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Strengthening Health Care Delivery in Michigan:

Physician Workforce Recommendations

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Executive Summary

In Michigan today, almost a third of the population lacks access to primary care. Costs are continually escalating, and the population is growing sicker. Over 30% of current physicians are over 60, and Michigan is only retaining 45.6% of the resident Graduate Medical Education physicians it trains. Physician shortages and underinvestment are even more dire in primary care, which is the first point of contact for most patients and the cornerstone of a high-performing health system.

In this spirit, the Michigan State Medical Society (MSMS) Board of Directors created a Subcommittee on Michigan's Physician Workforce Needs to inform solutions to strengthen the healthcare system and improve population health. Experts from organized medicine, academic medicine, health policy, and private and governmental payers and agencies collaborated to probe the current state, root causes, and key strategies. This report summarizes their findings and recommendations.

Given the skyrocketing cost of healthcare, the subcommittee focused on proposals that were cost-neutral and actionable. Since high-quality primary care is the foundation of a robust, effective, and efficient system—and the most essential element for improving the overall health of Michigan residents—many of the recommendations focus on primary care. This focus does not negate the importance of ensuring appropriate capacity for all medical specialties and the need to address those shortfalls in the future; however, subcommittee members recognized that without access to a robust primary care physician workforce, Michigan residents cannot attain their goals related to chronic care prevention and management.

As shown in the following table, the subcommittee's recommendations focus on four areas: (i) reforming primary care payment, (ii) reducing the systemwide administrative burden, (iii) reimagining the training and education of primary care physicians, and (iv) better recruitment and retention of primary care physicians to practice in Michigan.

Effectively implemented, these recommendations have the power to transform Michigan's primary care landscape, ultimately improving healthcare for all. Additional public benefits include greater social equity, a significant reduction in avoidable costs, and increased productivity.

The clock is ticking. Each day Michigan waits to strengthen and improve its primary care system, the greater the crisis grows.

Summary of Recommendations

Recommendation 1	Pass a legislative primary care spending target in Michigan of 12% of total medical expenditures so primary care physicians can employ care teams comprised of RN Care Managers, advanced practice providers (NPs/PAs), community health workers, and other health care team members as appropriate for the practice panel.
Recommendation 2	All payers (Medicaid, commercial, etc.) should transition their fee-for-service primary care payment models to a hybrid primary care payment model.
Recommendation 3	Encourage health systems, physician organizations, and similar entities to sign on to a voluntary compact to channel enhanced primary care investment funding to the practice level, ensuring practices can resource teams.
Recommendation 4	Utilize a common set of quality metrics such as CMS' Universal Foundation across health plans in Michigan.
Recommendation 5	All payers should agree upon and use a common attribution methodology, which should emphasize voluntary attribution across all product lines that honors a member's choice of primary care provider.
Recommendation 6	Explore the creation of a public benefit corporation to serve as a hub to ease the administrative burden experienced by independent primary care physician practices.
Recommendation 7	Work with payers and the state to fund targeted financial and technical assistance for small, independent, and rural practices to help them adopt technology that streamlines operational and clinical tasks, including incentives for interoperable solutions that seamlessly integrate with existing EHRs to reduce duplicative data entry and minimize workflow disruptions.
Recommendation 8	Adopt uniform policies that support transparency, independent validation, and continuous auditing of clinical AI tools , ensuring they are safe, effective, and trustworthy for use in medical practice.
Recommendation 9	Encourage students from communities of need through the development of pre-medical apprentice programs and early educational pathways to medicine.
Recommendation 10	Develop and fund community-based, primary care-focused special pathways to encourage graduating residents to return to their communities or remain in similar ones.
Recommendation 11	Increase the proportion of medical school graduates who choose a primary care specialty by encouraging medical schools to develop focused curricula and/or targeted pathways that provide 65–70% of cognitive and procedural care in a team-based model, as well as internal policies designed to change attitudes and negative bias toward primary care to encourage the brightest and best students into primary care.
Recommendation 12	Leverage Physician Organizations (POs) to strengthen the physician workforce pathway by establishing residency and fellowship partnerships within PO-affiliated practices; work with POs to identify geographic and specialty shortages using claims and workforce data, and deploy targeted recruitment strategies such as incentives and loan repayment programs to encourage physicians to practice in high-need rural and underserved areas.
Recommendation 13	Establish new funding sources to expand loan repayment and establish student incentive scholarship programs, such as: • Increase funding to MIDOCS to enable the program to expand annually. • Amend the statute regulating the Michigan Health Endowment Fund to add the primary care workforce as a priority focus, in addition to children and seniors. Allow for funds to be used to develop targeted loan repayment and/or practice establishment pilot programs for physicians who commit to practice in rural, medically underserved areas for seven years. • Encourage health plans, insurers, and businesses to leverage their respective foundations to invest in establishing and maintaining scholarship programs that support pathways to residency for graduating high school seniors.
Recommendation 14	Provide financial incentives to encourage primary care physicians to practice in underserved areas in community-based settings.

Overview: The Michigan Healthcare and Physician Workforce Landscape

Michigan's healthcare system is under growing strain from multiple, complex challenges. Patients struggle to access and afford care. Insurers and employers face ever-increasing healthcare spending, forcing them to consider less comprehensive benefit offerings and greater employee or member cost-sharing.

Moreover, the state's healthcare landscape has become increasingly consolidated, with three health systems controlling a majority of Michigan's care delivery. This has made it more challenging to transition from a fee-for-service-based model that rewards volume to a value-based system that incentivizes physicians to focus on patient outcomes and efficiency.

Additionally, Michigan physicians face compounding reporting and administrative requirements. Too often, it leads to concerns about clinical decision-making autonomy and impact on the patient-physician relationship. And finally, chronic disease has grown exponentially and is now routine in even younger populations.

Together, these pressures expose the limits of a healthcare system that continues to prioritize treatment over prevention.

Primary care physicians, the "quarterbacks" of patient care who deliver the greatest share of patient visits, play a critical role in prevention and coordination but receive the smallest share of total medical spending. The physician workforce in Michigan has been severely challenged, and there is a critical undersupply of many providers, especially in hard-to-service geographic areas. Especially hard hit has been the primary care workforce, which has reached a crisis point and, without thoughtful policy change, will be irreparably damaged.

Recognizing the seriousness and urgency of this issue, the Board of Directors of the Michigan State Medical Society directed a multidisciplinary ad hoc subcommittee of experts from organized medicine, academic medicine, health policy, and private and governmental payers and agencies to develop an actionable plan to address physician workforce needs such that the people of Michigan can receive better access to primary care.

The subcommittee began with an assessment of the current state of the physician workforce in Michigan and the larger environment in which it functions. Together, the group identified several key themes:

- **Affordability:** Health spending across the nation has risen sharply over the last several decades and has reached a crisis point for many individuals, employers, and groups. In 2025, the cost of healthcare for an American family of four in a typical employer-sponsored health plan was $35,119, up from $33,067 in 2024.[1]

  Trend projections for 2026 are even more concerning and are estimated to increase another 8.5% for groups and 7.5% for individuals during the coming year.[2] In addition, the introduction of Community Engagement Requirements ("work requirements") for Medicaid expansion populations in 2027 will further exacerbate cost challenges, with an estimated 500,000 people (5% of the state's total population) losing coverage.[3]

- **Health System Consolidation:** Our state is beset by hospital consolidations that have increased the market power of a small number of large systems. Crain's Detroit Business estimates that three systems now account for over 60% of Michigan's top 10 hospitals and nearly 61% of the state's largest insurer's medical spend.[4] The literature has shown that consolidation has led to higher healthcare prices, with an unclear effect on quality.[5]

  This increase in system ownership has reduced the number of independent-practice physicians, who are essential to retain statewide patient access. Indeed, studies suggest that independent physicians may be less costly and deliver better patient satisfaction than those affiliated with systems.[6] For example, physician-led Accountable Care Organizations (ACOs) tend to perform better in cost and quality outcomes than hospital-led ACOs.[7]

- **Chronic Disease Burden:** There is strong and growing evidence that our population is growing sicker and that chronic disease is striking people at younger ages. Approximately six in 10 young, eight in 10 midlife, and nine in 10 older U.S. adults reported having one or more chronic conditions, with trends in conditions worsening among young adults from 2013 to 2023.[8]

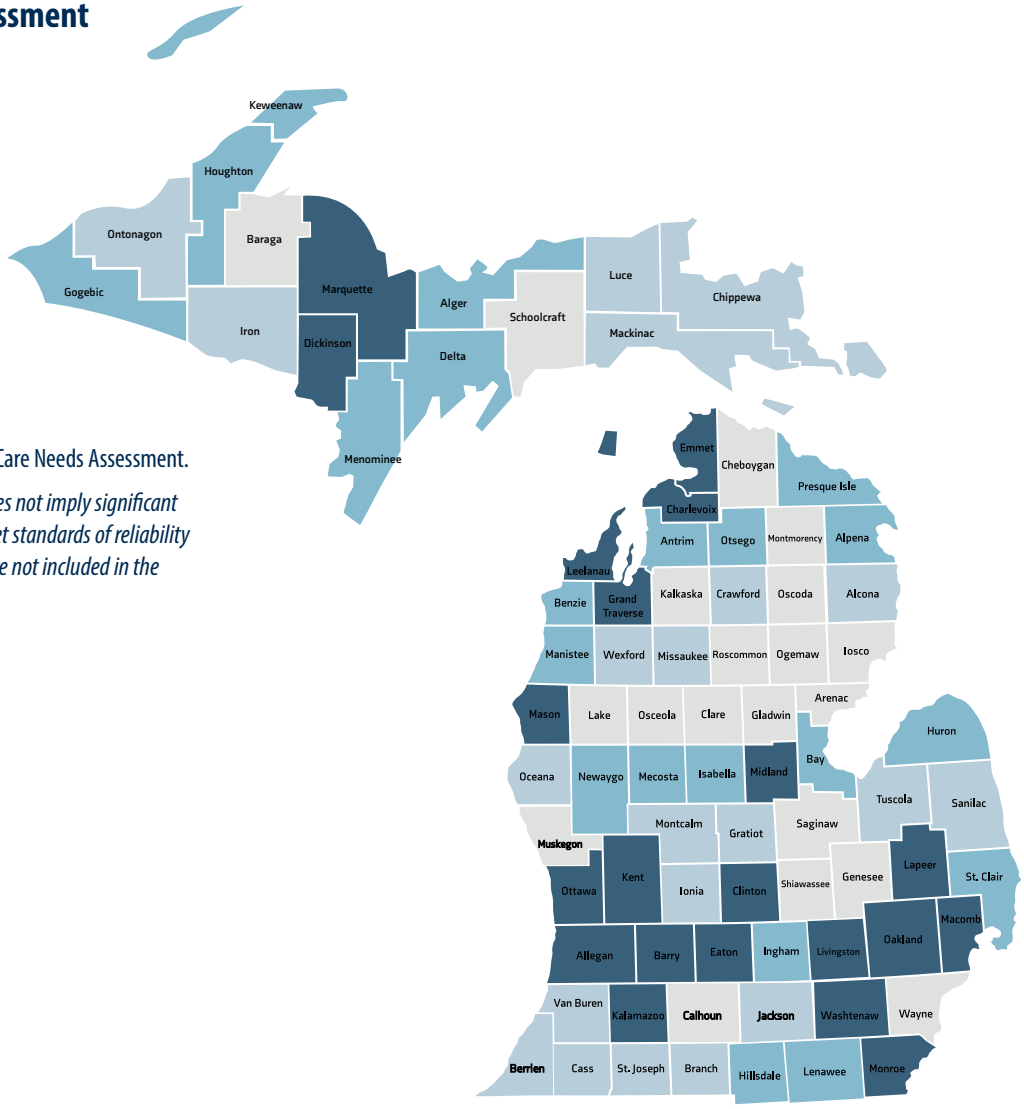
- **Excessive Administrative Load:** Many Michigan physicians—43% of them, in fact—report experiencing burnout.[9] Among primary care physicians, the proportion who reported feeling burned out has steadily increased from 31% in 2018 to 39% in 2021, and then to 46% in 2023. The vast majority (85%) of Michigan physicians reported that administrative burdens and regulatory requirements, including charting and paperwork, were significant contributors to their stress. The plethora of performance measures (with little overlap across health plans), prior authorization requirements, and complex coding and billing guidelines have compounded the problem.
- **Primary Care Capacity:**
  Moreover, primary care capacity varies substantially across Michigan. The state's 2020 Primary Care Needs Assessment[10] looked at 54 selected key measures in four composite areas: (i) data availability, (ii) shortage designation coordination, (iii) Michigan Department of Health and Human Services (MDHHS) health priorities, and (iv) national comparison and disparity. The assessment identified the areas of greatest need in Michigan as Wayne (urban), Clare (rural), Genesee (urban), Gladwin (rural), and Arenac (rural) counties. The counties with the best outcomes were Livingston (urban), Ottawa (urban), Washtenaw (urban), Leelanau (rural), and Oakland (urban).
- **Inadequate Investment in Primary Care:** There is ample, reliable evidence that, over time, primary care improves population health and improves affordability. Research demonstrates that areas with higher ratios of primary care physicians per capita have lower healthcare costs and better health outcomes.[11] Studies of the total U.S. adult population have found improved outcomes and lower costs with increased supply of primary care physicians.[12, 13]

