < .001

[b] Years in practice did not violate Levene's test for equality of variances, df(1,1939)=2.664, p= .103; therefore students t-test was used, t(1939)= 3.429, p < .001

[c] *p*-value from Pearson's chi-squared test

Table 5. Multivariate analysis of PCP influence in ER use, and PCP responsibility in decreasing ER use

	PCP influence (N= 1,786)		PCP responsibility (N= 1,773)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.99*	[0.98, 1.00]	0.98**	[0.97, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	0.81	[0.49, 1.35]	1.67	[0.70, 3.97]
Asian/Pacific Islander	1.89**	[1.27, 2.83]	1.61	[0.97, 2.69]
American Indian/Alaska Native	2.81	[0.35, 22.67]	1.00	[1.00, 1.00]
Other	1.35	[0.73, 2.51]	1.39	[0.58, 3.33]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.49	[0.64, 3.49]	4.82	[0.65, 35.91]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.93	[0.68, 1.26]	0.54*	[0.33, 0.88]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.93]	0.94	[0.57, 1.57]
Rural	1.00	[0.73, 1.36]	0.76	[0.51, 1.13]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.84	[0.66, 1.06]	0.66*	[0.48, 0.92]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.38]	1.20	[0.86, 1.67]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.90, 1.46]	0.93	[0.68, 1.28]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.81	[0.64, 1.03]	1.02	[0.75, 1.39]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.91, 1.44]	1.41*	[1.03, 1.94]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.16	[0.84, 1.60]	1.62	[0.97, 2.71]

Logistic regression with adjusted odds ratios; 95% confidence intervals in brackets. Each column is a separate model adjusted for the covariates shown.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6. Multivariate analysis of PCP influence on ER use: sensitivity analysis with random intercept for practice ID

PCP influence on ER use[a]	Original model (N= 1,786)		Practice adjusted model (N= 1,786)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.99*	[0.98, 1.00]	0.99*	[0.98, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	0.81	[0.49, 1.35]	0.80	[0.46, 1.39]
Asian/Pacific Islander	1.89**	[1.27, 2.83]	1.96**	[1.28, 3.01]
American Indian/Alaska Native	2.81	[0.35, 22.67]	3.04	[0.34, 26.82]
Other	1.35	[0.73, 2.51]	1.38	[0.71, 2.65]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.49	[0.64, 3.49]	1.59	[0.65, 3.91]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.93	[0.68, 1.26]	0.91	[0.66, 1.27]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.93]	0.63*	[0.42, 0.94]
Rural	1.00	[0.73, 1.36]	0.99	[0.70, 1.39]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.84	[0.66, 1.06]	0.83	[0.64, 1.08]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.38]	1.10	[0.84, 1.43]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.90, 1.46]	1.17	[0.90, 1.52]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.81	[0.64, 1.03]	0.79	[0.61, 1.03]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.91, 1.44]	1.15	[0.90, 1.46]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.16	[0.84, 1.60]	1.18	[0.84, 1.67]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "PCP influence on ER use" Responses dichotomized as Some influence or A great deal of influence vs. A little influence or No influence at all

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 7. Multivariate analysis of PCP responsible for decreasing ER use: sensitivity analysis with random intercept for practice ID

PCP responsible for decreasing ER use[a]	Original model (N= 1,773)		Practice adjusted model (N= 1,773)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.98**	[0.97, 1.00]	0.98*	[0.97, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	1.67	[0.70, 3.97]	1.73	[0.69, 4.34]
Asian/Pacific Islander	1.61	[0.97, 2.69]	1.59	[0.92, 2.76]
American Indian/Alaska Native	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Other	1.39	[0.58, 3.33]	1.42	[0.56, 3.59]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	4.82	[0.65, 35.91]	5.54	[0.70, 44.04]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.54*	[0.33, 0.88]	0.51*	[0.30, 0.87]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.94	[0.57, 1.57]	0.92	[0.53, 1.62]
Rural	0.76	[0.51, 1.13]	0.72	[0.46, 1.14]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.66*	[0.48, 0.92]	0.66*	[0.46, 0.95]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.20	[0.86, 1.67]	1.24	[0.86, 1.78]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.93	[0.68, 1.28]	0.92	[0.65, 1.31]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.02	[0.75, 1.39]	1.01	[0.72, 1.41]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.41*	[1.03, 1.94]	1.46*	[1.03, 2.05]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.62	[0.97, 2.71]	1.69	[0.97, 2.94]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "PCP responsible for decreasing ER use" Responses dichotomized as Major responsibility or Some responsibility vs. A little responsibility or No responsibility at all

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 8. Multivariate analysis of HRA completion: sensitivity analysis with random intercept for practice ID

Complete any HRA[a]	Original model (N= 1,637)		Practice adjusted model (N= 1,637)	
	aOR	95% CI	aOR	95% CI
PCP familiarity with completing HRA				
Very familiar (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat familiar	0.50	[0.20, 1.24]	0.50	[0.20, 1.24]
A little familiar	0.27**	[0.10, 0.71]	0.27**	[0.10, 0.71]
Not at all familiar	0.23*	[0.07, 0.76]	0.23*	[0.07, 0.76]
HRA useful for identifying health risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.95	[0.27, 3.36]	0.95	[0.27, 3.36]
A little useful	3.41	[0.42, 27.75]	3.41	[0.42, 27.75]
Not at all useful	11.13	[0.35, 350.17]	11.13	[0.35, 350.17]
HRA useful for discussing health risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.56	[0.13, 2.51]	0.56	[0.13, 2.51]
A little useful	0.04*	[0.00, 0.49]	0.04*	[0.00, 0.49]
Not at all useful	0.04	[0.00, 3.83]	0.04	[0.00, 3.83]
HRA useful for persuading patients to address risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	2.95	[0.62, 14.06]	2.95	[0.62, 14.06]
A little useful	26.95**	[2.87, 253.14]	26.95**	[2.87, 253.14]
Not at all useful	8.34	[0.33, 210.86]	8.34	[0.33, 210.86]
HRA useful for documenting patient behavior goals				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.71	[0.18, 2.84]	0.71	[0.18, 2.84]
A little useful	0.79	[0.14, 4.35]	0.79	[0.14, 4.35]
Not at all useful	1.32	[0.10, 17.34]	1.32	[0.10, 17.34]
HRA useful for getting patients to change behaviors				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	1.03	[0.25, 4.19]	1.03	[0.25, 4.19]
A little useful	0.87	[0.19, 3.94]	0.87	[0.19, 3.94]
Not at all useful	0.28	[0.03, 2.50]	0.28	[0.03, 2.50]
Provider type				
Non-physician (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.89	[0.40, 2.01]	0.89	[0.40, 2.01]
Practice location				
Non-urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Urban	0.39*	[0.17, 0.93]	0.39*	[0.17, 0.93]

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Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.42*	[0.18, 0.99]	0.42*	[0.18, 0.99]
Medicare	1.34	[0.54, 3.33]	1.34	[0.54, 3.33]
Uninsured	0.05*	[0.00, 0.83]	0.05*	[0.00, 0.83]
Mixed	0.71	[0.18, 2.84]	0.71	[0.18, 2.84]
HMP-MC members assigned to PCP as of 7-25-2016	1.22***	[1.16, 1.27]	1.22***	[1.16, 1.27]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.
[a] "Complete any HRA" Responses dichotomized as any completion rate greater than 0 vs completion rates equal to 0
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 9. Multivariate analysis of HRA completion rate: sensitivity analysis with random intercept for practice ID

HRA completion rate	Original model (N= 1,637)		Practice adjusted model (N= 1,637)	
	Coefficients	95% CI	Coefficients	95% CI
PCP familiarity with completing HRA				
Very familiar (ref)	-	-	-	-
Somewhat familiar	1.19***	[0.74, 1.63]	-0.25***	[-0.38, -0.12]
A little familiar	1.56***	[0.96, 2.16]	-0.32***	[-0.49, -0.15]
Not at all familiar	2.98***	[2.11, 3.85]	-0.52***	[-0.72, -0.33]
HRA useful for identifying health risks				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.45	[-1.07, 0.18]	0.08	[-0.12, 0.29]
A little useful	-0.39	[-1.24, 0.45]	0.09	[-0.18, 0.36]
Not at all useful	-0.50	[-1.68, 0.69]	0.12	[-0.28, 0.53]
HRA useful for discussing health risks				
Very useful (ref)	-	-	-	-
Somewhat useful	0.31	[-0.32, 0.93]	-0.08	[-0.28, 0.13]
A little useful	0.32	[-0.57, 1.20]	-0.08	[-0.37, 0.22]
Not at all useful	0.15	[-1.32, 1.62]	-0.08	[-0.55, 0.40]
HRA useful for persuading patients to address risks				
Very useful (ref)	-	-	-	-
Somewhat useful	0.01	[-0.65, 0.66]	0.02	[-0.19, 0.23]
A little useful	-0.47	[-1.31, 0.36]	0.14	[-0.13, 0.41]
Not at all useful	0.04	[-1.34, 1.43]	0.01	[-0.41, 0.43]
HRA useful for documenting patient behavior goals				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.54	[-1.20, 0.11]	0.10	[-0.10, 0.30]
A little useful	-0.57	[-1.35, 0.20]	0.09	[-0.15, 0.33]
Not at all useful	-0.62	[-1.67, 0.43]	0.10	[-0.22, 0.43]
HRA useful for getting patients to change behaviors				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.12	[-0.93, 0.68]	0.02	[-0.21, 0.26]
A little useful	0.00	[-0.86, 0.87]	-0.01	[-0.27, 0.25]
Not at all useful	0.07	[-1.04, 1.18]	-0.02	[-0.37, 0.32]
Provider type				
Non-physician (ref)	-	-	-	-
Physician	0.22	[-0.24, 0.68]	-0.03	[-0.19, 0.13]
Practice location				
Non-urban (ref)	-	-	-	-
Urban	0.48*	[0.09, 0.87]	-0.11	[-0.24, 0.02]

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Predominant payer mix				
Private (ref)	-	-	-	-
Medicaid	0.44*	[0.00, 0.88]	-0.08	[-0.23, 0.06]
Medicare	0.21	[-0.26, 0.68]	-0.04	[-0.19, 0.11]
Uninsured	0.21	[-1.58, 2.01]	-0.09	[-0.71, 0.53]
Mixed	0.50	[-0.22, 1.22]	-0.11	[-0.32, 0.11]
HMP-MC members assigned to PCP as of 7-25-2016	0.002*	[0.000, 0.004]	-0.0003	[-0.0008, 0.0001]

Generalized linear model with gamma distribution predicting the rate (%) of HRA completions; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 10. Multivariate analysis of consulted with care coordinator, case manager, or community health worker: sensitivity analysis with random intercept for practice ID

Consulted with care coordinators, case managers, community health workers in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.46***	[0.37, 0.59]	0.41***	[0.30, 0.56]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	2.30***	[1.59, 3.34]	2.53***	[1.61, 3.95]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.70	[0.47, 1.07]	0.77	[0.47, 1.27]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.79	[0.57, 1.09]	0.80	[0.54, 1.19]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.72*	[0.54, 0.95]	0.70*	[0.50, 0.98]
Medicare	0.73*	[0.53, 1.00]	0.68*	[0.47, 0.99]
Uninsured	1.36	[0.33, 5.66]	1.42	[0.26, 7.76]
Mixed	0.89	[0.58, 1.36]	0.87	[0.53, 1.44]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	3.58***	[2.65, 4.84]	4.23***	[2.89, 6.19]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.82	[0.56, 1.20]	0.79	[0.49, 1.26]
Rural	1.15	[0.84, 1.58]	1.26	[0.84, 1.87]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.02	[0.80, 1.30]	1.06	[0.80, 1.41]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.85	[0.64, 1.14]	0.85	[0.60, 1.21]
Non-physician provider	1.39	[0.98, 1.96]	1.41	[0.94, 2.11]
Other	0.98	[0.59, 1.62]	1.00	[0.55, 1.81]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.03	[0.70, 1.52]	1.00	[0.62, 1.60]
Employee	1.58*	[1.08, 2.31]	1.60*	[1.02, 2.50]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Consulted with care coordinators, case managers, community health workers in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 11. Multivariate analysis of co-located mental health within primary care in past year: sensitivity analysis with random intercept for practice ID

Co-located Mental Health within Primary Care in past year[a]	Original model (N= 1,652)		Practice adjusted label (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.57***	[0.41, 0.79]	0.43***	[0.26, 0.71]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	3.65***	[2.50, 5.33]	6.32***	[3.39, 11.79]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.85	[0.52, 1.39]	0.85	[0.42, 1.74]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.53**	[0.36, 0.79]	0.49*	[0.28, 0.88]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.18***	[1.45, 3.28]	2.65***	[1.51, 4.64]
Medicare	1.25	[0.76, 2.04]	1.44	[0.76, 2.74]
Uninsured	4.01*	[1.08, 14.96]	2.88	[0.47, 17.80]
Mixed	1.53	[0.81, 2.88]	1.13	[0.49, 2.61]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	2.15***	[1.50, 3.09]	2.41**	[1.39, 4.17]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.13	[0.66, 1.91]	1.55	[0.72, 3.35]
Rural	2.24***	[1.51, 3.33]	2.72**	[1.47, 5.02]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.99	[0.71, 1.37]	0.94	[0.62, 1.43]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.19	[0.78, 1.82]	1.05	[0.58, 1.91]
Non-physician provider	1.12	[0.74, 1.69]	1.21	[0.70, 2.10]
Other	0.94	[0.46, 1.90]	0.66	[0.25, 1.77]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.80	[0.36, 1.79]	0.59	[0.21, 1.65]
Employee	2.49**	[1.36, 4.58]	2.34*	[1.06, 5.15]
Years in practice	1.00	[0.99, 1.02]	1.00	[0.99, 1.02]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Co-located Mental Health within Primary Care in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 12. Multivariate analysis of hiring additional clinicians within the past year: sensitivity analysis with random intercept for practice ID

Hired additional clinicians within the past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.25***	[0.19, 0.31]	0.13***	[0.08, 0.20]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.64**	[1.15, 2.33]	1.89*	[1.10, 3.23]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.78	[0.53, 1.17]	0.81	[0.44, 1.47]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.87	[0.63, 1.19]	0.84	[0.52, 1.34]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.92	[0.70, 1.22]	0.99	[0.66, 1.50]
Medicare	0.83	[0.61, 1.14]	0.76	[0.49, 1.20]
Uninsured	0.51	[0.15, 1.77]	0.61	[0.10, 3.64]
Mixed	1.15	[0.75, 1.75]	1.18	[0.65, 2.14]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.95	[0.73, 1.25]	1.09	[0.70, 1.71]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.95	[0.65, 1.39]	1.22	[0.66, 2.25]
Rural	1.01	[0.74, 1.39]	1.18	[0.71, 1.98]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.97	[0.77, 1.23]	1.00	[0.72, 1.39]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.13	[0.85, 1.50]	1.21	[0.79, 1.86]
Non-physician provider	1.15	[0.82, 1.61]	1.11	[0.68, 1.79]
Other	0.66	[0.40, 1.09]	0.49	[0.23, 1.04]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.98***	[1.33, 2.93]	2.18*	[1.20, 3.96]
Employee	1.98***	[1.35, 2.90]	2.35**	[1.35, 4.10]
Years in practice	0.99**	[0.98, 1.00]	0.98*	[0.97, 1.00]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.
[a] "Hired additional clinicians within the past year" Responses dichotomized as Yes vs. No or Not checked
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 13. Multivariate analysis of hiring new office staff within the past year: sensitivity analysis with random intercept for practice ID

