Informing Evidence Based Policy Making: How to Conceptualize and Conduct Policy Relevant Research

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Outline

- How to ask a health policy relevant research question

- How to develop a rigorous study design to answer a policy relevant question

- How to translate research findings to achieve policy impact

How to **ask** a health policy relevant research question

Act No. 107
Public Acts of 2013
Approved by the Governor
September 16, 2013
Filed with the Secretary of State
September 16, 2013

EFFECTIVE DATE: 91st day after final adjournment of 2013 Regular Session

STATE OF MICHIGAN
97TH LEGISLATURE
REGULAR SESSION OF 2013

Introduced by Reps. Lori and Pscholka

ENROLLED HOUSE BILL No. 4714

— Social Welfare Act

AN ACT to amend 1939 P.A. 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, in... state with the social security... blind, and the permanently a... of delinquency, dependency... powers and duties of the de... county and district departme... and certain divisions and o... officers; to provide for appea... to county and district depart... to make an appropriation; to... of this act on specific dates,"... 400.107, 400.108, and 400.109c... and 107 as amended by 2006... 105e, and 105f.

The People of the State of Michigan enact:

Sec. 105. (1) The department of community health shall establish a program for medical assistance for the medically indigent under title XIX. The director of the department of community health shall administer the program established by the department of community health and shall be responsible for determining eligibility under this act. Except as otherwise provided in this act, the director may delegate the authority to perform a function necessary or appropriate for the proper administration of the program.

(2) As used in this section and sections 106 to 112, "peer review advisory committee" means an entity comprising professionals and experts who are selected by the director and nominated by an organization or association or organizations or associations representing a class of providers.

(3) As used in sections 106 to 112, "professionally accepted standards" means those standards developed by peer review advisory committees and professionals and experts with whom the director is required to consult.

(4) As used in this section and sections 106 to 112, "provider" means an individual, sole proprietorship, partnership, association, corporation, institution, agency, or other legal entity, who has entered into an agreement of enrollment specified by the director under section 111b(4).

Sec. 105a. (1) The department of community health shall develop written information that sets forth the eligibility requirements for participation in the program of medical assistance administered under this act. The written information shall be updated not less than every 2 years.

(66)

(2) The department of community health shall provide copies of the written information described in subsection (1) to all of the following persons, agencies, and health facilities:

(a) A person applying to the department of community health for participation in the program of medical assistance administered under this act who is considering institutionalization for the person or person's family member in a nursing home or home for the aged.

(b) Each nursing home in the state.

(c) Each hospital in the state.

(d) Each adult foster care facility in the state.

(e) Each area agency on aging.

(f) The office of services to the aging.

(g) Local health departments.

(h) Community mental health boards.

(i) Medicaid and medicare certified home health agencies.

(j) County medical care facilities.

(k) Appropriate department of community health personnel.

(l) Any other person, agency, or health facility determined to be appropriate by the department of community health.

Sec. 105e. The director of the department of community health shall submit a recommendation to the senate majority leader, the speaker of the house, and the state budget office on how to most effectively determine medicaid eligibility and enrollment for all applicants by January 1, 2015. The department of community health may delegate this function... *eligibility*

...the United States department of health ...ise incurring federal financial penalties, ...IX who meet the citizenship provisions ...rogram under this act into a contracted ...luding, but not limited to, the enrollee, ...can be deposited to pay for incurred ...e administered by the department of ...ird party administrator, as considered ...dividuals eligible under this subdivision ...ed by the United States department of health and human services, whichever is later.

(b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department of community health shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee shall be required to remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department of community health shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers. The department of community health shall report its plan of action for enrollees who consistently fail to meet their cost-sharing requirements to the legislature by June 1, 2014. *enforcement/punishment*

(c) Give enrollees described in subdivision (a) a choice in choosing among contracted health plans.

(d) Ensure that all enrollees described in subdivision (a) have access to a primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state and to preventive services. The department of community health shall require that all new enrollees be assigned and have scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The department of community health shall monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs. The department of community health shall ensure that the contracted health plans have procedures to ensure that the privacy of the enrollees' personal information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

> Ensure that all enrollees...have access to primary care...
> The department shall require that all new enrollees be assigned and have scheduled an initial appointment with a primary care practitioner within 60 days of initial enrollment.