Primary Care Needs Assessment

Overall Rank

Low Score (Best Outcomes)

High Score (Worst Outcomes)

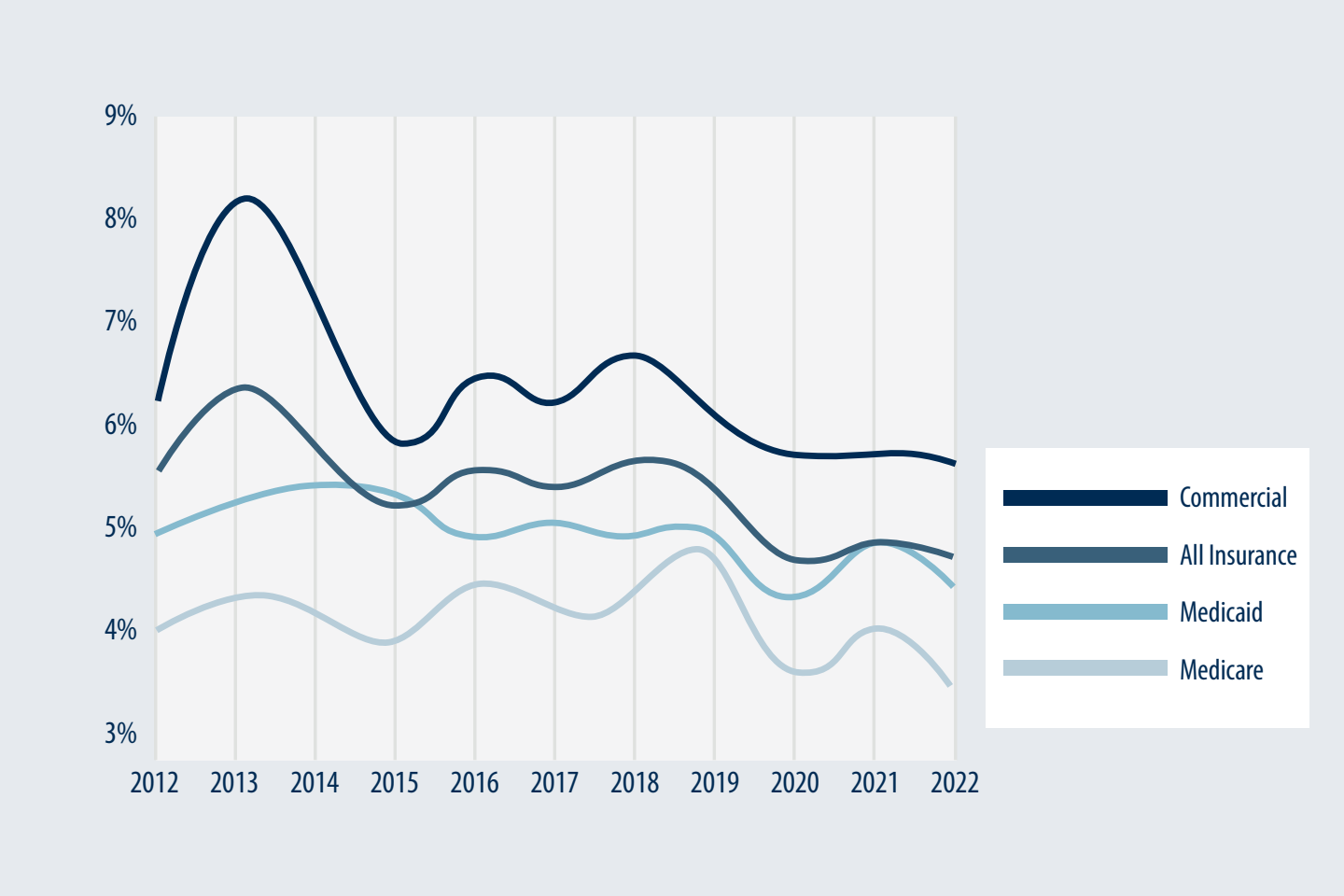


Data Source: Michigan 2020 Primary Care Needs Assessment.

Note: *Ordinal ranking system, which does not imply significant differences, Rates/ Data that did not meet standards of reliability or precision due to small sample size were not included in the overall ranking.*

Paradoxically, in Michigan and nationally, though primary care is desirable, we spend the least on it of any component of medical spending. Nationally, more than half (50.3%) of all office visits and 35% of visits overall[14] are made to primary care physicians.[15] However, the share of the healthcare dollar that goes to primary care services is estimated at only 5%, as shown in the graph below.

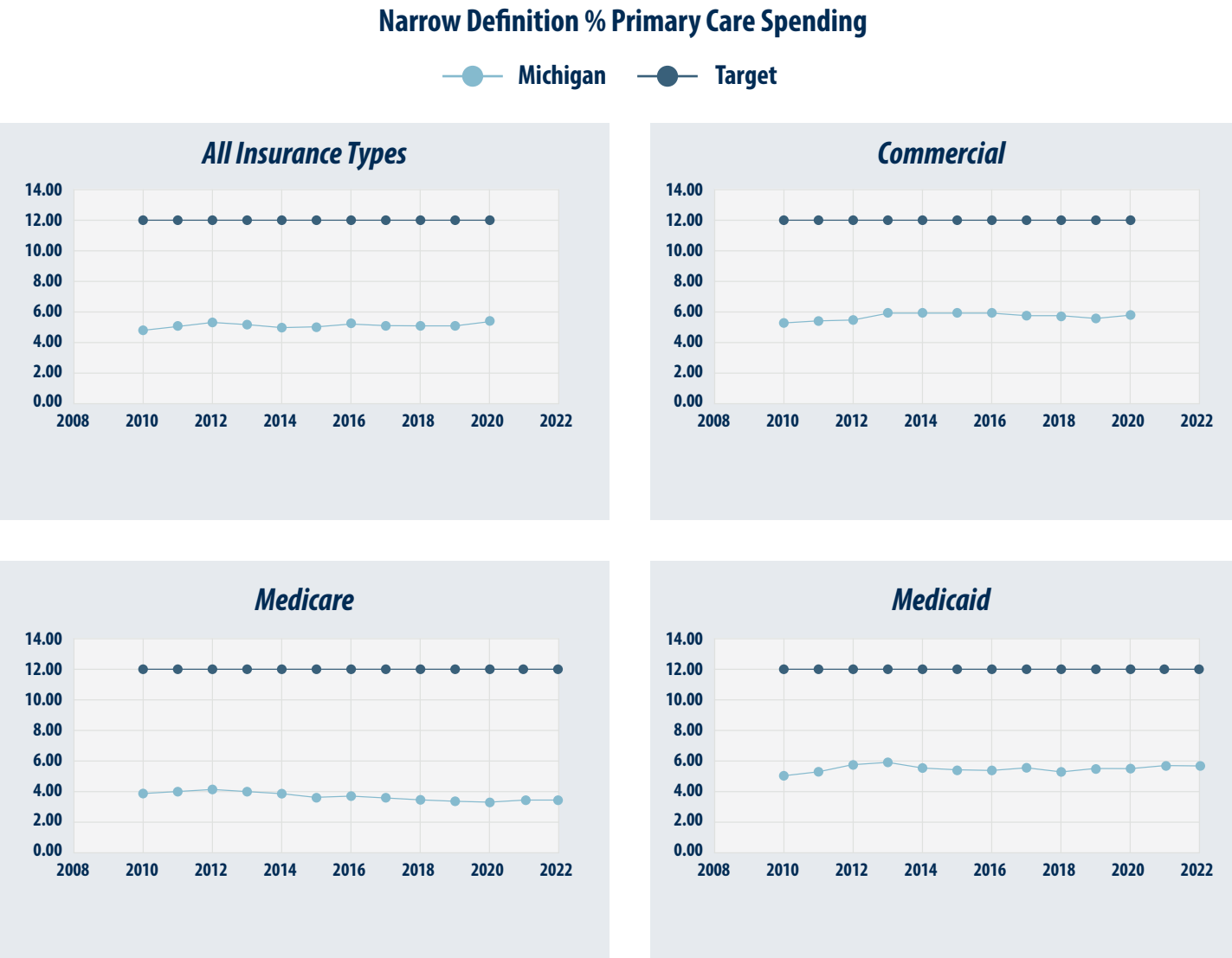
Primary Care Spending (Narrow Definition), 2012-2022



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012-2022.

Note: *The primary care narrow definition is restricted to primary care physicians only. Primary care specialties include family medicine, general practices internal medicine, geriatrics, pediatrics and osteopathy.*

Researchers studying the percentage of spending going to primary care (i.e., office-based expenditures for primary care physicians (PCPs) defined as general practitioners, family physicians, general internists, geriatricians, and general pediatricians) for each state estimate that in Michigan, the share of dollars spent on primary care is 5% overall, 5.8% for commercial payers, 4.2% for Medicaid, and 3.8% for Medicare.[16] All percentages are a far cry from the 12-15% that experts say is required for robust primary care. Even at a 12% target level, the gap between actual spending and a sustainable level of resourcing is substantial.



