

Access to Behavioral Health Care in Michigan

Results for the Medicaid-Enrolled Population | July 2019

Summary of Key Findings

- ▲ Hundreds of thousands of Medicaid-enrolled Michiganders experience mental illness, but only about half receive treatment. Of the 481,000 Medicaid enrollees in Michigan experiencing a mental illness, 51% receive treatment, leaving 236,000 people with unmet need.
- ▲ The majority of Medicaid-enrolled Michiganders with a substance use disorder go untreated. Of 148,000 Medicaid enrollees in Michigan with a substance use disorder, only 31% receive treatment, leaving 102,000 individuals untreated.
- ▲ *Anxiety disorders* and *depressive episode* are the most common mental health diagnoses, and those that are the most likely to go untreated.
- ▲ *Alcohol use disorder* is the primary substance use disorder among Medicaid enrollees in Michigan. Both *alcohol use disorder* and *cannabis use disorder* have very high unmet needs, with around 80% of individuals with these disorders going untreated.
- ▲ Barriers to behavioral health care access include shortages of providers, costs of care, and reluctance to seek care.
- ▲ Behavioral health provider capacity is low in the northern half of the lower peninsula and parts of the upper peninsula; seven counties in these areas have neither a psychiatrist nor a psychologist and no substance use disorder treatment facility.
- ▲ Geographic variations in access to care are evident. If all Michigan could achieve the rates of care seen in best access areas of the state, another 57,000 people with a mental illness and 27,000 people with a substance use disorder would receive care.
- ▲ Through research and expert input, we identify 15 strategies to improve access to behavioral health care in Michigan, with emphasis on:
 - 1) Increasing retention of behavioral health providers in Michigan;
 - 2) Removing restrictions on scope of practice to fully leverage all members of the health care team;
 - 3) Promoting effective use of trained lay providers such as Peer Support Specialists and Recovery Coaches;
 - 4) Using telemedicine to extend the reach of the behavioral health workforce;
 - 5) Expanding school-based behavioral health care; and
 - 6) Integrating primary care and behavioral health care delivery.

The Michigan Health Endowment Fund contracted with Altarum to study access to behavioral health care in Michigan. This document presents study findings for the Medicaid population. Please see our companion briefs for summaries of findings for the Medicare population, the privately insured population, and the total Michigan population. Study methods are documented in more detail in the accompanying full-length final report.

MICHIGAN HEALTH ENDOWMENT FUND

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Background & Approach

This study provides a comprehensive assessment of access to mental health and substance use disorder (SUD) treatment in Michigan. It identifies current challenges and provides a baseline against which progress can be tracked.

Behavioral health care in this study includes services to treat mild to moderate mental illness, serious mental illness, SUD, and co-occurring mental health and SUD conditions. Intellectual or developmental disabilities are outside the scope of the study.

The analysis considers behavioral health care provided in outpatient, intensive outpatient, and residential care settings. We do not focus on inpatient psychiatric care, chronic pain treatment, and medication assisted treatment, as these types of treatment are examined in detail in other studies.

In Michigan, treatment of a limited number of mild to moderate mental health visits are covered by one of the 13 Medicaid Managed Health Plans (MHPs) that cover physical health care. All inpatient care, long-term outpatient or serious mental illness care, and SUD treatment are covered by one of 10 Prepaid Inpatient Health Plans (PIHPs).

We use a complete set of Michigan Medicaid medical claims data to identify enrollees who receive behavioral health services. We estimate the underlying need for care by applying rates of mental illness and SUD by age, sex, and insurance type, with Michigan-specific adjustments, to the Michigan Medicaid population counts. Prevalence rates are from the National Survey on Drug Use and Health (NSDUH) and the National Survey on Children’s Health. Michigan population data by age, sex, insurance status, and location are from the Census Bureau’s American Community Survey.

Our measure of access quantifies the share of those with a behavioral health condition who receive any behavioral health care, compared to the share that remain untreated. It represents a minimum standard for access and does not indicate whether the appropriate type and volume of care was provided.

To inform our technical approach, we conducted a review of the literature on behavioral health prevalence, treatment, and access. We convened a Stakeholder Advisory Board representing health experts, payers, providers, and policy makers in Michigan, who reviewed our approach and findings throughout the duration of the study.

Overall Access to Care

Many Medicaid enrollees in Michigan are not receiving treatment for their behavioral health condition.

Of the nearly 2 million Michiganders covered under the Medicaid program, we estimate 481,000 experience any mental illness (AMI). We find that, despite having coverage, nearly half (49%) of those with AMI, nearly 236,000 people, are not receiving care (Figure 1).

For SUD care, the unmet need is even larger, and most Michiganders with SUD are not receiving care. Of the 148,000 Medicaid beneficiaries experiencing SUD, 69% of them, or 102,000 people, are not receiving care (Figure 2). As we discuss later in this brief, among other barriers, a sizable share of those untreated for SUD may be unwilling or unready to seek care.

Nationally, Michigan ranks in the middle to upper third of U.S. states on composite measures of behavioral health access. For example, Mental Health America ranked Michigan 15th and 18th in recent years on access to mental health care.¹

Figure 1: Unmet Need for Treatment, Medicaid Enrollees with Any Mental Illness

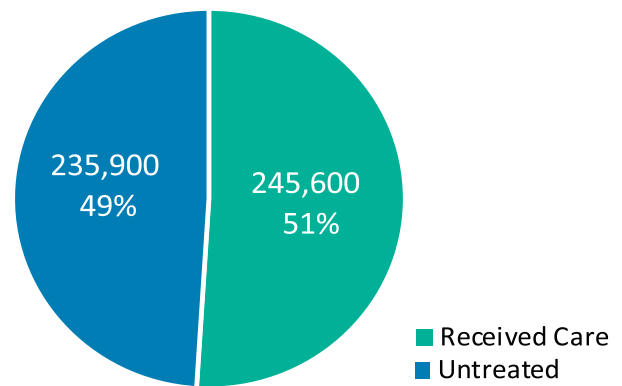
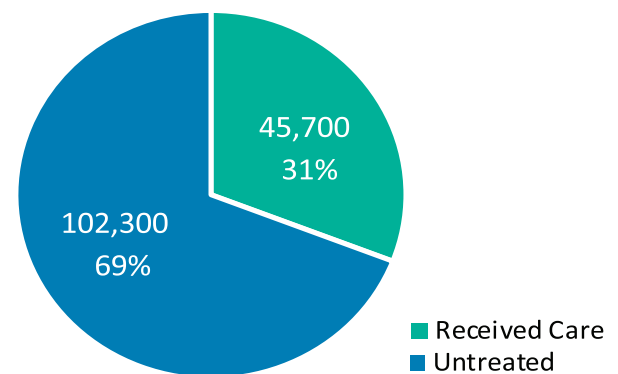


Figure 2: Unmet Need for Treatment, Medicaid Enrollees with Substance Use Disorder





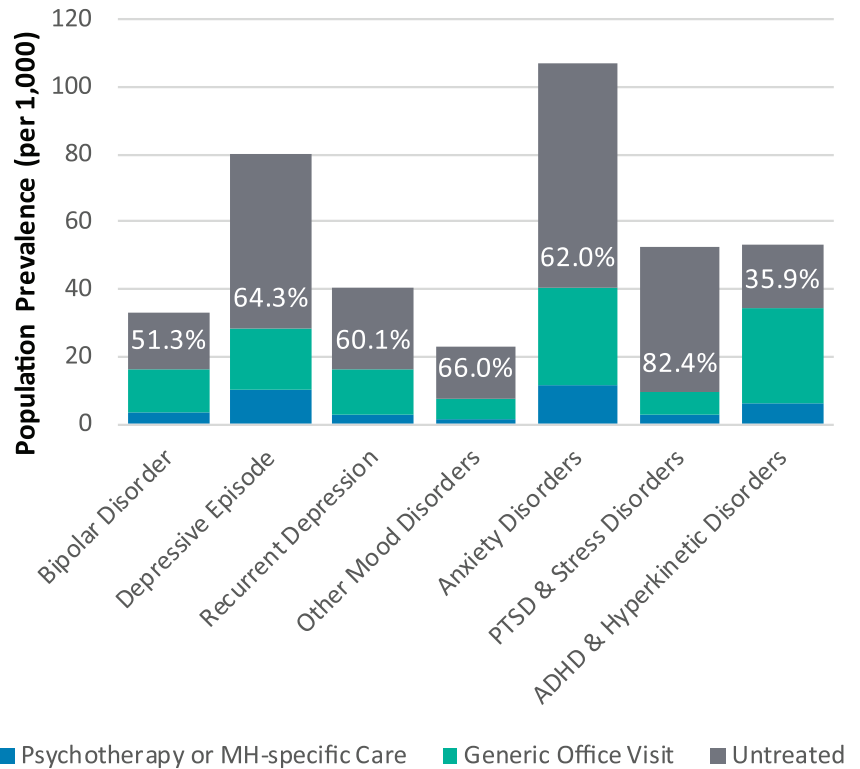
Results by Condition

Common Mental Health Conditions

In Michigan, across all Medicaid enrollees, unmet need was greatest for *post-traumatic and stress disorders*, with 82% of those with this condition remaining untreated (Figure 3). More than 60% of enrollees with *depression*, *anxiety disorders*, or *other mood disorders* were untreated. Those with ADHD and hyperkinetic disorders had the lowest rate of unmet need, at 36% untreated.

