Access to Behavioral Health Care in Michigan

Results for the Medicare-Enrolled Population | July 2019

Summary of Key Findings

- While most of the hundreds of thousands of Medicare enrollees in Michigan with a mental illness receive treatment, tens of thousands remain untreated. Of the 250,000 Medicare enrollees in Michigan experiencing a mental illness, 79% received treatment, leaving 21%, or nearly 52,000 people, with unmet need.
- In contrast, most of the Medicare-enrolled Michiganders experiencing a substance use disorder go untreated. Of the 50,000 Medicare enrollees in Michigan with a substance use disorder, only 41% received treatment, leaving 30,000 people, untreated.
- *Anxiety disorders* and *depressive episode* are the most common mental health conditions, and those with the highest unmet need.
- *Alcohol use disorder* is the primary substance use disorder in Michigan, and the disorder most likely to go 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 performing areas of the state, another 41,000 people with a mental illness and 8,000 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 Medicare population. Please see our companion briefs for summaries of findings for the privately insured population, the Medicaid population, and the total Michigan population. Study methods are documented in more detail in the accompanying full-length final report.

MICHIGAN HEALTH ENDOWMENT FUND

AUTHORS:

Ani Turner, Corwin Rhyan, Emily Ehrlich, and Christine Stanik

Altarum

CONTACT:

Ani.Turner@Altarum.org

Corwin.Rhyan@Altarum.org

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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.

We quantify gaps in access to care by comparing the underlying need for behavioral health services to the care currently being received, as identified in 2016 claims data. We use Medicare Limited Data Set (LDS) claims files for professionals and outpatient facilities and IBM *MarketScan* data for Medicare Advantage care to identify the population in Michigan with Medicare coverage who are currently receiving 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 Medicare population counts. Prevalence rates are from the National Survey on Drug Use and Health 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 Medicare enrollees in Michigan are not receiving treatment for their behavioral health condition.

Of the 1.6 million Michiganders covered under the Medicare program, we estimate about 250,000 experience any mental illness (AMI). We find that one-fifth (21%) of those with AMI, about 52,000 people, are not receiving care (Figure 1).

For SUD, the unmet need is even larger. Most Michigan Medicare enrollees with SUD are not receiving care. Of the roughly 50,000 Medicare beneficiaries experiencing SUD, 59% of them, nearly 30,000 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, Medicare Enrollees with AMI

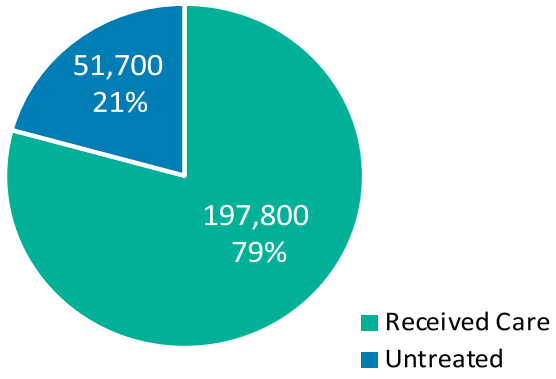
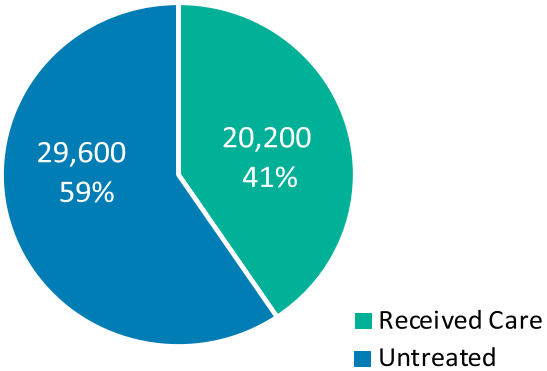


