Primary Care Physicians in Michigan

MAY 2019

CHRT has been surveying primary care physicians (PCPs) in Michigan since 2012—tracking key trends in practice patterns, capacity, payer mix and care team composition. Our latest survey also asked physicians about care continuity and Medicaid work requirements legislation (A full analysis can be found here).

PCPs are a key component of a successful, high quality healthcare system. As the baby-boomer generation ages and the needs of this cohort increase, there is ongoing concern about how well the healthcare workforce can meet the increasing demands of an older and presumably sicker population. Additionally, primary care is on the front lines of improving care delivery, such as increasing care management for complex cases, integration of behavioral health care and identifying and addressing social determinants of health.

Key Findings

- **Primary care capacity in Michigan is good today, but there is some evidence it may decrease in the future**. Capacity to accept new patients is high and has increased across all payer types since 2016. Almost two-thirds (62%) of PCPs indicated capacity for new Medicaid patients and over 80 percent reported capacity for Medicare and privately insured patients. However, 45% of PCPs indicate they intend to stop practicing medicine within the next 10 years—raising important questions about new PCPs or other practitioners in the training pipeline, and the need to continue tracking capacity over the next decade.
- **PCPs report more multi-disciplinary care team members than in 2016.** Practices with a relatively higher volume of Medicaid patients were almost twice as likely to have Community Health Workers (CHW) and co-located psychiatrists on the care team**.** And, for the most part, hospitals and groups practices were more likely to have support staff, such as care managers and nurse practitioners, than single physician practices.
- **High deductibles and other cost issues threaten continuity of care.** PCPs see cost and insurance-related issues as the biggest barriers to maintaining continuity of care with their patients; along with lack of transportation and limited health literacy.
- **The majority of PCPs are concerned about the impact Medicaid work requirements may have on care continuity and the complexity of the certification process.** They are more evenly split in their opinions about how the new Medicaid work requirements could change the number of Medicaid patients in their practices, whether they would need to hire more staff, and the ethical issues of determining if someone is able-bodied.

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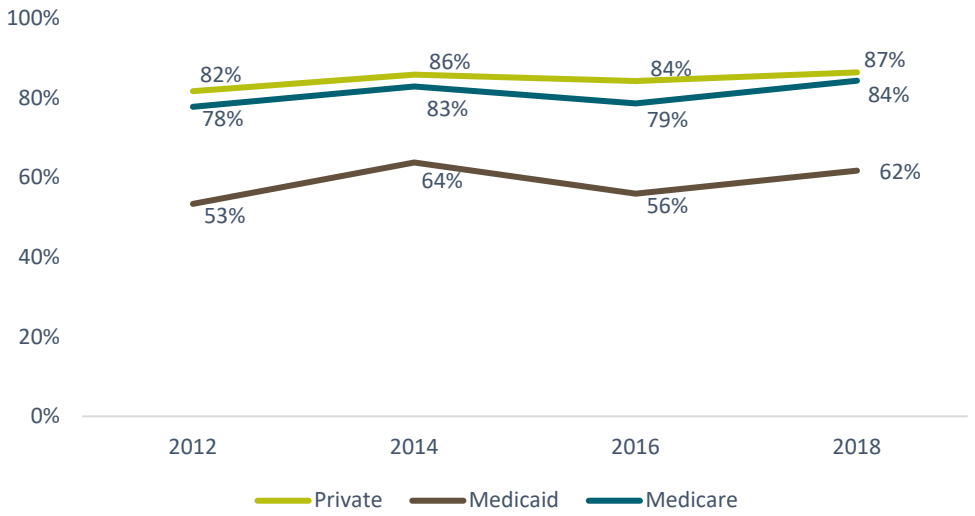
Profile of Primary Care Physicians in Michigan

Capacity

Overall, capacity to take new patients is high for all types of insurance. There was an increase in the proportion of physicians accepting both Medicaid and Medicare patients between 2016 and 2018 after decreases between 2014 and 2016. In 2018, most PCPs reported they were accepting privately insured patients and this has been consistent over the years (Figure 1).