For those treated, Figure 3 also distinguishes between members who received at least one psychotherapy visit or specific mental health treatment (shown in blue) versus those who received a general office visit with the primary purpose of treating a mental health condition (shown in green). For all of these mental health conditions, Michigan Medicaid enrollees were more likely to receive care under a general office visit code than a more specific mental health or psychotherapy code. This finding is unique to the Medicaid population in our study.

Figure 3: Prevalence and Unmet Need by Common Mental Illness Conditions, Medicaid Enrollees in Michigan



Source of payment by condition

In Michigan, contracted Managed Care Organizations (MCOs) cover payment for the majority of mild to moderate outpatient mental health care for their enrollees. The remainder of outpatient mental health care for the Medicaid population is covered by one of 10 Prepaid Inpatient Health Plans (PIHPs). Figure 4 shows, for each of the most common mental health conditions, the share of all members with each condition that had a claim paid by a PIHP during the year. The data show that most outpatient claims overall were covered by an MCO; for any mental illness, 22% of members had at least one claim paid by a PIHP and 78% had claims only paid by an MCO. The data also show that, as expected, a larger share of members with more serious conditions such as bipolar disorder (41%) and recurrent depression (40%) had a claim paid by a PIHP.

Figure 4: Percent of Members with a PIHP Paid Claim, by Mental Illness Condition

Condition	Percent with a PIHP Claim	Percent without a PIHP Claim
Any Mental Illness	22%	78%
Bipolar Disorder	41%	59%
Depressive Episode	8%	92%
Recurrent Depression	40%	60%
Other Mood Disorders	29%	71%
Anxiety Disorders	4%	96%
PTSD & Stress Disorders	22%	78%
ADHD & Hyperkinetic Disorders	10%	90%

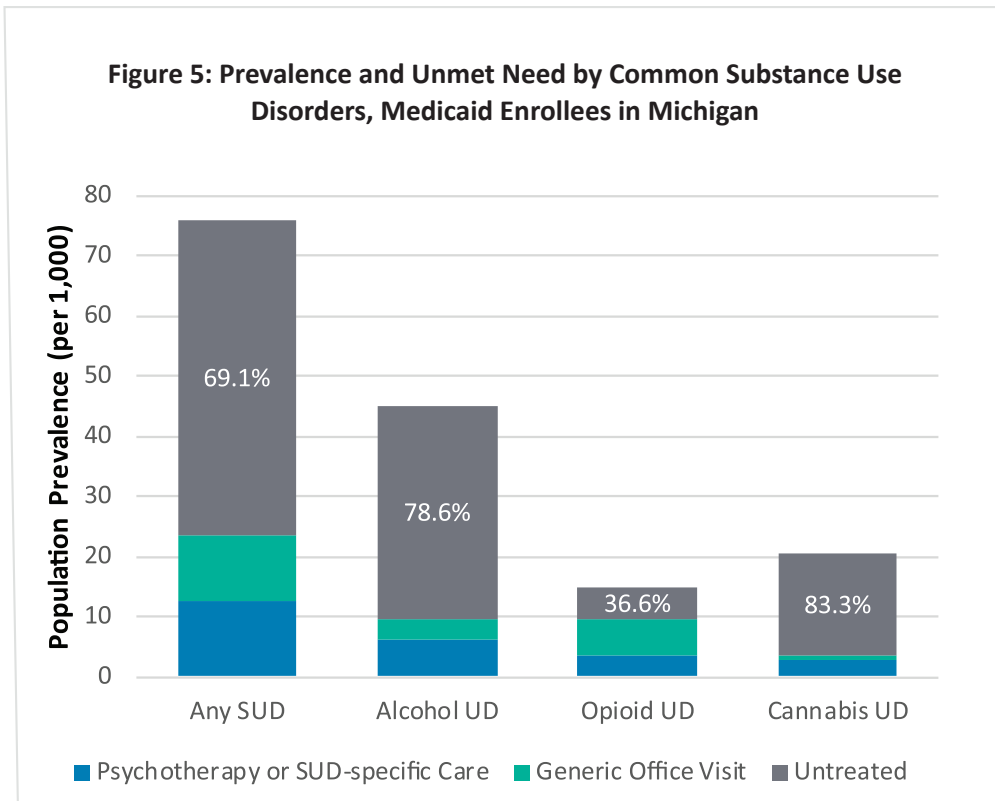
Source: Altarum analysis of 2016 Michigan Medicaid claims data



Common Substance Use Disorders

Figure 5 shows a similar comparison for the three most common SUDs in the Medicaid population. The share untreated for alcohol use disorder and cannabis use disorder is greater than the share untreated for opioid use disorder. The severity of opioid use disorder may be causing individuals to seek treatment at a greater rate, similar to the results seen in the mental illness conditions, where more serious conditions were associated with higher rates of treatment.

Compared to mental health conditions, those who received care for SUD were much less likely to have received care under a generic office visit procedure code. The majority of Medicaid enrollees with a SUD received a service specific to SUD treatment or a psychotherapy visit, with the exception of opioid use disorder care.





Variation by Race

African American/Black and Hispanic Medicaid enrollees have less than two-thirds the expected prevalence of any mental illness of White enrollees. American Indian Medicaid enrollees in Michigan have similar expected prevalence of AMI as Whites. The share of unmet need ranges from 55% for Hispanics to 39% for American Indians under Medicaid.

American Indians in Michigan have the highest prevalence of SUDs, followed by Whites. Hispanics have the lowest prevalence of SUDs. Rates of unmet need are similar across racial and ethnic groups, ranging from 68% to 75%.

Figure 6: Prevalence and Unmet Need by Race for Medicaid Enrollees with Any Mental Illness

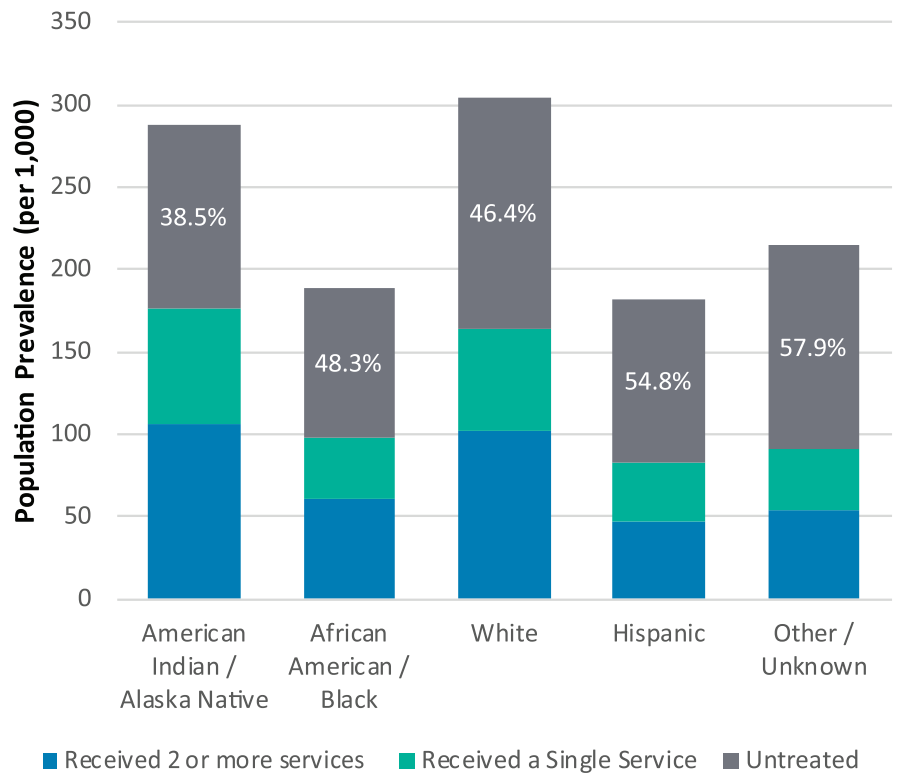
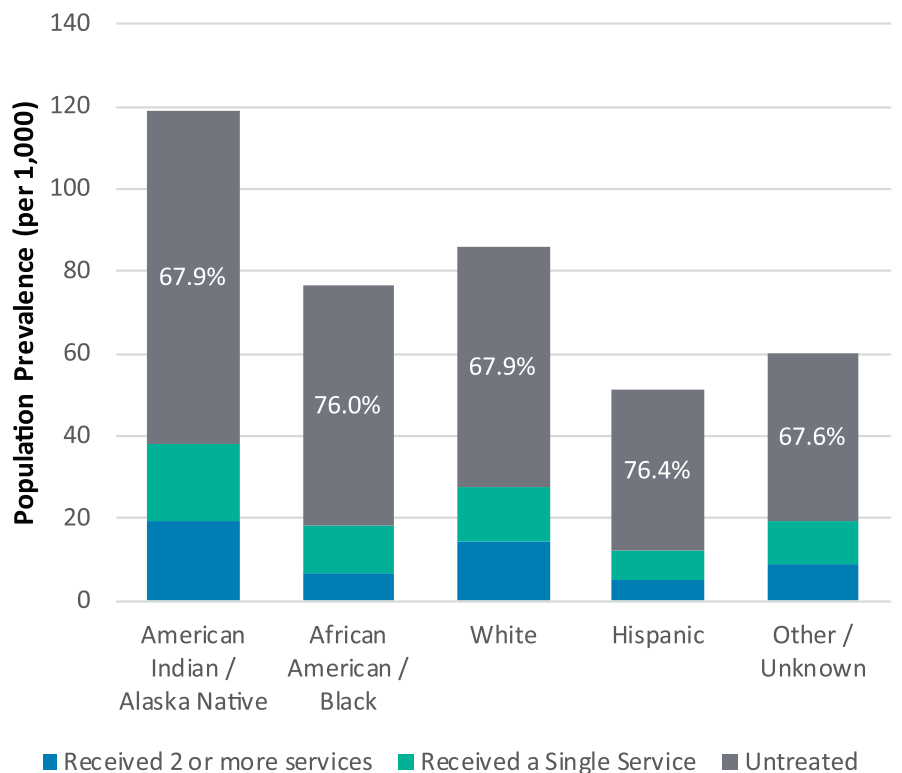