Figure 2: Unmet Need for Treatment, Medicare Enrollees with SUD



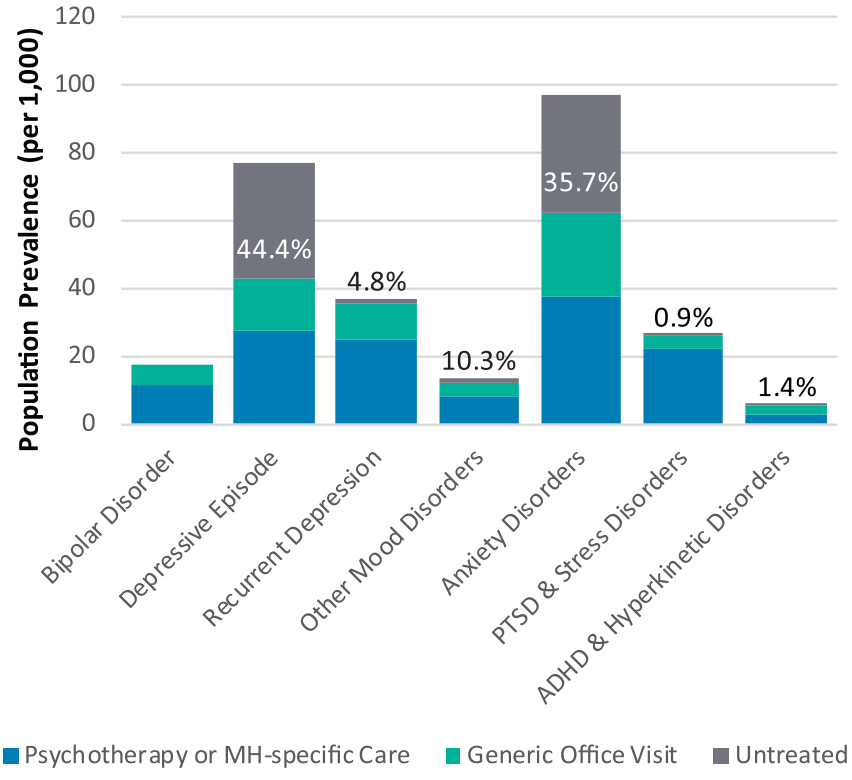
Results by Condition

Common Mental Health Conditions

In Michigan, across all Medicare enrollees, the unmet need is greatest for more prevalent mild or moderate conditions. Figure 3 shows the variation in estimated prevalence and unmet need for some of the most common mental illness categories. The conditions with bar far the largest shares going untreated are *anxiety disorders* (36%) and *depressive episode* (45%). More serious conditions such as *bipolar disorder, recurrent depression*, and *post-traumatic and other stress disorders* are less prevalent in the population and show very little unmet need.

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 illness (shown in green). Michiganders with *anxiety disorder, depressive episode,* and *attention-deficit and hyperactivity disorders* are relatively more likely to receive care under a general office visit, rather than a more specific mental health or psychotherapy code.

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

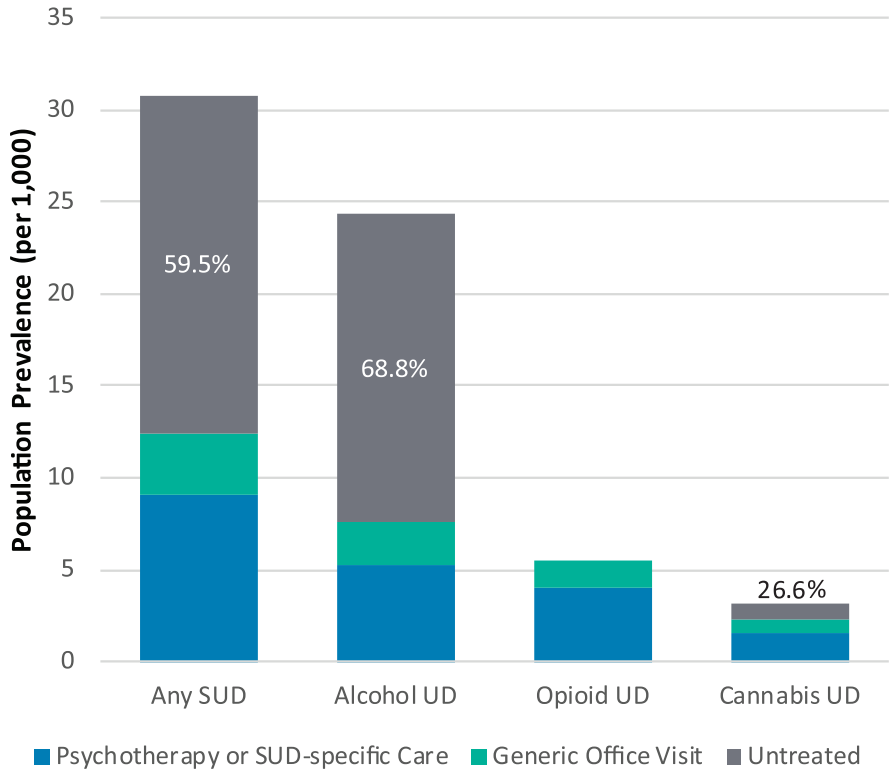


Common Substance Use Disorders

Figure 4 shows a similar comparison for the three most common SUDs in the Medicare-enrolled 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 Medicare enrollees with an SUD received a service specific to SUD treatment or a psychotherapy visit.

Figure 4: Prevalence and Unmet Need by Common Substance Use Disorders, Medicare Enrollees in Michigan



Variation by Age & Sex

Mental Illness

Female Medicare enrollees have a higher rate of any mental illness and higher shares untreated than males in corresponding age groups. As shown in Figure 5, the prevalence of any mental illness for Medicare enrollees is highest overall among females under the age of 65, at 420 per 1,000 beneficiaries. Unmet needs are also high for the Medicare population that is under age 65. For Medicare beneficiaries age 65 and older, the share of those with mental illness who are not being treated is relatively low, from 2.2% for females in fee-for-service, to 16.8% for males in Medicare Advantage.