Figure 1: Accepting new patients over time



Nearly half of physicians reported that they anticipate discontinuing practice in the next 10 years, and the majority of primary care physicians reported that they completed their clinical training more than 20 years ago (Figures 2, 3). So, while capacity to take new patients is currently high, the anticipated exodus of so many PCPs raises questions about changes in capacity for new patients and bears watching over the next decade. With PCP incomes in Michigan falling behind the national average[i] and some experts indicating a possible shortage of PCPs in the near future,[ii] policy makers may need to look to retention strategies to ensure an adequate number of providers are available to the population.

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Figure 2: Years since end of clinical training

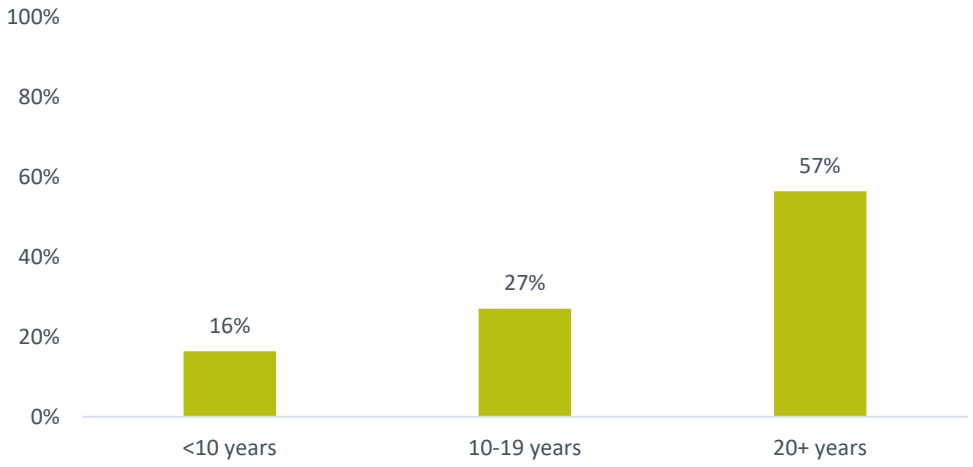
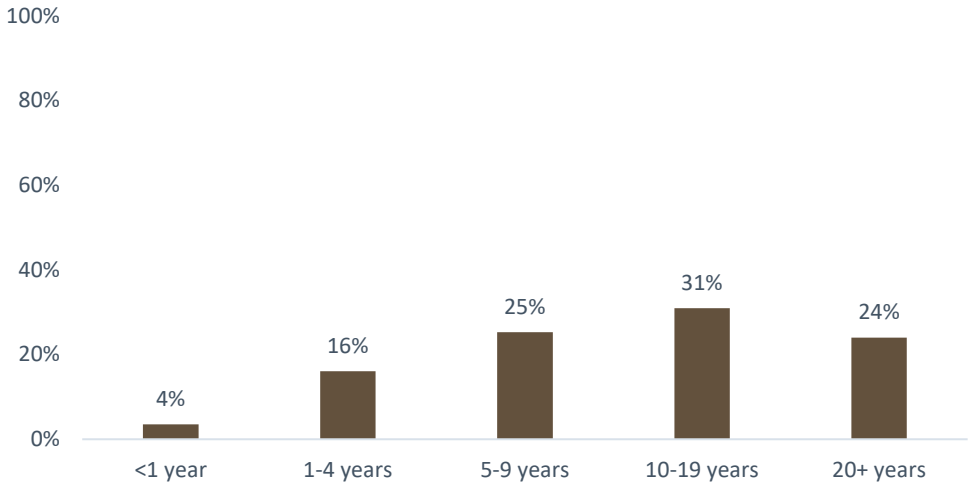


Figure 3: Anticipated years left practicing medicine



Analysis of 2018 Physician Survey respondent demographics found that though only two in five Michigan PCPs surveyed were female, they were more likely to have more recently completed clinical training compared to men—nearly 25 percent had completed clinical training within the past 10 years compared to 11 percent of men. This corresponds to national trends, which show more female physicians entering the medical field now than ever before -- especially evident in primary care[iii,iv].