New office staff hired in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.51***	[0.41, 0.65]	0.39***	[0.27, 0.56]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.82***	[1.28, 2.58]	2.00**	[1.23, 3.24]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.68	[0.47, 1.01]	0.76	[0.44, 1.29]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	1.03	[0.75, 1.40]	1.13	[0.74, 1.74]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	1.00	[0.77, 1.31]	1.01	[0.70, 1.46]
Medicare	0.95	[0.70, 1.28]	0.94	[0.62, 1.40]
Uninsured	0.32	[0.09, 1.10]	0.19*	[0.04, 0.99]
Mixed	0.69	[0.46, 1.04]	0.66	[0.39, 1.14]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.06	[0.82, 1.39]	1.10	[0.74, 1.63]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.94]	0.61	[0.36, 1.04]
Rural	0.95	[0.70, 1.29]	0.99	[0.63, 1.56]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.82	[0.65, 1.03]	0.77	[0.57, 1.03]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.86	[0.65, 1.13]	0.88	[0.60, 1.29]
Non-physician provider	0.95	[0.68, 1.32]	0.99	[0.64, 1.53]
Other	0.75	[0.47, 1.21]	0.73	[0.38, 1.40]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	2.25***	[1.53, 3.31]	2.80***	[1.63, 4.83]
Employee	1.38	[0.96, 1.99]	1.45	[0.88, 2.38]
Years in practice	0.98***	[0.97, 0.99]	0.98***	[0.96, 0.99]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "New office Staff hired in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 14. Multivariate analysis of changed workflow in the past year: sensitivity analysis with random intercept for practice ID

Changed workflow in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.65***	[0.52, 0.81]	0.61***	[0.46, 0.80]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.06	[0.77, 1.46]	0.99	[0.67, 1.47]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.85	[0.58, 1.24]	0.87	[0.55, 1.36]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.99	[0.73, 1.33]	1.00	[0.70, 1.42]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	1.15	[0.88, 1.50]	1.19	[0.87, 1.62]
Medicare	1.39*	[1.03, 1.87]	1.51*	[1.06, 2.14]
Uninsured	0.99	[0.30, 3.26]	0.88	[0.22, 3.56]
Mixed	0.78	[0.52, 1.18]	0.77	[0.48, 1.24]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.39]	1.12	[0.82, 1.54]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.18	[0.83, 1.68]	1.16	[0.75, 1.80]
Rural	1.33	[0.99, 1.78]	1.42	[0.99, 2.05]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.96	[0.77, 1.20]	0.95	[0.74, 1.23]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.75*	[0.57, 0.98]	0.71*	[0.51, 0.99]
Non-physician provider	1.05	[0.77, 1.44]	1.07	[0.75, 1.55]
Other	0.80	[0.50, 1.27]	0.77	[0.44, 1.35]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.00	[0.68, 1.45]	1.02	[0.65, 1.61]
Employee	0.86	[0.60, 1.23]	0.81	[0.53, 1.25]
Years in practice	0.98***	[0.97, 0.99]	0.98***	[0.97, 0.99]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Changed workflow in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 15. Multivariate analysis of an increase in the number of new patients: sensitivity analysis with random intercept for practice ID

Increase in the number of new patients[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.02	[0.81, 1.29]	1.05	[0.80, 1.37]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.34	[0.95, 1.90]	1.42	[0.95, 2.11]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.89	[0.60, 1.31]	0.87	[0.56, 1.35]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.81	[0.60, 1.12]	0.79	[0.55, 1.12]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	3.56***	[2.72, 4.65]	4.01***	[2.92, 5.50]
Medicare	1.16	[0.86, 1.56]	1.15	[0.83, 1.61]
Uninsured	6.43*	[1.36, 30.37]	7.31*	[1.36, 39.21]
Mixed	1.52*	[1.02, 2.27]	1.59*	[1.02, 2.48]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.48*	[1.01, 2.17]	1.55	[1.00, 2.42]
Rural	0.87	[0.63, 1.18]	0.85	[0.59, 1.22]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.45**	[1.15, 1.82]	1.48**	[1.15, 1.91]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.09	[0.82, 1.43]	1.09	[0.80, 1.49]
Non-physician provider	1.32	[0.94, 1.86]	1.36	[0.93, 1.98]
Other	0.71	[0.43, 1.15]	0.72	[0.42, 1.25]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.66*	[0.45, 0.97]	0.63*	[0.40, 0.98]
Employee	1.05	[0.73, 1.52]	1.08	[0.71, 1.63]
Years in practice	0.99	[0.98, 1.00]	0.99	[0.98, 1.00]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Increase in the number of new patients" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 16. Multivariate analysis of existing patients who had been uninsured or self-pay gained insurance: sensitivity analysis with random intercept for practice ID

Existing patients who had been uninsured or self-pay gained insurance[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.05	[0.83, 1.31]	1.05	[0.82, 1.34]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.92***	[1.36, 2.72]	1.98***	[1.36, 2.87]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	1.00	[0.69, 1.47]	1.01	[0.67, 1.51]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.81	[0.60, 1.11]	0.80	[0.58, 1.11]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.61***	[2.01, 3.39]	2.74***	[2.06, 3.65]
Medicare	1.11	[0.83, 1.50]	1.12	[0.82, 1.53]
Uninsured	2.08	[0.59, 7.29]	2.07	[0.55, 7.71]
Mixed	1.44	[0.97, 2.15]	1.47	[0.96, 2.23]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.32	[0.91, 1.91]	1.34	[0.90, 1.99]
Rural	1.16	[0.86, 1.58]	1.17	[0.84, 1.63]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.35*	[1.07, 1.69]	1.36*	[1.07, 1.73]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.96	[0.73, 1.26]	0.95	[0.71, 1.27]
Non-physician provider	1.54*	[1.10, 2.15]	1.55*	[1.09, 2.20]
Other	0.99	[0.61, 1.59]	1.00	[0.60, 1.65]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.75	[0.51, 1.10]	0.74	[0.49, 1.10]
Employee	1.01	[0.70, 1.46]	1.02	[0.70, 1.50]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Existing patients who had been uninsured or self-pay gained insurance" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 17. Multivariate analysis of existing patients changed from other insurance to HMP: sensitivity analysis with random intercept for practice ID

Existing patients changed from other insurance to Healthy Michigan Plan[a]	Original model (N= 1,639)		Practice adjusted model (N= 1,639)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.17	[0.92, 1.49]	1.16	[0.88, 1.52]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.11	[0.79, 1.56]	1.12	[0.76, 1.64]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.92	[0.61, 1.39]	0.91	[0.57, 1.43]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.82	[0.59, 1.13]	0.79	[0.55, 1.13]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.62***	[1.98, 3.47]	2.84***	[2.07, 3.89]
Medicare	1.13	[0.80, 1.58]	1.12	[0.78, 1.62]
Uninsured	0.61	[0.13, 2.91]	0.54	[0.10, 2.84]
Mixed	1.46	[0.94, 2.26]	1.49	[0.93, 2.40]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.22	[0.83, 1.78]	1.30	[0.85, 2.00]
Rural	1.57**	[1.15, 2.14]	1.66**	[1.16, 2.37]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.17	[0.91, 1.49]	1.17	[0.90, 1.53]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.22	[0.91, 1.65]	1.23	[0.88, 1.71]
Non-physician provider	1.45*	[1.05, 2.01]	1.55*	[1.08, 2.22]
Other	1.04	[0.62, 1.75]	1.05	[0.60, 1.84]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.92	[0.60, 1.40]	0.92	[0.58, 1.45]
Employee	0.98	[0.66, 1.44]	0.97	[0.63, 1.47]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Existing patients changed from other insurance to Healthy Michigan Plan" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 18. Multivariate analysis of an increase in the number of new patients who have not seen a primary care practitioner in many years: sensitivity analysis with random intercept for practice ID

Increase in the number of new patients who have not seen a primary care practitioner in many years[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.18	[0.94, 1.48]	1.19	[0.91, 1.54]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.45*	[1.02, 2.07]	1.54*	[1.04, 2.29]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	1.07	[0.72, 1.57]	1.06	[0.68, 1.63]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.97	[0.71, 1.32]	0.94	[0.66, 1.33]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	3.06***	[2.34, 4.01]	3.37***	[2.47, 4.59]
Medicare	1.18	[0.88, 1.57]	1.19	[0.86, 1.65]
Uninsured	1.87	[0.54, 6.51]	1.81	[0.46, 7.09]
Mixed	1.13	[0.76, 1.68]	1.17	[0.75, 1.81]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.19	[0.81, 1.74]	1.21	[0.78, 1.86]
Rural	0.79	[0.58, 1.07]	0.76	[0.53, 1.08]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.29*	[1.03, 1.62]	1.31*	[1.02, 1.68]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.94	[0.72, 1.23]	0.91	[0.67, 1.24]
Non-physician provider	1.54*	[1.09, 2.18]	1.61*	[1.10, 2.34]
Other	0.81	[0.51, 1.31]	0.88	[0.52, 1.51]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.83	[0.57, 1.22]	0.83	[0.54, 1.27]
Employee	1.00	[0.69, 1.44]	1.00	[0.67, 1.51]
Years in practice	1.00	[0.99, 1.01]	0.99	[0.98, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Increase in the number of new patients who have not seen a primary care practitioner in many years" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 19. Predictive margins of primary care physician impact on emergency room use and primary care physician responsibility for emergency room use

	Primary care provider influence on emergency room use[a]		Primary care provider responsibility for emergency room use[b]	
	Predictive margins %	95% CI	Predictive margins %	95% CI
Race				
White	72.1	[69.8, 74.4]	86.6	[84.9, 88.4]
Black/African American	67.7	[57.2, 78.3	91.4	[84.9, 98.0]
Asian/Pacific Islander	82.9**	[77.6, 88.2]	91.2	[87.4, 95.0]
American Indian/Alaska Native	87.8	[65.6, 110.0]	-	-
Other	77.7	[67.3, 88.0]	89.9	[82.3, 97.5]
Hispanic/Latino				
Yes	73.2	[71.2, 75.3]	87.3	[85.8, 88.8]
No	80.2	[67.1, 93.3]	97.0	[91.2, 102.8]
MD/Non-MD				
MD/DO	74.5	[69.4, 79.6]	92.1*	[88.9, 95.3]
Non-physicians	73.1	[70.8, 75.4]	86.6	[84.8, 88.3]
Urbanicity				
Urban	74.2	[71.8, 76.6]	88.0	[86.3, 89.7]
Suburban	65.5*	[58.4, 72.7]	87.4	[82.4, 92.4]
Rural	74.2	[69.0, 79.4]	84.9	[80.5, 89.3]
Practice size				
Large practice (6+)	75.3	[72.1, 78.4]	90.0	[87.7, 92.3]
Small practice (0-5)	71.9	[69.0, 74.8]	85.8*	[83.6, 87.9]
New clinicians hired in past year?				
No/Not checked	72.6	[69.4, 75.8]	86.5	[84.2, 88.9]
Yes	74.0	[71.0, 77.1]	88.5	[86.2, 90.7]
New office staff hired in past year?				
No/Not checked	71.8	[68.4, 75.3]	87.9	[85.6, 90.2]
Yes	74.5	[71.7, 77.2]	87.1	[84.9, 89.4]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked	75.6	[72.5, 78.7]	87.4	[85.1, 89.7]
Yes	71.6	[68.7, 74.5]	87.6	[85.4, 89.8]
Changed workflow in past year?				
No/Not checked	72.2	[69.4, 75.0]	86.0	[83.9, 88.2]
Yes	74.9	[71.7, 78.0]	89.6*	[87.3, 91.9]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked	72.9	[70.7, 75.2]	86.9	[85.2, 88.6]
Yes	75.7	[70.5, 81.0]	91.4	[87.6, 95.2]

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Years in practice (intervals)	*		**	
0 years	77.4	[73.8, 81.0]	90.6	[88.2, 93.1]
10 years	75.3	[72.8, 77.8]	89.2	[87.3, 91.0]
20 years	73.1	[71.1, 75.2]	87.5	[86.0, 89.1]
30 years	70.9	[67.9, 73.8]	85.7	[83.6, 87.9]

[a] "How much can primary care practitioners influence non-urgent ER use by their patients?" Responses dichotomized as A great deal or Some vs. A little or Not at all

[b] "To what extent do you think it is your responsibility as a primary care practitioner to decrease non-urgent ER use?" Responses dichotomized as Major responsibility or Some responsibility vs. Minimal or No responsibility

Logistic regression with predicted margins; each column is a separate model/outcome, adjusted for all covariates shown.

The variable "Years in practice" was originally continuous, margins are estimated at specific cut shown. Significance testing was conducted on the continuous variable.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 20. Bivariate and multivariate associations of any HRA completion

PCP familiarity with completing HRA (n=1,898)	%[a]	OR	*p*-value	95% CI
Very familiar (n=928)	48.9	-		
Somewhat familiar (n=440)	23.2	0.50	NS	[0.20, 1.24]
A little familiar (n=248)	13.1	0.27	0.008	[0.10, 0.71]
Not at all familiar (n=282)	14.9	0.23	0.02	[0.07, 0.76]
HRA useful for identifying health risks (n=1,730)				
Very useful (n=453)	26.2	-		
Somewhat useful (n=727)	42.0	0.95	NS	[0.27, 3.36]
A little useful (n=347)	20.1	3.41	NS	[0.42, 27.75]
Not at all useful (n=203)	11.7	11.14	NS	[0.35, 350.18]
HRA useful for discussing health risks (n=1,727)				
Very useful (n=579)	33.5	-		
Somewhat useful (n=696)	40.3	0.56	NS	[0.13, 2.52]
A little useful (n=288)	16.9	0.04	0.01	[0.004, 0.485]
Not at all useful (n=164)	9.5	0.04	NS	[0.004, 3.828]
HRA useful for persuading patients to address risks (n=1,728)				
Very useful (n=464)	26.9	-		
Somewhat useful (n=674)	39.0	2.95	NS	[0.62, 14.06]
A little useful (n=394)	22.8	26.95	0.004	[2.87, 253.14]
Not at all useful (n=196)	11.3	8.34	NS	[0.33, 210.86]
HRA useful for documenting patient behavior goals (n=1,727)				
Very useful (n=391)	22.6	-		
Somewhat useful (n=683)	39.6	0.71	NS	[0.18, 2.84]
A little useful (n=424)	24.6	0.79	NS	[0.14, 4.35]
Not at all useful (n=229)	13.3	1.32	NS	[0.01, 17.34]
HRA useful for getting patients to change behaviors (n=1,722)				
Very useful (n=267)	15.5	-		
Somewhat useful (n=551)	32.0	1.03	NS	[0.25, 4.19]
A little useful (n=620)	36.0	0.87	NS	[0.19, 3.94]
Not at all useful (n=284)	16.5	0.28	NS	[0.03, 2.50]
Provider type (n=1,972)				
Non-physician (n=315)	16.0	-		
Physician (n=1,657)	84.0	0.89	NS	[0.40, 2.01]
Practice location (n=1,972)				
Non-urban (n=488)	24.8	-		
Urban (n=1,484)	75.3	0.39	0.03	[0.17, 0.93]
Predominant payer mix (n=1,787)				
Private (n=610)	34.1	-		
Medicaid (n=640)	35.8	0.42	0.05	[0.18, 0.99]
Medicare (n=393)	22.0	1.34	NS	[0.54, 3.33]
Uninsured (n=11)	0.6	0.05	0.04	[0.003, 0.830]
Mixed (n=133)	7.4	0.71	NS	[0.18, 2.84]

Bivariate association and adjusted logistic regression with odds ratios predicting any completion of HRA from data warehouse records. Multivariate model was adjusted for all variables shown, as well as the number of HMP members assigned to the PCP.

[a] Percent of respondents per level of familiarity with completing HRA.