Tips on conceptualizing policy relevant research

- Read the bill / regulation / court case!

- Think about interesting and doable research questions

- Researchers should engage policy stakeholders when asking research questions: would they be interested in knowing this information?

- Workshop with researchers and policy stakeholders

How to **develop** a rigorous study design to answer a policy relevant question

Methods to consider

- Secondary data analysis, such as of federal or state surveys

- Analysis of visits in health care claims data

- Survey of primary care practitioners, clinics or health systems

- Surveys or interviews with enrollees

- Simulated patient ("secret shopper") study, calling clinics

1. Background/Objectives

Background:
Michigan's Medicaid expansion, *Healthy Michigan*, offers health insurance coverage to many low-income uninsured Michiganders, but many may be unable to find a doctor after obtaining an insurance card. While the law requires new Medicaid enrollees to obtain an appointment with a primary care provider within 60-90 days of enrollment, it remains uncertain how quickly enrollees will be able to do this. This study examines changes in availability and wait times for primary care appointments before and after the April 2014 start of *Healthy Michigan* enrollment. The goal is to get a sense of new patients' experiences in attempting to find care in order to assist primary care clinics and state health planners to work toward ensuring timely access to primary care for all patients.

Study Design:
Using simulated patient calls (a.k.a. audit calls, or "secret shopper" calls) to a representative sample of Michigan primary care practices, we will determine whether there are changes in the proportion of practices accepting new patients or the average wait times for a new patient primary care appointment. We will compare PRE-expansion to POST-expansion by placing repeated calls every 4 months during a 12-month period in 2014-2015.

Objectives:
1) **Determine availability of primary care appointments for newly insured patients.**
2) **Determine wait times for primary care appointments for newly insured patients.**
3) Determine whether after hours care (after 5pm on weekdays, or on the weekend) is available.
4) Determine how many attempts are required to schedule the appointment.

*The first two objectives are the most important for the study.

2. Simulated Patient Call Method

You will be trained to pose as a prospective patient requesting a new patient primary care appointment. Calls will be made to each clinic to request the next available routine appointment for a new patient. By *routine*, we mean you do not have a worrisome condition requiring urgent medical attention; you simply just got insurance and want to set up care with a new doctor. Each clinic will be called twice (research assistants will be randomly assigned to each call) – once posing as a patient with Medicaid and once posing as a patient with private insurance. Calls for the two different insurance scenarios will be separated in time to avoid clinics recognizing simulated patients. Appointments will be cancelled at the end of the call to avoid preventing actual patients from making appointments.

3. Scripts/Flow Chart

Audit Script for Clinics:

Hi, I want to schedule a check-up with [PCP NAME- as listed in spreadsheet or, if that doctor not available, check notes section] or any PCP.
→ I'm new to the area.
→ I haven't seen a doctor for a couple of years.
→ I'm looking for somebody to be my regular doctor. (This is important – emphasize you want to set up with a new doctor and get a physical; this is not an urgent visit.)
→ I'm feeling fine now, but I haven't had a check-up in a few years and want to get one.
→ I just got new insurance and I need to set up a primary care doctor.

If asked:

What is the appointment for?:
I have high blood pressure and wanted to get it checked. Last time I got it checked at the pharmacy, they said it was a little high and I should tell my regular doctor.

How high was it?:
I don't know exactly what the reading was. What is normal?... The pharmacy said it was just a little high but that I didn't need to go to the ER or anything like that.

Do you have any other symptoms or medical conditions?:
No.

Do you take any medications?:
I used to take one...I can't remember the name. The doctor told me it was a "water pill". [*If pressed*: I think it was hydrochlorothiazide.]

CANCEL THE APPOINTMENT IF YOU HAVE ONE!!!

*If you are unable to cancel an appointment before getting off the phone, call right back and cancel.

Tips on conducting policy relevant research

- Consider a variety of methods: from secondary data analysis to primary data collection

- Think about what approach best answers your question and is doable

- Develop and refine your study protocol, with input from research and policy collaborators

- Build your team

How to **translate** your findings to achieve policy impact

Different audiences

Document 1 (left)

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Research Findings
May 2015

Primary Care Access for Medicaid Patients Has Improved During Healthy Michigan Plan Implementation

Key Finding
After implementation of the Healthy Michigan Plan, primary care appointment availability has increased for Medicaid patients, while wait times for new patient appointments remain within 1-2 weeks.