Substance Use Disorders

As seen in Figure 6, for SUDs, prevalence is highest by far among males under age 65. Unmet needs in general are much higher for SUD than for mental illness. Females under age 65 have the lowest share untreated at 24%. For all other combinations of age and plan type, half or more of individuals with Medicare coverage with a SUD do not receive care.

Figure 5: Prevalence and Unmet Need by Age and Sex for Medicare Enrollees with Any Mental Illness

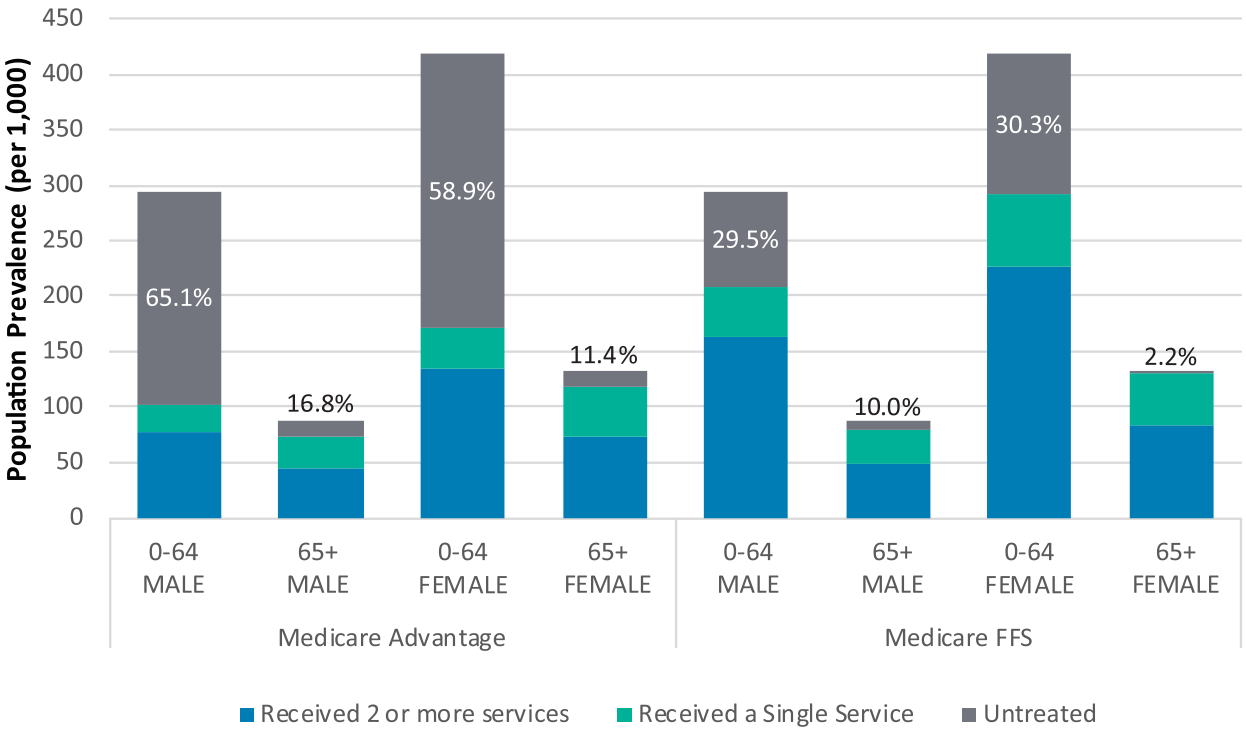
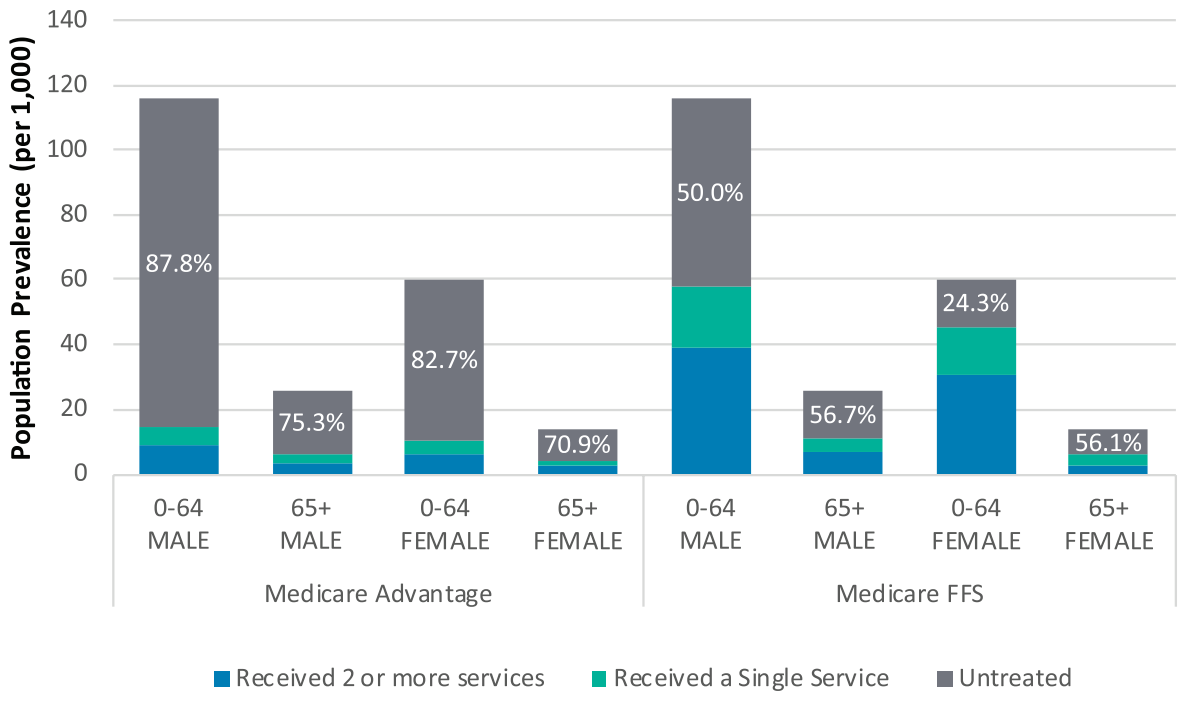