Table 21. Rate of HRA completion by predictive factor

PCP familiarity with completing HRA	Completion rate (%)	*p*-value	95% CI
Very familiar	23.3	-	[22.1, 24.4]
Somewhat familiar	18.2	<0.001	[16.8, 19.5]
A little familiar	17.0	<0.001	[15.4, 18.6]
Not at all familiar	13.7	<0.001	[12.1, 15.2]
HRA useful for identifying health risks			
Very useful	18.9	-	[17.0, 20.9]
Somewhat useful	20.7	NS	[19.4, 22.1]
A little useful	20.5	NS	[18.4, 22.6]
Not at all useful	21.0	NS	[16.8, 25.1]
HRA useful for discussing health risks			
Very useful	21.2	-	[18.8, 23.5]
Somewhat useful	19.8	NS	[18.5, 21.1]
A little useful	19.8	NS	[17.5, 22.0]
Not at all useful	20.5	NS	[15.2, 25.8]
HRA useful for persuading patients to address risks			
Very useful	19.8	-	[17.6, 22.0]
Somewhat useful	19.8	NS	[18.4, 21.1]
A little useful	21.9	NS	[19.7, 24.2]
Not at all useful	19.6	NS	[15.3, 24.0]
HRA useful for documenting patient behavior goals			
Very useful	18.5	-	[16.6, 20.5]
Somewhat useful	20.7	NS	[19.3, 22.0]
A little useful	20.8	NS	[19.7, 22.6]
Not at all useful	21.0	NS	[17.5, 24.5]
HRA useful for getting patients to change behaviors			
Very useful	20.1	-	[17.0, 23.2]
Somewhat useful	20.7	NS	[19.1, 22.2]
A little useful	20.1	NS	[18.8, 21.4]
Not at all useful	19.8	NS	[17.2, 22.5]
Provider type			
Non-physician	21.0	-	[19.2, 22.8]
Physician	20.0	NS	[19.2, 20.9]
Practice location			
Non-urban	21.8	-	[20.2, 23.3]
Urban	19.7	0.02	[18.8, 20.5]
Predominant payer mix			
Private	21.3	-	[20.0, 22.7]
Medicaid	19.4	0.05	[18.3, 20.6]
Medicare	20.4	NS	[18.7, 22.1]
Uninsured	20.4	NS	[12.7, 28.0]
Mixed	19.2	NS	[16.7, 21.7]

Predicted HRA completion rates from GLM regression with gamma distribution predicting rate of completed HRAs using data warehouse records. Multivariate model was adjusted for all variables shown, as well as the number of HMP members assigned to the PCP.

Table 22. Multivariate analysis of associations with self-reported numbers of HRAs completed

	Number of HRAs completed (N= 1,697)	
	aOR	95% CI
Region		
Upper Peninsula/Northwest/Northeast	Reference	
West/East Central/East	0.71	[0.27, 1.89]
South Central/Southwest/Southeast	0.48	[0.17, 1.34]
Detroit Metro	0.61	[0.22, 1.70]
Urbanicity		
Urban	Reference	
Suburban	1.75**	[1.18, 2.59]
Rural	1.06	[0.41, 2.79]
Practice size		
Large practice (6+)	Reference	
Small practice (0-5)	1.49***	[1.20, 1.87]
New clinicians hired in past year?		
No/Not checked	Reference	
Yes	0.86	[0.68, 1.08]
New office staff hired in past year?		
No/Not checked	Reference	
Yes	1.17	[0.93, 1.46]
Consulted with care coordinators, case managers, community health workers in past year?		
No/Not checked	Reference	
Yes	1.01	[0.80, 1.26]
Changed workflow in past year?		
No/Not checked	Reference	
Yes	0.89	[0.72, 1.10]
Co-located Mental Health w/in Primary Care in past year?		
No/Not checked	Reference	
Yes	1.46*	[1.07, 1.99]
Payment arrangement		
FFS-predominant	Reference	
Capitation-predominant	1.72	[0.85, 3.49]
Salary-predominant	1.45**	[1.16, 1.82]
Mixed payment	1.06	[0.78, 1.45]
Other payment arrangement	1.50	[0.71, 3.17]
Predominant payer mix		
Private	Reference	
Medicaid	2.34***	[1.81, 3.03]
Medicare	0.75*	[0.58, 0.97]
Uninsured	3.41	[0.66, 17.53]
Mixed	1.24	[0.84, 1.83]
Practice has process to identify HMP patients who need HRA completed		
No/Don't know	Reference	
Yes	1.80***	[1.40, 2.32]

Continued on next page

Continued from previous page

Practice has process to submit completed HRAs		
No/Don't know	Reference	
Yes	7.88***	[6.16, 10.07]
Received financial bonus for HRA		
No/Don't know	Reference	
Yes	1.14	[0.84, 1.55]
Familiarity with HMP expenses		
Very familiar	Reference	
Somewhat familiar	0.49*	[0.27, 0.87]
A little familiar	0.47**	[0.27, 0.83]
Not at all familiar	0.48*	[0.27, 0.87]
Familiarity with healthy behavior incentives		
Very familiar	Reference	
Somewhat familiar	0.60*	[0.39, 0.92]
A little familiar	0.51**	[0.33, 0.80]
Not at all familiar	0.24***	[0.15, 0.38]
Model cuts		
Cut 1[a]	0.15**	[0.05, 0.50]
Cut 2[b]	0.43	[0.13, 1.43]
Cut 3[c]	2.48	[0.75, 8.18]

Ordered logistic regression with adjusted odds ratios adjusted for the covariates shown; 95% confidence intervals in brackets

Dependent variable ordinal categories are "None", "1-2", "3-10", and ">10"

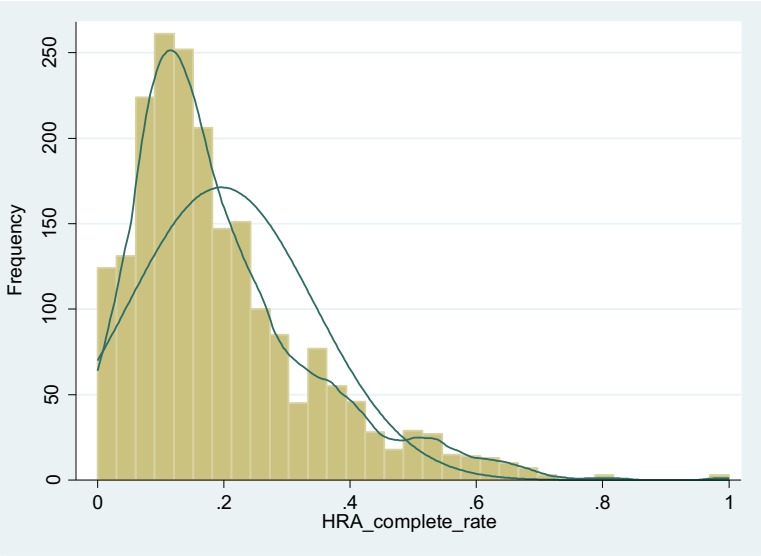
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

[a] Cut 1: Estimated cut point on the underlying latent variable used to differentiate category of None completed from 1-2, 3-10, and > 10 completed when the predictor variables are evaluated at zero

[b] Cut 2: Estimated cut point on the underlying latent variable used to differentiate categories of None and 1-2 completed from 3-10 and > 10 completed when the predictor variables are evaluated at zero

[c] Cut 3: Estimated cut point on the underlying latent variable used to differentiate categories of None, 1-2, and 3-10 completed from > 10 completed when the predictor variables are evaluated at zero

Figure 1. Distribution of HRA completion rates by PCP



Variable definitions

HRA rate: Calculated variable based on data warehouse information compiled 7/25/16. Rate represents the number of HMP members assigned to the PCP with a completed HRA attestation date divided by the total number of HMP members assigned to the PCP. PCPs with 0 HMP patients assigned at the date of data collection were marked as missing.

MiPCT: Indicator variable from the data warehouse marking practice participation in the Michigan Primary Care Transformation Project (MiPCT).

Predominant payer mix: Composite variable of all current payers: payer is considered predominant for the practice if it represents the highest share of payer types and >30% of physician's patients have this payer type. "Mixed" includes practices with more than one payer representing >30% of patients where there is a tie, or practices with <30% of patients for each payer type.

Urbanicity: 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.

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

Appendix B: Quotes from In-Depth Interviews with Primary Care Practitioners

1. Patient Descriptions

1.1 Unmet Needs

I think just the fact that so many things had not been addressed in the past and some of them just came in with lists. Like, "I've got bad teeth." "I have a hernia." "I haven't had a Pap smear in how long?" "I think my blood pressure is a problem." "I've got this skin thing." You know, "My hand is numb." . . . It's like the dam burst.

(Rural physician assistant, Rural health clinic)

I would say, you know, overall the patients are overall unhealthy in terms of having uncontrolled diseases which have been there for a while and which have resulted in some end-organ damage. They overall tend to be, you know, more overweight. Unhealthier habits such as smoking I would say are definitely more prevalent. Issues with both mental health as well as substance abuse.

(Urban physician; Large, hospital-based practice)

So we see a lot of people with asthma, and a number of patients who, you know, are just kind of eeking by on borrowed medications . . . Some part of medications that now we're able to get inhalers for them and do a pulmonary function test and start working on improving things instead of just damage control. Also, there's a number of people with diabetes . . . a number of people who hadn't had labs in two or three years and were just kind of type 1 diabetics who were managing their insulin, rarely checking their blood sugars and never getting the hemoglobin A1C.

(Rural physician; Large, hospital-based practice)

1.2 Long Time without Care

Most of the new people we got last year probably…. You know, I'd say, "When was your last physical?" And they'd say, "I don't know. I don't think I've ever had one," or "It's been 5 years plus." … Or the only thing they had was just going to the emergency room.

(Urban physician; Small, private practice)

So, for instance…two cases where gentlemen have walked in, not having been seen in, you know, in twenty years perhaps, if at all. One gentleman said he hadn't been to see the doctor in forty years. One had multifocal carcinoma upon presentation, and the other had hypertension, diabetes and was later found to have had a stroke, all prior to arrival at the office, but those were all new diagnoses made.

(Urban physician assistant, FQHC)

Literally I've had some patients who haven't seen a doctor for twenty years, and those who were kind of getting primary care in the emergency room, through like free clinics and things of that nature.

(Urban physician; Large, hospital-based practice)

Some are existing patients that now have insurance, and so now they can get the things done you had been wanting them to do, but I would say I've seen several that didn't have a doctor for years. They knew they had diabetes and other problems, but they didn't . . . They had no health insurance, and so they just ignored it for years. Now they're coming in and getting established.

(Urban physician; Small, private practice)

1.3 Patient Insurance Status

Back in the day prior to the Affordable Care Act and the Medicaid expansion, we had maybe 20% of our patients were insured, and the rest were low-income, uninsured. Most of our patients are employed...but, as I said, most of them had no insurance. So when Affordable Care passed and when Medicaid expansion in particular passed, then we started doing a lot more of insurance billing, and it kind of expanded the Medicaids which we participated with.

(Urban physician, Free/low-cost clinic)

We had a 45% increase in the people who basically signed up and named us at their providers. Some of those actually came out of our . . . offices, and so they were not necessarily new patients every one of them, but a large majority of them were. . . They were being seen other places or not being seen at all, and when they signed up and we increased, you know, basically our commitment to 45% new patients in the Medicaid plan, we didn't increase our providers by 45%, and I know we're having a real struggle here at times getting some of these people in when we've got already established patients who pretty much filled our time up even before we started this.

(Rural physician, FQHC)

1.4 Churn

You know, they'll say something like, "Can we do this before the end of the month because my insurance is going to lapse?" And then they come back and, you know, a few months later, "Well, I'm back on insurance." I mean it's just crazy.

(Rural physician assistant, Rural health clinic)

I have a sense that that seems to happen somewhat regularly, meaning like annually it seems like, but this is all new and so it's hard to say. ... I have no way of knowing if they've recently changed or if they're planning to change.

(Urban physician, FQHC)

It matters what they have now or if ... they know and bring it up, like "Hey, I'm gonna lose this," or "Let's not do that now. I'm enrolled for this new insurance plan.... Let's let these things off until next month or the first of the year or whatever.

(Rural physician, FQHC)

Especially with the county health plans, those were a month-to-month thing. They covered nothing.

(Urban physician; Small, private practice)

1.5 New Patient Population

We have so many working poor people up here. You know, they work two and three jobs, barely can scrape it together, and they're coming in after years of little or no care, especially the men because the women at least have the breast and pelvic exam program ... And it's like they are getting everything done. They are . . . It's like problems that have backed up over the years. Dental stuff is being taken care of. Vision is being taken care of, but they usually start with me, and it's been really wonderful.

(Rural physician assistant, Rural health clinic)

These are deserving people. They have genuine issues. They're not, you know, lying around. These are a lot of working poor people.

(Rural physician assistant, Rural health clinic)

We're in an area where there's a lot of working poor out there with no insurance at all. We're in a big, kind of logging and mom and pop machine shop area kind of thing. So those people basically didn't have any kind of insurance up until a year ago. ....A lot of them are these independent sorts that don't want anything to do with the federal government or anything having to do with government in general, and yet they kind of come in and on one hand they slam-bam the administration that got their insurance for them, and yet they'll turn around and say, "It's kind of nice having insurance."

(Rural physician, FQHC)

I think the majority have jobs ..., but they didn't have insurance ... Their employer didn't offer it ... They fell through the cracks because they weren't poor enough and they're working....

(Urban physician assistant, FQHC)

I think the newer patients I've had who've recently had insurance tend to be a little bit healthier because I think they have been engaged in the workforce somehow. . .

(Urban physician; Large, hospital-based practice)

2. Practice Characteristics

2.1 Patient-Centered Care

. . . we are really trying to follow an integrated health model, you know, with [organization] and because we have on-site behavioral health services in the primary care clinic, yes. There have been a number of patients who have walked in, been evaluated and had a subsequent behavioral evaluation and counselling services scheduled subsequently as a result of coming in.

(Urban physician assistant, FQHC)

Because we have onsite dental and, you know, often times with just the general evaluation, you know we will refer not only for just routine cleaning but obviously if we see some problematic issues. So, yes, they can receive care pretty seamlessly. We often times can even get patients seen for dental the same day that they are seen for medical.

(Urban physician assistant, FQHC)

So I would say that a primary care physician making an initial referral to a psychiatric or behavioral health has about a 10% chance of actually working due to all of the complexities in the systems and how they work ... This is if you're not co-located ... But if I have the psych social worker here and we can work out a plan right on site, then he/she can be active in making sure that the appointments are actually set up. . . making sure that the person knows where they're going and that they have transportation. It's much more effective. It's like going from a 10% to 80% chance that they will, you know, have . . . That they will actually connect with their therapist.

(Urban physician; Small, private practice)

So I mean we emphasize that we have. . . someone answering our phones 24/7. So if they have a concern and they're not sure if they should wait until tomorrow or go to the ER, call us first. We can help you talk through that. So we mention that as an option. For our patients that tend to go to the ER frequently, we have a nurse case manager as well. So for people who go frequently, we always touch base with them after the ER visit to say, "What happened? How could we prevent this? Do you need follow-up with our office?" So then we have a chance to talk in the office and say, "Look, what happened? Next time that that happens, please call us first. We're happy to talk." Sometimes that helps; sometimes it doesn't.

(Urban physician; Large, hospital-based practice)

2.2 Provider on Call/Phone Triage

The other thing we have is 24/7 phone call availability for a provider. So we pretty much insisted with our patients that they call us first unless, you know, they're sucking air on their back with chest pain . . . Then it's pretty clear they need to be in an ambulance, but short of that, we want them to call us and talk to us before they go running to the emergency room.

(Rural physician, FQHC)

There's been kind of a new promotion going on here which is called "Call Us First," which is just to try to repeat this message over and over to people that they should call their primary physician's office first before deciding what to do if they're sick after hours ... It's just a series of different messages throughout the system.

(Urban physician; Small, private practice)

They call the doctor on call. I think there's a difference between that and a hotline. A hotline implies to me somebody you don't know who just calls and they give you some good advice, but if they call me, I can tell them "I will see you tomorrow morning at 8:00."