Background
Since the program began on April 1, 2014, over 600,000 Michiganders have enrolled in the Healthy Michigan Plan (PA 107 of 2013), in addition to over 275,000 who have enrolled in individual private insurance plans on the Marketplace. The law requires new beneficiaries to obtain a primary care appointment within 60-90 days of enrollment. While a 2013 study by the Center for Healthcare Research & Transformation suggested that primary care capacity would grow under the law, it is unclear how primary care practices are accommodating the additional strain of large numbers of newly insured.

This study used simulated patient calls to examine primary care appointment availability and wait times for new patients with Medicaid and private insurance before and after implementation of the Healthy Michigan Plan. Pre-implementation calls were placed in March 2014 and post-implementation calls were placed at 4-month intervals in July-August 2014, November-December 2014 and March-April 2015.

Change in Proportion of Michigan Primary Care Clinics Accepting New Adult Patients

Appointment Availability (Proportion of Clinics)				
	Pre-Implementation	4 months Post-Implementation	8 months Post-Implementation	12 months Post-Implementation
Medicaid	49%	55%*	56%*	55%*
Private insurance	88%	86%*	85%*	86%*

Differences between pre- and post-implementation appointment availability are statistically significant for both Medicaid and private insurance.

Document 2 (center)

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JULY 2015 | **RESEARCH BRIEF**

Primary Care Access Before and After Medicaid Expansion Under the ACA

Tipirneni R, Rhodes KV, Hayward RA, Lichtenstein RL, Reamer EN and Davis MM. Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion In Michigan. Health Affairs August 2015; 34:8.

What the Research Tells Us
The Affordable Care Act expands health insurance coverage to millions of Americans, but as more individuals enroll in expanded state Medicaid programs, questions remain about the availability of health care services for this influx of newly insured adults.[1] As of June 2015, 29 states and the District of Columbia have expanded Medicaid.[2] Medicaid and CHIP enrollment has grown by over 11.7 million since October 2013,[3] including nearly 600,000 adults who have enrolled in Michigan's Medicaid expansion, the Healthy Michigan Plan, since this program began in April 2014.[4]

This substantial coverage expansion has led some experts to express concern over access to primary care providers and long appointment wait times for the newly insured.[5,6] The distinctive design of the Healthy Michigan Plan makes access to primary care providers even more essential,[7] requiring new Medicaid beneficiaries to obtain a primary care provider appointment within 60–90 days of enrollment. In a 2012 survey of primary care providers in Michigan, providers expressed optimism about their capacity to accept new patients under a then-hypothetical Medicaid expansion.[8] However, Michigan's higher than expected enrollment in the first months of coverage expansion[9,10,11] has prompted uncertainty about the capacity of the primary care workforce to meet this challenge.

At the University of Michigan, Dr. Renuka Tipirneni is evaluating the implications of coverage expansion and program design on access to primary care. To provide state policymakers and other stakeholders with timely estimates of the impact of Medicaid expansion on primary care access in Michigan, Dr. Tipirneni examined primary care appointment availability and wait times for new patients with Medicaid and private insurance before and after the implementation of the Healthy Michigan Plan.

Dr. Tipirneni and colleagues conducted a simulated patient (or "secret shopper") study of 295 primary care practices in Michigan to measure appointment availability and wait times. Callers posed as prospective Medicaid and privately insured patients seeking to schedule new patient appointments with a primary care provider. Calls were placed during the two-week period immediately preceding the Healthy Michigan Plan start and again 3–4 months later.