Figure 7: Prevalence and Unmet Need by Race for Medicaid Enrollees with Substance Use Disorder





Variation by Age & Sex

Mental Illness

Females have a higher rate of any mental illness than males in most corresponding age groups, but similar gaps in access (Figure 8). While there are some Medicaid enrollees aged 65 and older who are dually-eligible for both Medicare and Medicaid, we do not display their results here. Medicare, not Medicaid, is the first and primary payer for the majority of mental health and SUD care; therefore, details on the 65 and older population are included in the accompanying Medicare brief.

Substance Use Disorder

For SUDs in the Medicaid population, prevalence is highest among males aged 18 to 54. As seen in the overall results, treatment gaps for all age groups are higher for SUD than for mental illness. At any age, most individuals with a SUD do not receive care. The prevalence of SUDs among individuals under the age of 18 are significantly lower than other age groups; however, the percentage gap in those not receiving treatment for SUDs under the age of 25 for both males and females are a greater percentage than those between 25 and 64 in the Medicaid population. The percent of individuals not receiving SUD care exceeds 90% for the youngest enrollees, whereas gaps for those ages 25 to 64 are closer to 60%. Again, data on individuals over the age of 65 are included in the accompanying Medicare brief as Medicare the first payer for the majority of SUD treatment.

Figure 8: Prevalence and Unmet Need by Age and Sex for Medicaid Enrollees with Any Mental Illness

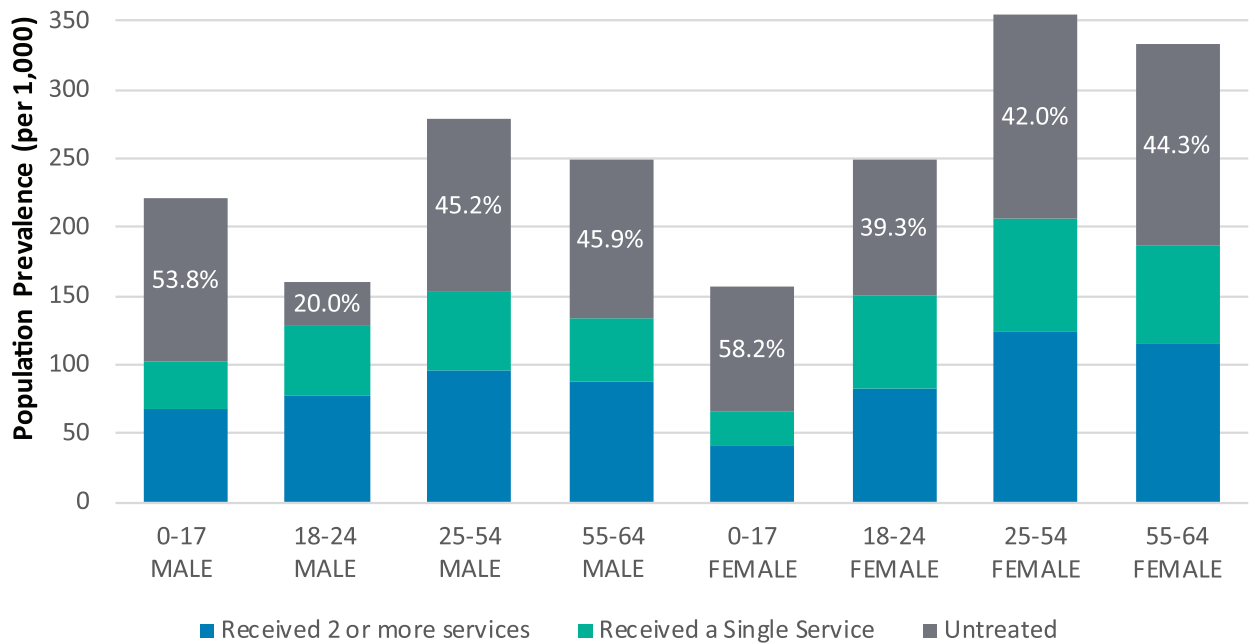
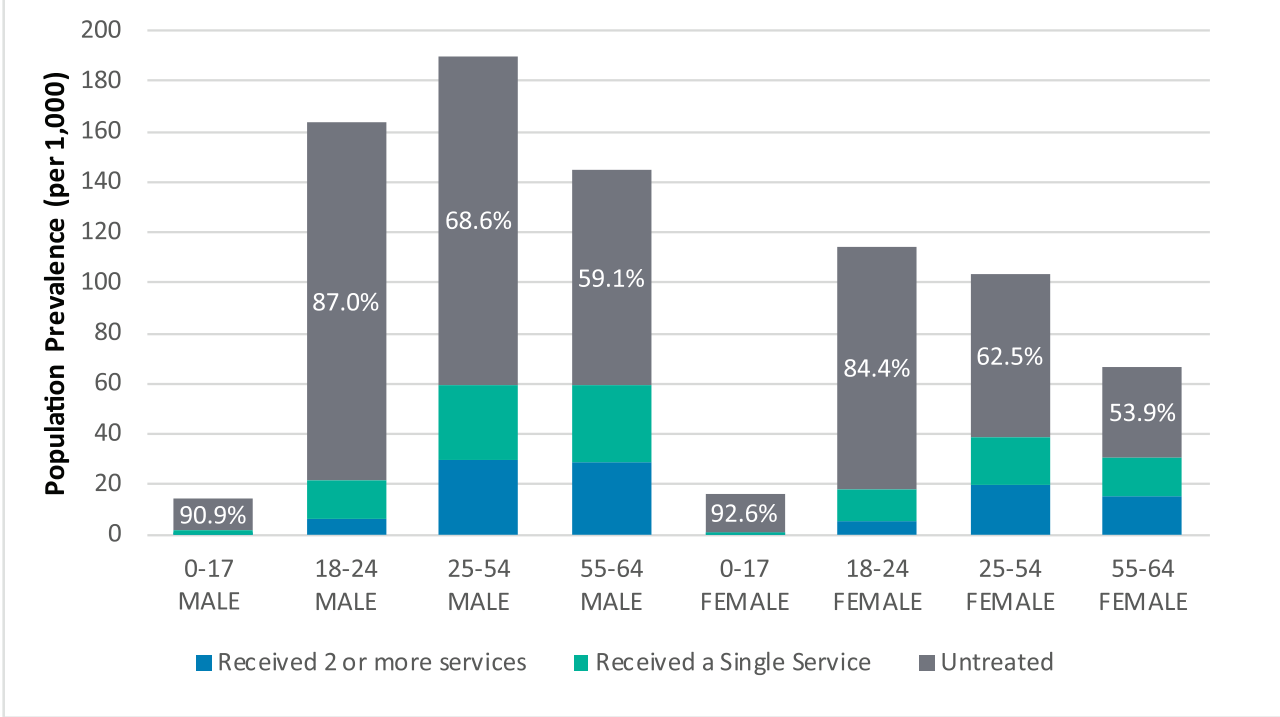




Figure 9: Prevalence and Unmet Need by Age & Sex for Medicaid Enrollees with Substance Use Disorder



Geographic Variation

Variation by Region

Access to mental health and SUD treatment services varies by geographic area across the state of Michigan. Among the 10 Michigan Prosperity Regions, the percentage of Medicaid enrollees with AMI not receiving care ranges from a low of 31.2% in Region 1 (Upper Peninsula) to a high of 58.8% in Region 10 (Detroit Metro Area) (Figure 10). Medicaid enrollees in the counties in and around Detroit have some of the highest shares of unmet need for mental illness treatment. This contrasts with our findings for individuals covered under private insurance or Medicare, where the Detroit region did not stand out as having very high unmet need. Gaps in access to SUD care range from a low of 55% in Region 9 (Southeast Michigan) to a high of 72.4% in Region 4 (West Central Michigan).