(Rural physician; Small, private practice)

Our clinic specifically does not have after-hours service. So, you know, our clinic has traditional hours. . . . Our health system has set up some urgent care clinics. They are not very near our community, and that might be part of the reason why our patients go to the ED, but definitely kind of in the extended area there are urgent care centers which do have kind of extended hours, same-day clinics and that kind of thing. But I still don't really see our patients buying into that as much as we would hope.

(Urban physician; Large, hospital-based practice)

We do have a pretty good network with our home nurses to increase their visitations on our chronic disease patients to help adjust things as best they can. I get frequent phone calls from them when I'm on call at night after 8:00... trying to decide what to do with a patient who may be having some problems.

(Rural physician; Large, hospital-based practice)

2.3 Urgent Appointments

We keep slots open every day. If you call at 8:00 in the morning, you will be able to get in with your practitioner because even the busiest, fullest practice guy has got openings . . . Patients have learned I'm here, and if they come in and they're [another provider's] patient, but I'm seeing them and I realize this is bad, I'm going to immediately find [that provider] and bring him in. You know, and so that's another thing that I think has cut down on, "Well, let's just go to the ER" is that we can look right there.

(Rural physician assistant, Rural health clinic)

Just in parallel with Healthy Michigan, we re-formatted our schedule, . . . I guess that we just found that all of a sudden we had patients who are more willing to come in to see us. All the providers have re-formatted their schedule so that all of us now have whole half days where we're just dealing with acute emergent urgent care type stuff. Just trying to open up access to people who . . . just trying to decrease them going to the ER.

(Urban physician, FQHC)

3. Changes in Practice

3.1 Hired New Clinicians or Staff

So organization-wide. . . Thirty-nine persons have been slotted for new employment. So it's about an 8 or 10% staff addition as a result of Healthy Michigan.

(Urban physician, FQHC)

There are more PA's at our clinic than there used to be.

(Rural physician; Large, hospital-based practice)

Other things is we've been able to increase the number of persons who are answering phones so that our wait times for patients are improving. Another big problem we've had for years is how long patients have to wait for referrals. We've increased the staff for people processing referral requests, decreasing wait time for that…Patients don't have to wait as long to get their referrals processed.

(Urban physician, FQHC)

I know that we've hired new . . . new staff and support care . . . in support roles . . . a medical assistant.

(Urban physician assistant, FQHC)

This is kind of my personal beef with the Medicaid expansion plan is the huge requirement for prior authorization. So we have had to bring in a new secretary to the office just to handle prior authorization requests for our practice. Basically, even she alone cannot keep up with it. So, we have a couple of other secretaries who do prior authorizations, but that has been the biggest, I would say, my downside….

(Urban physician; Large, hospital-based practice)

3.2 Changes in Number of Patients

We've overwhelmed. (LAUGHTER) That's the short version. I mean, we are already, as you know with a federally qualified health center, we accept, always have accepted, Medicaid because we have a cost-base reimbursement agreement with the state for seeing those patients with the Medicaid expansion going up to whatever it was 133 or 137% or whatever that was . . . Then that gave us a whole lot more patients . . . current patients who now qualify for Medicaid under the Medicaid expansion. So, I guess that's the biggest change. All of a sudden, we've got a whole lot more patients serving the same population, but now they've got insurance.

(Urban physician, Free/low-cost clinic)

3.3 Wait Times

Whoa, we're sort of overrun and the house is full. So, we're still open. Any Healthy Michigan patient can call us and come see us, but it's not like you're going to probably get as timely care as would be ideal.

(Urban physician, FQHC)

Well, the goal has been to improve wait times. I just think that, to be honest, because we're encountering patients who may have been kind of off the grid, so to speak, without healthcare for so long, that when they come in, they have . . . It takes a lot . . . It's requiring more of us . . . more time to thoroughly evaluate the patient and kind of get them moving forward, you know, as far as healthcare.

(Urban physician assistant, FQHC)

It hasn't been a problem for us because . . . There's enough of us present and there's enough availability for appointments that I don't think it's been much of a problem.

(Rural physician; Large, hospital-based practice)

3.4 Administrative Burden

Say if they have [health plan A], a written referral on a prescription pad is pretty much useless. It's got to be all done online. For [health plan B], they don't have to have a formal referral, and for C and D [health plans] it's just gotta be written on a prescription pad. So, it [which HMP affiliated health plan] kind of basically steers me in the direction of how I give them referrals, and it also determines how I give them a prescription for an MRI or a CT scan. Some I know are going to require prior authorization right out of the gate, and some of them don't require prior authorization, and some of them I have to go online. Same thing. So, their insurance kind of determines, you know, what's going to be involved in getting them the necessary tests and medications.

(Urban physician; Small, private practice)

3.5 Practice Capacity/Flow

I know there's demands on how fast we've got to get them in, and that's probably the thing that got us the worst. I mean if they said, "Well, as long as you see them in the first year and start to pick up their care after that," we could have handled that, but the idea of a huge wave of people knocking on the door saying, "We need our first exam in three months," …It was overwhelming.

(Rural physician, FQHC)

3.6 Revenue

Since my center opened in like '95, they really hadn't done any facility updates in that twenty years. Now in the last six months, moneys have been freed up to . . . So for the first time ever, we had some rooms repainted. This is despite like bullet holes in the walls and other crazy stuff. They were patched and painted. Again, this all ties back to not so much like Healthy Michigan is directly paying for these things, but we went from having not an extra penny at the end of the fiscal year to, "Okay, we can breathe. So maybe we can start to do the things we want to do."

(Urban physician, FQHC)

So, we're actually getting revenue now. That's a new experience. It's certainly fairly low, but it's more than zero, and so that's awesome.

(Urban physician, Free/low-cost clinic)

[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)

4. Acceptance of Medicaid/Healthy Michigan Plan Patients

We just don't take anybody off the street. No. No matter what plan. We screen. They're screened.

(Urban physician; Small, private practice)

So unless we get new providers or, you know, somehow we can increase the providers we have up here available, we're gonna have to kind of turn the screws down a little bit and just slow down the intake

until we can get some. We're always working on that. I'll be honest, the pipeline for primary care in rural America is not getting more open. It seems to be getting tighter.

(Rural physician, FQHC)

Since we are part of this large health system, there are a lot of administrators that are involved in this decision-making process. So we do have monthly meetings with them, the physicians and the administrators, and these topics are discussed. Thus far, most providers have figured out... how to accommodate the higher number of patients without it having too much of an impact on how much time they're in the clinic. Clearly the more patients you see, the more paperwork and other after-hours work that a physician has to provide, and that does have its limits.

(Rural physician; Large, hospital-based practice)

Well, I mean that's kind of, sort of the fundamental basis of our clinic. So that's not really any decision at this point as to whether we're going to accept them. That's really kind of who we are. So that's kind of what our main mission is is to see people who are underinsured or uninsured.

(Urban physician; Small, private practice)

I chose to work at a clinic where I knew there was an 80% Medicaid population. So I think it's a population I knew I wanted to work with. I'm not sure what else to say, but I mean it's a population that I think needs care for many different perspectives in terms of, you know, social work, financial, mental health, and I think it's a valuable population for me to provide care to. It's meaningful for me.

(Urban physician; Large, hospital-based practice)

I guess the thing right now is that we're short staff providers, and so we don't have a lot of capacity for adding new patients. That's at my clinic. We recently had a provider that left, and we weren't able to fully replace that position. So the same amount of people, but less providers.

(Rural physician; Large, hospital-based practice)

For us it's a little bit different critter because we accept patients without insurance. And we don't charge. If you don't have insurance, we ask people for a $10 copay. If they can't afford it, we don't send them to collections or nothing like that. We still take care of people. So when they get Medicaid, now we're just getting paid for what we did when we didn't have that before.

(Urban physician, Free/low-cost clinic)

If they're coming from outside the county and there are chronic pain meds involved, you know we want the MAPs . . . that Michigan automated program where we can see where they've been getting the stuff from. Because you'll find somebody who is perfectly compliant, who has maybe gotten a few here and a few there, and then you see the person who's averaging over 300 pain pills/month, and they're getting them from multiple people. And you realize, "Oh, I don't want this person anywhere near my practice."

(Rural physician assistant, Rural health clinic)

5. Reimbursement Rates

You know, the previous Medicaid rate was not very good. . . We tended to limit new patients. We would occasionally take a new patient, but sometimes we'd feel like we just couldn't, but it's certainly better than the Medicaid rate. We're looking forward to when they can pay us like [the] Medicare rate at the time of service.

(Rural physician; Small, private practice)

Well, if they cut the reimbursement by half, then I can't afford to see them. Then I'd just see the new patients. Other people that I've been treating for free for years, I'll keep seeing. I have to pay my bills.
(Urban physician; Small, private practice)

I have heard that the reimbursement rates for primary care will be better or are better than they used to be, but that's about the extent of what I know.
(Urban physician; Large, hospital-based practice)

What I understand is they are currently at Medicare rates. And that that is supposed to change in 2015, and there's a debate about whether or not to extend them. If we are talking about access for patients long-term, they have to be extended or we're going to have a different crisis in this state in terms of again people with[Medicaid/HMP] cards with no access. I know the stories that we hear from our patients coming back from other Medicaid providers. . . haven't been positive. If we're serious about giving these folks true access to healthcare, then the providers need to be paid to provide that.
(Urban physician, Free/low-cost clinic)

Well, that would be great whenever we get it, but [HMP health plan] bundles it all up and sends it to us twice a year, and we have no idea when they're going to send it.... We don't get paid as we go along. Michigan Medicaid does, but [HMP health plan] does not ... When we get a check, it's just a check with no numbers attached to it, and we beg for the data. On which patient did we get this? Which bill did we get the uplift, because there's no accountability. It's just sort of a lump sum.
(Rural physician; Small, private practice)

6. Impact of Healthy Michigan Plan on Patients

6.1 Overall Impact on Patients and Their Health

We're getting a lot more . . . smoking cessation right now because the individuals coming in . . . now they can afford to get the patches or the gum or whatever . . . We're getting a lot more people trying to quit smoking, which is encouraging, but that's about the only change that I've seen.... I think there's a little bit of . . . maybe a little bit of freedom of choice there that they maybe didn't have before.
(Rural nurse practitioner, Rural health clinic)

It is a huge benefit. I think it's so interesting to hear some of the political rhetoric that you hear on TV... they don't really understand the waste that goes on in terms of . . . when people don't have insurance and what ends up happening that could have been fixed much sooner if they did have insurance.
(Urban physician, FQHC)

The people I've seen so far, lives are improving. You know, blood pressure is getting treated. Smoking is getting dealt with. Diet is . . . people are looking at eating, you know, somewhat differently.
(Rural physician assistant, Rural health clinic)

6.2 Reduced Financial Concern by Patients

They are no longer petrified about, "Oh, I can't afford that," or "I can't do that."
(Urban physician, FQHC)

So they have come to see me, and I've tended to bandage them when they got sick. We've done little in-office screens . . . limited, but this patient has almost no money but they're financially responsible. They have a little job, and they make their money and they do their job, but they're really scared of debt. So

they have never let me do much. They have never let me offer much. . . . They'll come to see me when they need me and that kind of thing. They got their Healthy Michigan. They show up and they're like, "Alright doctor, I want everything."

(Urban physician, FQHC)

The primary care and prescription parts . . . They just didn't do it because they knew they couldn't afford it. So now it's within reach. That makes it a little smoother for them.

(Rural nurse practitioner, Rural health clinic)

Her particular issue is mental health, and she's got a few mental health things. One of them is attention deficit disorder. Another is anxiety and panic disorder, and so the impact is a couple fold. First off, it's going to make it easier getting medications because she's no longer trying to pay cash to get medicines.

(Urban physician, Free/low-cost clinic)

6.3 Control of Chronic Conditions

Well, they're benefiting from being able to have any preventive services available to them…. Maybe they had high blood pressure and had other conditions when they were incarcerated, that they're now able to follow up on and get their medications for and so forth.

(Urban physician; Small, private practice)

I think the impact of that overall . . . this patient is now going to have some pretty longstanding health conditions managed, hopefully managed well. . . The risks for further sequelae due to those chronic medical conditions will be hopefully minimized. His risk for recurrent stroke . . . Now we can, you know, try and modify . . .minimize that risk. The same for end-organ damage with his kidneys, retinopathy . . . those types of things. I think we can positively impact that.

(Urban physician assistant, FQHC)

It's hard to measure that [impact of HMP on patients], but I really think that especially these people who knew they had chronic health problems, they were just ignoring them, and now they can actually get them taken care of. It's gonna add years onto their life because now it's not going to be uncontrolled diabetes. It's gonna be controlled diabetes and controlled hypertension and hyperlipidemia.

(Urban physician; Small, private practice)

6.4 Ripple Effect

Many patients in coming to our clinic with Healthy Michigan thought that they needed to have Healthy Michigan or have some sort of insurance to even be able to access care which is, in our case, being a federally qualified health center not the case. I mean they could come even if uninsured. So there have been a number of individuals who. . . I believe that they have been seen as a result of having the insurance . . . [they've] been able to get things like mammography, Pap smears, optometry services quite easily, and then also I believe have referred family members and friends who may not be insured to receive primary care because they understand that they can be seen without insurance here.

(Urban physician assistant, FQHC)

6.5 Disease Detection and Treatment

But I've had new people come in and say that they didn't have insurance until this came up. They're working two jobs, and luckily they fall just under the level where they can get it . . . We run cholesterol tests and sugar tests on them and anemia, and we find things with them.

(Urban physician; Small, private practice)

A guy said to us, "I'm so thankful to come in." We just checked him over, and criminy…. He's got all kinds of issues, you know, with cholesterol. We found out he's a diabetic now. We found out this prostate thing is elevated. Where he would have been out in the cold. A young guy, too.

(Urban physician; Small, private practice)

Getting new uninsured patients in, these folks have multiple problems going on. So like I did a new patient visit this last week where my problem list at the end of the visit had like twelve items on it. Most of them haven't had any preventive care.

(Urban physician, Free/low-cost clinic)

6.6 Patient Activation

I think they felt, and for whatever reason, that when they were coming in on sliding fee, that basically we were just covering their nickel for them. . . . They tended not to take advantage of primary care as much as they might have otherwise. And now that they've got coverage, I think they sort of feel empowered.

(Rural physician, FQHC)

They seem to feel freer to come to the office with the same things they might have taken to the ER a year ago, but that's also part of being established in an office practice for the first time in some cases, too.

(Rural physician, FQHC)

The only thing I have seen more directly for me . . . and this hasn't happened very often, but a few times it's like, "Oh, well I have insurance now. So, doc, can you get me that full body MRI? I need to make sure I get all the cancer blood tests because, you know, now I have insurance and I can get all that stuff." That discussion sometimes comes up a little bit more for me. "That's great that you have insurance, but that's not necessarily what we need to get for you."

(Urban physician, FQHC)

I think there's less barrier, and they're more willing to come in and talk about things because they know there's not going to be a problem every time we make a recommendation with trying to afford it and that kind of a thing .... I think they're more like a partner in the whole situation again rather than a one-sided recipient.

(Rural physician; Small, private practice)

7. Providers' Thoughts on ER Use

7.1 Appropriate/Inappropriate Use

I think a lot of times we have good relationships with people. They'd rather be seen by us, but we've also got people who just abuse the system in general. Every little twinge is, you know, Armageddon and they need to be seen immediately.

(Rural physician assistant, Rural health clinic)

The ones that abuse the ER don't call first. They just don't. The ER . . . The closest one . . The staff is very helpful there. They're very nice. It's probably a pleasant experience for them to go get pampered for simple things. So the ones that abuse it, I don't think that the Healthy Michigan Plan is going to change that. The only thing that will change is maybe some of the diabetics or the people who are being identified with high blood pressure and, you know, we work with those . . . We may save them a visit to the ER once a year, but the ones who are big abusers, it makes no difference if they have insurance or not. They just go there.