This study found that appointment availability for new Medicaid patients increased from 49% to 55% before and after the implementation of Medicaid expansion in Michigan, and availability for new privately insured patients decreased slightly from 88% to 86%. (Figure 1) Wait times for new Medicaid and new privately insured did not significantly increase before and after expansion, contrary to potential concerns that Medicaid expansion

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Document 3 (right)

By Renuka Tipirneni, Karin V. Rhodes, Rodney A. Hayward, Richard L. Lichtenstein, Elyse N. Reamer, and Matthew M. Davis

Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion In Michigan

ABSTRACT The Affordable Care Act expands health insurance coverage to millions of Americans, but the availability of health care services for the newly insured population remains uncertain. We conducted a simulated patient (or "secret shopper") study to assess primary care appointment availability and wait times for new patients with Medicaid or private insurance before and after implementation of Michigan's Medicaid expansion in 2014. The expansion, which was made possible through a section 1115 waiver, has a unique requirement that new beneficiaries must be seen by a primary care provider within 60–90 days of enrollment. During a period of rapid coverage expansion in Michigan, we found that appointment availability increased 6 percentage points for new Medicaid patients and decreased 2 percentage points for new privately insured patients, compared to availability before the expansion. Wait times remained stable, at 1–2 weeks for both groups. Further research is needed to determine whether access to primary care for newly insured patients will endure over time.

Renuka Tipirneni (rtipirne@med.umich.edu) is a Robert Wood Johnson Foundation Clinical Scholar and clinical lecturer in the Department of Internal Medicine at the Medical School and a member of the Institute for Healthcare Policy and Innovation, both at the University of Michigan, in Ann Arbor.

Karin V. Rhodes is an associate professor of emergency medicine and director of the Center for Emergency Care Policy and Research at the Perelman School of Medicine, University of Pennsylvania, in Philadelphia.

Rodney A. Hayward is a professor of internal medicine and public health and a member of the Institute for Healthcare Policy and Innovation at the University of Michigan and a senior research scientist at the Veterans Affairs Center for Clinical Management Research, both in Ann Arbor.

Richard L. Lichtenstein is the S. J. Axelrod Collegiate Professor of Health Management and Policy at the School of Public Health and a member of the Institute for Healthcare Policy and Innovation, both at the University of Michigan.

Elyse N. Reamer is a research assistant at the Robert Wood Johnson Foundation Clinical Scholars Program in the Medical School at the University of Michigan.

The Affordable Care Act (ACA) offers many Americans the promise of increased access to care and improved health. Coverage expansions in several states have previously demonstrated improved health.[1-3] However, increased coverage might not translate to health improvement without timely access to primary care appointments.[4-8] For example, following Massachusetts's health reform in 2006, concerns were raised about lack of access to primary care providers and long wait times for appointments.[9,10]

Barriers to care for patients with Medicaid may be even higher than those for patients with private insurance.[11-14] As millions of Americans gain coverage through subsidized private insurance or Medicaid in states that have chosen to expand Medicaid eligibility, demand for care is increasing without a corresponding increase in the supply of primary care providers.[15,16]

It remains unclear what impact the ACA's insurance expansions will have on access to primary care. A recent report from the Office of Inspector General in the Department of Health and Human Services (HHS) suggests that states vary widely in their enforcement of standards for Medicaid patients' access to care;[17] another calls for states to directly assess the availability of their provider networks.[18]

To mitigate the limitations of provider and household surveys that are likely to have social desirability and nonresponse biases,[19] HHS has recommended simulated patient (or "secret shopper") studies[17,18] to directly examine access to care for Medicaid beneficiaries.[11,13,14,18,20-27] Moreover, the information provided by simulated patient studies is complementary to that from other modalities measuring access to care.[28,29] A simulated patient study conducted in ten states