For Medicaid enrollees, we also examined access across the ten Prepaid Inpatient Health Plan (PIHP) Regions (Figure 11). The PIHP regional definitions break out Wayne, Oakland, and Macomb counties separately. Under this scheme, we see that the Detroit Wayne MSA Region has the largest numbers and highest shares of Medicaid enrollees going untreated for both AMI and SUD.



Figure 10: Unmet Need by Michigan Prosperity Region, Medicaid Enrollees

Number of Untreated Individuals with AMI and SUD (Percent of those with AMI/SUD who are untreated)

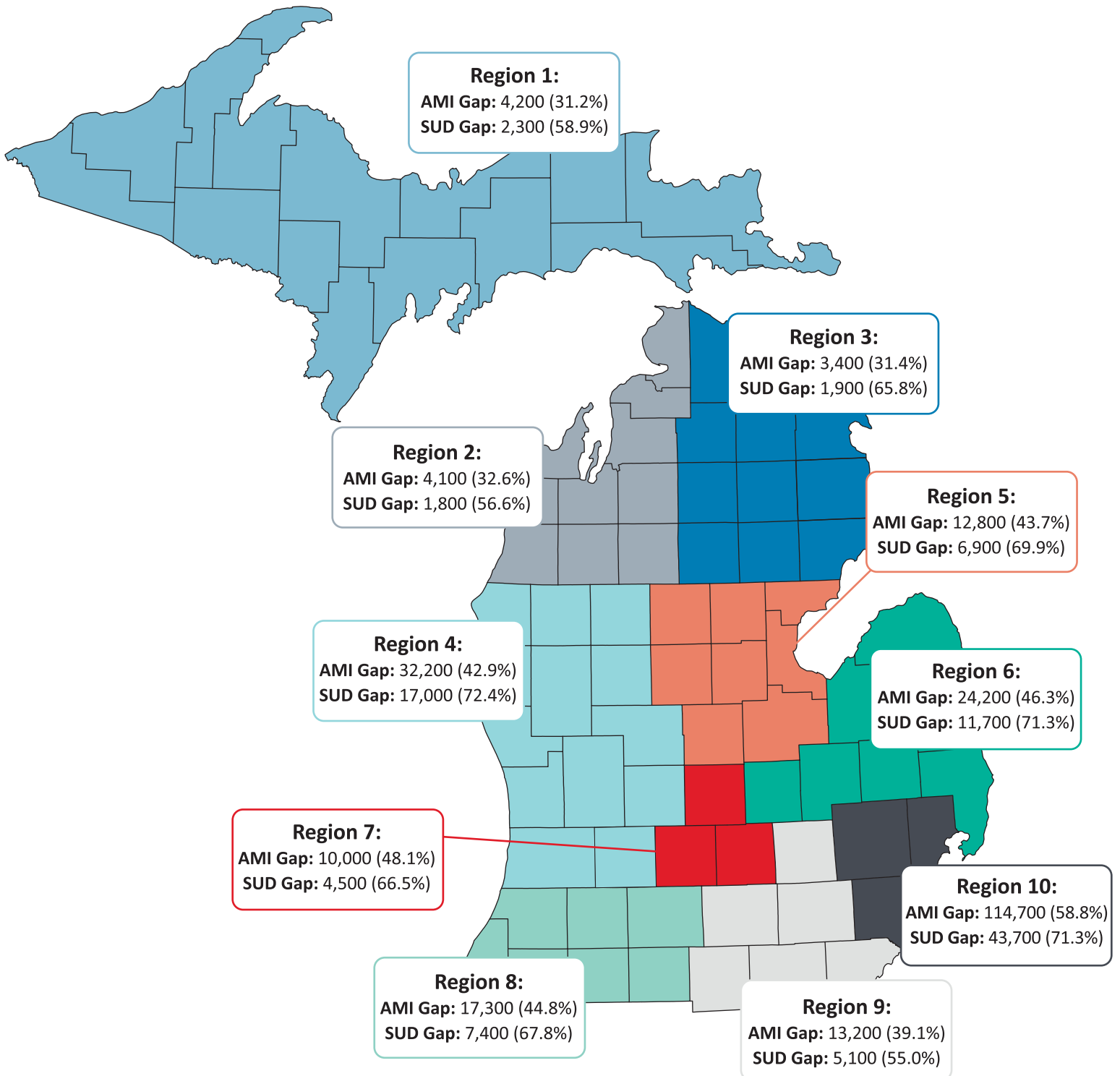
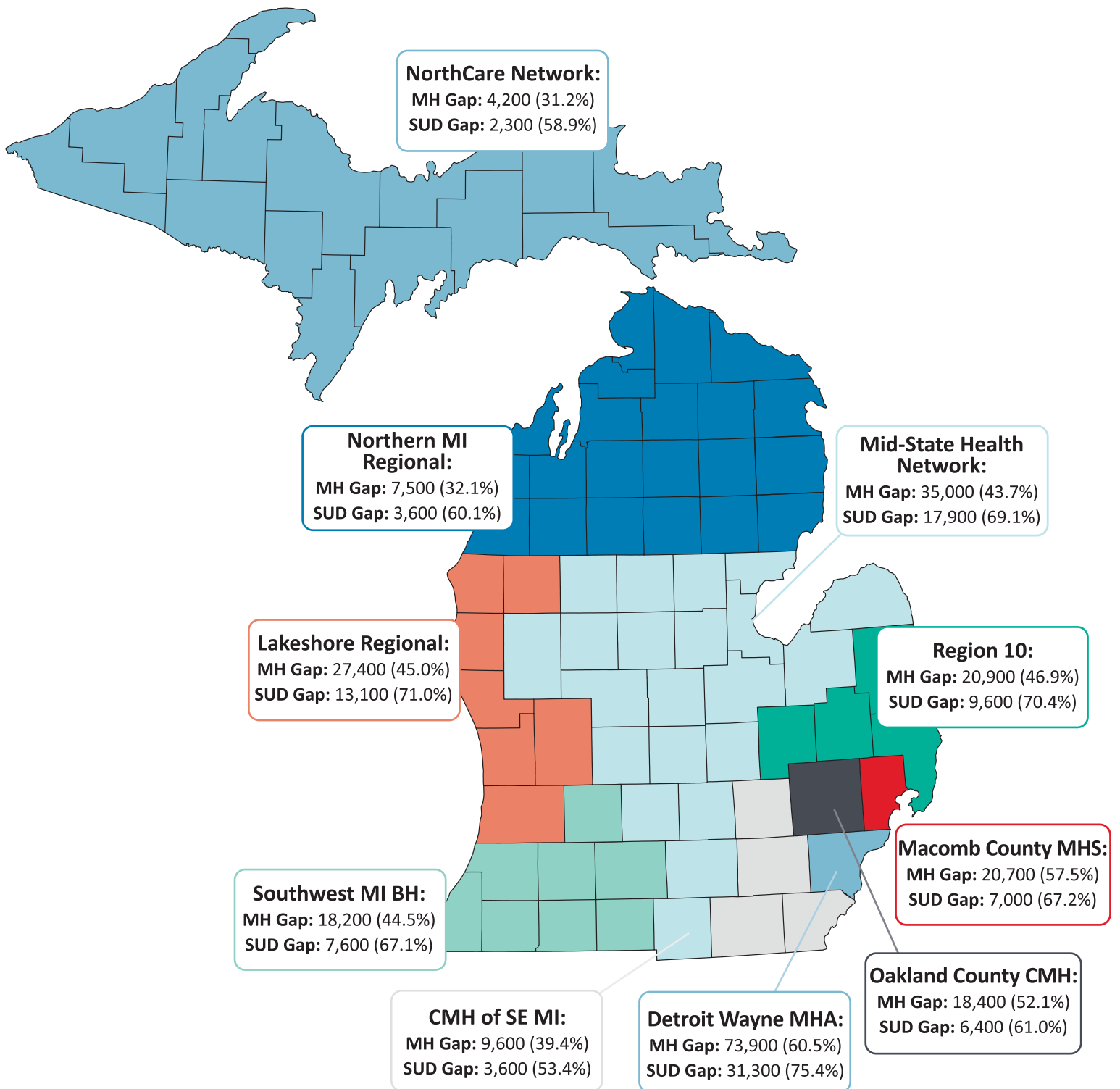




Figure 11: Unmet Need by Michigan Prepaid Inpatient Health Plan (PIHP) Region, Medicaid Enrollees

Number of Untreated Individuals with AMI and SUD (Percent of those with AMI/SUD who are untreated)





Variation by MSA

There is more variation in unmet need across the state’s Metropolitan Statistical Areas (MSAs) than by the Prosperity Regions (Figures 12 and 13). The Detroit-Dearborn-Livonia MSA stands out for having the highest share of unmet need for both mental health care and SUD treatment. The Ann Arbor, MI and Monroe, MI MSAs have some of the smallest shares untreated individuals for both types of behavioral health care. In the non-MSA region (the combination of rural areas outside of any city’s metropolitan region) there are 35% untreated, below the state average. This is somewhat surprising as gaps in access in rural regions might have been expected to be near the top of the state’s range.