(Rural nurse practitioner, Rural health clinic)

You know, I've seen ER visit reports where it's been something relatively serious, and then I've seen it where it's been something ridiculous, to the point where I don't actually ask the patients this question, but what's running through my head is, "You went in over this?" So, I don't know if there's an absolute way to decrease ER visits. One of the things I encourage my patients to do is if it's not that serious or if it's just a sore throat, try urgent care first You won't wait as long, and it's not nearly as expensive .... We do have an after-hours phone number for people to call if it's something that needs attention right now this minute, but it's not an absolute emergency which requires an ER visit. Sometimes we get a call, and sometimes we don't.

(Urban physician; Small, private practice)

I mean they can ignore that recommendation and go there [the ER] directly, but then we'll catch them after they've made a few inappropriate visits and then we'll start . . . It's usually one of our nurse educators will get ahold of them during a visit and counsel them about how to take advantage of the system outside the ER ...

(Rural physician, FQHC)

They're always encouraged to call our office, and with the expanded hours we're going to be more apt to get them in. ... In fact, almost all of our patients that have an acute care issue when they call our office, we get them in, and that's a high priority. ... but we do know what the . . . The serious issues . . . They go to the ED.

(Rural physician; Large, hospital-based practice)

You know, I think that principally, lack of access as well as extended hours I'm sure does play a role, but I think some of it is . . . "If I'm really sick, I'm going to go to the ER" kind of an attitude which is also a problem there. Maybe it's our failure to pre-communicate to our patients that we are available to answer questions and kind of help manage the problem . . . help triage the problem. So it's certainly one of the things that's on our mind is to try to figure out how we can get a better handle on this to help our patients.

(Urban physician; Large, hospital-based practice)

Well, if they had a copay.. . . I don't know if you can do that, but like if it's not an urgent thing and you end up in the ER, you end up with a copay with some sort of penalty. To bring it to their attention that they need to call their doctor first before they go to the ER, unless it's life threatening.

(Urban physician; Small, private practice)

Probably the majority of the ER visits tend to be something that could have been dealt with at our office. Probably in terms of hours and I think having patients understand that, you know, sometimes you can call us and it's okay to wait a little bit longer . . .But again, I think if we had more openings markedly available, then they might not feel they'd have to wait another week to get seen or if there is something urgent, that they can get seen that day, not have to wait until the next morning.

(Urban physician; Large, hospital-based practice)

There was a big partnership with [organization], and so somebody was able to prove to [organization] maybe 15 years ago now that, "Hey, if you take care of these patients up front and maybe you allow them to get specialized care, then …they won't come to the ER and get admitted for unnecessary care that could have been taken care of, you know, previously." ….I think a lot of docs do amazing work in primary care, but when there's an issue that needs to see a specialist, it's like, "Alright. Here's a list of docs. Go call them." And then the patient goes there, and it's like, "Well, you need to pay $250 to get seen," and they may not have that money.

(Urban physician, FQHC)

When we get ER reports, they follow through with the patient to see what is their plan for follow-up because a lot of times people get into this routine of you went to the ER once and now a week later you're not better, and so you go back to the ER. We're trying to prevent that because that's something we can have an effect on.

(Urban physician, Free/low-cost clinic)

I mean what can a health system do? I don't know. Change people's attitude. Change people's philosophy. I don't know. I don't know that health systems can do a whole lot about that, I mean without being punitive. I mean the way to fix it, of course, is be punitive and tell the patients after the fact this wasn't an emergency and we're not going to pay for it. What is that going to do? They've got no money to pay for it themselves.

(Urban physician, Free/low-cost clinic)

First of all, we've gone out in trying to change this for long before we ever started the new Medicaid folks because we're also in an ACO, and so there's financial incentive to try to keep them out of the ER. Plus, we know that the care there is going to be expensive. We also know that it's fractured.

(Rural physician, FQHC)

7.2 Patient Education about ER Use

Patient education [about ER use], but it doesn't work. We stress that to our people. "What the hell are you doing in urgent care again?" "What are you doing going to the emergency room again?" "Well, there was a 2 hour wait out there, doctor. … In my office sometimes… I'll see 60 -80 . . . rarely 80, but sometimes 80 . . . 60-70 people/day….We go through and evaluate each patient, but that goes when you sign up with me. If you don't like it, then sign up with another doctor. I can't do anything about it.

(Urban physician; Small, private practice)

I think a lot of it is education…. a lot of the young don't read newspapers any more. Thinking things that come across phones… The fact that if you have a cold, if you have these symptoms, going onto an antibiotic is not going to make you better faster. You know, that kind of mass education. Keep it simple, straightforward might help.

(Rural physician assistant, Rural health clinic)

I do a lot of teaching. Like if someone comes here for a sore throat or something, I teach them how they got what they got, what the natural progression is before it's going to be over. If they take a medication for it, teach them what the common side effects are and what allergic symptoms would be to try and make them educated enough so they don't feel the need to go to the ER over every little thing. . . . I guess that's what we do here. I spend a ton of time teaching, but that only works for the people who listen, I guess.

(Rural nurse practitioner, Rural health clinic)

Well, yeah, in my mind, a caseworker solves like a remedial problem, a very high intensity of inputs, and I think that can be good for people who are really quite somewhat impaired in their abilities, but there's kind of like a basic level in which maybe we should anticipate that most of these people don't know how to use a primary care physician. Things that you and I assume because of how we've grown up . . .They don't have in their baseline. And so, some sort of just like basic education to people about how to use a doctor's office… Like how does it work? How do you make an appointment? How do you come in? When should you call us? When should you call us if something's going wrong? If you don't get your medicine . . . What should you do if you're sick?

(Urban physician; Small, private practice)

I actually saw a patient yesterday . . . . I think he has Medicaid, not necessarily Healthy Michigan . . . But like he went [to the ER] last month for, you know, an upper respiratory infection and two months ago for like allergies. So I asked him what was the point? And his response, and I think this is kind of classic for a lot of people, was like, "Well, I didn't know if it was an emergency or not, and so that's why I went." Luckily it wasn't, and so we kind of talked about, you know, what other options could you go to get some other reassurance that it's not an emergency. And so we talked to him specifically about, "Just give a call, and we'll . . . We'll keep in touch."

(Urban physician, FQHC)

Is it an emergency? My throat is really sore. "Well, do you think you're going to die?" "No, of course, I'm not going to die." But they've got a really sore throat, so I'd better go to emergency. So I don't know if the education fixes that per se…. I don't know what fixes that.

(Urban physician, Free/low-cost clinic)

7.3 Recommending Other Sources of Care

I think convenience is an issue, and as more practices either have more extended hours and/or we make more use of urgent care versus emergency care, I think that can help a bit with that issue.

(Urban physician, Free/low-cost clinic)

8. Reasons for ER Use

8.1 Culture of ER Use

They don't listen. They don't pay attention. We've dismissed many patients because of that. It's more convenient to go to the emergency room. I can see on a weekend if they call me first and there's an issue, I'll tell the answering service or I'll talk to them and say, "Yeah, well, you'd better be checked. Do not wait until Monday." But a lot of them are just constantly going into the ER, and that's always been a problem….The pain, they feel, is worse, and they need to be seen right then.

(Urban physician; Small, private practice)

People go to the ER way more for many things. . . that aren't anyway near an emergency unfortunately, and it's just sort of a culture. "Oh, I don't feel good; I'll go to the ER," in the community where we're at. So it's hard. And I can envision how maybe Healthy Michigan or, excuse me, having Medicaid and getting some care may over time reduce that.

(Urban physician, FQHC)

In the whole state of Michigan, I think we're one of the highest ED utilization clinics in the state of Michigan. Our kind of copartner in this is, I believe, like another [city] clinic, and some of it is we think possibly some kind of a cultural issue. When you're really sick, you go to the ER type of attitude, but we

do have a lot of ED utilization, even amongst patients who just have had insurance and they're back in the ED with a problem, in spite of the fact that we do give literature and information about some urgent care centers and how to access us if it's after hours and things like that, but that is a challenge.

(Urban physician; Large, hospital-based practice)

I think some of these people honestly since they haven't had insurance, maybe ever, or haven't been to the doctor in a long time . . . They don't understand why they can't come in that day to be seen and why they can't go to the ER and tell everybody I'm their doctor, and then I start getting all these reports to review and I've never heard of this person. Some of these people are so ignorant of the healthcare system that they just don't really understand that I'm not your doctor until you see me, but I would say that's the case of people even who have private insurance.

(Urban physician; Small, private practice)

I think people use the ER whether they have insurance or not. They don't even think of, "I'm going to the ER and I'm going to get a bill." Their mindset is, "Well, I can't afford it anyway, and so I'm not paying for it." It's not even a big deal. So, whether they have insurance or not, I don't necessarily think I've seen an increase in people saying, "Well, I have insurance, and now it'll cover."

(Urban physician, FQHC)

8.2 Perceived Need

The vast majority of my patients that go to the ER took it upon themselves to go to the ER. They didn't call us first. If they called us first, it would be things like chest pain or can't breathe or might be having a stroke, or they're calling when we're closed. But then we usually say Urgent Care unless it's chest pain, I can't breathe or I'm having a stroke.

(Urban physician; Small, private practice)

Sometimes. . . it's a benign thing, but it's something they're very frightened about. So we had a young man who was having vertigo, and he had been seen here a couple of times for it. He didn't fully understand and was still frightened by it . . . And so he went to the ER.

(Urban physician, Free/low-cost clinic)

I think for some folks with mental health problems, until we get the mental health problem solved, there is nothing to be done because they're going to be scared in the middle of the night, have difficulty interpreting what they're feeling, and they're going to end up there.

(Urban physician, Free/low-cost clinic)

They're just worried. . . . I mean it's me judging them by the telephone…. I can't allay all of their fears that they have something bad going on. So that's the main thing . . . They're worried that they have a serious illness. They don't understand what's serious and what's not sometimes.

(Rural physician; Small, private practice)

8.3 Need for Off Hours Care/Convenience

Some other ones go there because the best ride they can get or the family members that give them transportation work during the day and are only available in the evening. So they just go to the ER because that's when they have a ride.

(Rural nurse practitioner, Rural health clinic)

I always ask them, "Why did you go? What happened? Are you feeling any better?" And usually it's, "Well, Saturday morning I woke up and . . ." or "Saturday I had a fall," or "Saturday I had trouble breathing and I went to the ER."

(Urban physician; Small, private practice)

We have a lot of population that lives downtown, and there is not an urgent care. The ER is much more accessible than an urgent care is downtown.

(Urban physician; Large, hospital-based practice)

8.4 Encouraged to Go by Their Provider

So sometimes we'll just order . . . I'll just order a troponin and order it stat. Then they call me. If it's elevated, I'll send them right over to the emergency room then . . . I tell them, "Hold them there. If it's elevated . . . It only takes a few minutes to run it . . . send them to the ER." People come in with leg pain. I send them over to the lab. I send them over to get a Doppler right away . . . venous . . . and if it comes back positive . . . Send them right to the emergency room. They evaluate them, and get them on medication right away . . . Or admit them if they need to be.

(Urban physician; Small, private practice)

We'll have people come in and realize they need to be in the ER. We got the wheelchair and I take them down there and confer with the ER doctor and tell them why. So it kind of goes both ways.

(Rural physician assistant, Rural health clinic)

Let's say someone had a patient this week with an abrupt turnaround from a recent hospitalization, had abnormal labs. He followed up the way he was supposed to have, but when we got his lab results, you know, the tests revealed that his acute condition was, you know, recurring. So in those instances, you know, we'll give them a call and say, "Hey, you've got to go to the ER for further evaluation, only because we can't directly admit you ourselves."

(Urban physician assistant, FQHC)

So most of the ones that have gone, so far that I'm aware of, have been people we've sent from the office… Two diabetics actually that we've sent, one twice and one once, who were completely out of control and things like that.

(Urban physician, Free/low-cost clinic)

Many of our patients have difficulty expressing what they're feeling adequately or giving a really good history, it's even hard to triage it on the phone. I know I have sent people into the ER where I'm 90% sure it's relatively benign, but I can't be certain enough with the history I'm getting to say "no, they don't belong there."

(Urban physician, Free/low-cost clinic)

9. Barriers to/Facilitators of Care

9.1 Wait Times

And yes, some people I want to get in where they have depression and things. They need somebody. It's very hard to get them in. It's a six-month wait, or they don't take them anymore. A six-month wait!

(Urban physician; Small, private practice)

Mental health services are always a problem. I don't recall offhand, but it depends on the plan and where they get referred to. . . . Most of the plans participate with one or two of the mental health facilities that are around. . . They have to call and make the appointment . . . the patient does, and a lot of times they are then seen by a psychologist. They are not seen by psychiatrists . . . seen by psychiatrists if they're needed . . . but that's usually a couple of months down the line.

(Urban physician; Small, private practice)

Some of those people were coming to see me already and they just didn't really have insurance .... But a lot of these people weren't accessing healthcare, and now they're trying to access healthcare. And while we've expanded. . . You know, we already had a shortage of family docs or internists or whatever primary care person you're thinking of. And so, you know, if you want a new appointment with me, you're looking at like a 10 or 12 week waiting list, okay? So that's just crazy… So all of these people have coverage. Now they all want to come to the clinic and be seen. They can't get to see me for a long time. "Well, I'll go to the ER." So while it's helped with coverage, there's a long way to go in terms of improvement for access.

(Urban physician, FQHC)

I just saw a guy today. . . He said, "They can't get me in for three months." …He said, "They told me you'd fill my psych meds." I told him, "And they're right. I will." . . . He's a guy who's had issues over the decades. He needs to actually be sitting down with a shrink. They can't do anything for three months? He does not need to be without his meds.

(Rural physician assistant, Rural health clinic)

We have occasional newbies who move up here. "Oh, I have diabetes and where's the nearest endocrinologist?" "Sixty-five miles down the road, and he's booked three months down the road." We tell them, "We'll handle your diabetes unless you are totally out of whack or you have an insulin pump, or you're a really touchy brittle diabetic." I've got lots of diabetics in my practice.

(Rural physician assistant, Rural health clinic)

So now they're [CMH] starting to use Telehealth where they have psychiatrists from all over the country skyping with patients. Unfortunately, the psychiatrist is only available the one day a week they're skyping, and then if there's a medication question or question from me to that psychiatrist during the week, they're not available. But the staff takes a message, and they wait to ask them on the next Tuesday that they're skyping. It makes getting patients in to see a psychiatrist very difficult.

(Urban physician; Small, private practice)

I guess for the patients who have Medicaid, there are [dental] clinics that will accept Medicaid patients, but either there's a really long wait list or they have to go and just wait in line.

(Urban physician; Large, hospital-based practice)

You know dental is the same problem as it is in the whole state. You know, we have a Medicaid dental clinic here, but it's a long wait to get in. It's still a problem because regular dentists don't . . . I don't know about downstate, but up here no one accepts Medicaid.

(Rural physician; Small, private practice)

9.2 Administrative Burden

Philosophically I would say I would want my practice to accept Medicaid patients. If there were something that was in my power to make the process of taking care of the Medicaid patients less onerous. . . At the collective level as you are making that decision, I would hope that my system leadership

would advocate for kind of cutting the red tape that is sometimes required . . . which is what makes it difficult to care for Medicaid patients.

(Urban physician; Large, hospital-based practice)

Well, we accept three of them [Medicaid health plans] right now. We don't accept every one that's in [area of] Michigan. We no longer accept Healthplan A Medicaid or Healthplan B Healthy Michigan simply because they're such a pain ... to deal with.

(Urban physician, Free/low-cost clinic)

9.3 Acceptance of Medicaid/Healthy Michigan Plan Patients

My staff will do like a little quick run-through what medications do they take . . . Briefly, what are their health issues. If it's someone who has morphine addiction and they're trying to be brought down using suboxone ... that's not a good fit for her.... So we pretty much take everybody except we weed out the ones where I don't think it's a good fit.