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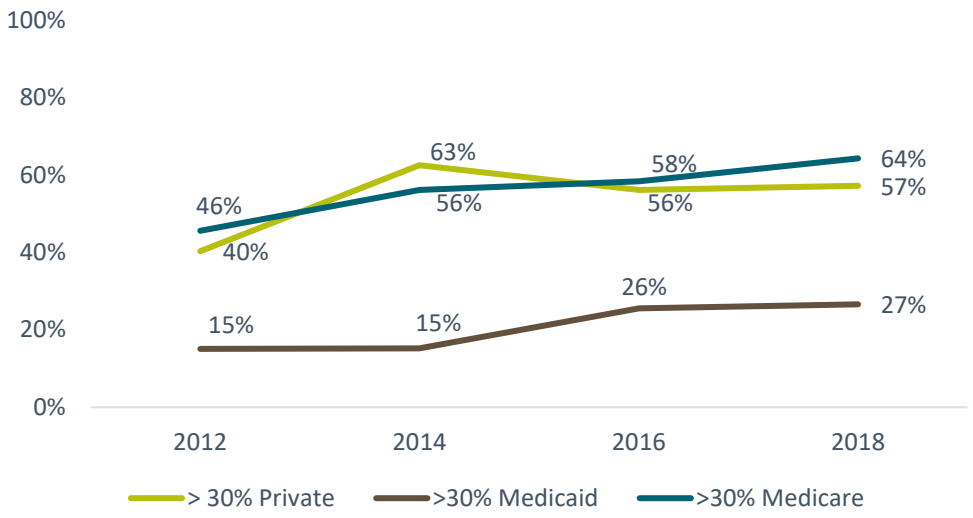
Payer Mix

Physicians' practices have seen a steady growth in the proportion of patients covered by Medicare and Medicaid. In 2018, nearly two-thirds of physicians reported having large volumes (>30% of self-reported patient volume in practice) of Medicare patients, an increase of six percent from 2016. The proportion of physicians having large volumes of Medicaid patients jumped by 11 percent between 2014 and 2016, but remained steady in 2018. The proportion of physicians reporting large volumes of privately insured patients has stayed fairly constant since the 23 percent increase that occurred between 2012 and 2014 (Figure 4).

Figure 4: Payer mix over time



Practice Settings

Primary care physicians are most likely to be in a group practice compared to other practice settings. Over one-quarter reported practicing in a hospital, and around one-quarter of PCP's reported practicing in a single-physician setting. These proportions of PCP's in different practice settings have remained fairly constant since 2012 (Figure 5).

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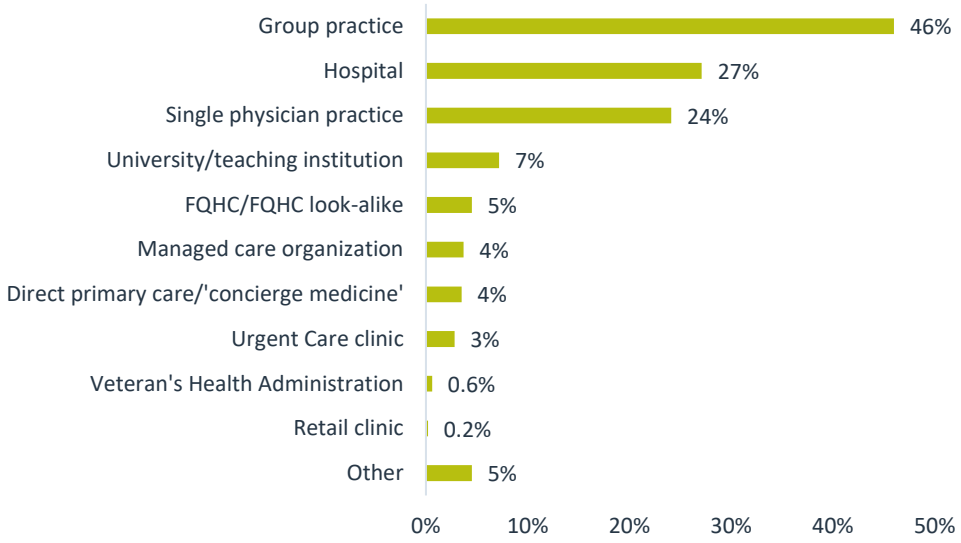
Editor's Note 1: Participants were able to select more than one practice type