Source: Y. Jabbarpour, The Health of US Primary Care: 2025 Scorecard, February 18, 2025

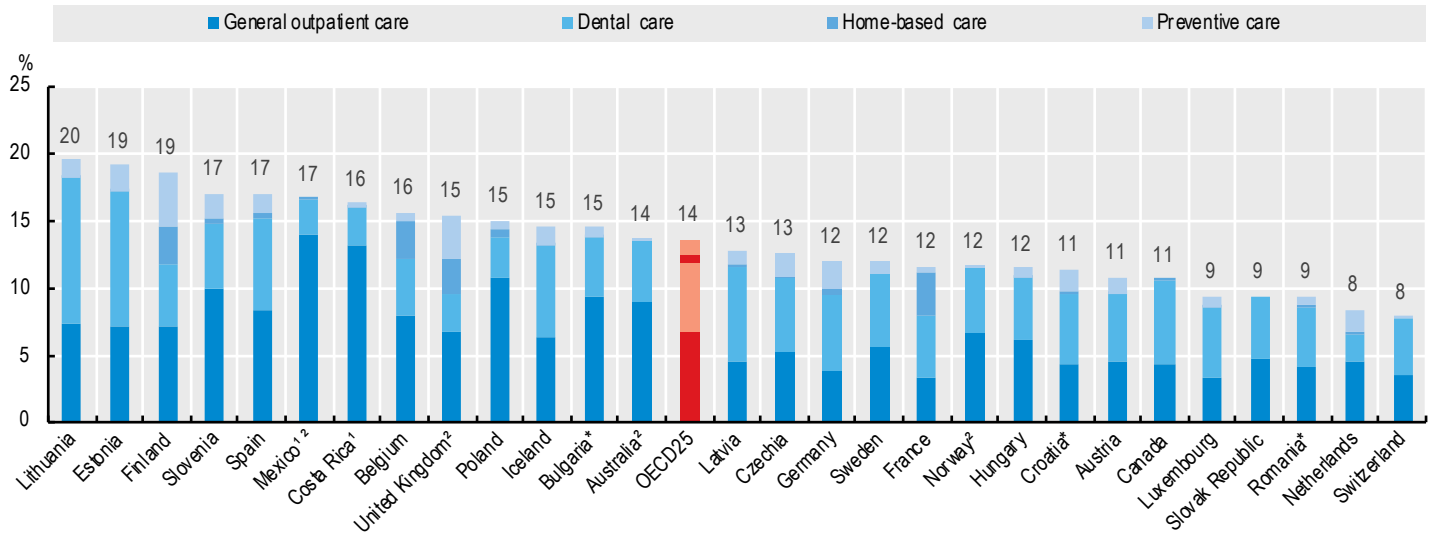
Note: *Narrow Definition = Office-based expenditures for primary care physicians (PCPs) defined as general practitioners, family physicians, general internists, geriatricians, and general pediatricians.*

In Michigan, there are too few primary care physicians, they are paid too little, and they are burdened with considerable administrative requirements. Payers are struggling with losses, and strategies that once worked for them are now outdated. Patients are frustrated by a lack of access. All stakeholders are eager for change.

Primary care is the foundation of the healthcare system, and Michigan's structures are failing it. There are very good reasons to reexamine the state's current approach and modify it to support the success of primary care.

In other developed countries with lower healthcare spending and better outcomes, as shown below, a larger share (14% on average) of the healthcare dollar is spent on primary care.

Spending on Primary Healthcare Services as a Share of Current Health Expenditure, 2023 (or nearest year)



Note: *1. Spending on general outpatient care can include pharmaceuticals. 2. 2022 data. *Accession/partner country.*

Source: OECD Health Statistics 2025

Desired State: A System of Integrated Whole-Person, Coordinated, Patient-Centered Care for Michiganders

The subcommittee embraced the Implementing High Quality Primary Care report[17] authored by the National Academy of Sciences, Engineering, and Medicine (NASEM) and its desired model of integrated, whole-person health delivered by an interprofessional team that partners with patients. In this model, the primary care physician serves as the "quarterback," coordinating care with specialists, hospitals, etc., and supporting patients in lifestyle changes, disease prevention, and self-management.

The model has been extensively studied, and the workforce necessary to deliver it has been quantified. Using a combination of practice-level data from 73 practices and eight site visits, researchers have determined that, to provide high-quality primary care to 10,000 adults, a primary care practice needed about 37 full-time team members, including six physicians and two nurse practitioners (NPs) or physician assistants (PAs), supported by a mix of nurses, medical assistants, and registered nurses (RNs) and licensed clinical social workers to help manage those with more complex chronic needs.[18] Other team members, such as a pharmacist, care coordinator, and office staff, were also included. For a 10,000-person panel with a larger proportion of geriatric individuals, the authors modeled a larger team with about 52 members, more devoted to complex care management. For a 10,000-person panel with high social needs, the team included about 50 members, but relatively fewer physicians compared to the other models, and with additional members, such as community health workers (CHWs), behavioral health, and other social supports. The model for a smaller, rural panel of 5,000 included about 22 full-time team members, including a CHW.[19]

The population of Michigan in 2025 is estimated at 10.14 million.[20] Using the above model would require Michigan's healthcare system to have 6,084 primary care physicians working with an interdisciplinary team that practiced at the top of their licenses.

This offers some hope that, with reasonable, rational reform, an improved primary care experience is within reach for the people of Michigan.

Recommendations

As noted, the NASEM Implementing High-Quality Primary Care report[21] served as the guiding document for the subcommittee's recommendations. The subcommittee took care to formulate recommendations that were actionable and cost-neutral so that they would have the greatest opportunity to improve the health of Michigan's population.

The overarching goal of greater investment in primary care is to solidify the foundation of care delivery so that the people of Michigan have increased access to care, greater focus on prevention of chronic illness, strengthened relationships and more time with physicians and other health team members, and healthy outcomes.

Recommendations are grouped into four sets, addressing: (i) increasing primary care investment in Michigan, (ii) reducing administrative burden systemwide, (iii) medical education and training, and (iv) improving physician recruitment and retention.

Increasing Investment in Primary Care

Recommendation 1:

Pass a legislative primary care spending target in Michigan of total medical expenditures, so primary care physicians can employ care teams comprised of RN Care Managers, advanced practice providers (NPs/PAs), community health workers, and other health care team members as appropriate for the practice panel.

Primary care is overlooked as a lever to obtain better value for our health care dollars. It is the underpinning of a high-quality healthcare system and the first point of contact for many patients. Still, Michigan has chronically underfunded it and has overburdened it with excessive administrative expectations. As established earlier in this report, spending more on primary care, with its focus on prevention and chronic disease, keeps people healthier and reduces the need for costly treatment down the road.[22]

Many other states are already making progress toward increasing dollars for primary care. By joining the Center for Medicare and Medicaid Innovation's (CMMI) Achieving Healthcare Efficiency through Accountable Design (AHEAD) model, participating hospitals and primary care providers in Maryland, Connecticut, Hawaii, Vermont, Rhode Island, and New York have committed to increased primary care investment and accountability targets for total cost of care.

In addition to federal action in the AHEAD model, a growing number of states have taken steps to increase their own primary care investment. Seven states across the political spectrum have passed legislation or taken executive action to increase spending on primary care as a share of total medical costs, sometimes paired with affordability or health-cost growth containment efforts.

The seven states with primary care spending targets are:

- **California:** The California Office of Health Care Affordability has set a goal of increasing primary care investment to 15% of overall medical spending by 2034.[23] Their expectation is that spending on primary care as a share of total medical expenses increases each year in the interim by .5 to 1%. Though directionally constructive, the goal is not enforceable and requires voluntary cooperation from health plans. In addition, the state's Medicaid program, Medi-Cal, increased primary care provider rates to 87.5% of Medicare rates, effective January 1, 2024.
- **Delaware:** Delaware has set a primary care target of 11.5% of total medical spending by 2025 for private insurers and a requirement to match Medicare reimbursement rates for primary care.[24] However, a recent Delaware Primary Care Reform Collaborative strategic plan report[25] expressed concern about the extent to which Medicaid and commercial payers are meeting their expectations.

- **Oregon:** Oregon requires both Medicaid Coordinated Care Organizations (CCOs) and the state plans to spend at least 12% of total medical expenditures on primary care. The state also has public-facing dashboards (see Appendix 1) that have demonstrated success in reaching its targets. Its 2023 report showed a commercial plan average spend of 13.3% of total medical expenditures. The Oregon report cards show not only primary care spending as a percent of total spending by plan type, but also the extent of non-claims spending on primary care and primary care spending by plan. Oregon also has a cost growth target program that sets a 3.4% cost growth target for most payers. The overall cost growth targets ensure that increased investment in primary care will not be inflationary.
- **Oklahoma:** SB 563 requires reporting of the percentage of health care expenses by each contracted entity on primary care services, with 11% devoted to primary care, no later than the fourth year of a contract with the Medicaid program.
- **Rhode Island:** Rhode Island was the first state to establish a target requirement for commercial insurers to invest at least 10.7% of their total medical expenses in primary care. The state requires corrective action plans with an enforcement mechanism to motivate improvement. The state has reached the target, though the definition of primary care spending used was quite broad and included indirect spending to support the state's health information exchange. The state has now narrowed the definition of primary care spending to a 10% target level.[26]
- **Washington:** SB 5589 charges the state's Health Care Cost Transparency Board with measuring and reporting on primary care expenditures and progress toward increasing primary care spending to 12% of total healthcare expenditures.
- **Connecticut:** Executive Order No. 5, issued in 2020, requires progressively increasing spending on primary care to reach a target of 10% by 2025. So far, however, the state has not met its primary care spending target, though the 2025 report has not yet been published.

There are several lessons to be drawn from states with primary care expenditure targets. First, it is vital to motivate progress toward targets by including consequences for failure to reach them. Second, the addition of an overall total medical expenditure cost growth target can help to achieve budget neutrality for increases in primary care investment. And finally, primary care spending should be defined to reflect payments to primary care providers.

Given the experience in other states, the subcommittee recommends that Michigan establish a 12% primary care target over four years, using the narrow definition of primary care spending as defined by the Milbank Fund's Primary Care Scorecard research.[27] As noted previously, the narrow definition includes office-based expenditures for PCPs defined as general practitioners, family physicians, general internists, geriatricians, and general pediatricians. Twelve percent of the US national average per person spending amount of $14,570[28] equates to $1,748 per person per year or $145.66 per month. Given existing levels of primary care spending, it should take Michigan four years using a 2% annual incremental increase target to reach the 12% target level.

In achieving a 12% primary care spending target, employers, labor groups, trusts, and other purchasers are essential stakeholders. State legislation applies only to fully insured products, not to self-insured, ERISA-exempt products. However, self-insured groups and trusts should voluntarily replicate these provisions in their self-insured coverage designs (e.g., require that 12% of total medical spending be for primary care).

Recommendation 2:
All payers (Medicaid, commercial, etc.) should transition their primary care payment models to a hybrid primary care payment model.

In addition to paying primary care a larger share of total medical spending, NASEM's Implementing High-Quality Primary Care report[29] calls for payers to pay for primary care differently. They urge moving away from the fee-for-service system and toward hybrid payment models for primary care. This is because the fee-for-service structure, even when paired with retrospective incentives and uplifts, is poorly equipped to fund primary care teams so they are available to care for a panel of patients. At the other extreme of payment methods, sub capitation for primary care may impose greater risk than many practices can bear.