(Rural nurse practitioner, Rural health clinic)

So I would say it's 10 times as hard to get dental care as it is medical care.

(Urban physician; Small, private practice)

So the mental health situation in this area . . .We have a couple of private psychiatrists . . . The only ones I'm really familiar with work for the hospital. They don't take Medicaid or Medicare.

(Urban physician; Small, private practice)

9.4 Workforce

I think the fundamental problem with regard to ER is related to access . . . primary care access. So I live in a real huge bottleneck. There's just not enough of me . . . There's not enough primary care . . .

(Urban physician, FQHC)

Well, we have a particular problem in this area because we're very underserved as far as mental health goes. In this county, all we have is the community mental health office, and...They don't have a full-time psychiatrist. ... if the counselor believes the person needs psychiatric intervention by the MD, then they get ahold of me and say, "Please write a referral so we can slide this person in with the psychiatrist." So it takes a long time.

(Rural nurse practitioner, Rural health clinic)

But it's [i.e. transportation] definitely a problem up here because where . . . Where we're located, the nearest hospital is 40 miles away. All of the specialists are a minimum of 40 miles away. So it's very . . . Travel is a very difficult obstacle here.

(Rural nurse practitioner, Rural health clinic)

We have no dermatologists in this county. So when I try to refer one of my patients to a dermatologist, there are no offices that will take the patients. So that's kind of a problem for us is the lack of specialists who take Medicaid patients in certain fields.

(Rural nurse practitioner, Rural health clinic)

Well, we were already getting a lot of new patient requests even before this because there's just not enough doctors in this area. I guess it picked up a little bit with that expansion, but I mean the hospital won't let us hire more staff. …So we just had to limit how many new patients we'll take.

(Urban physician; Small, private practice)

It doesn't help them very much if they have an insurance, but the nearest orthopedist is 1-1/2 hours away.

(Urban physician, Free/low-cost clinic)

9.5 Out-of-Pocket Costs

But, you know, those are two examples that I could repeat in my practice of people who didn't want any health intervention screening care because they were just nervous about the bills that would be generated. They don't want to know if they're supposed to be on a medicine because they're nervous about paying for it. Now they're okay to explore that.

(Urban physician, FQHC)

our population in general doesn't go to the ER very often and I think it's because when you're uninsured, you don't go to the ER because then you just get a big ass bill and now you've got to go to collections and then you bankrupt.

(Urban physician, Free/low-cost clinic)

You know, my practice style has and always will be do what's right for the patient and then worry about the cost afterwards, but it has made things a little easier now that they do have insurance. So my recommendations were always the same, but whether the individual went through with the plan when they didn't have insurance, did vary depending upon their own personal beliefs and, you know, personal financial situation.

(Rural physician; Large, hospital-based practice)

9.6 Patient-Primary Care Interactions

I just think that kind of . . . I believe it kind of helps to kind of develop the working relationship between the provider and the patient because we're talking, and they're allowed to talk relatively freely.

(Urban physician assistant, FQHC)

9.7 Transportation

That's a problem up here. It's a a widespread rural area. There are 320,000 people in the entire [area]. People live on the bush. People's cars freeze. People will have drunk driving on their record. They have to rely on other people to drive them in. I had three cancellations in one day where the driver fell through.

(Rural physician assistant, Rural health clinic)

I had two guys yesterday in my office who called their insurance, got transportation arranged, and came to see me. Most of the people I see are Medicaid. So, it's possible. But I can guarantee you that [lack of] transportation is a huge hindrance to good healthcare in the population that I see. So that as a benefit is a huge help.

(Urban physician, FQHC)

I think that's [transportation] actually a really good service because, again, my office is located in [city]. A lot of my patients, particularly Medicaid patients, have big transportation barriers….there is, I believe, like a three-day advance notice or something they have to give. So sometimes that can get in the way if the patient needs to come back … for . . . like an immediate short-term follow-up.

(Urban physician; Large, hospital-based practice)

A lot of the poor folks who would be on this program would live in Sawyer which is 18 miles away. They are offered like bus vouchers or something or advised they can take the bus, or they can actually get a voucher for a door-to-door bus, but it's very limited and very strict …. If you take a bus to the doctor's office and the office is behind, your bus has to leave.

(Rural physician; Small, private practice)

I didn't go to medical school to be screwing around with signing forms about getting people to and from their doctor's appointment. That doesn't help them be healthier per se. It doesn't require my involvement or my signature.

(Rural physician; Large, hospital-based practice)

10. Types of Care

10.1 Serious/Complex Mental Health

It's difficult but, you know, we do so much mental health stuff. I treat depression every day. I treat generalized anxiety every day. I don't need [organization] for that. I need them for my schizophrenic patients. I need them for out of control bipolars who've jumped off their meds. . . . You need them for the stuff that's really heavy duty. Severe depression or nonresponsive or, you know, you're thinking, "Does this person need shock therapy?" I can't order that.

(Rural physician assistant, Rural health clinic)

If they don't think you're bad enough, they won't see you. "Oh, ADHD? We don't do that." "Oh, it's just mild depression. No, you're okay. Go back to your doctor." . . . Even if they're severe enough to need a psychiatrist, I've seen people wait four to six months on a waiting list. If you miss any of your counseling appointments in between, they might kick you off the list. It's kind of brutal.

(Urban physician; Small, private practice)

You know, I think where you see this specifically is like I've had a couple of patients that I've been like long-term . . . you know, maybe has long-term psychiatric needs and not been able to get the correct care, and we've done our best to help them, but now you say, "Hey, let's get you set up," and now they're going to therapy, they're getting the correct medications that they need. That makes a humungous difference, I think, for them.

(Urban physician, FQHC)

The colocation is primarily they are health psychologists. So they're psychologists. They're not psychiatrists. So they do have limitation that they can do initial evaluations and counseling, but not really manage kind of complex . . . If the patient needs a prescription and it's for a simple condition like depression, we can certainly co-manage with them. But when we're dealing with more complex psychiatric illnesses, we do need these patients to be referred on to a psychiatrist, and at that point we have had problems with the patients not always having access to behavioral health, because many of the Medicaid plans, part of Healthy Michigan, are not accepted by the behavioral health department in our health system.

(Urban physician; Large, hospital-based practice)

10.2 Mental Health

Because there are so many mental health and social issues, it's probably overwhelming for most primary physicians to have a significant percentage of their practice be Medicaid without having a social worker or a care manager or an integrated psychiatric part to their practice.

(Urban physician; Small, private practice)

I think we would love to have colocation of mental health, but it hasn't been feasible from our discussions so far. You know, I mean we're trying to work more on group models of care to help with waiting times for patients and with patient satisfaction and just overall care, but that's been an ongoing theme we've been trying to improve.

(Urban physician; Large, hospital-based practice)

They can get into Psychiatry, but it's much more challenging. They have to go to three psychology visits. They can't miss those visits. Then they get referred to a psychiatrist who will see them for a short-term basis. Often I hear a lot of negative comments about the psychiatry experience that they have. The counseling piece generally has been okay and doable. If the patient is motivated to call and make the initial appointment, then I think it has been going well for them.

(Urban physician; Large, hospital-based practice)

10.3 Dental Care

The new one, they get some dental stuff too. They've had dental problems for years, and their teeth are falling out, affecting their hearts and everything else….

(Urban physician; Small, private practice)

I can't tell you how many times a day I get asked for antibiotics because of some form of dental infection, and either they can't get a dental appointment or it's two months into the future. I really don't know of very many patients that have an easy time getting dental.

(Urban physician; Small, private practice)

I mean even to get access to dental care. That was a huge problem in the past . . . Primary care doctors would see people with dental pain with abscesses, and they couldn't get in to see a dentist. So our job was often to put them on antibiotics and pain meds, and knowing that what they needed was to have an extraction or a root canal done.

(Rural physician; Large, hospital-based practice)

10.4 Primary Care

Access to preventative services, prescriptions, and more just access to physicians for medical problems . . . chronic disease management . . . All that is improved with Healthy Michigan. No question in my mind, and I'm sure that your data is going to support that.

(Rural physician; Large, hospital-based practice)

Because they just weren't going to come in for a complete physical that might cost them a lot of money, as much as we begged them to, or even if we gave them a deal. So now we can sit down, and they get sort of top notch review just like anybody else with good insurance. Complete exam, screening labs and talk about preventative care . . . Like finally they've recognized that they need this too…. It seems like

they're happy and relieved now to be covered, and they feel . . . that sense that there is a safety net there for them.

(Rural physician; Small, private practice)

I think one of the biggest benefits that I see from the insurance …now there's a lot of help in terms of the chronic disease management. I think we do see a high proportion of chronic disease, whether that's diabetes, blood pressure, smoking, obesity. And you know the nice thing about that is that it allows . . . more options.

(Urban physician, FQHC)

From the patient perspective though, I see tons of benefits because they get . . . preventative care . . . One of the big things is if you don't have insurance, you know the idea of getting a colonoscopy. That's not even feasible. You know, that's so expensive. And now that they have insurance . . . The same thing with some of the screening stuff, specifically mammograms and Pap smears, things like that.

(Urban physician, FQHC)

10.5 Specialty Care

With [healthplan], it's very easy. They don't have to have a formal referral, either prescription or online. They can just find one in the [healthplan] directory and go see them. . . . Sometimes the specialist will call me and say, "did you recommend this?" Sometimes I have, and sometimes I haven't. But, again… they don't need a formal referral.

(Urban physician; Small, private practice)

Specialists had a limited number of openings for the uninsured in the past… There were a certain number per month that different groups allowed . . . As far as I know, there's no change in saying "yes" to anybody who's got Healthy Michigan insurance. I would assume that all the specialists accept that in this area.

(Rural physician; Large, hospital-based practice)

So, for some specialties we had very good access. For other specialties, we had very limited or no access. So, there's a gynecologist . . . who's been incredibly generous, and so we've always had really good access for that. But things like neurology and neurosurgery have been a little more difficult. Dermatology is kind of forget it. Podiatry . . .If somebody had a significant problem, we could. Ear, Nose, Throat – again, you had to really have a very significant problem. Sleep studies for sleep apnea - which is very prevalent in our patients – we had no access for a long time. Over the last year or so, we've had some limited access, but with them having insurance, now I've got really good access for them.

(Urban physician, Free/low-cost clinic)

[C]ertain specialties we struggle with getting patients with Medicaid in. Like Rheumatology is probably the biggest one. Other than that, it's been actually pretty good. We've been able to get most of our patients with Medicaid into most specialties or other care that they need.

(Urban physician; Large, hospital-based practice)

Specialists – If they have no insurance versus they have Medicaid or Healthy Michigan Medicaid, again, there's just a world of difference because now I can get stuff done. You know, back in the day, we never used to order colonoscopies for patients if they were uninsured because nobody can afford $2,000 to have that done. But with Medicaid where that's a covered benefit, yeah, now we get to order them all the time on people.

(Urban physician, Free/low-cost clinic)

10.6 Testing and Pathology

Another great thing is screening colonoscopies for colon cancer. So under the program I was talking about, we could get them a colonoscopy . . . if I saw a polyp on sigmoid, I could send them. If they had a disease like ulcerative colitis, I could send them, but I could not get a screening colonoscopy, even for people with family history of colon cancer. Now, I can write the referral. They go! It's fantastic! I'm very excited.

(Urban physician, Free/low-cost clinic)

Let's say somebody has got a heart murmur. Somebody has got fluid in their legs, and you're listening to their heart and thinking, "Hmmm. I can get an EKG. I can send them for an echocardiogram . . . I can do this stuff. I can check a pro BNP. I can look at their kidney function." Before I'd have to call over to the lab and say, "Alright, how much is it going to cost this person to pay cash so we can check their kidney function?" ...You know, I'm not a money person. I'll take care of people, and Healthy Michigan has made that easier.

(Rural physician assistant, Rural health clinic)

So if you have diabetes, the good thing is that we can get labs. That's not an issue. [organization] has allowed us to get labs and actually doesn't even charge the patient for labs, which is pretty awesome.

(Urban physician, FQHC)

I am seeing patients come in and getting the care that they need. Yes, it sometimes is a headache because if I need something, I will have to run in through many channels and sometimes things don't get done. I have had patients, for instance, coming with a belly mass where they needed a CAT scan, and you know the prior authorization didn't go through and they waited like three months or four months before somebody figured out that they hadn't had a CAT scan. It delayed care which possibly could have had some adverse outcome.

(Urban physician; Large, hospital-based practice)

10.7 Hearing and Vision

. . . hearing aids. That's fantastic. Vision. . . . Most all the plans cover the vision. They get a checkup for that. They don't pay for their glasses….

(Urban physician; Small, private practice)

People like my age . . . fifties/sixties . . . [I] ask… "When's the last time you've had a good eye exam?" It's not like they need to go to an ophthalmologist, but, you know, I want them to go. We've got good optometry. If they see something that needs an ophthalmologist, I know they can refer them on.

(Rural physician assistant, Rural health clinic)

10.8 Medications and Supplies

[T]hey 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)

So if you are somebody who needs insulin, it can get really tricky if you don't have insurance because insulin can be hundreds of dollars. You would get people who would resist seeing you because they're afraid of how much things are going to cost, and so they just persist in their uncontrolled diabetes, and then all the complications that come with it. Once they're sort of like, "Okay, well, insulin is covered and

I can get my routine labs because that will get covered," well then they show up, and it just makes my life easier for sure, and theirs, I think. And then COPD . . . Some of the inhalers and other things that, you know, are recommended in terms of standard of care treatment . . . Those are also quite expensive and... If things are expensive, people are just not going to do it. It doesn't matter if it's the right thing or even if it helps them.

(Urban physician, FQHC)

I'm not a huge fan of [healthplan]. I mean it's better than no insurance, but they're pretty restrictive on a lot of things. If you call and you sit on hold and you fill out forms, then they finally give them the medicine. Half of the time, no, they still won't give them the medicine. So that's a frustration. You start to remember the drugs they're just never going to cover, and you just try to avoid those . . . Just like private insurance formularies. They change all the time... You just prescribe, and if the pharmacist shrugs his shoulders and says, "No, that's not covered," you say, "Then, what is? What do they cover?" It usually involves my staff having to call all the insurance companies, sit on hold and ask them that question.

(Urban physician; Small, private practice)

If I prescribe a medication that's not covered, the person doesn't call me often times. It's just not out of their mindset to think they can call me and say, "I'm having trouble." So, they either don't know that they should call or they can't call, or they're not skilled at using the phone and leaving a message and so forth. So what happens is if I prescribe somebody something on March 1st, they didn't get it at the pharmacy. They just let it drop until the next time they're here, and then I find out six weeks later that they didn't get the medication . . . So we could have solved the problem right away because I would have used some alternative, but to start with I don't have clear information about what's covered, and then secondly the patient isn't used to expecting to get something, and so they just take it for granted that they can't get it. End of story.

(Urban physician; Small, private practice)

Glucometer strips were our number one pharmacy cost. So, the fact that that cost is going away means we can do a lot more work in other areas. Awesome.

(Urban physician, Free/low-cost clinic)

The main challenges have been with contraception because they will only cover things like the NuvaRing or the patch if the patient can prove that they failed OCPs [oral contraceptives]. It's completely ridiculous because so many people can't remember to take those.

(Urban physician; Large, hospital-based practice)

The other issue that's been a problem is that there are some things that are covered by [healthplan] that are over-the-counter, but the pharmacies don't know about it. For example, vitamin D is covered in certain dosages. So I'll tell patients, "Look, I know it's covered. I've talked to [healthplan]. They've confirmed for me that it's covered. They go to the pharmacy, and the pharmacy says, "Sorry. You'll have to pay out of your pocket."

