Cost Conversations Between Primary Care Providers and Patients with Expanded Medicaid Coverage

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INTRODUCTION

Patients face increasing out-of-pocket (OOP) costs for healthcare,[1] which have been associated with medication non-adherence and poor health outcomes.[2,3] While low-income patients may frequently have concerns about OOP costs—even if they have insurance with generous covered benefits—they may not raise cost concerns with physicians. Little is known about cost conversations between primary care providers (PCPs) and low-income patients. Our objective was to determine the frequency, predictors, and PCPs' perceptions of the impact of cost conversations with low-income patients in an expanded Medicaid program in Michigan ("Healthy Michigan Plan" [HMP]), a state program for adults ages 19–64 with incomes ≤ 138% of the federal poverty level (FPL) and includes limited cost-sharing for beneficiaries (≤ 2% of income).

METHODS

We conducted a mailed survey of all PCPs caring for ≥ 12 HMP patients in June–November 2015. The sample was derived from the Michigan Department of Health and Human Services (MDHHS) Medicaid claims data warehouse and included both physician and non-physician (nurse practitioner or physician assistant) PCPs. The University of Michigan and MDHHS institutional review boards considered the study exempt.

Respondents were asked, "Have you ever discussed out-of-pocket medical costs with a HMP patient?" Respondents who answered "yes" were asked: (a) "Thinking of the most recent time you discussed out-of-pocket medical expenses with a HMP patient, who brought up the topic?" and (b) "Thinking of the most recent time you discussed out-of-pocket medical expenses with a HMP patient, did the conversation result in a change in the management plan for the patient?"

Descriptive statistics report responses to individual survey items. χ^2 and logistic regression analyses were used to examine the unadjusted and adjusted associations between PCPs' personal, professional, and practice characteristics, and (1) the likelihood of cost conversations, and (2) change in management due to cost conversations. Statistical analyses were performed using Stata version 14.2; two-sided $p < 0.05$ was considered significant.

RESULTS

The response rate was 56% ($N = 2104$). Respondent PCPs were 55% male, 79% White, 5% Black, 2% Hispanic/Latino, and 83% physicians. Four hundred forty-five (22%) said that they had discussed OOP medical costs with a HMP patient. Of those who had cost conversations, the topic was brought up 56% of the time by the patient, 39% by the PCP, 4% by somebody else in the practice (e.g., clerical or nursing staff), and 1% by another person. When a cost conversation occurred, 56% of PCPs reported it resulted in a change in management.

Cost conversations were more frequent among female, White, and non-physician PCPs, those with prior care for the underserved, working in federally qualified health centers, or in practices with Medicaid/uninsured-predominant payer mixes or rural settings (Table 1). Changes in management due to cost conversations were more common among non-physician PCPs, those with fewer years in practice and in rural settings. In multivariable regression analyses, the adjusted odds of cost conversations were greater for White, Hispanic/Latino, and non-physician PCPs, and those with Medicaid/uninsured-predominant payer mixes (Table 2). PCPs with fewer years in practice or in non-suburban settings had greater adjusted odds of management changes due to cost conversations.

DISCUSSION

Only one in five PCPs reported conversations about out-of-pocket medical costs with low-income Medicaid patients. The frequency of cost conversations we observed appears on the

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Table 1 Association of PCP Personal, Professional, and Practice Characteristics with Frequency of Cost Conversations and Change in Clinical Management Due To Cost Conversations