The primary care hybrid payment method combines three elements. The first is a prospective, population-based, risk-adjusted payment to provide practices with the resources to operationalize robust care management and population health. The second portion covers face-to-face (whether in-person or virtual) visits on either a per-member-per-month (PMPM) basis or on a per-visit basis. A third incentive-based portion motivates person-centered, value-based outcomes and performance, ensuring that the

model delivers benefits to patients and value for the health care dollars invested. This incentive-based portion should be developed in partnership with health plans through multipayer and state collaboration, so that providers are not additionally burdened by varying requirements across plans. See Appendix 1 for an example of how payers and other stakeholders in Oregon developed a common metric set.

The prospectively paid portion could be enhanced for practices that deliver advanced primary care management to their patient panel. This improved model should leverage the Center for Medicaid and Medicaid Services' (CMS) Advanced Primary Care Management (APCM) risk-adjusted bundles (G0056-G0058) that resource practices prospectively and with low administrative burden. These code sets employ simplified billing and do not require time-based tracking.

The codes cover a range of advanced primary care management services, including:

- Principal care management (PCM) – disease-specific services to help manage a patient's care for a single, complex chronic condition that puts them at risk of hospitalization, physical or cognitive decline, or death
- Transitional care management (TCM)
- Chronic care management (CCM)
- Communication technology-based services, including virtual check-ins, remote evaluations of pre-recorded patient information, and interprofessional consultations.

Imposing patient financial liability for care management and non-face-to-face services creates a barrier to patient engagement. Thus, the prospective portion of primary care hybrid payment should be free of patient cost-sharing.

A growing number of payers have already begun implementing hybrid primary care payment models. A multipayer consortium in California (Purchaser Business Group on Health, Integrated Healthcare Association) is implementing a hybrid model with:

- A monthly PMPM (capitated) payment
- Volume-based payment for specific pre-defined services (focusing on preventive care)
- Population health management payment to support practice improvements that will deliver better outcomes, and
- Incentives for strong performance on a standard set of outcome measures.

Blue Shield of California is the largest participating payer in the model and has made their payment model manual public to ease the path for payers in other states to also operationalize primary care hybrid payment.[30] In Michigan, Blue Cross Blue Shield of Michigan has made good progress in using the CMS APCM framework through an APCM uplift, which could serve as a transitional mechanism for implementing a common primary care hybrid payment framework across health plans.

Recommendation 3:

Encourage systems, physician organizations, and similar entities to sign on to a voluntary compact to channel enhanced primary care investment funding to the practice level, ensuring practices can resource teams.

The NASEM report emphasizes the importance of payments reaching practices so they can hire staff and invest in better preparing their practices to provide whole-person, integrated care. When investment in primary care is increased and payment goes to systems or physician organizations affiliated with primary care practices, rather than to the practice itself, absent an express commitment to flow the funding, there is a danger that the funding is diverted and absorbed by the organization. To guard against this, some programs cap the amount that entities can retain for administration and overhead. In the Michigan Primary Care Transformation demonstration, for example, organizations (health systems, physician organizations, etc.) were required to flow down at least 80% of primary care demonstration payments to participating practices and to use no more than 20% for administration and overhead.

Voluntary compacts are another way to encourage increased funding to be passed through to primary care practices. Organizations would thus sign on to the compact and commit to passing along the majority (e.g., at least 80%) of primary care funding to primary care practices. Employers, labor groups, trusts, and other purchasers of care could be valuable allies in communicating this information to their respective members so that they can consider it when they declare a usual source of care.

Easing Administrative Burden

Recommendation 4:

Utilize a common set of quality metrics such as CMS' Universal Foundation across health plans in Michigan.

The cacophony of performance incentive metrics among payers confuses providers. It makes it difficult for them to determine which metrics to use, as their panels include patients with coverage from many different health plans. For this reason, states and business coalitions often use common measure sets. One example is the Purchaser Business Group on Health's Advanced Primary Care Measure Set (Appendix 2).

The noise in the system caused by the multitude of quality metrics has been recognized as a problem by CMS as well. They have created The Universal Foundation,[31] a set of high-priority quality measures that they have begun to deploy across CMS programs. Importantly, CMS has also indicated that it will prioritize these for digitization. The Universal Foundation is comprised of a streamlined set of adult measures and a set of child measures as follows:

Universal Foundation Adult Measures

Domain	Measure Identification Number and Name
Wellness and Prevention	139: Colorectal cancer screening 93: Breast cancer screening 26: Adult immunization status
Chronic Conditions	167: Controlling high blood pressure 204: Hemoglobin A1c poor control (>9%)
Behavorial Health	672: Screening for depression and follow-up plan 394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)

Universal Foundation Child Measures

Domain	Measure Identification Number and Name
Wellness and Prevention	761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits) 124 and 363: Immunization (childhood immunization status; immunizations for adolescents) 760: Weight assessment and counseling for nutrition and physical activity for children and adolescents 897: Oral evaluation, dental services
Chronic Conditions	80: Asthma medication ratio (reflects appropriate medication management of asthma)
Behavorial Health	672: Screening for depression and follow-up plan 268: Follow-up after hospitalization for mental illness 264: Follow-up after emergency department visit for substance use 743: Use of first-line psychosocial care for children and adolescents on antipsychotics 271: Follow-up care for children prescribed attention deficit-hyperactivity disorder medicine
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)

Recommendation 5:

All payers should agree upon and use a common attribution methodology, which should emphasize voluntary attribution across all product lines that honors a member's choice of primary care provider.

Integrated, whole-person, patient-centered care requires that patients have access to a responsive primary care practice. Health plans often use attribution methodologies that prioritize the practitioner who performs the majority of evaluation and management codes for a patient as the attributed provider, who receives per-member payments.

The methodologies vary from one health plan to another. Health plans should agree on a common attribution methodology and use it for payment and accountability measures, as recommended by NASEM.

The common attribution method should prioritize the member's choice of a care provider. Members across coverage types should be allowed to declare their preference and to renew this election annually. Methodology-based attribution using historical data would be reserved for members who choose not to declare a usual source of care.

The business of practicing medicine has become increasingly complicated and costly. The growing administrative burdens, coupled with declining reimbursement and rising operational expenses, has led to a sharp decline in the number of physicians entering or remaining in private practice. In response, there has been a significant shift toward health system employment, venture-capital-backed practices, and direct primary care models. While these evolving structures may achieve some goals of delivering high-quality, cost-effective care, they often operate under missions and incentives that diverge from the patient-centered principles outlined in the NASEM report on primary care reform. Ensuring that operational efficiency supports, not undermines, the foundational values of continuity, equity, and comprehensiveness in care will be essential to achieving a sustainable future for primary care.

Recommendation 6:

Explore the creation of a public benefit corporation to serve as a hub to ease the administrative burden experienced by primary care physician practices.

Many of the barriers that discourage physicians from entering or remaining in primary care stem not from clinical challenges, but from the administrative complexities of running a medical practice. Services such as human resources, revenue cycle management, accounting, compliance oversight, facilities management, contracting, and quality reporting all contribute to the administrative burden physicians face.

To reduce the burden of entry into primary care and the complexity of operating a practice for independent providers, a public benefit corporation could be explored to leverage economies of scale at cost. By offloading administrative tasks, practice operations could better align with the goal of delivering high-quality, low-cost care, and more time would be available to focus on patient care. The utilization of such a mechanism would be voluntary.

This kind of organization would enable individual physicians, Physician Organizations, and small groups to purchase operational support at fair market value. Examples of such services might include shared billing infrastructure, credentialing support, electronic health record (EHR) optimization, human resource and payroll systems, patient scheduling and communication platforms, and assistance with payer negotiations and value-based care contracting. For smaller or rural practices, a public benefit corporation could also provide access to group purchasing for medical supplies, malpractice insurance, and continuing education programs. The demand for these services could be systematically assessed through survey studies of independent physicians, currently employed clinicians, residents, and medical students. These studies would help identify which operational supports are most valued and the perceived gaps in existing resources.

Recommendation 7:

Work with payors and the state to fund targeted financial and technical assistance for small, independent, and rural practices to help them adopt technology that streamlines operational and clinical tasks, including incentives for interoperable solutions that seamlessly integrate with existing EHRs to reduce duplicative data entry and minimize workflow disruptions.

The thoughtful integration of technology into medical practice has become essential for improving patient outcomes and reducing the administrative workload that contributes to physician burnout. Advances in population health management, clinical decision support, and data-driven quality-improvement tools enable physicians to deliver more proactive, coordinated, and efficient care. When designed and implemented effectively, these technologies transform the way practices operate—helping clinicians focus on what matters most: their patients.

A growing body of evidence supports the effectiveness of these tools. In a 2025 analysis,[32] researchers reviewed seven studies on risk-stratification tools in primary care. They found consistent reductions in emergency visits and hospitalizations, with several studies also showing lower mortality rates. These outcomes were achieved when technology-enabled risk identification was coupled with proactive interventions, such as early follow-up, care coordination, and remote monitoring. Platforms that can combine robust risk stratification with actionable workflows, demonstrate how digital tools can guide physicians toward timely interventions, improving both patient outcomes and system efficiency. Although cost savings varied across studies, the overall trend points to better utilization and measurable population health impact when data insights are translated into clinical action.

Similarly, patient registry-based tools have shown significant promise in improving the quality of care and adherence to clinical guidelines. A 2017 analysis reviewed 17 registry studies and found that 16 of them demonstrated improvements in care quality, guideline compliance, and in several cases, patient survival or reduced complication rates.[33] The key to success, the authors noted, lies in active, feedback-driven patient registries, those that engage clinicians with real-time performance data and peer comparisons—rather than passive data repositories that offer little practical insight. By closing the feedback loop between data collection and clinical practice, such technologies help physicians make evidence-informed decisions while maintaining accountability and professional growth.

Beyond measurable outcomes, technology can also alleviate one of the most pressing challenges in healthcare today: clinician burnout. A large-scale survey of 4,257 primary care clinicians within the U.S. Veterans Health Administration in 2018 revealed a strong association between the use of population health management tools and lower burnout rates.[34] In fact, higher importance ratings for nine of 10 tools were linked to significantly reduced odds of high burnout. These findings underscore how well-designed digital systems can reduce cognitive load, streamline administrative tasks, and restore a sense of control and purpose in physicians' daily work.

Collectively, these studies highlight a critical truth: technology, when thoughtfully integrated into medical practice, does not replace the human touch—it enhances it. By simplifying data management, enabling proactive care, and reducing administrative friction, digital tools empower physicians to spend more time building relationships with their patients, improving outcomes, and sustaining their own professional well-being.

Recommendation 8:

Adopt uniform policies that support transparency, independent validation, and continuous auditing of clinical AI tools, ensuring they are safe, effective, and trustworthy for use in medical practice.

The integration of artificial intelligence (AI) into medical practice operations will be necessary to achieve the next level of efficiency and sustainability in primary care. Properly implemented, AI can streamline a wide range of administrative and clinical processes, from automating prior authorizations and managing appointment scheduling to assisting with documentation and clinical decision

support. For example, AI-enabled scribe tools can significantly reduce time spent on EHR documentation, allowing physicians to focus more directly on patient interaction. Predictive analytics can identify patients at high risk for hospitalization or non-adherence, enabling proactive outreach and better chronic disease management. Similarly, AI-supported revenue cycle tools can optimize claims processing and identify billing errors in real time, improving cash flow and reducing staff workload.