(Urban physician; Large, hospital-based practice)

And we had. . . a lot of people with asthma who were being managed with a borrowed nebulizer and the nebules from Walmart, packs of 100 because. . . That was the cheapest way for them to get asthma medication because they couldn't afford inhalers . . . So we're able to get medications for them and do a pulmonary function test ...start working on improving things instead of just damage control.

(Rural physician; Large, hospital-based practice)

But for the most part, I think, the access to medication makes a huge difference and especially when we're talking about chronic disease management. It's such a benefit.

(Urban physician, FQHC)

For generic drugs that are covered, not a problem, but even some of the generic drugs aren't covered. We have a formulary that is updated in our electronic medical record that works most of the time, that lets us know what's covered and what's not, but even then it's not accurate. The patient will go to the pharmacy to pick up their prescription, and it's not covered and then they can't dispense it, and then it's a big hassle for everybody and it doesn't . . . It's not resolved in a very timely fashion. So sometimes these individuals will go without their prescription for a couple of days until Medicaid processes their prior authorization.

(Rural physician; Large, hospital-based practice)

10.9 Substance Use Disorder

They don't come in actively seeking treatment. The only ones that I found here are the ones who have been sent in by court order or have lost their job and family is getting after them to either straighten up or get out. Those individuals don't come looking for help until something really dire happens, and some of them have, you know, even gone to jail and had their children taken away and have been given a choice, "Either straighten up or we'll take the children"….They have to be forced into it.

(Rural nurse practitioner, Rural health clinic)

They do provide evaluation and they can certainly provide the patient with some resources to get help, but we don't really do substance abuse counseling or treatment at our center.

(Urban physician; Large, hospital-based practice)

For a lot of our folks with substance abuse, … when they are ready to make the change, we've referred them through the state programs . . . Almost all of them have been uninsured to date. I haven't had anybody that's really under [healthplan] yet that's really ready to make that change.

(Urban physician, Free/low-cost clinic)

10.10 Pain Management

I'd say the one area where we have probably some limitations is the person who is outside our county who wants to come in with complex pain and mental health issues... You've got somebody who's on beaucoup pain meds. You get the feeling, you know, "why are you not in your own county?" It's either that people are refusing to prescribe any pain meds, which is ridiculous, or these are people who've burned their bridges.

(Rural physician assistant, Rural health clinic)

One of our biggest referrals for behavioral health for new people coming in are people who are on chronic pain meds. We pretty much insist that they participate . . . at least be offered, you know, assistance in behavioral health for chronic pain management, and it seems like pretty good numbers in the last year have taken advantage of that.

(Rural physician, FQHC)

If you turn in your paperwork and you're on a bunch of controlled substances and it appears that you expect me to start filling those, that sends off red flags. Not to say we don't, but we look and see why you're taking those things and let you know that we may disagree and may want to transition you to a

different medication or wean you off of them. If you're seeing a pain specialist and you plan on continuing the meds, fine. Then we don't . . . That's not a red flag.

(Urban physician; Small, private practice)

A lot of people go there [the ED] for pain medication. They ran out of the pain medication they have or they're not getting their pain treated in a way that they want. So they'll go to the ER and at least get a. . . short supply of opiate medications. That's it. That's a big component. A lot of people with musculoskeletal complaints, back pain that's chronic, will go to the ER.

(Rural physician; Large, hospital-based practice)

11. Health Risk Assessment

11.1 Process

[T]hey always complete their portion of it [HRA] prior to seeing me. So I don't discuss their . . .I don't go through the, "how do you feel your health is?" "Are you smoking?" "What are your goals?" I can see where that's probably trying to generate conversation. I don't do any of their portion with them. That's all done prior to me sitting down. So then I fill out everything . . . the physician portion; 80% of the time I fill that out in the room with them, and then that leads to a conversation about some appropriate health screenings . . . whether or not we want to check their cholesterol or, "Okay, I'm just looking at your BMI here. This is something that's going to be reported."

(Urban physician, FQHC)

I review it with them. If they haven't completed it, we go over it. I'll just ask them, you know, "what do you want to be serious about on here?" "Is there something you'd really like to go after?" For some guys, it's simple. I've . . . Guys say, "I want to drop 20 pounds." I'll ask them, "What do they drink?" "I drink a lot of pop." You know, "Hey. Just stop drinking pop. You'll probably drop 20 pounds right there."

(Rural physician assistant, Rural health clinic)

My girls would look on the computer first and see that they had straight Medicaid, which isn't the HMP . . . the Healthy Michigan plan. So the people would come in and they would have their HRA forms half filled out, or they would have been faxed to us half-filled out. So we were seeing on the computer that they didn't have HMP, but yet they were walking in with forms for it. So in the beginning, it was very confusing… Now people are starting to come through right from the get-go… It's a little smoother now than it was last year.

(Rural nurse practitioner, Rural health clinic)

The health risk assessment [sometimes] comes to us partially filled in based on the conversation that the caseworker had with the member, and so there was a real good lead-in that way because the person on the phone explained to the member "this is where you're going to go," and they helped them understand where my office is. So when they come in, they already feel like they actually belong here…They actually come in with a sense of continuity, like they're just on the next step of the ladder.

(Rural nurse practitioner, Rural health clinic)

But filling out that form facilitates those discussions . . . Usually the first visit is kind of more of a Q and A and introduction to each other, and the next we schedule for a full physical. So it gives us the opportunity to kind of prep folks for what they're going to get in a physical and why.

(Urban physician assistant, FQHC)

I would have to say we have not really done a good job of accommodating it...it's one of those, at the end of a visit, after the fact type of thing. ...I'm thinking maybe one of the better ways to facilitate it is to actually ask the patient at the check-in, "Do they have any forms that need to be completed?"

(Urban physician; Large, hospital-based practice)

Well, we've just had to change our policy so that the receptionist knew that when they called and said they had that form, it had to be scheduled as a physical. Yeah, that's really the big thing was just making sure they were scheduled appropriately and then billed appropriately. I mean it's supposed to be billed as a physical . . . To get that checkmark that "yes, you've done it," it's not going to register with [healthplan] that they've done it unless it comes in as a physical.

(Urban physician; Small, private practice)

It's a pretty long form. It would be nice to figure out a way to make it more simple and smaller.

(Urban physician; Small, private practice)

I think the nurses help do it before I get in the room. They'll like put some of the data in when they talk with the patient.

(Rural physician; Small, private practice)

Those sorts of things . . . a good primary care doctor would already have reviewed with the patient. So I feel it's kind of duplicate work and unnecessary clerical work for our staff . . . that it's already documented in the record, and I just don't think it changes behaviors.

(Rural physician; Large, hospital-based practice)

Well, all of the plans are doing the health risk assessment, which is great and we've been able to set up a process here so that. . . If they're patients that have been ours... we're able to do the health risk assessment here with their first visit. If it's a new patient, we do it at their second visit because we have some additional information that we can put into that to help set their goals. You know, having those tools to be able to help patients make . . . do goal-setting and move forward has been really helpful.

(Urban physician, Free/low-cost clinic)

A lot of times we get that as a fax where they've already pre-filled out their part [of the HRA] on either online or over the phone. You know, asking questions like, "So you actually do eat healthy?" "You do exercise." Sometimes they answer "no," and sometimes . . . Sometimes it's like, "Well, yeah, I do that. I walk a lot." Sometimes, it's "No, I just thought that's what they wanted to hear." You know, when they say . . . They checkmark on there, "I do want to quit smoking." And I'll say, "Well, would you like to try the patch?" They'll say, "No, not yet. I'm not ready just yet."

(Urban physician; Small, private practice)

11.2. Impact of HRA Completion and Discussion

Oh, we usually will talk about strategies to improve their health. Usually with obesity, addressing some of the factors that may be contributing to obesity, cholesterol issues and diabetes risk. Probably higher . . . equally as high on the totem pole, I guess, would be tobacco use. We talk a lot about cessation, and I refer a lot of people over to Michigan Quit line as a result of us kind of sitting down and specifically talking about those kinds of areas of interest on the HRA forms.

(Urban physician assistant, FQHC)

I think that it helps to focus what the patient wanted to work on with regard to their health issues, you know, and their risk factors.

(Urban physician; Small, private practice)

I'll tell you one patient for whom this was extremely helpful for me and hopefully for the patient, was a patient who I'd been taking care of for a long time, serious depression. We had been battling with the depression. I've known her for over twenty years. In the past, I knew she'd used marijuana, but she had stopped. The question that we had not talked about, and when my coordinator this on the front, it was about her marijuana use again. It was like, "Oh, you're using again," and it led us into that discussion, which we might not have had. She at least reportedly has stopped again so far, and her depression has improved, not controlled but better, and so that was a huge help. So sometimes it can clue us into things that we thought were addressed and done, but they're not.

(Urban physician, Free/low-cost clinic)

I think I do remember something at the end about something they were going to try to improve, but I've not seen anybody come back and have like some sort of . . . made some achievement or have I been asked to document that they made that change, do you know what I mean? I haven't seen that come back yet.

(Urban physician; Small, private practice)

Now what I have seen is that although I may bring that up on one visit and maybe I bring that up before I do the [HRA] questionnaire, over time they know because the next time they come back and they've had some goals that we've talked about and they got printed out and they were given to them, and then they come back and I can say, "How did these go?" Sometimes they say, "I didn't do any of them," and sometimes they say, "I did all of them."

(Urban physician, FQHC)

I haven't sensed that it's helped motivate them to be healthier. It's more a process that they have to go through.

(Rural physician; Large, hospital-based practice)

We've got weight management programs. We've got healthy eating classes every evening. We have a nutritionist that come in and hold "How to Grill Vegetables" classes. We do a lot of that stuff already, and so maybe because that's an option we already have available for patients that we've been running for a number of years. . . Maybe it's just kind of second nature to us and to our patients that these options are there. So…Does this help me in a discussion with the patient? I don't think so really whatsoever. Does it somehow tweak the patient that maybe they ought to get a flu shot this year? No. People either want it or they don't want it. Like I said, filling out a questionnaire is not going to help them decide that kind of stuff, I don't think.

(Urban physician, Free/low-cost clinic)

It seems to encourage not being passive about it. You know, that you are a partner in this.

(Rural physician assistant, Rural health clinic)

So when I get in and introduce myself and whatever the niceties are, then we usually start with that because that opens up the conversation and gets them talking about things . . . Because I have to reinforce what they're doing well already and the things where they need some improvement perhaps and then we get into the physical part of it.

(Rural nurse practitioner, Rural health clinic)

There are a few people who come in and say, "Well, I'm here because my insurance company told me I had to." They don't fully grasp it as being a part of health maintenance yet, but that will probably come with time.

(Rural nurse practitioner, Rural health clinic)

You know, there's still a long way to go in terms of people understanding their situation, but, you know, at least it's still . . . It's creating the conversation.

(Urban physician, FQHC)

11.3 HMP Impact on Health Behaviors

He got his first physical . . . He said it was the first one he had had in his life. He had never had a physical before. Also he started on the smoking cessation.

(Rural nurse practitioner, Rural health clinic)

The smoking cessation resources . . . Those are quite helpful. Also for the obese group, they haven't actually taken advantage of dietician services yet, but some of the diabetics have. So that's a resource that's helpful. Those are probably the two biggest ones. Smoking and diabetes are big in this area.

(Rural nurse practitioner, Rural health clinic)

Like I'll take advantage of community resources. For instance, the YMCA has a program to help patients who may be prediabetic or at significant risk for diabetes. So we'll initiate their participation in that program to help them additionally with behavioral and lifestyle changes for better health outcome and to minimize risk for, you know, diabetes and other chronic medical conditions . . . hypertension, and that type of thing.

(Urban physician assistant, FQHC)

12. Cost Sharing

I don't know anything about it because most of my patients . . . The ones that I'm seeing have no copays on the plans and they're mostly indigent.

(Urban physician; Small, private practice)

Well I actually don't pay attention to the copay part. I just like to know what insurance they have in case I need to do a referral or order medications or something. That's why I look at it, but I don't stand with them at their checking out at the end of their visit. So I wasn't sure if any of them had copays or not…. People have a hard time understanding copay versus deductible, and I guess I didn't realize that applied to anybody in our county on the Healthy Michigan plan.

(Rural nurse practitioner, Rural health clinic)

They could start making people pay something [for nonurgent ER visits] whether they have to pay $5 or $10 or $20. I think the biggest problem with healthcare is people have these little plastic cards that allow them to go somewhere and it doesn't cost them.

(Rural nurse practitioner, Rural health clinic)

Well, the first thing that comes to mind is the same way we give them benefits . . . you know, give them financial incentives for being healthy. We should take some of it back away if they overuse the ER inappropriately.

(Rural physician, FQHC)

The only other thing I really see that's important on the negative side is . . . that six-month lapse between service and payment. The other question I know that we've had in this office is . . . Let's say the patient gets that bill at the end of six months and they don't pay it. What happens to these folks? Because that's gonna be important for our planning down the road. Are those folks going to go back to being uninsured because then we have to be able to plan in six months to a year to be taking on a load of uninsured patients again.

(Urban physician, Free/low-cost clinic)

There's that stupid list of a dozen or so diseases that when people have regular Medicaid, but Healthy Michigan plan that if this is the primary diagnosis, then they're exempt from the copay, and if it's not, then they've got to pay the $2 copay. I mean that kind of stuff is a pain in the neck.

(Urban physician, Free/low-cost clinic)

13. Financial Incentives

I know that people have come in and they have told me they're here because they want a reward, or their insurance told them they would be rewarded for doing . . . whatever it is. . . As far as if they do particular behaviors, they get particular rewards? I've never had a conversation with a patient about that aspect. So I feel like the only rewards I'm aware of is they showed up, they filled out their health risk [assessment], and they get some reward.

(Urban physician, FQHC)

I have heard some people comment that if they come in, they get a $25 gift card to Wal-Mart or something like that. It didn't sound as though it was tied to anything other than coming in for their first visit.

(Rural nurse practitioner, Rural health clinic)

The only rewards program I know of is on [healthplan] and, you know, people bring their paperwork in and say, "Can you just basically sign this that I completed my mammogram this year so I can get a $15 gift card?" Or, "If my diabetes is controlled, I get a $20 gift card." Those are usually the ones that I see. I've got a couple of patients who every year, they're all over their [health plan] insurance. They know exactly what they have to do to get their gift cards, and they bring them in like clockwork, but not a whole lot of them do that. There's only a couple of people that I know of who routinely bring me in health rewards.

(Urban physician; Small, private practice)

They've never mentioned like, "Hey, I came in today because I know this is waived." They might know that it's a covered benefit and so they'll do it, but I would be unaware that it was because they had costs waived. But it's important for me to know because I can encourage them to come in then.

(Urban physician; Large, hospital-based practice)

I thought that it doesn't take effect for like a year, like to discount some premiums and that kind of stuff or discounts on co-insurance. That's just starting to take effect now. And most of ours qualify for the gift card because, again, their income is low enough that they don't have a lot of copays and stuff yet.

(Urban physician, Free/low-cost clinic)

14. PCP Communication

14.1 PCP Communication with Health Plans

All I know is that we got the communications and we got something telling us about . . . certain forms that we have to fill out for the . . . called the HRA forms. But I don't remember exactly, you know, the initial communications and how it was determined that we were going to get it.

(Urban physician; Small, private practice)

Like with [healthplan A and B], they have representatives who stop in periodically and actually do face-to-face questions and answers and verbally went over their programs.

(Rural nurse practitioner, Rural health clinic)

I got a couple of memos by mail. I didn't really pay that much attention to them…" until I started getting all these new patient requests.

(Urban physician; Small, private practice)

Well, it [i.e., communication with health plans] at least gave. . . a clear expectation of what those patients should receive upon initial evaluation and kind of help to explain what the goals were from the health care organizations in evaluating the patient's health status.

(Urban physician; Small, private practice)

The first we got was from a group called Free Clinics of Michigan, and then Michigan Primary Care Association …and, since then, of course, you've spoken to the provider reps of the individual insurance plans and that kind of stuff.