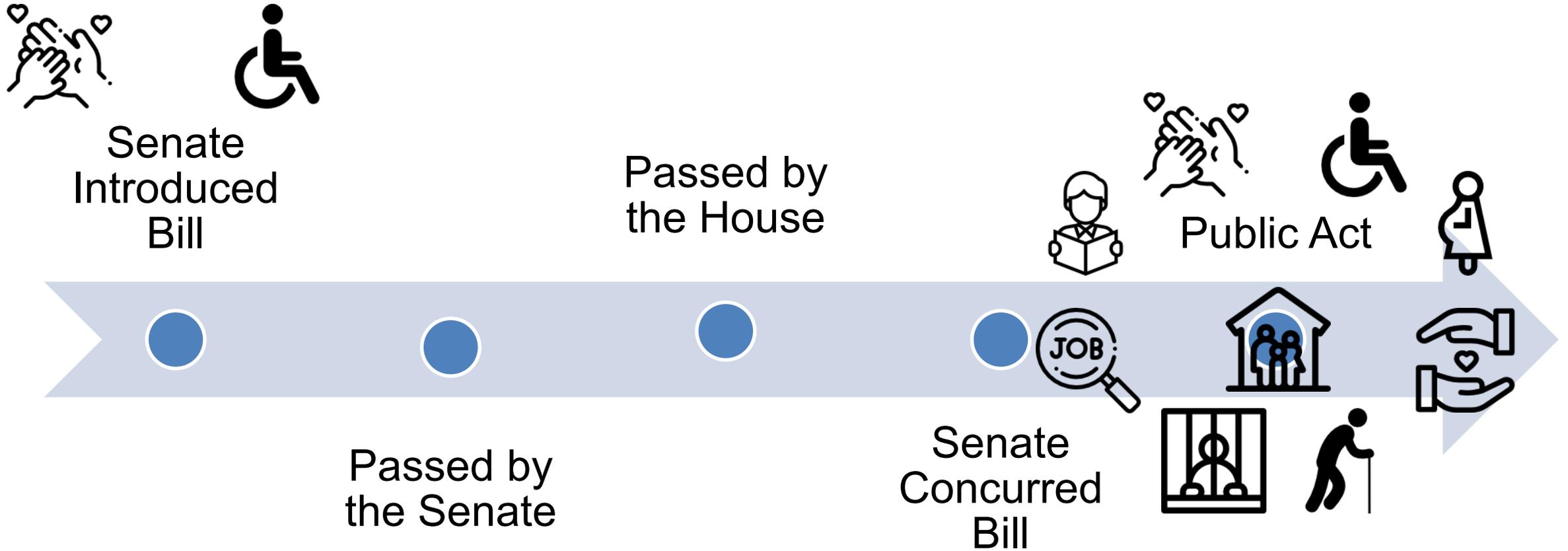# Tips on translating research for policy impact

- Think about who to target and when – local vs. state vs. national dissemination

- Researchers should engage policy stakeholders early and often

- Tailor message to your audience

- Importance of issue brief and writing in a nonpartisan way

- Continue to engage and develop relationships with stakeholders

Examples of research with policy impact

Research on Medicaid work requirements

- Research conducted in state Medicaid expansion evaluation found:
  - Most enrollees already working
  - Expanded Medicaid coverage associated with improved health and ability to work
  - Enrollees who were unable to work reported significant barriers including poor health

State legislative policy impact

Senate Introduced Bill

Passed by the Senate

Passed by the House

Senate Concurred Bill

Public Act

Impact on federal court case

"…studies…point to the positive economic impact of the Medicaid expansion, both for people able to return to work because of improved access to medical care and as a jobs-creating economic engine."

"Similar results have been achieved… in Michigan…Tipirneni et al…found that Medicaid enabled greater work engagement from people previously unable to do so because of poor health."

Research on health insurance difficulties for adults approaching retirement age

- Nearly half of adults age 50-64 worried about affordability of health insurance when they retire

- Those individuals who had health insurance worries were more likely to avoid medical care and avoid filling a prescription medication

Federal legislative policy impact

DEBBIE STABENOW United States Senator for Michigan

NATIONAL POLL ON HEALTHY AGING

Today, 27% of adults approaching retirement are not confident that they can afford health insurance over the next year, and more than a quarter have issues navigating health insurance options, coverage decisions, and out-of-pocket costs. Many did not get the care they needed because of how much it would cost or kept a job or delayed retirement to keep their employer-sponsored health insurance.

from the Kaiser Family Foundation indicates that 77 percent of the public supports giving people between the ages of 50 and 64 the option to buy Medicare.

Today, 27% of adults approaching retirement are not confident that they can afford health insurance over the next year, and more than a quarter have issues navigating health insurance options, coverage decisions, and out-of-pocket costs. Many did not get the care they needed because of how much it would cost or kept a job or delayed retirement to keep their employer-sponsored health insurance.

Medicare, VA, or military coverage; 8% had individual private insurance including exchange

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Take home messages

- Engage policy stakeholders early and often, from asking research questions to translating the findings

- Actually read the policies you are interested in!

- Consider a variety of methods: from secondary data analysis to primary data collection

- Research is an iterative process: workshop and develop your questions and methods with both researchers and policy stakeholders

- Write issue briefs, not just academic papers, to translate research findings

- Researchers should develop relationships with policymakers over time

Questions?

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