Figure 12: Prevalence and Unmet Need by MSA for Medicaid Enrollees with Any Mental Illness

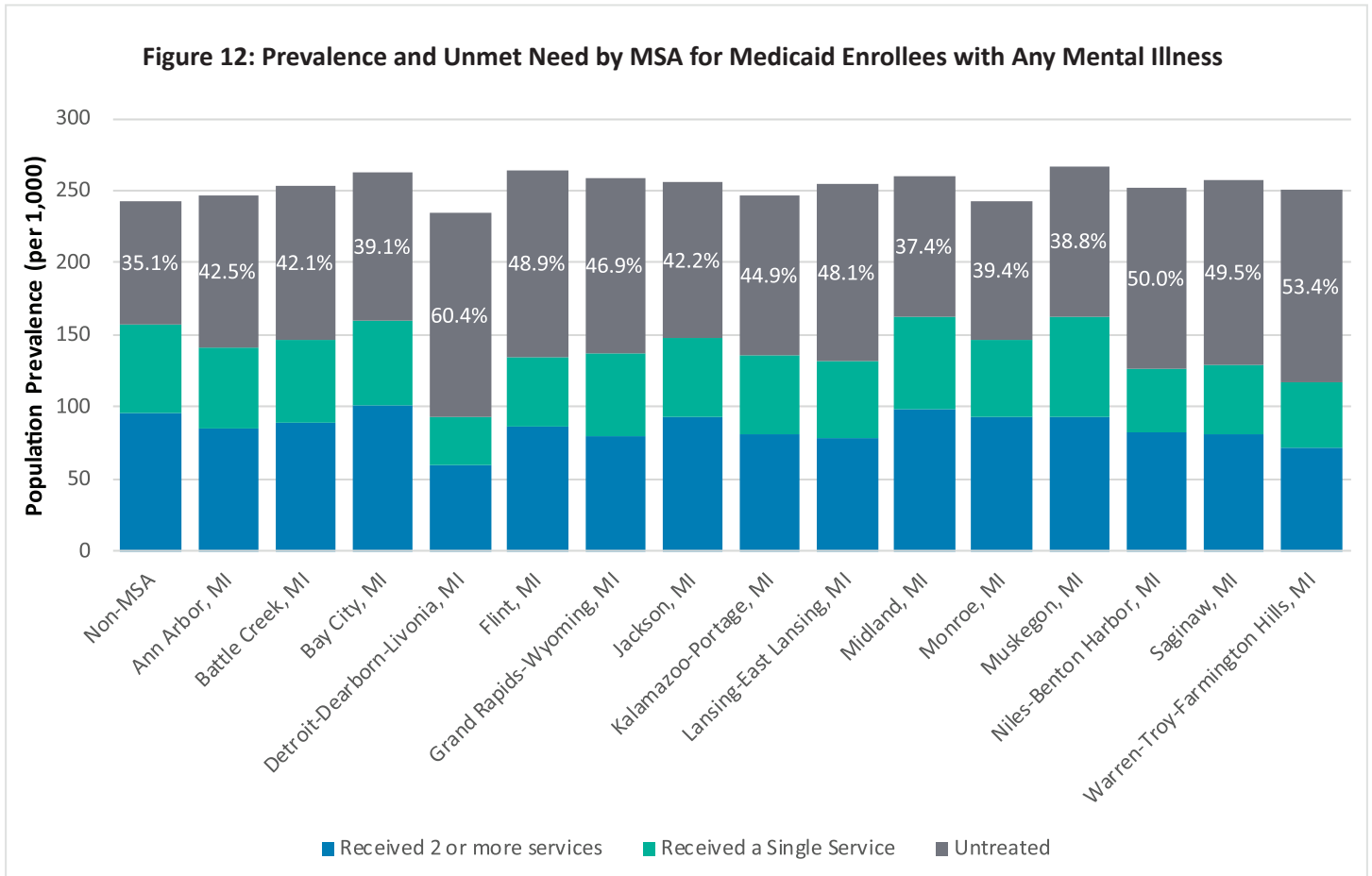
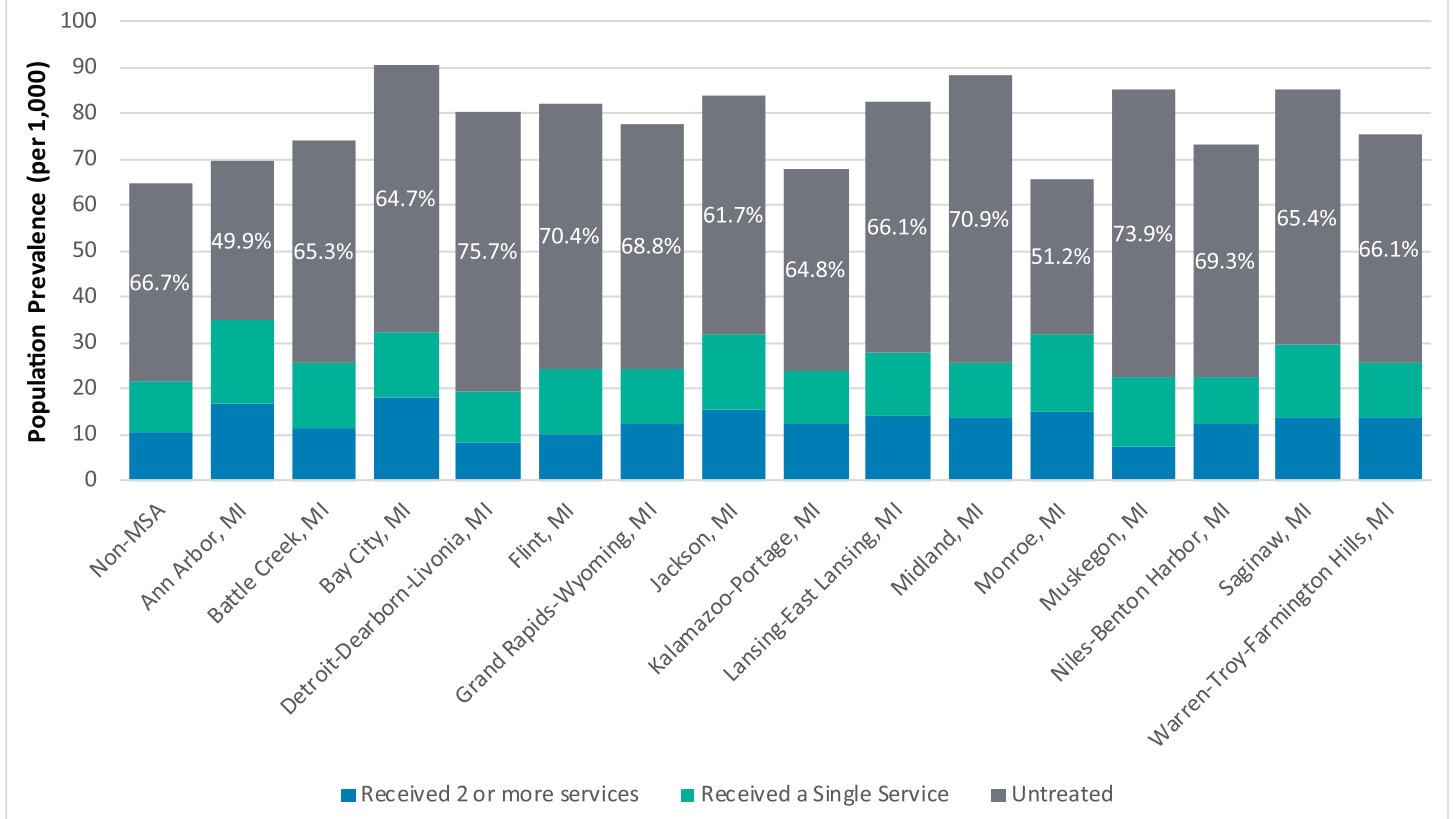




Figure 13: Prevalence and Unmet Need by MSA for Medicaid Enrollees with Substance Use Disorder



Variation by Managed Care Plan

Because the plan names are blinded in our data, we cannot compute the expected population prevalence to get the share untreated for each of the 12 Managed Health Plans in Michigan. However, the data do support computing the percent of covered enrollees receiving care for AMI or SUD during the year for each of 12 unidentified plans.

For AMI, the share of covered enrollees receiving care by plan ranges from 7.8% to 18.8%. For SUD, the share of covered enrollees receiving care ranges from 1.8% to 3.0%. While some of these differences may be due to variation in the prevalence of behavioral health conditions, the wide ranges suggest that there may be differences in barriers to care experienced by enrollees across the 12 plans.



Barriers to Access

Shortages of Behavioral Health Providers

Michigan, like most of the country, has a shortage of psychiatrists and other behavioral health providers. While there are pockets of low supply throughout the state, shortages are especially concentrated in the northern half of the lower peninsula and parts of the upper peninsula.

There are 25 counties in Michigan with no psychiatrist (Figure 12, shaded orange and light blue). Ten of these counties (those in light blue) have neither a psychiatrist nor a psychologist. With many of these counties adjoining, there are sizable geographic areas in the state with no MD or PhD behavioral health clinician.