(Urban physician, Free/low-cost clinic)

14.2 PCP Communication with Patients

We've got some people who qualify for that [i.e., Medicaid cell phone]. Cell phones can be a problem though because a lot of times, you know, people let them lapse, like especially if they have something like a Trac fone. All of a sudden the number is out of order. It's harder to get a hold of people because there are less land lines. If it's something where we need to get a hold of the person, we'll dictate letters and send them. But a lot of times they get returned. People move around.

(Rural physician assistant, Rural health clinic)

A lot of my patients have those [Medicaid cell phones]. The minutes are quite limited, and so they are sort of always out of minutes, it feels like. I had a guy yesterday. I said, "Okay, so we're gonna have to call you when these labs come back. What's the best way to reach you?" And he pulls out his phone. "Oh, just call my Obama phone." We call people who utilize these . . . the Obama phones on a daily basis.

(Urban physician, FQHC)

I know some people that are on their third phone number. …That's one of our problems is people come in, they give us a phone number, and then a month or two later they'll call to make an appointment… And then when they go to do the courtesy call the day before to remind them, we don't have a good number. So when they do show up, we say "Okay, we need a better phone number for you," and they say, "Oh, yeah, I got a new Obama phone." Well, a lot of my patients go through phones faster than I go through shoes . . . No, I mean I'm sure it's [Medicaid cell phone] helped. I mean a lot of people wouldn't have access to a cell phone either way.

(Urban physician; Small, private practice)

The Obama phone is great. Yeah. People very . . . My understanding from those folks who have mentioned having it . . . That's enabled them to, for the most part, stay connected to the office and to, you know, maintain means by which to be contacted for information relating to medical care and whatnot.

(Urban physician assistant, FQHC)

As part of a medical home, we have a lot of services that we are trying to provide, by telephone services like titrating insulin and things like that, and the lack of available phone service has impacted. You know, many of the patients we cannot help are people that we cannot communicate with because. . . One week they have a phone; the next week they don't. I know I have had a few patients tell me that they have this [i.e., Medicaid cell phone] . . .

(Urban physician; Large, hospital-based practice)

Some [cell phones] are not really working, and some are….

(Urban physician; Small, private practice)

Here we have phone interpretation. Yeah, we have phone interpretation at the front desk. So if they call, you know, we schedule appointments and we can see them with phone interpretation, but if they're home and they need to call to make an appointment, that's when it gets challenging.

(Urban physician; Large, hospital-based practice)

15. Provider Knowledge about HMP and Medicaid Expansion

I may have received some emails [about HMP]. You know, I'm sure I did. As far as the . . . I have a variety of routine emails that come from state agencies that keep physicians apprised of things.

(Urban physician assistant, FQHC)

Well, I think that when the governor was trying to get this to be approved in Michigan, he had to go around to all the hospital systems and get CEO's of different hospital systems to get on board and say, "We guarantee that we are going to help you to see these people," because there wouldn't be any point in having a new program if everybody declined to see the patients.

(Urban physician; Small, private practice)

Oh, I think it was back when the governor finally got the motion in Congress to get that rolling after working with the feds. They had published a list of the requirements for being on Medicaid, and that was online. So that's probably . . . I learned about the same time everybody else did.

(Rural physician, FQHC)

…frankly I didn't even really understand that Healthy Michigan was the Medicaid expansion (LAUGHTER) until you called and started talking about it that way because there used to be a plan called… I'm thinking there was something with a very similar name that phased out when Medicaid expansion went through. We used to have a community charity voucher or discount program.

(Urban physician; Small, private practice)

I was impressed that our governor bucked his own party to do it because, of course, I was very much aware of how many people were falling through the cracks who were definitely poor and were told that they didn't qualify for Medicaid, but worked at a crappy job that didn't offer insurance. So, I knew we had expanded Medicaid. I just didn't understand…how they were doing it.

(Urban physician; Small, private practice)

My recollection is I first became aware of it [i.e., the Healthy Michigan Plan] in the newspaper, but more so from a bulletin from the Michigan State Medical Society.

(Rural physician; Large, hospital-based practice)

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

Appendix C: Primary Care Practitioner Survey Instrument

Healthy Michigan Plan Evaluation: Perspectives of Primary Care Practitioners

Thank you for completing this survey about your views and experiences caring for patients enrolled in the Healthy Michigan Plan (the expansion of Medicaid in Michigan). We recognize the difficulty distinguishing Healthy Michigan Plan patients from others, especially other Medicaid managed care patients. Please do the best you can. ***All individual responses will be kept confidential. Only aggregate responses will be reported.***

Section 1: Practice, Patient, and Personal Characteristics

Please answer questions about your practice with your primary practice location in mind.

1. **In what year did you complete clinical training?** _____

2. **Are you board certified?** ☐ No ☐ Yes → **2a. If yes, in which specialties?** _____

3. **What is the zip code for your primary practice location?** ___ ___ ___ ___ ___

4. **Not including yourself, how many of the following practitioners are associated with you at this location?**
   a. Physicians: _____ c. Physician assistants: _____
   b. Nurse practitioners: _____ d. Nurse midwives: _____

5. **Has your practice made any of the following changes in the past year?** *(check all that apply)*
   ☐ Hired additional clinicians (physicians, nurse practitioners, physician assistants, nurses, medical assistants)
   ☐ Hired additional office staff
   ☐ Consulted with care coordinators, case managers, community health workers, or similar professionals
   ☐ Changed workflow processes for new patients
   ☐ Co-located mental health within primary care

6. **Regarding ownership of your practice, are you a:**
   ☐ Full-owner
   ☐ Partner/part-owner
   ☐ Employee → **6a. If employee, what type of entity is your employer?**
      ☐ University or teaching hospital
      ☐ Hospital
      ☐ Other (*specify*):_____

7. **What best describes the primary way you are paid for seeing patients?**
   ☐ Fee-for-service ☐ Salary based
   ☐ Capitation or patient enrollment-based ☐ Other (*specify*): _____

8. In the past three years, have you provided care in a setting that serves poor and underserved patients with no anticipation of being paid?

☐ Yes ☐ No

9. What proportion of your <u>established</u> patients who request a same- or next-day appointment at your primary practice can get one?

☐ Almost all (>80%) ☐ Most (60-80%) ☐ About half (~50%) ☐ Some (20-40%) ☐ Few (<20%) ☐ Don't know

9a. Over the past year, this proportion has:

☐ Increased ☐ Decreased ☐ Stayed the same ☐ Don't know

10. Are you Hispanic or Latino? ☐ Yes ☐ No

11. What is your race? *(check all that apply)*

☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ White (European, Middle Eastern, other)
☐ Native Hawaiian or Pacific Islander
☐ Other (*specify*): _____

12. Please estimate the proportion of patients you see who are: *(these do not have to add up to 100%)*

a. African American or Black: _____%
b. Hispanic or Latino: _____%
c. Do not speak English well enough to give an adequate history: _____%

13. Please estimate the percent of your patients who have each of the following as their primary source of health insurance coverage: *(total should add to 100%)*

a. Private insurance _____ %
b. Medicaid _____ %
c. Healthy Michigan Plan _____ %
d. Medicare _____ %
e. No insurance (i.e., self-pay) _____ %

Total = 100%

14. Are you currently accepting new patients with…?

a. Private insurance	☐ Yes	☐ No	☐ Don't know
b. Medicaid	☐ Yes	☐ No	☐ Don't know
c. Healthy Michigan Plan	☐ Yes	☐ No	☐ Don't know
d. Medicare	☐ Yes	☐ No	☐ Don't know
e. No insurance (i.e., self-pay)	☐ Yes	☐ No	☐ Don't know

Section 2: Experience with the Healthy Michigan Plan (HMP)

These questions ask about your experiences caring for patients enrolled in the Healthy Michigan Plan (Medicaid expansion). For more information about the Healthy Michigan Plan, see the enclosed Fact Sheet.

15. In general, how familiar are you with the Healthy Michigan Plan?

☐ Very familiar ☐ Somewhat familiar ☐ A little familiar ☐ Not at all familiar

16. How familiar are you with the following:

	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
a. Specialists available for Healthy Michigan Plan patients	☐	☐	☐	☐
b. How to complete a Health Risk Assessment	☐	☐	☐	☐
c. Out-of-pocket expenses Healthy Michigan Plan patients have to pay	☐	☐	☐	☐
d. How to submit a Health Risk Assessment	☐	☐	☐	☐
e. Healthy behavior incentives that Healthy Michigan Plan patients can receive	☐	☐	☐	☐
f. Mental health services available for Healthy Michigan Plan patients	☐	☐	☐	☐
g. Dental coverage in the Healthy Michigan Plan	☐	☐	☐	☐

17. To what extent has your practice experienced the following since the Healthy Michigan Plan began in April 2014?

	To a great extent	To some extent	To a little extent	Not at all	Don't know
a. Increase in number of new patients	☐	☐	☐	☐	☐
b. Existing patients who had been uninsured or self-pay gained insurance	☐	☐	☐	☐	☐
c. Existing patients changed from other insurance to Healthy Michigan Plan	☐	☐	☐	☐	☐
d. Increase in the number of new patients who haven't seen a primary care practitioner in many years	☐	☐	☐	☐	☐

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

☐ The decision is entirely mine ☐ I have some influence

☐ I have a lot of influence ☐ I have no influence

19. 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
a. Reimbursement amount	☐	☐	☐	☐	☐
b. Capacity to accept new patients with any type of insurance	☐	☐	☐	☐	☐
c. Availability of specialists who see Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐
d. Illness burden of Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐
e. Psychosocial needs of Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐

20. How often do your <u>Healthy Michigan Plan</u> patients have difficulty accessing the following?

	Often	Sometimes	Rarely	Never	Don't know
a. Specialists	☐	☐	☐	☐	☐
b. Medications	☐	☐	☐	☐	☐
c. Mental health care	☐	☐	☐	☐	☐
d. Dental/oral health care	☐	☐	☐	☐	☐
e. Treatment for substance use disorder	☐	☐	☐	☐	☐
f. Counseling and support for health behavior change	☐	☐	☐	☐	☐

21. How often do your <u>privately insured patients</u> have difficulty accessing the following?

	Often	Sometimes	Rarely	Never	Don't know
a. Specialists	☐	☐	☐	☐	☐
b. Medications	☐	☐	☐	☐	☐
c. Mental health care	☐	☐	☐	☐	☐
d. Dental/oral health care	☐	☐	☐	☐	☐
e. Treatment for substance use disorder	☐	☐	☐	☐	☐
f. Counseling and support for health behavior change	☐	☐	☐	☐	☐

The questions on this page ask about your experiences with Health Risk Assessments (HRAs).

22. Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients?

☐ None ☐ 1-2 ☐ 3-10 ☐ More than 10

23. How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit?

☐ Almost always ☐ Often ☐ Sometimes ☐ Rarely/never

24. Please report your experience with the following:

	Yes	No	Don't know
a. My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA.	☐	☐	☐
b. I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA.	☐	☐	☐
c. My practice has a process to submit completed HRAs to the patient's Medicaid Health Plan.	☐	☐	☐
d. I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs.	☐	☐	☐

25. How much influence do the following have on completion and submission of the Health Risk Assessment?

	A great deal of influence	Some influence	A little influence	No influence	Don't know
a. Financial incentives for patients	☐	☐	☐	☐	☐
b. Patients' interest in addressing health risks	☐	☐	☐	☐	☐
c. Financial incentives for practices	☐	☐	☐	☐	☐

26. For Healthy Michigan Plan patients who have completed their Health Risk Assessment, how useful has this been for each of the following:

	Very useful	Somewhat useful	A little useful	Not at all useful
a. Identifying health risks	☐	☐	☐	☐
b. Discussing health risks with patients	☐	☐	☐	☐
c. Persuading patients to address their most important health risks	☐	☐	☐	☐
d. Documenting patient behavior change goals	☐	☐	☐	☐
e. Getting patients to change health behaviors	☐	☐	☐	☐

The questions on this page ask about non-urgent emergency room (ER) use.

27. How much can primary care practitioners influence non-urgent ER use by their patients?

☐ A great deal ☐ Some ☐ A little ☐ Not at all

28. To what extent do you think it is your responsibility as a primary care practitioner to decrease non-urgent ER use?

☐ Major responsibility ☐ Some responsibility ☐ Minimal responsibility ☐ No responsibility

29. Does your practice offer any of the following to help Healthy Michigan Plan patients avoid non-urgent ER use?

	Yes	No	Don't know
a. Walk-in appointments.	☐	☐	☐
b. Assistance with arranging transportation to appointments	☐	☐	☐
c. 24-hour telephone triage	☐	☐	☐
d. Appointments during evenings and weekends	☐	☐	☐
e. Care coordination/social work assistance for patients with complex problems	☐	☐	☐

30. In your opinion, to what extent do the following factors influence non-urgent ER use?

	Major influence	Minor influence	Little or no influence
a. The ER will provide care without an appointment	☐	☐	☐
b. Patients believe the ER provides better quality of care	☐	☐	☐
c. The ER offers quicker access to specialists	☐	☐	☐
d. Hospitals encourage use of the ER	☐	☐	☐
e. The ER offers access to medicines for patients with chronic pain	☐	☐	☐
f. The ER is where patients are used to getting care	☐	☐	☐

31. What, in your experience, could decrease non-urgent ER use by Healthy Michigan Plan patients?

_____

_____

32. Please think about what has changed for your patients <u>who were previously uninsured</u> 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: *(If you have no previously uninsured patients now covered by the Healthy Michigan Plan, choose "Don't know" for all.)*

	Great impact	Some impact	Little impact	No impact	Don't know
a. Better control of chronic conditions	☐	☐	☐	☐	☐
b. Improved medication adherence	☐	☐	☐	☐	☐
c. Better ability to work or attend school	☐	☐	☐	☐	☐
d. Improved ability to live independently	☐	☐	☐	☐	☐
e. Improved health behaviors	☐	☐	☐	☐	☐
f. Improved emotional wellbeing	☐	☐	☐	☐	☐
g. Early detection of serious illness	☐	☐	☐	☐	☐

33. When was the most recent time, if ever, you discussed out-of-pocket medical costs with a Healthy Michigan Plan patient?

☐ Yes ☐ No → ***If no, SKIP to Question 36***

34. Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, who brought up the topic? *(check one)*

☐ The patient

☐ Me

☐ Somebody else in the practice (e.g., clerical or nursing staff)

☐ Other (*specify*): _____

35. 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?

☐ Yes ☐ No ☐ Don't remember

36. Given what you know about it, in general, do you support or oppose the continuation of the Healthy Michigan Plan?

☐ Support ☐ Oppose ☐ Don't know

37. What changes would you suggest for the Healthy Michigan Plan?

_____

_____

38. Please rate your agreement with each of the following statements.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. All providers should care for some Medicaid/Healthy Michigan Plan patients.	☐	☐	☐	☐	☐
b. Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice.	☐	☐	☐	☐	☐
c. Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction.	☐	☐	☐	☐	☐
d. It is my responsibility to provide care for patients regardless of their ability to pay.	☐	☐	☐	☐	☐

39. In general, to what extent do you agree or disagree with the following statements:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. I know what kind of insurance a patient has at the beginning of an encounter.	☐	☐	☐	☐	☐
b. I ignore a patient's insurance status on purpose so it doesn't affect my recommendations.	☐	☐	☐	☐	☐
c. If I need to know a patient's insurance status it is easy to find out.	☐	☐	☐	☐	☐
d. I only find out about a patient's insurance coverage if they have trouble getting something I recommend.	☐	☐	☐	☐	☐

40. Is there anything else you would like to tell us about the impact of the Healthy Michigan Plan on your patients or your practice?

_____

_____

41. If you are you interested in receiving a special summary of survey findings, please provide your email address below. *(Your email will be used only for the purpose of sending survey findings.)*

Email address: _____@_____

Thank you for completing this survey. Please return the survey in the envelope provided.