Given the rapid expansion of AI applications in healthcare, rigorous vetting of available tools and services is essential. Oversight should occur at the organizational level through established professional associations such as the American Academy of Family Physicians (AAFP), American Medical Association (AMA), American Osteopathic Association (AOA), Michigan Osteopathic Association (MOA), and Michigan State Medical Society (MSMS), and major insurers like Blue Cross Blue Shield of Michigan. These organizations are well-positioned to evaluate technologies for clinical validity, security, bias mitigation, and interoperability. By coordinating evaluation and approval processes, they can help prevent fragmentation, duplication, and inconsistent practice standards across care settings.

Ultimately, the goal of AI integration should not be automation for its own sake, but the advancement of care models that are more efficient, equitable, and sustainable. When properly vetted and deployed, AI can serve as a force multiplier for overextended primary care practices, reducing cognitive load, optimizing operations, and improving both physician well-being and patient experience.

Medical Education and Training

Recommendation 9:
Encourage students from communities of need through the development of pre-medical apprentice programs and early educational pathways to medicine.

Michigan is fortunate to have seven medical schools[35] – six allopathic and one osteopathic – graduating approximately 1,300 students annually. Collectively, Michigan's 2025 White Coat Ceremonies welcomed 1,260 new medical students comprising the class of 2029.

Although more than half of these students are from Michigan, a study by the National Center for the Analysis of Healthcare Data at Virginia Tech found that only 42% of the graduating medical students will remain in the state to continue their training.[36] This makes Michigan one of the largest U.S. exporters of medical students to other states.

Of the 12,718 residents who completed a residency program in Michigan from 2014 through 2023, 55.6% (7,076) are currently practicing in Michigan. For the class of 2025, the medical schools reported the number of their students matching into primary care for their residencies as follows:

- Central Michigan University College of Medicine — 74%
- Michigan State University College of Human Medicine — 38.9%
- Michigan State University College of Osteopathic Medicine — 37%
- Oakland University William Beaumont School of Medicine — 42%
- University of Michigan Medical School — 38%
- Wayne State School of Medicine — 31.1%
- Western Michigan Homer Stryker M.D. School of Medicine — 41%

Studies have shown success in physicians returning to areas in which they grew up to practice medicine when they have a connection to and support from those communities. The Association of American Medical Colleges (AAMC) reports that "medical students who grow up in small communities far from urban centers are much more likely to return to them to practice..."[37] Additionally, the findings from a study of a statewide, county-based rural pipeline program in Alabama showed that the greater the involvement by a county in supporting prospective medical students in this program, the more likely they were to see an increase in the number of family medicine physicians and other health care providers returning to their home counties.[38]

Several communities have developed programs that encourage adolescents to consider medical careers early in their educational journeys. For example, the University of Illinois Chicago (UIC) offers several programs designed to provide awareness, education, and support to students interested in exploring healthcare career opportunities. Below are some of the programs:

- **Early Outreach Program (EOP)** – This program, offered through the UIC Urban Health Program, provides a pre-college academic pathway for students who are economically and educationally disadvantaged, introducing them to the medical and health sciences professions.[39] EOP goals are as follows:
  - » To help program participants succeed academically and socially in any grade level,
  - » To provide academic and technological resources and services to the global community through academic enrichment,
  - » To promote responsible academic inquiry, digital citizenship, critical thinking, and the expression of diversity, and
  - » To serve the families and students by fostering an appreciation of literacy development, literacy activism and lifelong learning.
- **Prep for Health Careers High School Academy** – The Academy offers programs for high school juniors and seniors from historically marginalized communities who have an interest in health careers and is held at the University of Illinois' Chicago, Peoria, and Rockford campuses. These programs include college prep, financial literacy, health career exploration, and interactive public health and health advocacy projects.[40]
- **Medicina Academy Apprentice Program** – This pre-medical apprentice program is designed to provide Latino high school students with pathways to explore and prepare for professions in the medical field. It is a pre-college initiative through the UIC College of Medicine Hispanic Center of Excellence.[41]

In Michigan, the HOSA program (MI HOSA) includes a Future Health Professionals initiative that equips students with the knowledge and skills needed to pursue a healthcare career. Students can participate in extracurricular activities and competitive events to develop critical leadership, technical, and communication skills. According to MI HOSA, over the past 25+ years, they have grown "to serve just over 7,950 students in the 2024-2025 school year."

Recommendation 10:
Develop and fund community-based, primary care-focused special pathways to encourage graduating residents to return to their communities or remain in similar ones.

Some medical schools are offering programs with special primary care pathways. The theory is that "when students who are interested in primary care are separated from the rest of the medical school class and are taught by faculty who are especially passionate about the field, they are not exposed to an unofficial negative attitude and are not dissuaded from choosing primary care. In addition, students who participate in a special pathway have an opportunity to receive more exposure to, and to develop a deeper understanding of, the field."[42] Two such programs with reported success are as follows:

- **Jefferson Medical College in Pennsylvania**[43] — Since 1974, the College has offered its Physician Shortage Area Program (PSAP). Applicants who have grown up or spent a substantial part of their lives in rural areas are recruited to the program. Successful applicants must also be competitive medical school candidates who have a desire to return to a similar community to practice. Mentorship with an advisor and a second-year medical student is a key component of the program, as is training in a rural or small-town setting. According to outcomes published in the New England Journal of Medicine and the Journal of the American Medical Association, and on their website, PSAP graduates: (i) are more than eight times as likely as their peers to become rural family physicians, and (ii) have a retention rate of 79% after 11–16 years in practice.
- **Mercer University School of Medicine in Georgia**[44] — The medical school was founded with the explicit goal of educating "physicians and health professionals to meet the primary care and health care needs of rural medically underserved areas of Georgia." They report that "more than 60 percent of graduates currently practice in the state of Georgia, and of those, more than 80 percent are practicing in rural or medically underserved areas of Georgia."

The success of programs that emphasize the recruitment of individuals from communities of need and training experiences in those areas is also acknowledged in a 2020 Australian meta-analysis. The analysis sought to identify factors predicting return to practice in rural areas by combining data from 24 studies across different countries. The findings show that not only are physicians from rural backgrounds more than twice as likely to practice in small towns than their urban counterparts, but also that medical students who trained in rural areas were almost twice as likely to practice in rural areas, regardless of whether they grew up in a small town.[45]

Recommendation 11:

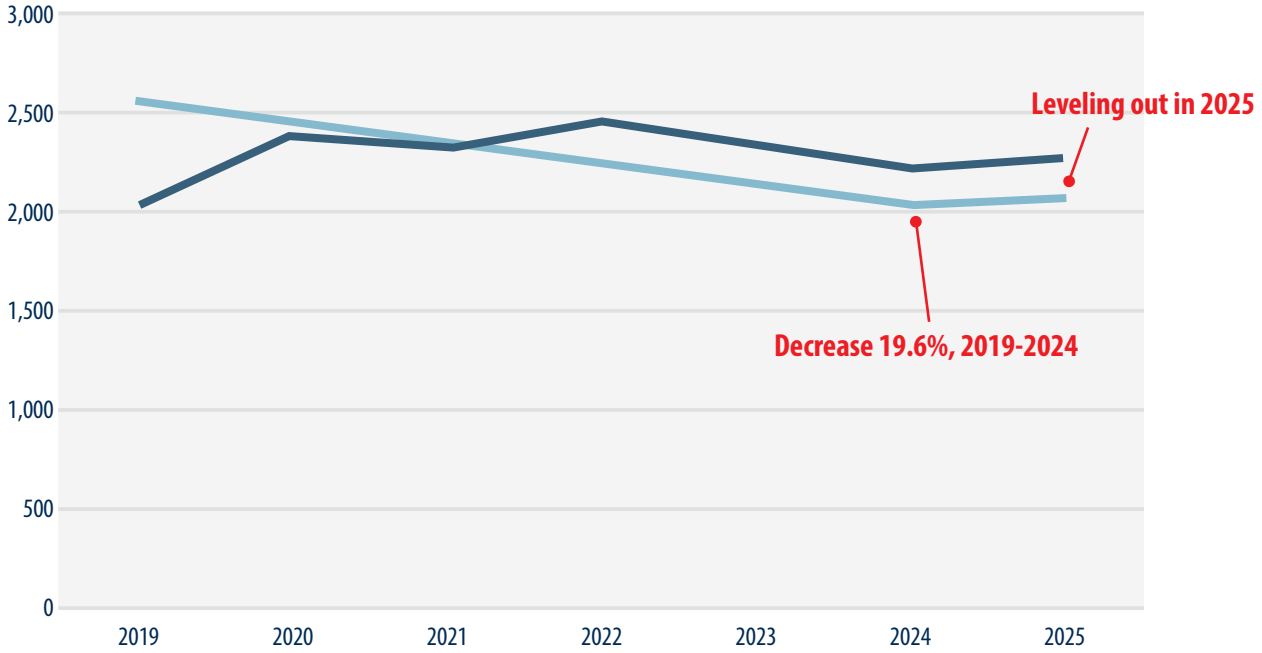
Increase the proportion of medical school graduates who choose a primary care specialty by encouraging medical schools to develop focused curricula and/or targeted pathways that provide 65–70% of cognitive and procedural care in a team-based model, as well as internal policies designed to change attitudes and negative bias toward primary care to encourage the brightest and best students into primary care.

During medical school, students will be exposed to practice in various settings and specialties. This is intended to provide comprehensive training to prepare medical students for their residencies, selection of their specialty fields, and equip them with basic skills to care for patients. Studies have shown the unofficial culture of the school and attitudes of the faculty and physicians in non-primary care specialties can influence whether some students choose to pursue a career in primary care. By the fourth year of medical school, negative feedback and derogatory comments are commonplace. As a result, the number of students applying to primary care residencies is significantly reduced. Information below from the American Academy of Family Physicians (AAFP) shows the downward trend in applicants to Family Medicine, as well as the number of students who were interested in family medicine who experienced some form of disrespect.