Figure 6: Prevalence and Unmet Need by Age & Sex for Medicare Enrollees with Substance Use Disorder



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 share of Medicare enrollees with AMI who are untreated ranges from a low of 11.2% in Region 9 (Southeast Michigan) to a high of 41.9% in Region 1 (Upper Peninsula) (Figure 7).

While large numbers of the estimated 51,000 Medicare enrollees not receiving care for mental health services are found in the more populated regions of the state (Region 4 and Region 10), relative access gaps are greater in the more rural parts of the state.

For SUD, the share untreated ranges from a low of 47.6% in Region 6 (Eastern Central Michigan, including the "Thumb") to a high of 67.9% in Region 4 (Eastern Central Michigan).

Variation by MSA

There is more variation in unmet need across the state's Metropolitan Statistical Areas (MSAs) than by the Prosperity Regions.

For AMI care, the share untreated ranges from 0% in the Ann Arbor MSA to 37% in the Benton Harbor MSA (Figure 8). In the non-MSA areas of the state (rural areas outside of any city's metropolitan region), about one-third of the need for AMI care is unmet (31.8%), somewhat higher than the state average of 21%.

For SUD care, the share untreated ranges from 40% in Battle Creek to 67% untreated in Benton Harbor and Grand Rapids (Figure 9).