Michigan also has a severe shortage of child and adolescent psychiatrists. A ratio of 47 child and adolescent psychiatrists per 100,000 population is considered a mostly sufficient supply; Michigan has 11 per 100,000. There are no child psychiatrists in all of the upper peninsula and most of the northern half of the lower peninsula.

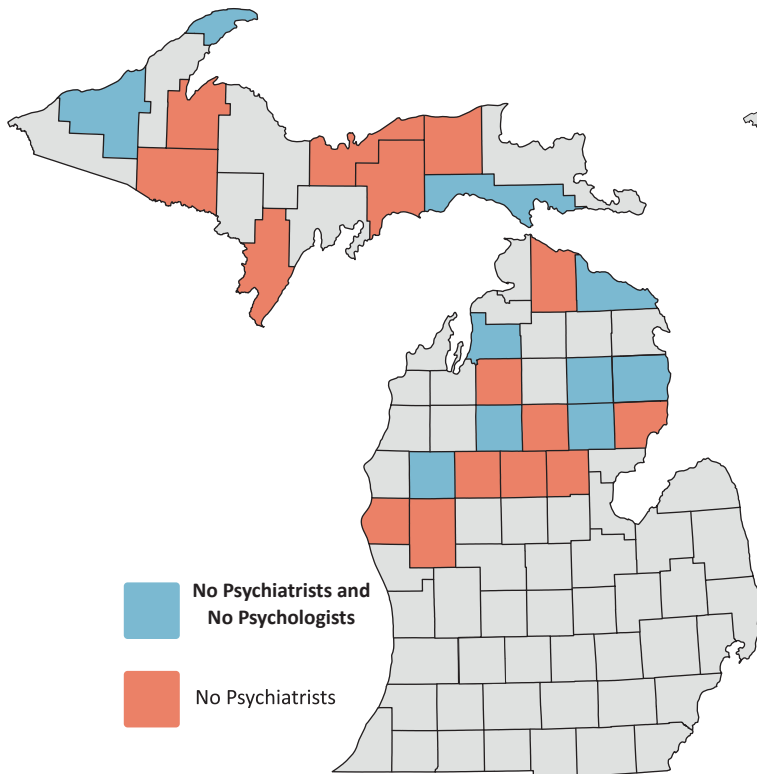
There are 292 mental health facilities in Michigan, a density comparable to the U.S. average of one for every 34,000

people. Mental health facilities offering residential services are in shorter supply; with 17 such facilities, there are 590,000 people per facility in Michigan compared to the U.S. average of 240,000 people per residential facility.

There are 430 SUD treatment facilities in Michigan, about one for every 23,000 people, a slightly greater supply than the U.S. average of one for every 25,000 people. SUD facilities offering detox services are less prevalent, with 78 facilities, about one for every 128,000 people, compared to the U.S. average of one for every 122,000 people.

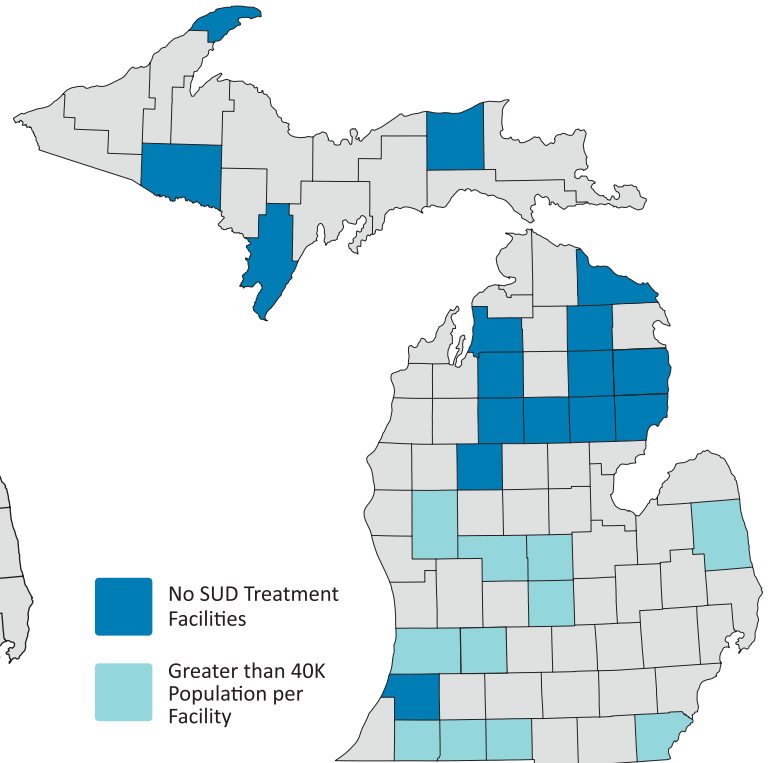
While the total number of facilities relative to the population in Michigan is consistent with the national average, there is considerable geographic variation within the state. There are 16 counties in Michigan with no SUD treatment facility (Figure 13, shaded dark blue) and an additional 11 counties (shaded light aqua) with high population to facility ratios. Overall, seven counties in Michigan have no psychiatrist, no psychologist, and no SUD treatment facility: Missaukee, Ogemaw, Oscoda, Alcona, Antrim, Presque Isle, and Keweenaw.

Figure 14: Counties Lacking Behavioral Health Clinicians



Source: Altarum analysis of National Plan and Provider Enumeration System data, accessed December 2018

Figure 15: Counties Lacking SUD Treatment Facilities



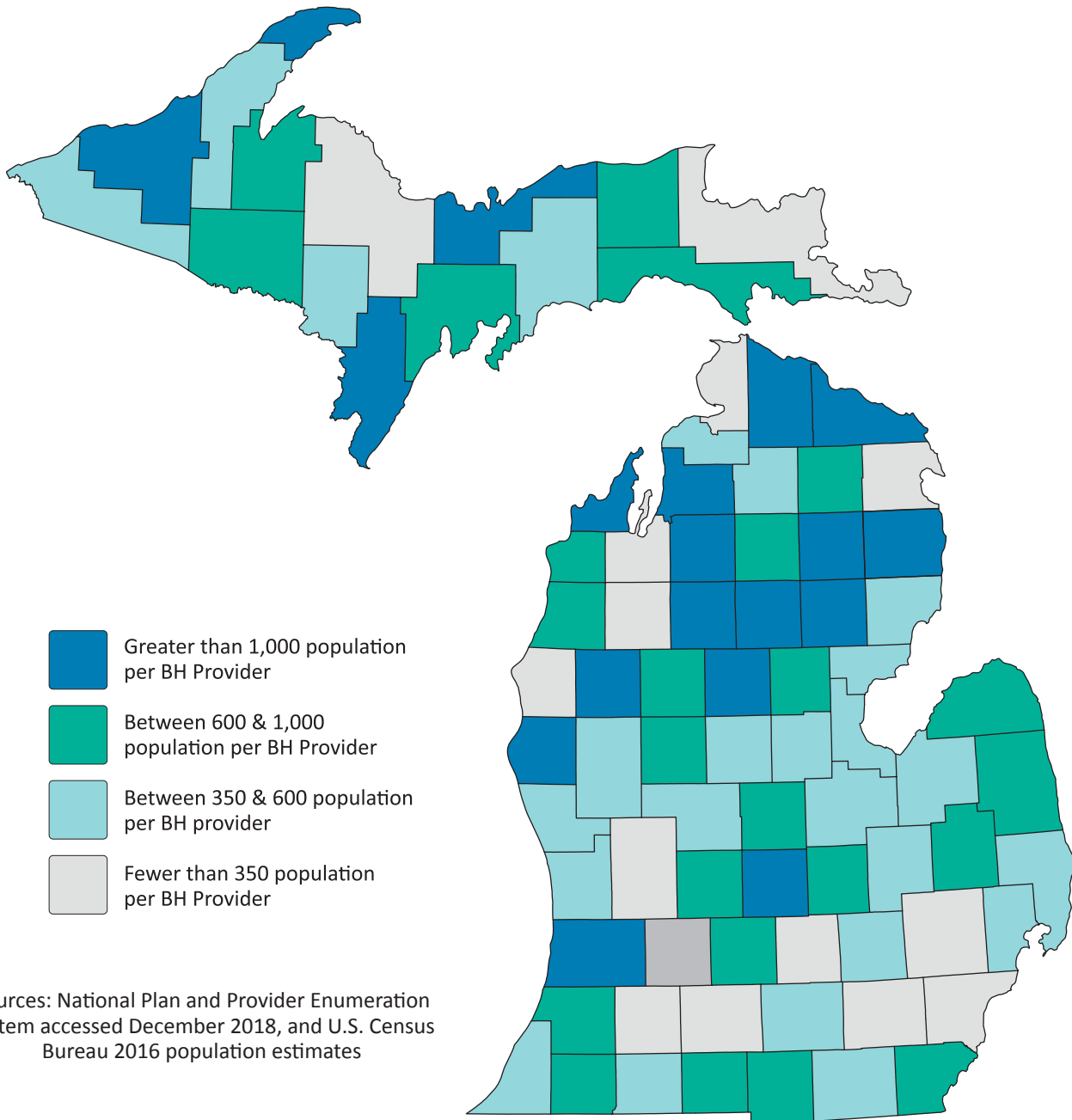
Source: SAMHSA Behavioral Health Treatment Facility Locator, <https://findtreatment.samhsa.gov/locator>, which uses data from the National Survey of Substance Abuse Treatment Services and the National Mental Health Services Survey, accessed June 2019.