Fewer applicants are applying to Family Medicine 2019-2025

Applicants to Family Medicine Residencies for 2019-2025 Match Seasons - US MD and DO Only

As of December 9 each year

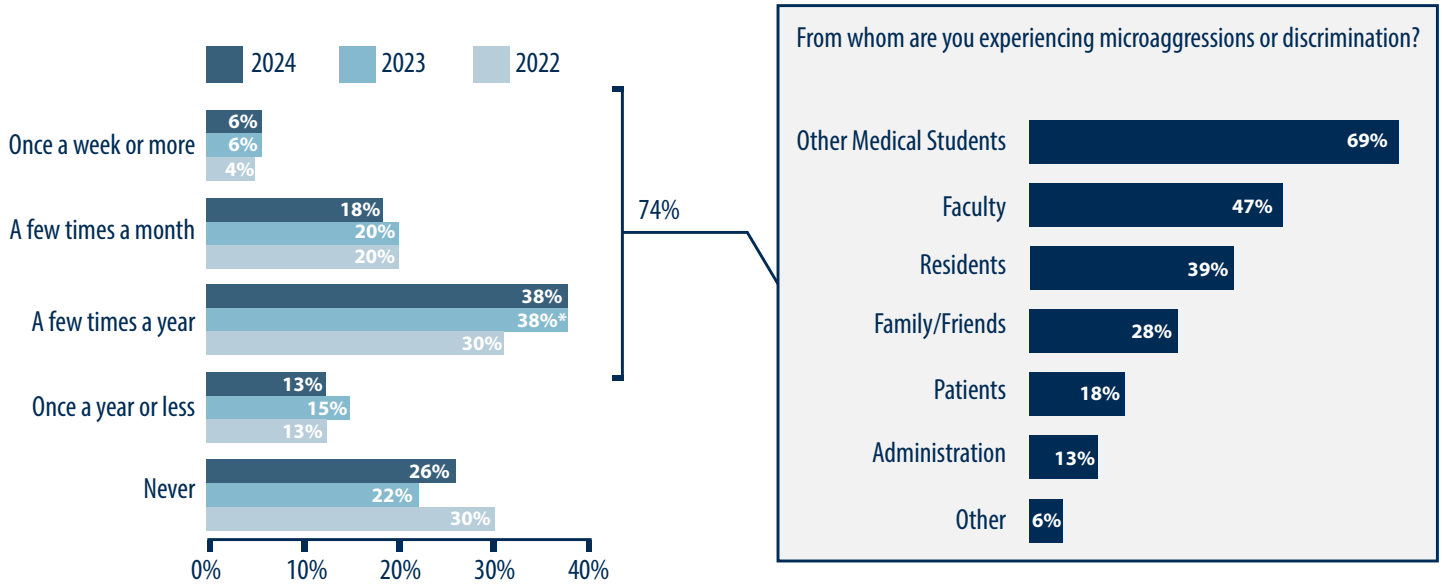


	2019	2020	2021	2022	2023	2024	2025
DO	2,030	2,377	2,321	2,442	2,338	2,218	2,265
MD	2,537	2,466	2,344	2,232	2,114	2,041	2,061

Data from ERAS - Electronic Residency Application System

FM-Interested Students More Likely to be Disrespected

Frequency for students who selected FM as their top choice



Q. Family medicine is my top choice of specialty - *How often have you experienced microaggressions or discrimination in medical school based on your specialty preference? (n=702) From whom are you experiencing microaggressions or discrimination related to your specialty preference? Mark all that apply (n=521) *Significantly different from the previous year's values at the p<.05. Note: Verbatims are located in the appendix file.*

There are efforts underway to reverse this trend. The AAFP, through its Four Pillars for Primary Care Physician Workforce Development, is strategically focused on addressing the primary care workforce pipeline, the medical education process, practice transformation, and payment reform to grow the primary care workforce and provide patients with access to quality, sustainable team-based care.[46] (See Appendix 3) These pillars emphasize:

- Encouraging interest in primary care practice by exposing students from a young age to high-quality primary care practices and then providing support to those who choose a pathway to medicine (e.g., mentoring programs throughout medical school and residency).
- Ensuring excellence in training, reducing bias and negative talk against primary care, and providing experience at diverse training sites, including rural areas.
- Training medical students in the Patient-Centered Medical Home model of care, which embraces interprofessional practice teams and the medical neighborhood of other specialists and health professionals as the gold standard of care.
- Addressing the need for fair and appropriate reimbursement by closing the gap in primary care/specialty care payment with a focus on value-based payment.

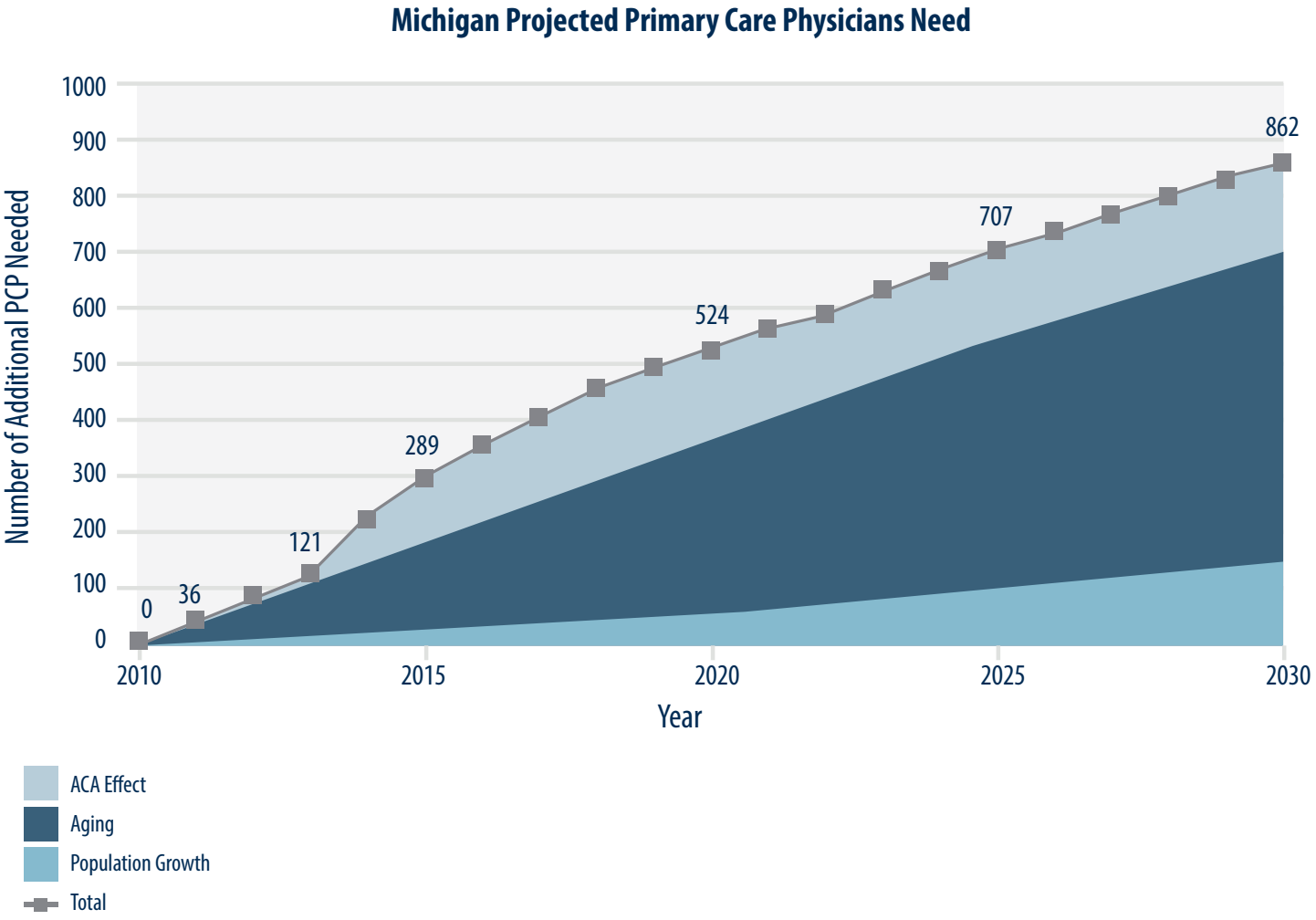
The AAFP also created the Family Medicine Champions program designed to promote and support family medicine careers.

Physician Recruitment and Retention

Recommendation 12:
Leverage physician organizations (POs) to strengthen the physician workforce pathway by establishing residency and fellowship partnerships within PO-affiliated practices; work with POs to identify geographic and specialty shortages using claims and workforce data, and deploy targeted recruitment strategies such as incentives and loan repayment programs to encourage physicians to practice in high-need rural and underserved areas.

Although Michigan's seven medical schools welcome about 1,300 students each year, only 56% of physicians trained in Michigan in 2014 were practicing in our state in 2023.[47] This contrasts with California's 78% retention rate of physicians trained there. Not only are we losing physicians trained in Michigan to other states, but the physician workforce that chooses to practice here is also aging. Nationally, 20% of physicians are aged 65 or older, and 22% are between 55 and 64 years of age.[48]

In Michigan and nationally, the problem is more severe in primary care. Researchers at the Robert Graham Center[49] estimate that, under the traditional model of care, Michigan will be short 862 primary care physicians by 2030.



Michigan's established PO infrastructure provides a unique opportunity to support the development of a robust primary care workforce, particularly in high-need areas such as rural and underserved communities. By leveraging existing operational capabilities, data analytics, and collaborative networks, POs can serve as platforms for innovative workforce pipeline programs that both attract new physicians and retain existing providers.

One approach is to establish residency and fellowship partnerships with PO-affiliated practices. For example, POs can coordinate clinical rotations for medical students and residents in primary care practices that already have care management infrastructure, quality reporting systems, and patient-centered workflows. This exposure helps trainees gain firsthand experience in high-functioning, team-based care settings while understanding the operational support available to independent practices. Programs could be designed to rotate residents through rural or underserved clinics, with mentorship from experienced primary care physicians, enhancing both clinical skills and a commitment to community-focused care.

POs can also facilitate mentorship and professional development programs that target early-career physicians and medical students. Experienced clinicians within the PO network can provide guidance on practice management, care coordination, patient engagement, and navigating value-based payment models. In addition, structured mentorship around work-life balance, financial planning, and career advancement can address factors that commonly contribute to physician burnout, making primary care a more attractive long-term career choice.

Another strategy is to use the PO infrastructure to identify and address geographic and specialty shortages. By analyzing claims data, utilization patterns, and workforce distribution, POs can target recruitment efforts where the need is greatest. Incentives, loan repayment programs, or shared service support—coordinated through the PO network—can be deployed to encourage placement in high-need areas. For example, a PO could offer centralized revenue cycle support, shared staffing, or technology resources to reduce the operational burden for a new physician entering a rural practice.

Recommendation 13:

Establish new funding sources to expand loan repayment and establish student incentive scholarship programs, such as:

- Increase funding to MIDOCS to enable the program to expand annually.
- Amend the statute regulating the Michigan Health Endowment Fund to add the primary care workforce as a priority focus, in addition to children and seniors. Allow for funds to be used to develop targeted loan repayment and/or practice establishment pilot programs for physicians who commit to practice in rural, medically underserved areas for seven years.
- Encourage health plans, insurers, and businesses to leverage their respective foundations to invest in establishing and maintaining scholarship programs that support pathways to residency for graduating high school seniors.

According to the AAMC, the median debt for the class of 2024 was $205,000, and the median cost of attendance over four years ranged from $286,454 (public school) to $390,848 (private school).[50] In Michigan, all of the medical schools except the Western Michigan University Homer Stryker M.D. School of Medicine are public. While the cost varies by medical school, in-state tuition ranges from $34,300 to $68,400 and out-of-state tuition ranges from $61,838 to $79,694.[51] This debt can be a heavy burden, especially when the average starting salary for residents is $63,800.[52] Therefore, earning potential is often a factor in selecting a specialty.

Other factors that contribute to the selection of specialties other than primary care include non-supportive and even hostile medical school attitudes toward primary care, a lack of information or role models exemplifying how to be successful in primary care practice, and perceptions that such practice is not prestigious or intellectual enough. In addition to proper remuneration and

improved operational efficiency in practice, fundamental changes in the recruitment and training of primary care physicians are needed to attract and deliver high-quality, cost-effective care in Michigan. Through continued innovation, the state is uniquely positioned to achieve physician workforce adequacy with a strong primary care foundation.

Michigan is fortunate to have four homegrown programs that are designed to encourage medical school graduates to stay and practice in the state. Two of the programs provide a financial incentive if the eligible resident or physician agrees to practice for a period in a medically underserved area.