Figure 7: Unmet Need by Michigan Prosperity Region, Medicare Population

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

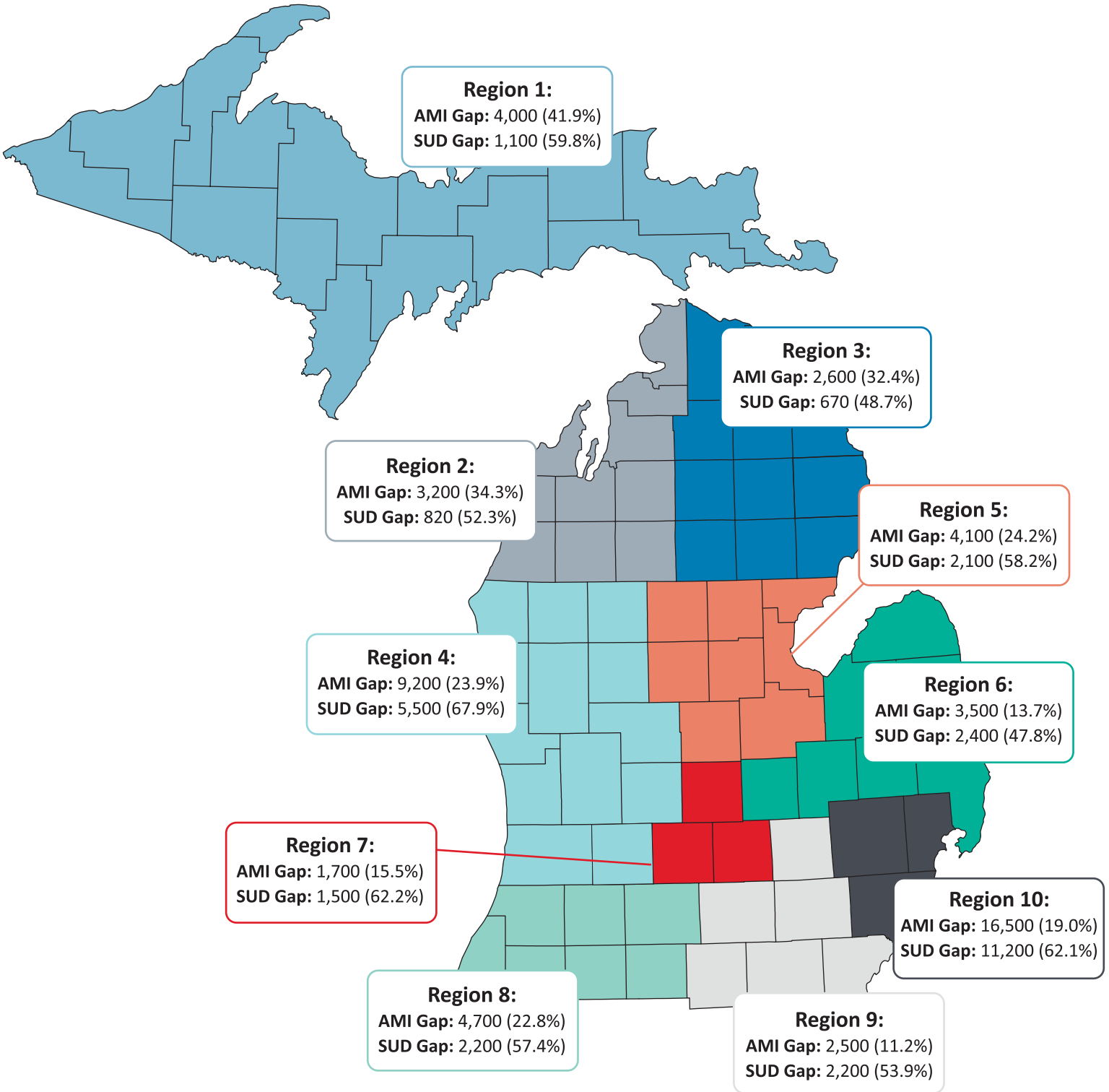


Figure 8: Prevalence and Unmet Need by MSA for Medicare Enrollees with Any Mental Illness