Figure 5: Practice setting (see editor's note)



A newer concept in primary care practice arrangements is direct primary care or "concierge medicine". Just 4 percent of PCPs report practicing in a direct primary care arrangement (Figure 5), but the concept seems to have piqued some interest —with nearly 1 in 4 (23%) indicating they might consider this practice model in the future. Although a very small proportion of PCPs reported practicing in retail clinics in Michigan, this model has been steadily expanding throughout the state and may provide more access for patients and more competition for primary care physician practices in the future.[v]

Staffing and Multi-Disciplinary Care Teams

The proportion of physicians with multi-disciplinary care team members has increased since 2016. Half of primary care physicians reported having care managers and nurse practitioners on their teams, and about one-third reported having social workers. Far fewer PCP's have CHWs and co-located psychiatrists (Figure 6). Physicians with a high volume of Medicaid patients were nearly twice as likely to use CHWs and co-located psychiatrists on their care teams than physicians with a lower volume of Medicaid patients (Figure 7). Physicians working in hospitals and group practices were significantly more likely to have multi-disciplinary support staff (with the exception of co-located psychiatrists) than physicians in single practice (Figure 8).

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Figure 6: Primary care team members (2016 – 2018)

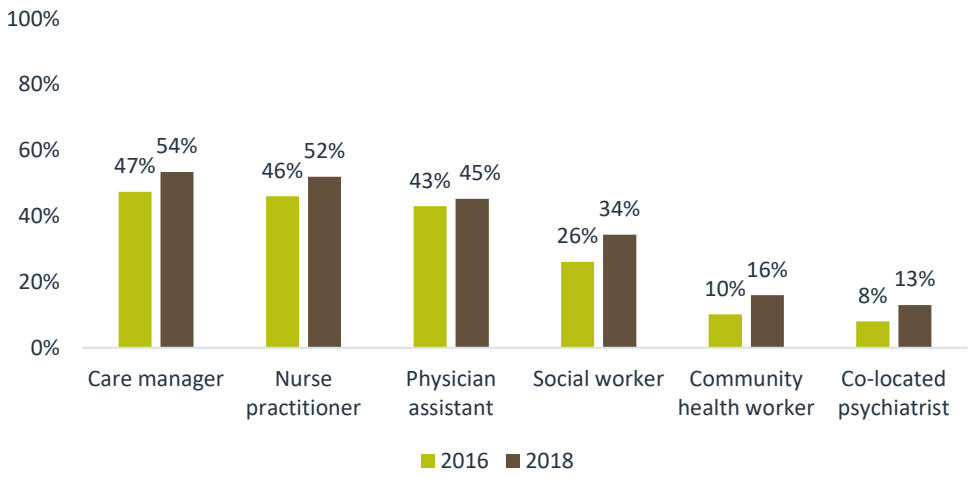

Figure 7: Primary care team members by Medicaid patient volume

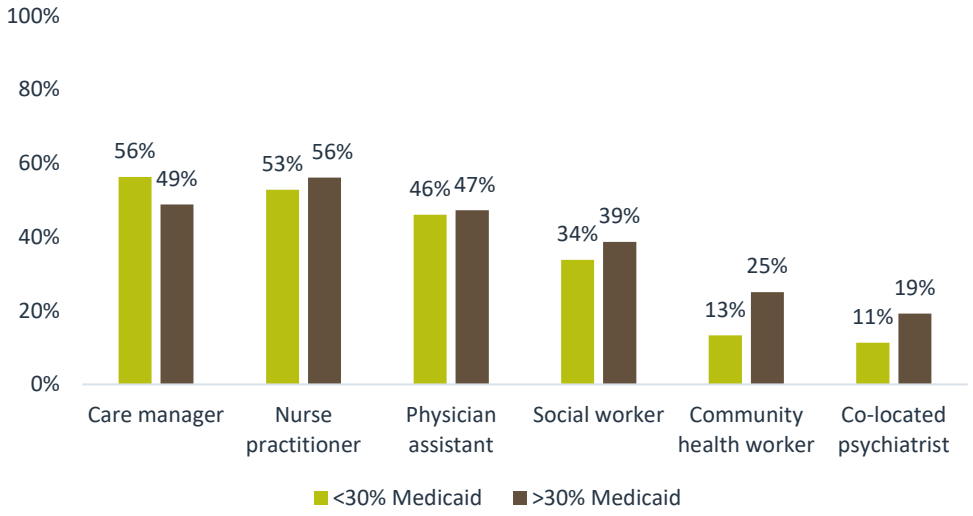

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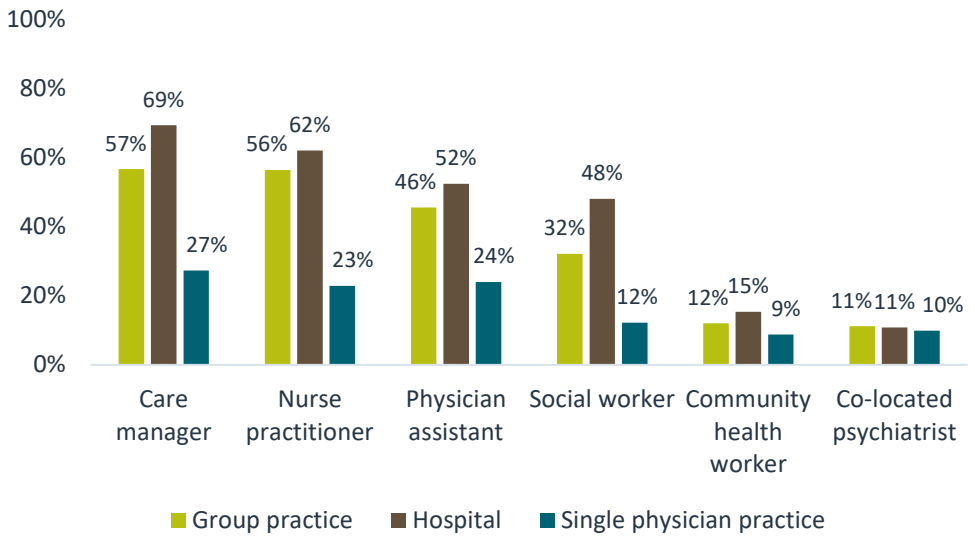
Figure 8: Primary care team members by practice setting



Physician perspectives on factors impacting their patients

Continuity of care

As emphasis on establishing patient-centered medical homes has grown, understanding potential barriers to continuity of care between a PCP and their patients has become an important subject in the Physician Survey. Three in four Michigan PCPs reported their patients' inability to pay insurance deductibles was a barrier to continuity of care, and over half indicated that patients' ability to meet other cost-sharing requirements and a lack of insurance were also barriers. Social determinants of health also figured prominently in PCPs' perception of difficulties in patient care continuity, with around half indicating lack of transportation and health literacy as barriers (Figure 9). Physicians with larger volumes of Medicaid patients were more likely to report both of these issues as barriers (Figure 10). These findings indicate an ongoing need to assess the impact of social determinants of health on care delivery and the integration of social support services in the primary care setting.