MIDOCs is a state- and federally-funded program expanding graduate medical education residency positions in select specialties to recruit and retain physicians in underserved areas of Michigan. The MIDOCs program was developed in partnership with four medical schools: Central Michigan University College of Medicine, Michigan State University College of Human Medicine, Wayne State University School of Medicine, and Western Michigan University Homer Stryker M.D. School of Medicine. Funding is a combination of federal, state, and university dollars. MIDOCs residencies may feature a variety of enhanced curricular elements in areas such as ambulatory care, quality improvement, population health, interprofessional collaboration, and care of diverse and underserved populations.

Physicians matched to a MIDOCs residency agree to work in a medically underserved area of Michigan for two years post-residency. The program also offers a loan repayment award. Pre-2025 cohorts receive a $75,000 loan repayment. In 2024, MIDOCS secured additional appropriations to cover a greater share of training costs, so that academic year 2025 residents will receive $150,000. Although the fiscal year 2026 state budget removed one-time MIDOCS funding from FY 2025, the MIDOCS board voted to continue loan repayment at $150,000 for future cohorts. The impact will likely be smaller cohorts; however, with the increasing cost of medical school, a larger loan repayment amount was deemed necessary to continue engaging future residents.

The Michigan State Loan Repayment Program (MSLRP) is a state-federal partnership that recruits and retains medical, dental, and mental healthcare providers in underserved communities. Selected applicants can receive up to $300,000 in tax-free loan repayment over 10 years. In return, they are required to complete consecutive two-year service obligations. To fulfill the service obligation, the participant must provide full-time (at least 40 hours/week) primary care services at an eligible nonprofit site in a designated Health Professional Shortage Area (HPSA). There is also an employer match component.[53]

To incentivize participants practicing in specialties for which severe shortages have been identified, the following targeted loan repayment programs have been established:[54]

- **Michigan Opioid Treatment Access Loan Repayment Program (MIOTA-LRP):** This program provides loan repayment to physicians and other providers who offer or expand opioid addiction treatment services. Settlements with pharmaceutical companies fund this program.
- **Behavioral Health Loan Repayment Program (BHLRP):** This program is designed to incentivize behavioral health providers, including psychiatrists, to work in underserved areas. It offers up to $300,000 in loan repayment over 10 years for a two-year service obligation.

Several states have explored creative ways to help medical students cover medical school tuition through scholarships. These scholarships are then repaid with a service obligation for a specified number of years, typically in a medically underserved area. For example, the Vermont Legislature created a program that allows a specified number of third- and fourth-year medical students at the University of Vermont College of Medicine to receive a scholarship based on the in-state tuition rate (an anticipated award of $40,000 for the 2026-2027 academic year).

In addition to the fundamental systemic changes discussed earlier in this Call to Action, activities to directly attract and retain physicians to long-term primary care practice in Michigan can be employed.

Recommendation 14:
Provide financial incentives to encourage primary care physicians to practice in underserved areas in community-based settings.

Other state-level efforts have focused on attracting physicians to establish practices, often in a rural or other medically underserved areas. For instance, Indiana has passed the Physician Practice Ownership Tax Credit, available to primary care physicians who acquire ownership interests in certain practices that begin providing primary care services after December 31, 2023. Eligible primary care physicians are permitted a credit of $20,000 per year for three years beginning with the first taxable year in or after which the entity is established and also bills for primary care services at least six months during the taxable year.[55] In Missouri, certain primary care physicians are able to apply for a grant award of up to $200,000 in return for residing and practicing primary care in a Missouri rural county for a continuous five-year period. The availability of funding is subject to appropriations and there is a priority tiering system in the awarding of grants.[56]

Michigan could also adopt policies to enable and encourage communities to offer financial incentives to recruit physician practices through direct financial assistance and subsidies such as signing bonuses and loan repayment, reduced-cost office space or housing, malpractice insurance coverage, and income guarantees for private practice income.

It is also important to acknowledge that Michigan physicians contribute significantly to the state's economy by spurring economic growth, creating jobs, buying local goods and services, and paying state and local taxes. A 2018 AMA study on the economic impact of Michigan physicians reports the average economic output generated by each physician to be $2.2 million. Direct and indirect wages and benefits were estimated to be $24.8 billion. An investment in the recruitment and retention of physicians is an investment in Michigan's economy.

Conclusion: A Time for Action

Michigan's healthcare system stands at a crossroads. The evidence presented in this report makes clear that the challenges facing the physician workforce—particularly in primary care—are not isolated or temporary. They are structural, cumulative, and consequential. Left unaddressed, these challenges will continue to erode access to care, worsen health outcomes, accelerate clinician burnout, and drive costs higher for patients, employers, and the state.

Yet this report also makes clear that Michigan is not without options. The recommendations put forward by the Subcommittee on Physician Workforce Needs are grounded in evidence, informed by national best practices, and designed to be actionable and fiscally responsible. They recognize that high-quality primary care is not an optional enhancement to the state's healthcare system—it is its foundation. When primary care is adequately resourced, administrative burden is reduced, training pathways are aligned with community needs, and physicians are supported to practice at the top of their licenses, the entire system functions more effectively.

Importantly, these recommendations do not call for wholesale reinvention. Rather, they call for intentional alignment: aligning payment with value, policy with evidence, and investment with outcomes that matter to patients and communities. Other states have demonstrated that this alignment is possible. Michigan can do the same—while honoring its unique healthcare landscape and workforce needs.

The cost of inaction is no longer theoretical. Each year of delay deepens workforce shortages, widens disparities, and increases avoidable spending. Conversely, timely and coordinated action offers Michigan a path toward a more stable physician workforce, improved population health, and a more sustainable healthcare system.

The time to act is now. Strengthening primary care is not merely a workforce strategy—it is a commitment to the health, equity, and economic vitality of Michigan's future.

Appendix 1: Oregon Primary Care Scorecards

Key Takeaways: Oregon primary care spending in 2023

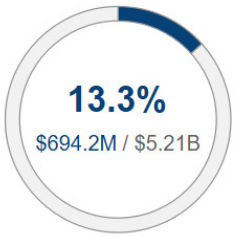
Single line of business

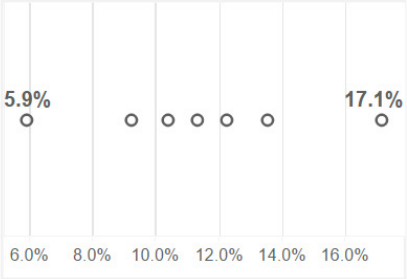
In 2023, **primary care spending** by commercial plans averaged 13.3% of total medical spending.

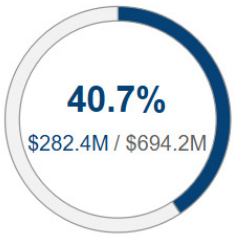
In 2023, total medical spending allocated to primary care by commercial plans ranged from 5.9% to 17.1%.

In 2023, 40.7% of primary care spending by commercial plans was **non-claims spending**.

Select line of business: Commercial

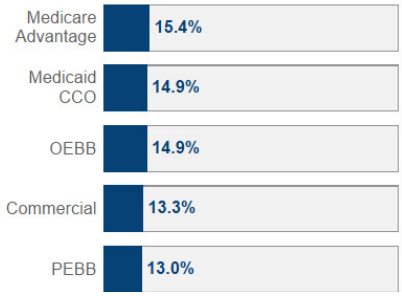




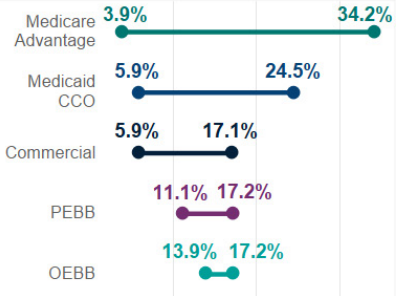


All lines of business

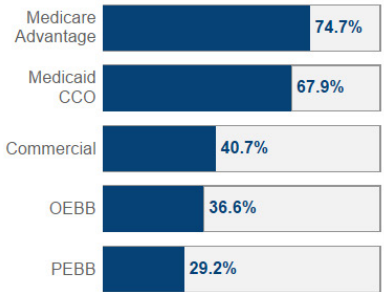
Primary care spending as a percent of total medical spending by line of business



Range of percent of total medical spending allocated to primary care by line of business



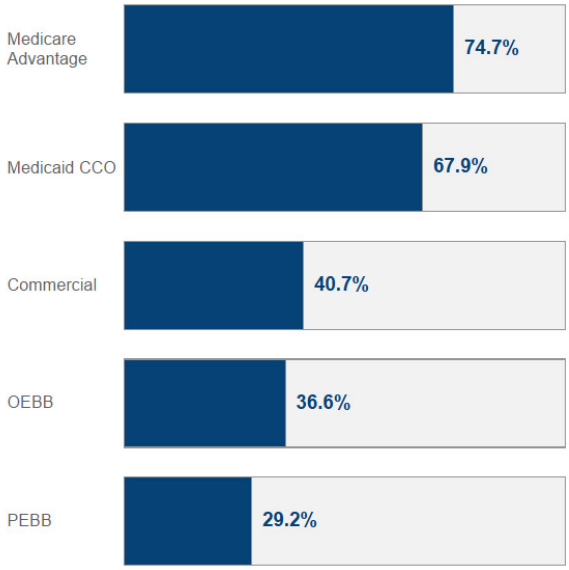
Non-claims spending as a percent of total primary care spending by line of business



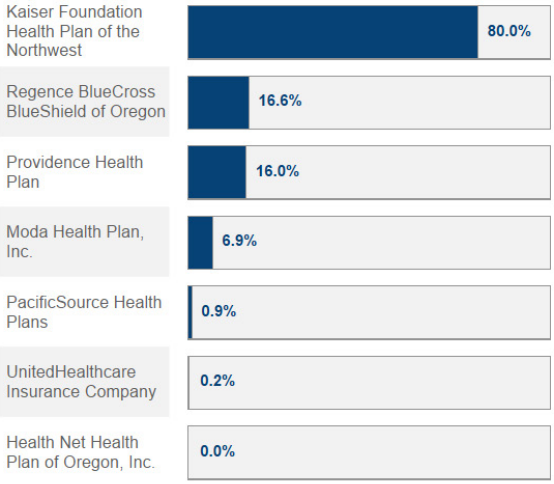
Non-Claims Spending - 2023

Non-claims primary care spending as a percent of primary care spending

Non-claims and **claims** spending as a percent of total primary care spending by plan, 2023



Non-claims and **claims** spending as a percent of total primary care spending by line of business, 2023