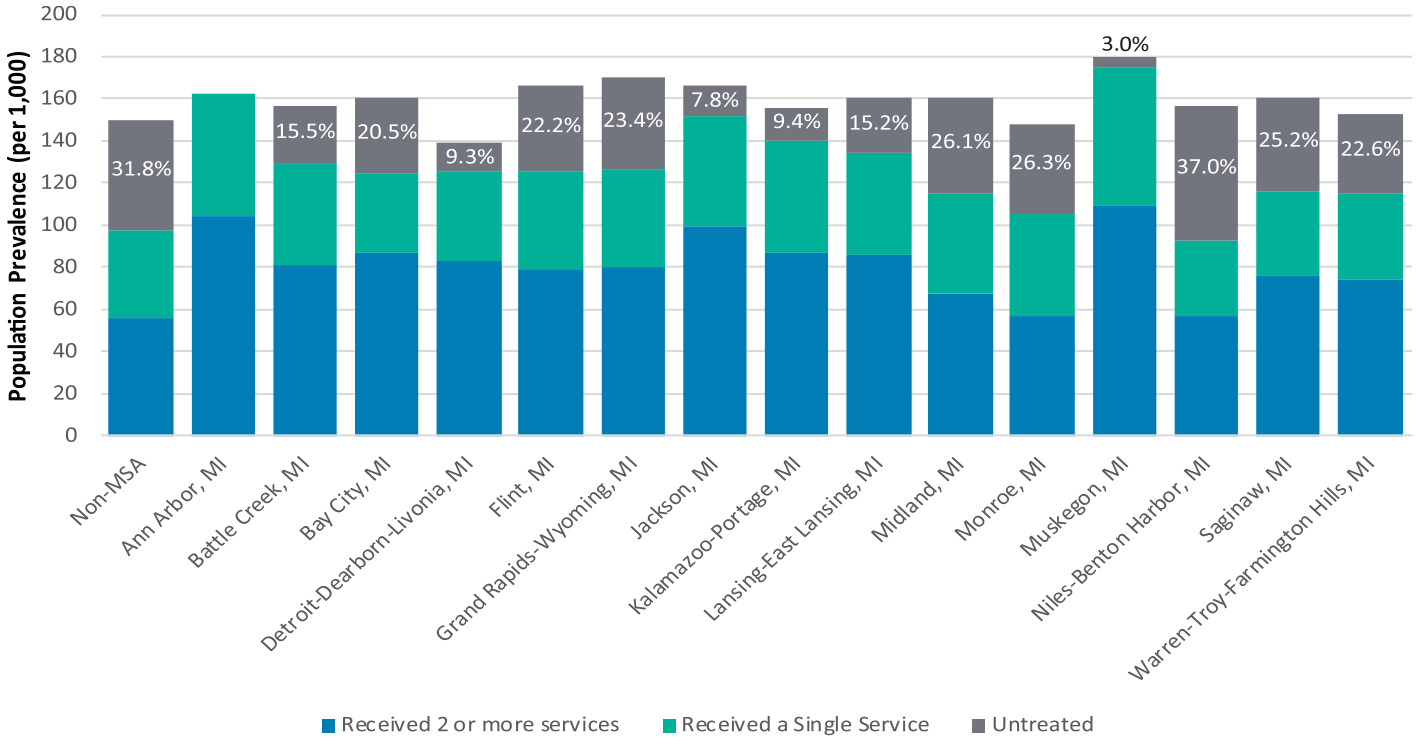
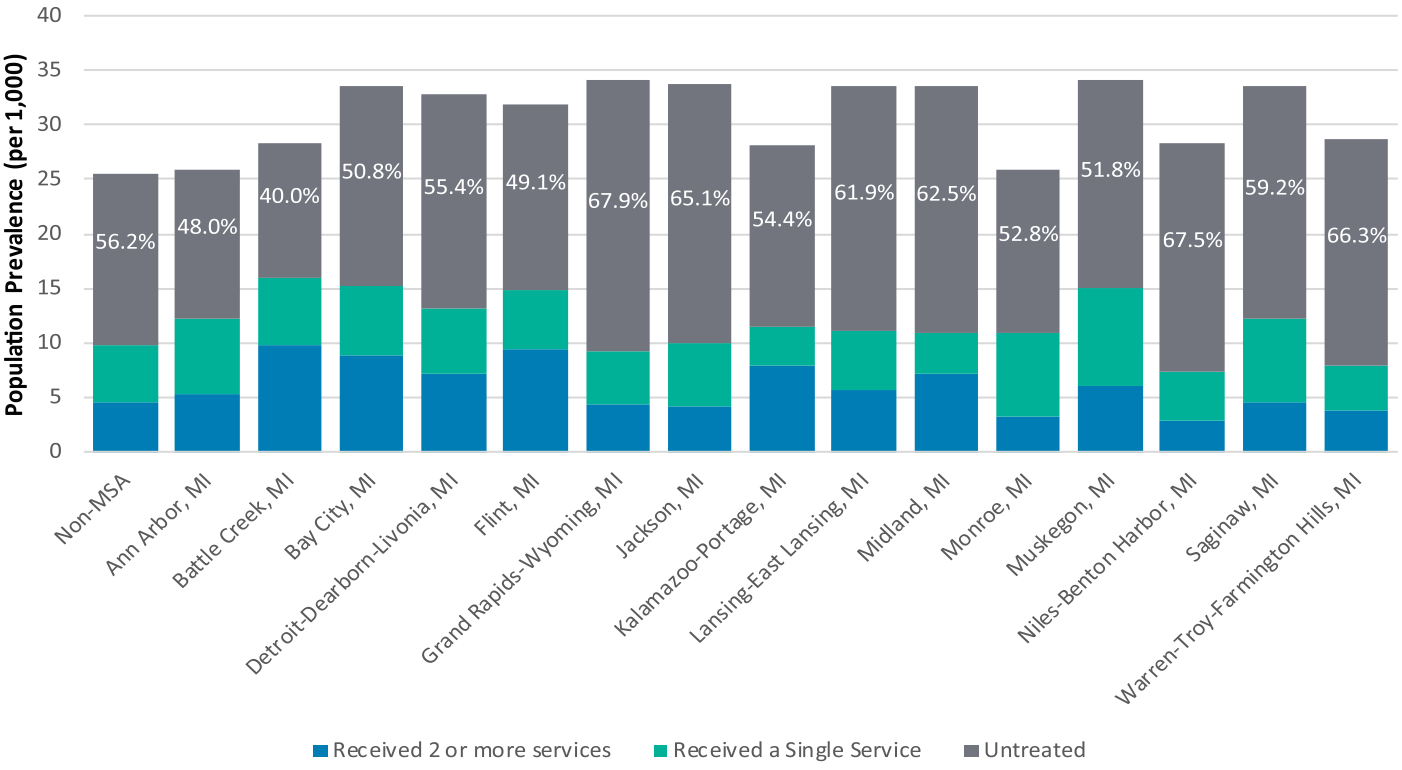


Figure 9: Prevalence and Unmet Need by MSA for Medicare Enrollees with Substance Use Disorder



Variation by Plan Type

In addition to analyzing the gaps in treatment for mental illness and SUD by the geographic location of the enrollee, we also compared the share untreated by Medicare plan type. We find that a larger share of enrollees in Medicare Advantage plans are untreated compared to Medicare fee-for-service (FFS). This finding held for both mental illness and SUD (Figures 10 and 11).