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Figure 9: Barriers to patients' continuity of care

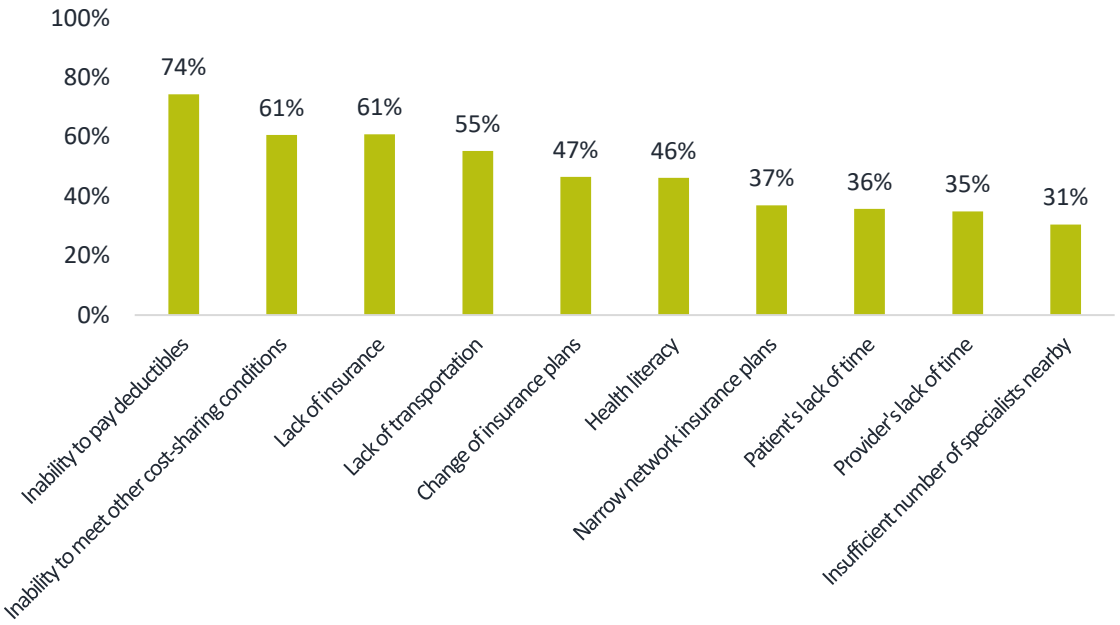
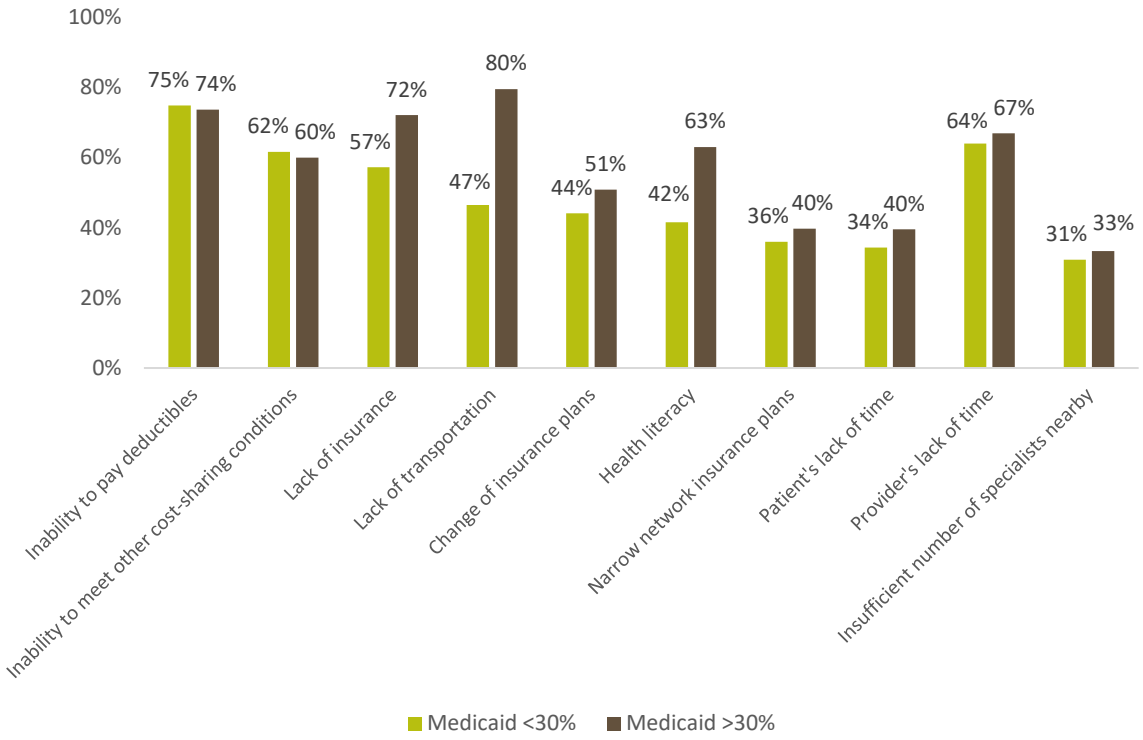