PCP characteristics	All respondents *N* (col %)	Cost conversations *n* (row %§)	Change in management due to cost conversation *n* (row %†)
Total	2104 (100%)	445/1988 (22.4%)	248/440 (56.4%)
Personal characteristics			
Gender			
Male	1165 (55.4%)	227/1107 (20.5%)§	118/224 (52.7%)
Female	939 (44.6%)	218/881 (24.7%)	130/216 (60.2%)
Race‡			
White	1579 (79.1%)	367/1145 (24.3%)¶	204/364 (56.0%)
Black/African American	92 (4.6%)	14/91 (15.4%)	8/14 (57.1%)
Asian/Pacific Islander	218 (10.9%)	25/204 (12.3%)	14/23 (60.9%)
Other/more than one	107 (5.4%)	18/103 (17.5%)	10/18 (55.6%)
Ethnicity‡			
Hispanic/Latino	46 (2.3%)	15/45 (33.3%)	8/15 (53.3%)
Not Hispanic/Latino	1978 (97.7%)	416/1475 (22.0%)	234/411 (56.9%)
Professional characteristics			
Provider type			
Physician	1750 (83.2%)	337/1653 (20.4%)¶	180/333 (54.1%)
Non-physician (NP or PA)	357 (16.8%)	108/335 (32.2%)	68/107 (63.6%)
Specialty			
Family medicine	1123 (53.4%)	230/1064 (21.6%)¶	119/228 (52.2%)§
Internal medicine	574 (27.3%)	96/538 (17.8%)	58/94 (61.7%)
Other physician specialty	53 (2.5%)	11/51 (21.6%)	3/11 (27.3%)
Non-physician (NP or PA)	354 (16.8%)	108/335 (32.2%)	68/107 (63.6%)
Years in practice‡			
< 10 years	520 (25.9%)	126/502 (25.1%)	87/125 (69.6%)§
10–20 years	676 (33.7%)	134/644 (20.8%)	72/133 (54.1%)
> 20 years	810 (40.4%)	172/753 (22.8%)	84/169 (49.7%)
Prior care for underserved patients‡			
Yes	1153 (57.0%)	284/1102 (25.8%)¶	161/282 (57.1%)
No	871 (43.0%)	151/834 (18.1%)	82/148 (55.4%)
Practice characteristics			
Practice size‡			
Small (≤ 5 providers)	1157 (57.5%)	252/1087 (23.2%)	141/250 (56.4%)
Large (> 5 providers)	855 (42.5%)	181/820 (22.1%)	103/178 (57.9%)
FQHC practice‡			
Yes	311 (14.9%)	94/299 (31.4%)¶	58/94 (61.7%)
No	1770 (85.1%)	347/1669 (20.8%)	188/343 (54.8%)
University/teaching hospital practice‡			
Yes	276 (13.4%)	48/263 (18.3%)	27/47 (57.5%)
No	1786 (86.6%)	388/1687 (23.0%)	217/384 (56.5%)
Hospital-based practice (non-teaching)‡			
Yes	643 (31.2%)	134/609 (22.0%)	82/132 (62.1%)
No	1419 (68.8%)	302/1341 (22.5%)	162/299 (54.2%)
Payer mix‡			
Medicaid/uninsured predominant	689 (36.0%)	177/670 (26.4%)§	104/177 (58.8%)
Private/Medicare/other predominant	1223 (64.0%)	232/1160 (20.0%)	128/230 (55.7%)
Urbanicity			
Urban	1584 (75.3%)	312/1492 (20.9%)§	168/309 (54.4%)§
Suburban	193 (9.2%)	42/185 (22.7%)	20/42 (47.6%)
Rural	327 (15.5%)	91/311 (29.3%)	60/89 (67.4%)

**Row percent among respondents who answered the question about cost conversations (N = 1988)*
†Row percent among those respondents who had a cost conversation (N = 440)
‡All respondents column does not sum to 2104 due to skipped responses
§$p < 0.05$
¶$p < 0.001$

low-end range of 4–65% observed in other studies examining cost conversations in the general population.[4]

However, half of PCPs who had cost conversations reported a resulting change in management, attesting to the value of such conversations for patient-centered care, even for Medicaid patients with generous covered benefits and limited cost-sharing. Although OOP costs may be declining for some groups after Affordable Care Act coverage expansion, even nominal OOP costs may be considerably burdensome for low-income patients.[2,3] Thus, greater investment is needed to improve the frequency and quality of cost conversations.[5,6]

Potential study limitations include self-reported outcomes, survey questions limited to Medicaid expansion patients in a single state, a sample enriched for PCPs caring for at least 12 Medicaid expansion patients, the study's focus on assessing cost conversations from the PCP perspective, and the absence of data on types of changes in management. Frequency of cost conversations may differ for other healthcare provider or patient groups, or in other states. Future research may examine

Table 2 Multivariable Association of PCP Personal, Professional, and Practice Characteristics with Likelihood of Cost Conversations, and Likelihood of Change in Clinical Management Due To Cost Conversations

PCP characteristics	Adjusted odds ratio* (95% CI)	
	Odds of cost conversation	Odds of change in management due to cost conversation†
Personal characteristics		
Male gender	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)
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]

**Each column represents a different multivariable model*
†Odds of change in management among those respondents who had a cost conversation
‡$p < 0.05$
§$p < 0.001$

facilitators and barriers to cost conversations, and resulting management changes.

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COMPLIANCE WITH ETHICAL STANDARDS:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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