Our findings by plan type follow a consistent pattern for mental health and substance use care, but the size of the effects may be overstated due to data constraints. Prevalence data are not available separately by Medicare plan type, so the same rates of prevalence of mental illness and SUD were used to compute the share untreated. If, for example, people enrolled in Medicare Advantage plans had lower rates of mental illness or SUDs than those enrolled in traditional Medicare, then the estimates of the shares untreated under Medicare Advantage will be too large.

Figure 10: Prevalence and Unmet Need for Any Mental Illness by Plan Type

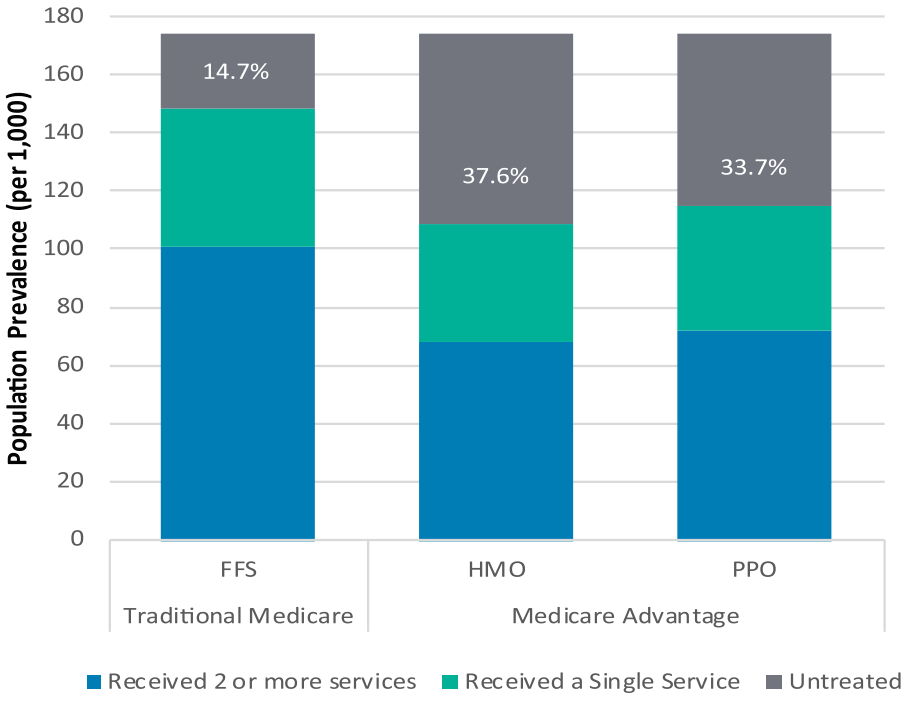
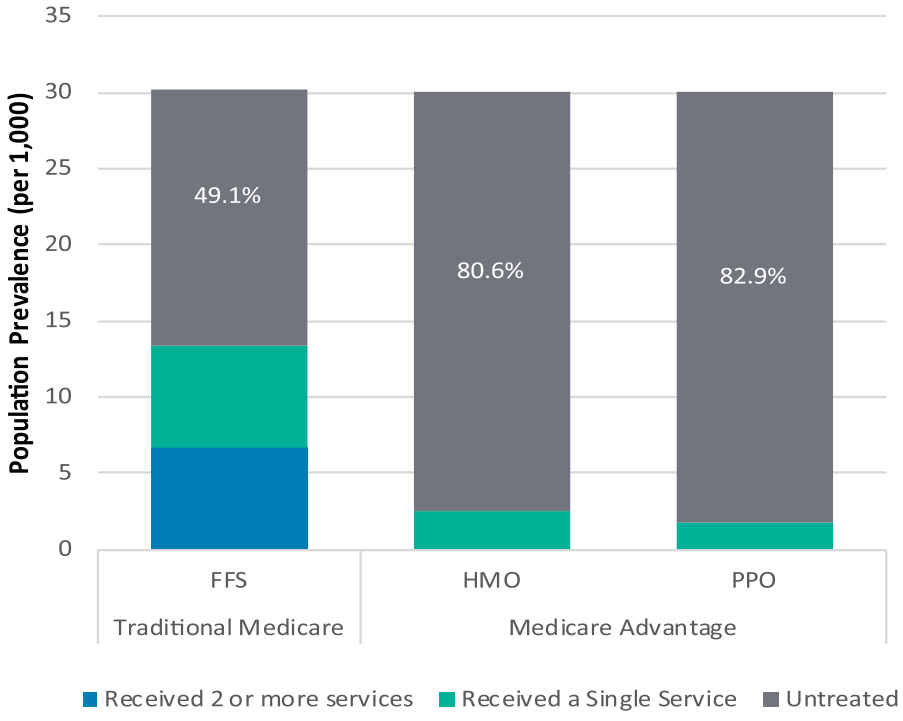


Figure 11: Prevalence and Unmet Need for Substance Use Disorder by Plan Type



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.