Broadening the definition of behavioral health provider to include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care, the supply of providers per capita in Michigan is better than the national average but varies considerably across the state. Overall, Michigan has a population-to-provider ratio of 450:1 compared to the national average of 529:1. Figure 14 shows Michigan counties by quartile for per capita supply; the darker the shading, the more people per provider, and thus the sparser the supply.

There are three times the number of people per provider in the low supply counties compared to the counties with the most plentiful provider supply. Areas in the central and northern section of the lower peninsula tend to have the lowest supply of behavioral health providers per capita. These are also counties that tend to have a relatively greater share of the privately-insured population going untreated. Conversely, counties in the more populated areas of the state, such as southeast Michigan, have the greatest supply of providers and tend to have relatively lower shares untreated.

Figure 16: Population per Behavioral Health Provider by County in Michigan



Sources: National Plan and Provider Enumeration System accessed December 2018, and U.S. Census Bureau 2016 population estimates



Affordability Concerns

Even for those with coverage, there are financial barriers to access. This study finds large shares of those with behavioral health conditions who have coverage under Medicaid or other public or private plans do not receive treatment for their conditions. One reason may be that psychiatrists are more likely than other specialties to opt out of participation in public or private insurance networks, with many not taking insurance at all, greatly increasing patient exposure to costs.²

Survey data in Michigan and nationally confirm that cost is a strong barrier to access. In the 2016 National Survey on Drug Use and Health (NSDUH), the Medicaid population across the US most commonly reported costs or a lack of knowledge of where to go for care as the top reasons for not receiving treatment for mental illnesses, with 29% saying lack of affordability was a factor (Figure 17). Similarly, 27% of respondents to this same survey reported affordability was a reason for not receiving SUD treatment.

Lack of Transportation

Respondents to the NSDUH survey also report transportation issues as a barrier to receiving care. For any mental illness, 11% of Medicaid enrollees report transportation as a factor. For SUD care, 8% of all respondents cite transportation as a factor.

Public Awareness and Perceptions

Survey data show that both lack of awareness and information about conditions and treatment options, and discomfort about possible social stigma or other negative consequences are barriers to receiving treatment for behavioral health conditions. There may be cultural norms that increase reluctance in some groups more than others.

Figure 17: Self-Reported Reasons for Not Receiving Behavioral Health Care

TOP REASONS FOR NOT RECEIVING TREATMENT	% Citing Each Reason, AMI Care	% Citing Each Reason, SUD Care
Couldn't Afford Costs	29%	27%
Didn't Know Where to Go	23%	19%
Thought Could Handle/Not Ready to Get Treatment	18%	38%
Didn't Have Time	14%	5%
Concerned Might Get Committed/Have to Take Meds	16%	-
No Transportation/Too Far	11%	9%

Source: 2016 National Survey on Drug Use and Health. Respondents could select multiple answers. For AMI care, respondents are those covered under Medicaid. For SUD care, payer-type specific results were not available.

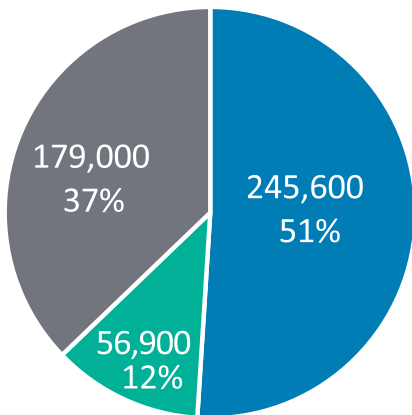


Initial Access Targets

A significant portion of Michiganders with a behavioral health condition are not receiving treatment for a variety of reasons that include provider availability and financial concerns along with cultural attitudes that lead to reluctance to seek care. Shifting our capacity and our culture to fully meet the state’s behavioral health needs is likely to be a long-term process. A more feasible near-term goal might be to strive to achieve the state’s best levels of access in all parts of Michigan. We define “best access” as having the smallest share currently untreated.

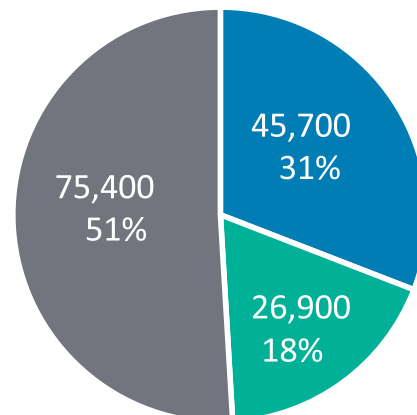
We estimate that all areas of the state achieved the current best access for Medicaid enrollees in Michigan, computed as the average of the top quintile of Metropolitan Statistical Areas, an additional 56,900 Medicaid enrollees would receive mental health services each year and 26,900 would receive treatment for SUDs. Achieving this goal would increase the share of Medicaid enrollees receiving mental health services from about half (51%) to 63% and increase the share of enrollees receiving substance abuse treatment from about one-third (31%) to nearly half (49%). Figures 18 and 19 display counts and shares of Medicaid enrollees treated for AMI and SUD and the additional counts and shares that would be treated if the best access seen in Michigan was seen statewide.

Figure 18: Unmet Need for Medicaid AMI Care if Best MI Access is Statewide



- Received Care
- Would Receive Care Under Best MI Regions
- Remaining Untreated

Figure 19: Unmet Need for Medicaid SUD Care if Best MI Access is Statewide



- Received Care
- Would Receive Care Under Best MI Regions
- Remaining Untreated



Strategies to Improve Access

Based on our review of the literature, action plans from other states, and input from Michigan health care stakeholders and thought leaders, we identified 15 strategies to improve access to behavioral health care in Michigan. For discussion, we group the strategies into three broad domains based on primary barrier: increasing the effective supply of providers, improving patient affordability, or increasing willingness to seek treatment.

As shown in Figure 18, many of the strategies have the potential to address more than one barrier to access. For example, the use of telemedicine, while primarily implemented to increase the availability of behavioral health providers in underserved areas, can improve affordability by increasing access to in-network providers and increase willingness to seek care by reducing travel requirements and fear of stigma associated with receiving care at a behavioral health facility.

Of the 15 strategies, our top six recommendations, building on current initiatives in Michigan and having the potential to reduce multiple barriers to care, are:

- ▲ Increase retention of behavioral health providers in Michigan [Strategy 4];
- ▲ Expand provider scopes of practice to top of training [Strategy 6];
- ▲ Promote effective use of trained lay providers [Strategy 7];
- ▲ Advance the use of telemedicine [Strategy 8];
- ▲ Expand school-based behavioral health care [Strategy 9]; and
- ▲ Integrate primary care and behavioral health care delivery.

Given the importance of cost as a barrier to seeking treatment, we also encourage exploration of benefit design changes that reduce the patient cost burden for behavioral health care, recognizing that this may increase health care spending.

Figure 18: Strategies to Improve Access to Behavioral Health Care in Michigan, with Barriers Affected

	STRATEGIES	Provider Availability	Patient Affordability	Willingness to Seek Care
1	Expand programs to train behavioral health clinicians	✓		
2	Expand programs to train behavioral health non-clinician providers	✓		
3	Recruit and support applicants for workforce training from underserved areas	✓		✓
4	Increase retention of behavioral health providers in Michigan	✓		
5	Train more providers in needed behavioral health competencies	✓		
6	Expand provider scopes of practice to top of training	✓	✓	
7	Promote effective use of trained lay providers	✓	✓	✓
8	Advance the use of telemedicine	✓	✓	✓
9	Expand school-based behavioral health care	✓	✓	✓
10	Integrate primary care and behavioral health care delivery	✓	✓	✓
11	Maintain and enforce recent gains in coverage and parity		✓	
12	Encourage coverage design that reduces patient cost burden for BH		✓	
13	Increase public awareness of resources and paths to care			✓
14	Improve access to non-emergency medical transportation			✓
15	Support patient self-care and technology-assisted care		✓	✓



Strategies for Increasing the Effective Supply of Providers

Strategies to address provider shortages can focus on increasing numbers of behavioral health providers, better aligning provider location with need, or maximizing the productivity and effectiveness of the existing workforce through practice change or technology. Michigan would need 167 additional psychiatrists practicing in underserved geographic areas to alleviate federal government-designated mental health professional shortage areas.³