Figure 10: Barriers to patients' continuity of care by Medicaid patient volume



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Medicaid Work Requirements

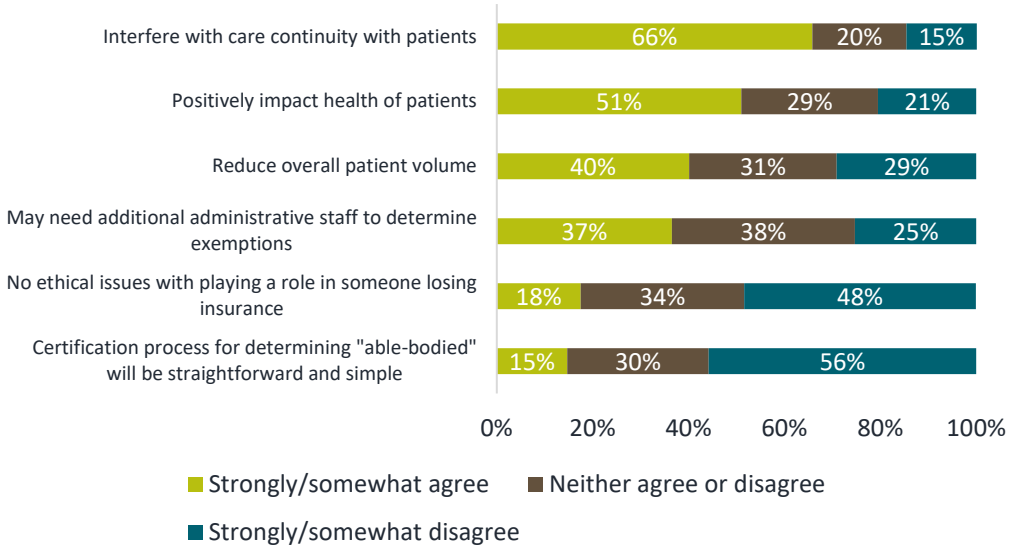
In 2018, Michigan passed a work requirement policy for certain enrollees in the Healthy Michigan Plan, Michigan's expanded Medicaid program for low-income adults. In January 2020, the new law will require most able-bodied adults under age 63 covered through HMP to work or be involved in other "community-engagement" activities for an average of 80 hours per month. The policy includes several exemptions, including one for those who have medical conditions that prohibit their ability to meet such requirements, as certified by a physician (see editor's note).

Editor's Note 2: Medicaid work requirements in other states are the subject of ongoing litigation. Michigan has not been directly impacted by this at the time of publication, but could be in the future.

See: Goodnough, A. (2019, March 29) "Judge Blocks Medicaid Work Requirements in Arkansas and Kentucky" *New York Times*.