View data as:
- (●) Percent of total spend
- ( ) Spending in dollars

Select line of business: Commercial

Select plan: All

Primary Care Spending - 2023

Select line of business:
Commercial

Select plan:
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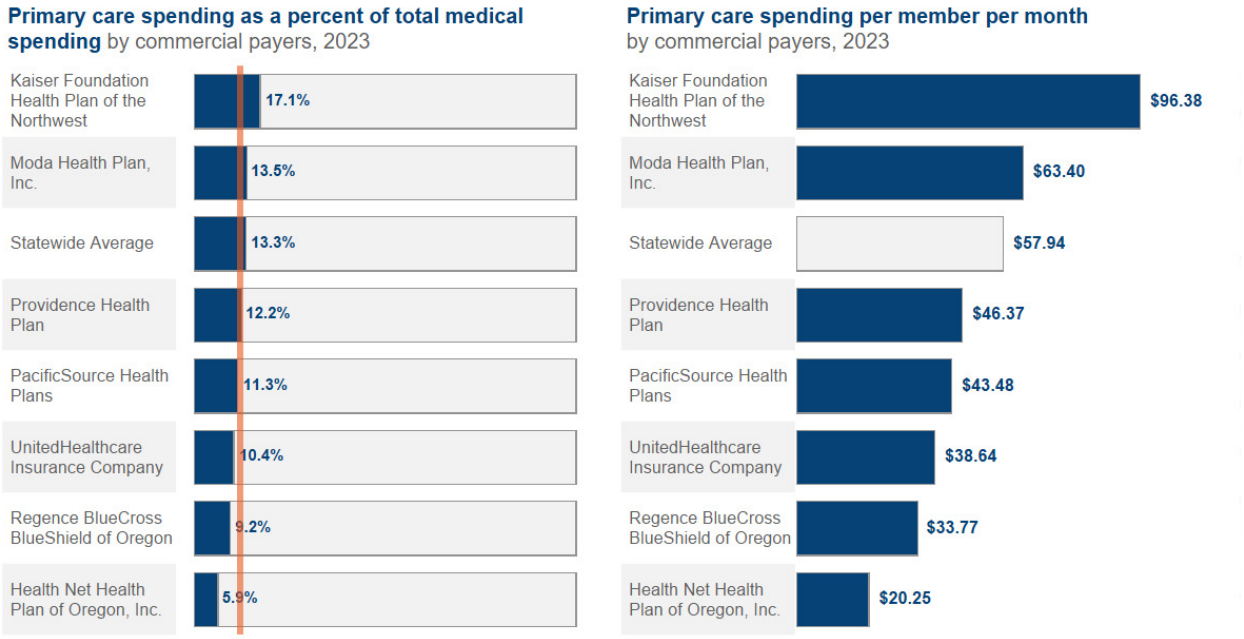


Updated 9/2025

Appendix 2: Purchaser Business Group on Health 2025 Advanced Primary Care Measure Set[57]

Measure Set: Alignment with Attributes

The Purchaser Business Group on Health's (PBGH) California Quality Collaborative (CQC) has articulated attributes of advanced primary care, which result in high quality, high value primary care with patients at the center of every interaction.

To help identify practices having implemented these attributes, CQC, the Integrated Healthcare Association and stakeholders defined a measure set focused on patient health outcomes and experience of care.

Quality Domain	Measure	NQF ID	Population	Attributes of Advanced Primary Care: Person & Family Centered	High Value	Team Based & Collaborative	Accessible	Coordinated & Integrated
Health Outcomes & Prevention	Asthma Medication Ratio (AMR)	1800	Pediatric/ Adult			●		●
	Breast Cancer Screening (BCS-E)	2372	Adult	●		●		●
	Childhood Immunization Status Combo 10 (CIS-E)*	0038	Pediatric	●		●		●
	Colorectal Cancer Screening (COL-E)*	0034	Adult	●		●		●
	Controlling High Blood Pressure (CBP)*	0018	Adult			●		●
	Glycemic Status Assessment (GSD) HbA1c Poor Control (>9%)*	0059	Adult			●		●
	Glycemic Status Assessment (GSD) HbA1c (<8%)*	0575	Adult			●		●
	Immunizations for Adolescents (Combo 2) (IMA-E)	1407	Pediatric	●		●		●
Patient Reported Outcomes	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	–	Pediatric/ Adult	●	●	●	●	●
	Depression Remission or Response for Adolescents and Adults (DRR-E)**	–	Pediatric/ Adult	●	●	●	●	●
Patient Safety	New measures are being considered							
Patient Experience	Patient Experience (CG-CAHPS)	0005	Pediatric/ Adult	●		●	●	●
High Value Care	Emergency Department Visits	–	Pediatric/ Adult		●		●	●
	Inpatient/Acute Hospital Utilization	–	Pediatric/ Adult		●		●	●
	Total Cost of Care	1604	Pediatric/ Adult		●			

* Priority measures for stratification across race, ethnicity and other variables by Covered California and/or the National Committee for Quality Assurance (NCQA).
** A phased approach will be used for organizations not currently able to report.

Four Pillars for Primary Care Physician Workforce Development

An expanded primary care physician workforce is necessary to meet our country's population health needs and to address the priorities of better access, better health, a better care experience, and reduced costs. These Four Pillars provide consistent language to improve communication and advocacy about the need for increased numbers of well-trained primary care physicians.

Pipeline

Efforts need to be focused on identifying, recruiting and retaining students and residents into primary care throughout the continuum of training. Activities should:

- Expose elementary, high school and college students to high-quality primary care practices and physician role models
- Develop more holistic medical school admissions processes, and enhance participation of primary care physicians on admission committees, to identify students who are more inclined toward primary care (e.g., those with more service-orientation and those from rural and low-income families)
- Enhance outreach and mentoring programs designed to sustain interest in primary care throughout medical school and residency

Process of Medical Education

All levels of medical, residency and fellowship education should model excellence in training physicians who practice evidence-based, compassionate and comprehensive primary care. This includes the traditional concerns of curriculum and educational research, as well as:

- Appropriate exposure to excellent and inspiring role models throughout the continuum of medical school and residency
- Systemic efforts to respond to the "hidden curiculum," including bias and "trash talk" about specialty choice
- Integration with Interdisciplinary Professional Education
- A diversity of sites with community clinicians outside of the AHC, incluing rural offices and CHCs

Practice Transformation

The Patient-Centered Medical Home (PCMH) model of care provides the framework for primary care practices in the future. Learners must be exposed to practices that deliver this desirable and sustainable model of patient-centered care:

- Practice teams must include generalist physician leaders who serve as role models and who deliver comprehensive, broadscope primary care
- Learners are part of interprofessional practice teams
- Continuity of care is maintained throughout multiple delivery settings (ambulatory, inpatient, extended care, etc.)
- Population-based care is enhanced and supported by system changes to reinforce the "medical neighborhood" of colleagues and consultants

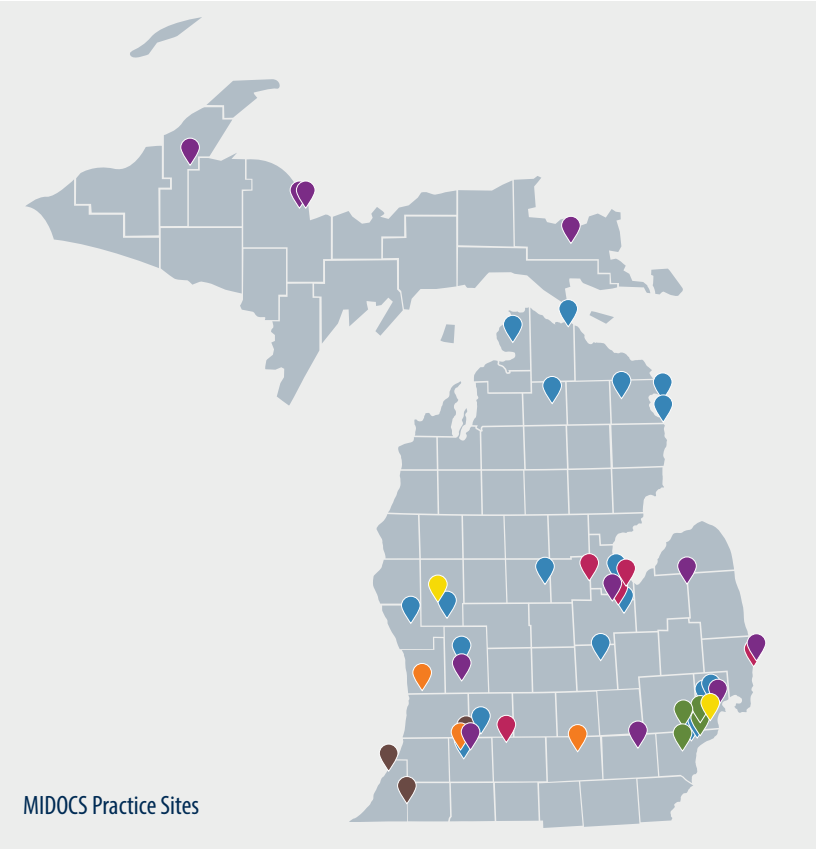
Payment Reform

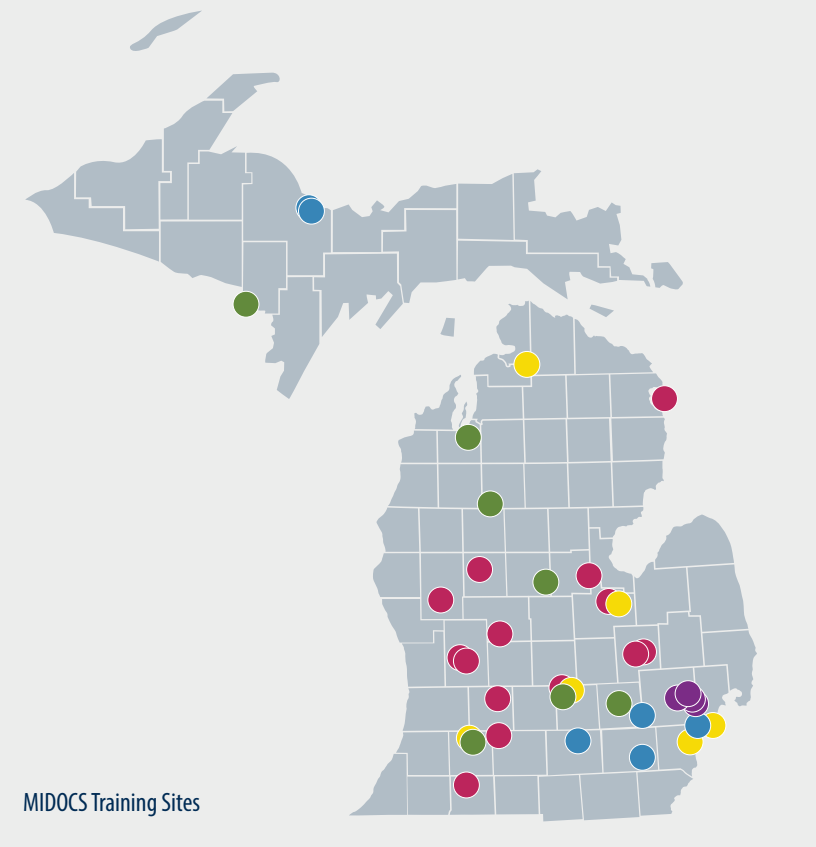
National advocacy must continue to address the need for approximate reimbursement of primary care practice as well as primary care medical education. Activities should target ways to:

- Address student debt, which differentially impacts specialties
- Close the gap in primary care/specialty care payment
- Transition from volume-based payment to value-based payment
- Reform graduate medical education to allow payments to non-hospital educational entities, support appropriate, additional primary care ambulatory training, and cover actual costs of training in the community

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs developing a sustained partnership with patients, and practicing in the context of family and community. (OM definition)

Developed by the Family Medicine Organizations (9/13/13)





Source: MIDOCS

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