1. Expand the number or size of programs to train behavioral health clinicians in Michigan, including graduate medical education (GME) residencies in psychiatry and psychiatric specialty training for nurse practitioners and physician assistants. Michigan has more than the average number of medical school slots per capita (52 per 100,000) and double the number of GME slots per capita (57 per 100,000) compared to other states, but there is an opportunity for more GME slots to shift to or be created for psychiatry and psychiatric subspecialties.⁴
2. Expand the number or size of programs to train non-clinician mental health or addiction health professionals in Michigan such as licensed professional counselors or licensed certified social workers.
3. Recruit applicants to behavioral health provider training from rural or underserved areas of the state. Example approaches include:
 - 3a. To maximize the access gains from new training programs, create initiatives to recruit program candidates from rural or underserved communities who are more likely to return to practice in these areas;
 - 3b. Expose children from underserved communities or populations to health careers through school-based or other programs;
 - 3c. Offer scholarships or loan repayment to encourage and support members of underserved communities to pursue training in behavioral health.
4. Increase the retention of behavioral health providers in Michigan. For physicians, current data on retention show that of those who receive undergraduate medical education (UME) in Michigan, 44% stay in the state, higher than the national average of 40%. Of those who receive GME, 45% stay in Michigan, about average. Of those who receive both UME and GME in Michigan, two-thirds stay to practice, but this is a bit below the national average of 69%.⁵ A variety of incentives may be available to retain physicians and other behavioral health providers, for example:
 - 4a. Examine the process for receiving and maintaining licensure or certification in the behavioral health professions and reduce the burden as needed and appropriate;
 - 4b. Compare Medicaid payment policies or other financial incentives in Michigan with other states, particularly Midwestern states that currently attract 11% of the physicians receiving GME training in Michigan. Consider adjustments needed to make Michigan more competitive;
 - 4c. Continue to fully participate in Conrad 30 J-1 Visa Waiver program sponsoring the maximum 30 international medical school graduates and prioritizing primary care and psychiatry;
 - 4d. Maintain and expand loan repayment programs rewarding commitments to practice in Michigan, especially in underserved areas. Leverage federal dollars through HRSA programs and continue or expand local programs such as the Michigan Health Council's Michigan Loan Reimbursement and Employment Solution (MiLES);
 - 4e. Create new provider retention programs informed by provider surveys or evidence-based strategies used in other states.
5. Expand existing provider training in needed behavioral health competencies; for example, work to increase the number of physicians in Michigan qualified to provide medication assisted treatment.
6. Remove restrictions on scope of practice that limit the ability of non-physician providers to practice to the full extent of their training and professional certification.



7. Promote effective use of trained lay providers such as Community Health Workers, Peer Support Specialists, or Recovery Coaches. Develop and implement certification to support reimbursement of peer support services. This strategy can also strengthen the cultural competency of care provided.
8. Extend the reach of the existing provider supply and support patient convenience through telemedicine, using approaches such as the following:
 - 8a. Support the use of telepsychiatry between patients and providers by aligning payment policies, especially for underserved areas;
 - 8b. Close gaps in broadband and technology capacity to support telemedicine throughout the state, including rural areas;
 - 8c. Sustain and grow teleconsultation programs that expand the reach of scarce psychiatrist resources through payment policies that reimburse for these consultations beyond grant funding. For example, develop a business model to sustain the MC3 program (<https://mc3.depressioncenter.org/>) connecting Michigan primary care providers to behavioral health specialists.
9. Expand use of school-based mental health providers. Michigan has historically had one of the highest ratios of students per school psychologist in the country. Recent state funding (Section 31N School Mental Health and Support Services Grant Opportunity) begins to address this by making \$31M available to expand school-based behavioral health, with the ability to bill Medicaid after two years. School-based health centers have a strong evidence base for improving access and health outcomes.⁶ For mental health or SUD conditions, the ability to diagnose and treat problems early can prevent more serious illness and the associated negative life impacts.
10. Integrate delivery of behavioral health care and primary care. Integration promotes treatment of the whole person as well as increasing access to behavioral health care. This is an active area of innovation across the state. A recent Community Mental Health Association of Michigan report found 663 healthcare integration efforts of various types underway in Michigan.⁷ Several opportunities for further integration of services exist, for example:
 - 10a. Promote additional training of primary care providers for early detection and screening and ongoing follow up;
 - 10b. Co-locate primary care and behavioral health providers;
 - 10c. Implement integrated care models including the Collaborative Care Model, which has a strong evidence base of positive outcomes.

Strategies for Addressing Affordability

Even for those with health care coverage, cost concerns are the most common reason cited for not receiving care. Our analysis of the privately insured under this study shows that a greater share of Michiganders in high-deductible plans do not receive treatment. Beyond the financial barriers that higher deductibles and copayments can create for all health care, psychiatrists and other behavioral health clinicians are less likely to participate in public insurance programs or private insurance networks than other specialties, so patients more often face tradeoffs between location and timeliness of care and paying out-of-pocket. In addition to increasing the available supply of providers, actions to lower the patient cost burden of behavioral health care will be needed to fully close the treatment gap.

11. Maintain and fully enforce existing provisions for financial coverage of behavioral health. For example:
 - 11a. Continue operation and funding of the Healthy Michigan program;
 - 11b. Support the requirement for coverage to include essential benefits;
 - 11c. Support and enforce full implementation of the mental health parity law.
12. Encourage insurance plan design that lowers the patient cost burden of behavioral health care, including policies around deductibles and non-participating or out-of-network providers. It is important to address patient costs as this is a major reason individuals forgo care. However, lowering patient costs to improve financial access will likely increase health care spending, potentially impacting premiums, capitated payments, or margins.



Strategies for Increasing Willingness to Seek Treatment

Public awareness or education programs are one approach to increasing the public’s understanding of when and where to receive services and reducing perceptions of stigma associated with having a mental illness or SUD. Another approach is to explore ways to increase the convenience to patients of connecting with care. Finally, we note that integration with primary care, use of telemedicine, and school-based care, each listed under strategies to leverage the provider supply, also have the potential to increase convenience and comfort with receiving behavioral health care.

- 13. Increase public awareness of what types of local behavioral health resources are available and how to seek care.
- 14. Improve access to non-emergency medical transportation (NEMT) in Michigan.
- 15. Support increased patient self-care and technology-assisted self-monitoring and treatment, which is easy and private for patients to access and leverages scarce provider resources. For example:
 - 15a. Promote appropriate use of Internet-Based Cognitive Behavioral Therapy, which evidence shows to be effective in advancing patient outcomes, especially when combined with positive reinforcement and connection with a provider;
 - 15b. Examine or create mobile apps or computer or internet-based programs to support patient education, practice, or monitoring.

Michigan policy and provider programs can implement each of the 15 strategies for improving access to varying degrees and using various approaches. We can, however, characterize each strategy broadly in terms of likely impact and resource intensity, informed by previous implementations and estimates made for specific programs in other states. Figure 19 displays such a characterization. The six strategies we emphasize combine medium to high impact with medium to low cost.

Figure 19: Matrix of Strategies Arranged by Degree of Impact and Additional Cost

		→ → Impact on Access → →		
		Low	Medium	High
↑ ↑ Additional Cost	High		[2] Expand programs training non-clinician providers [3] Recruit from underserved areas and support provider training [12] Design insurance coverage to reduce patient cost burden for BH	[1] Expand programs training behavioral health clinicians
	Medium	[11] Maintain and enforce current coverage and parity [14] Improve access to NEMT	[4] Apply incentives to increase workforce retention in Michigan [8] Advance use of telemedicine	[7] Promote use of trained lay providers [9] Expand school-based care [10] Integrate behavioral health and primary care delivery
	Low	[5] Expand provider training in particular needed competencies [13] Increase public awareness of resources and paths to care [15] Support patient self care	[6] Expand scopes of practice to match full scope of training	



Endnotes

- 1 Hellebuyck Michele, Halpern Madeline, Nguyen Theresa, & Danielle Fritze, “The State of Mental Health in America,” 2019, Mental Health America.
- 2 Bishop Tara F., Press Matthew J, Keyhani Salomeh, & Harold Alan Pincus, “Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care,” *JAMA Psychiatry*, February 2014, Vol 71, No 2.
- 3 Henry J. Kaiser Family Foundation, *Mental Health Care Health Professional Shortage Areas as of December 31, 2017*. Accessed at <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- 4 Association of American Medical Colleges, *2017 State Physician Workforce Data Report*, November 2017.
- 5 Ibid.
- 6 Knopf JA, Finnie RKC, Peng Y, Hahn RA, Truman BI, Vernon-Smiley M, Johnson VC, Johnson RL, Fielding JE, Muntaner C, Hunt PC, Jones CP, Fullilove MT, Community Preventive Services Task Force. School-based health centers to advance health equity: a Community Guide systematic review. *American Journal of Preventive Medicine* 2016;51(1):114–26.
- 7 Center for Healthcare Integration & Innovation, Community Mental Health Association of Michigan, “Healthcare Integration and Coordination – 2018/2019 Update: Survey of Initiatives of Michigan’s Public Mental Health System,” January 2019

Acronyms

ADHD	Attention-Deficit Hyperactivity Disorder
AMI	Any Mental Illness
FFS	Fee-for-Service
GME	Graduate Medical Education
IHS	Indian Health Service
MHS	Military Health Service
MI	Michigan
MCO	Managed Care Organization
MSA	Metropolitan Statistical Area
NEMT	Non-Emergency Medical Transportation
NSDUH	National Survey on Drug Use and Health
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder
UME	Undergraduate Medical Education
VA	Veterans Administration