PCPs are split in their opinions about the impact new Medicaid work requirements (MWRs) could have on their patients and their practices. While more than two-thirds of physicians surveyed have concerns about care continuity and more than half did not think the certification process would be straightforward, they are more divided on whether they would need to hire additional staff, whether MWRs would decrease patient volume, and on the ethical issues of determining "able-bodied" status (Figure 11).

Figure 11: Michigan primary care provider perceptions on MWRs



Providers with large volumes of Medicaid patients were more likely to report that the MWRs would interfere with patient care continuity and would reduce their overall patient volume. However, they were no more or less likely to see an ethical problem with certifying patients as able-bodied, or have concerns about the ease of the certification process (Figure 12).

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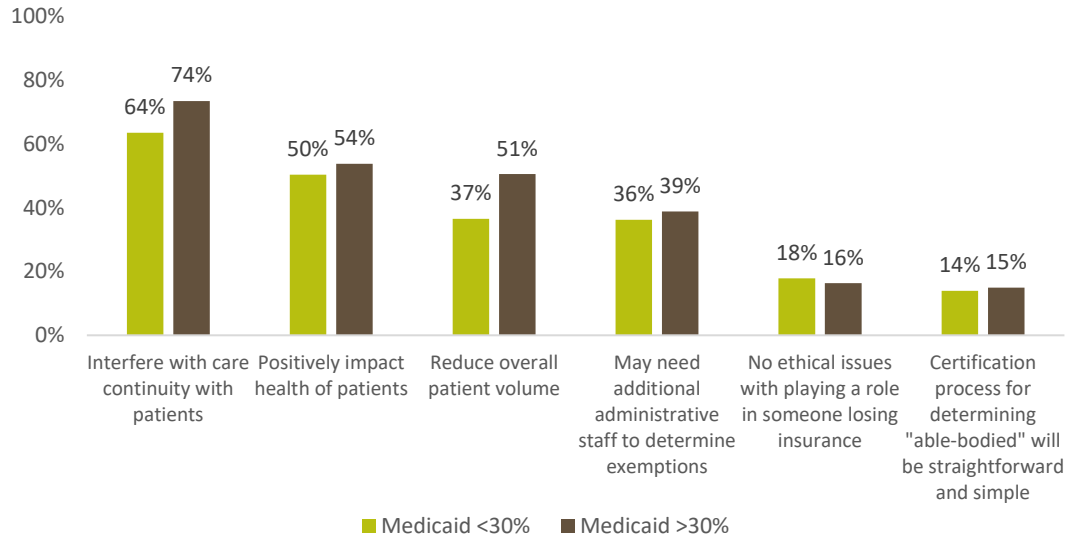
Figure 12: Agreement with anticipated impacts of MWR by Medicaid patient volume



Conclusion

In Michigan, current primary care capacity for taking new patients is high but will require monitoring as more doctors age and look towards leaving practice within the next decade. Primary care teams are slowly becoming more multi-disciplinary and are including more advanced practice nurses, social workers, community health workers and psychiatry on their teams -- facilitating high-quality care for older and more complex populations. PCPs in Michigan see insurance and cost-related barriers as significant factors that interfere with the continuity of care for their patients. In a related manner, PCPs major concern about new work requirements for the Medicaid population is that potential loss of coverage will interfere with care continuity for their patients. They were slightly less concerned about the administrative burden any certification process might have for their practice.

Endnotes

[i] Callison, K., Linde, S., Muller, L., Simons, G. (2019). *Health check: Analyzing trends in West Michigan 2019*. Grand Valley State University.
[ii] Citizens Research Council of Michigan (2015). *Where are the primary care doctors? A look at Michigan's primary care physician shortage*. Livonia, MI.
[iii] Johnson, M. (2018). *The healthcare future is female.* Aetna Health.
[iv] The Physicians Foundation (2018). *2018 survey of America's physicians practice patterns and perspectives.*
[v] Wisely, R. (2019 April 17). Why More People Are Using CVS, Walgreens Instead of Family Doctor. *Detroit Free Press*.

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