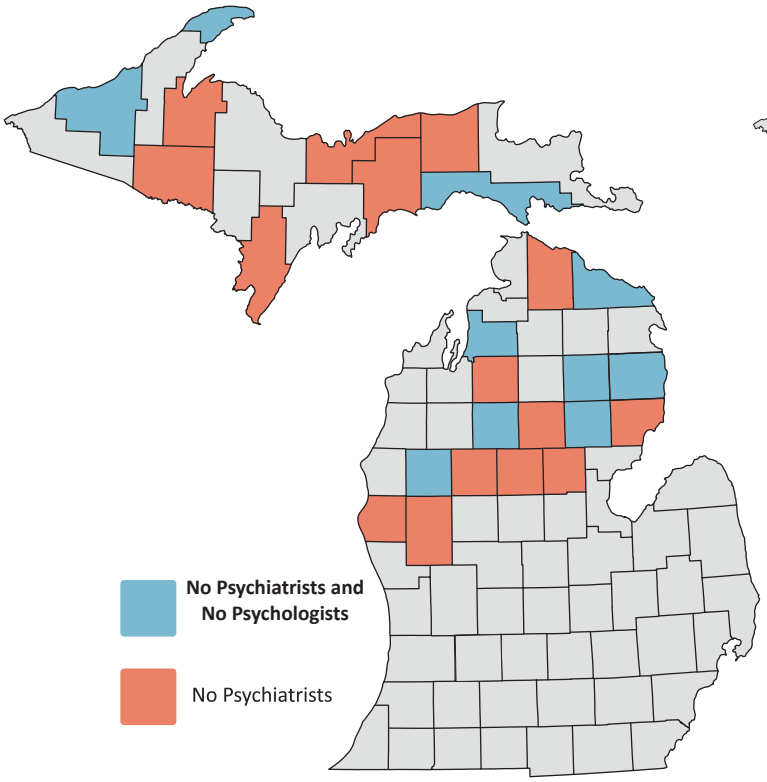
There are 292 mental health facilities in Michigan, a density similar to the U.S. average of one for every 34,000 people.

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.

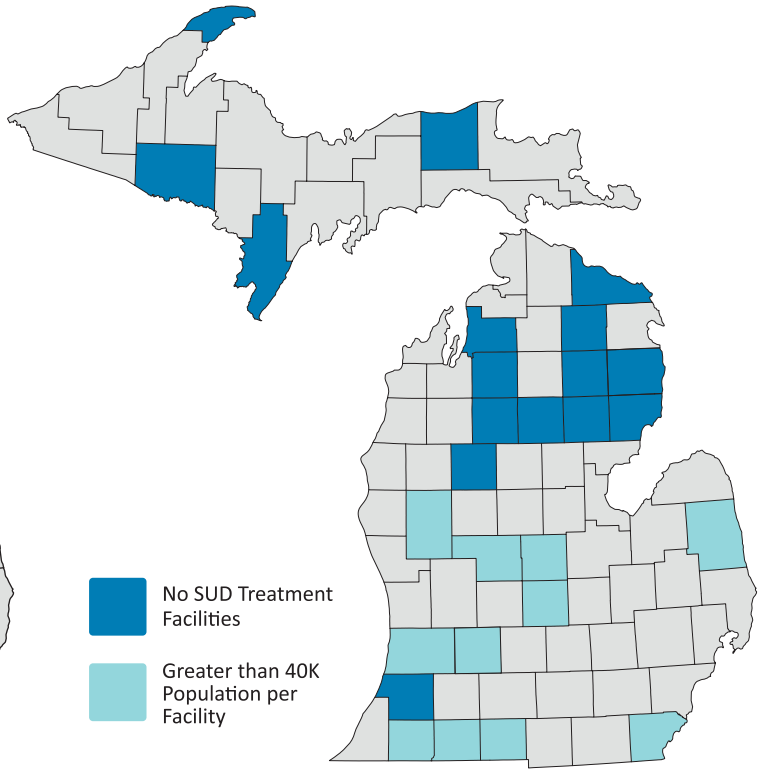
While the total number of facilities relative to the population in Michigan is consistent with the national average, there is considerable geographic variation within the state. There are 16 counties in Michigan with no SUD treatment facility (Figure 13, shaded dark blue) and an additional 11 counties (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 12: Counties Lacking Behavioral Health Clinicians



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

Figure 13: Counties Lacking SUD Treatment Facilities

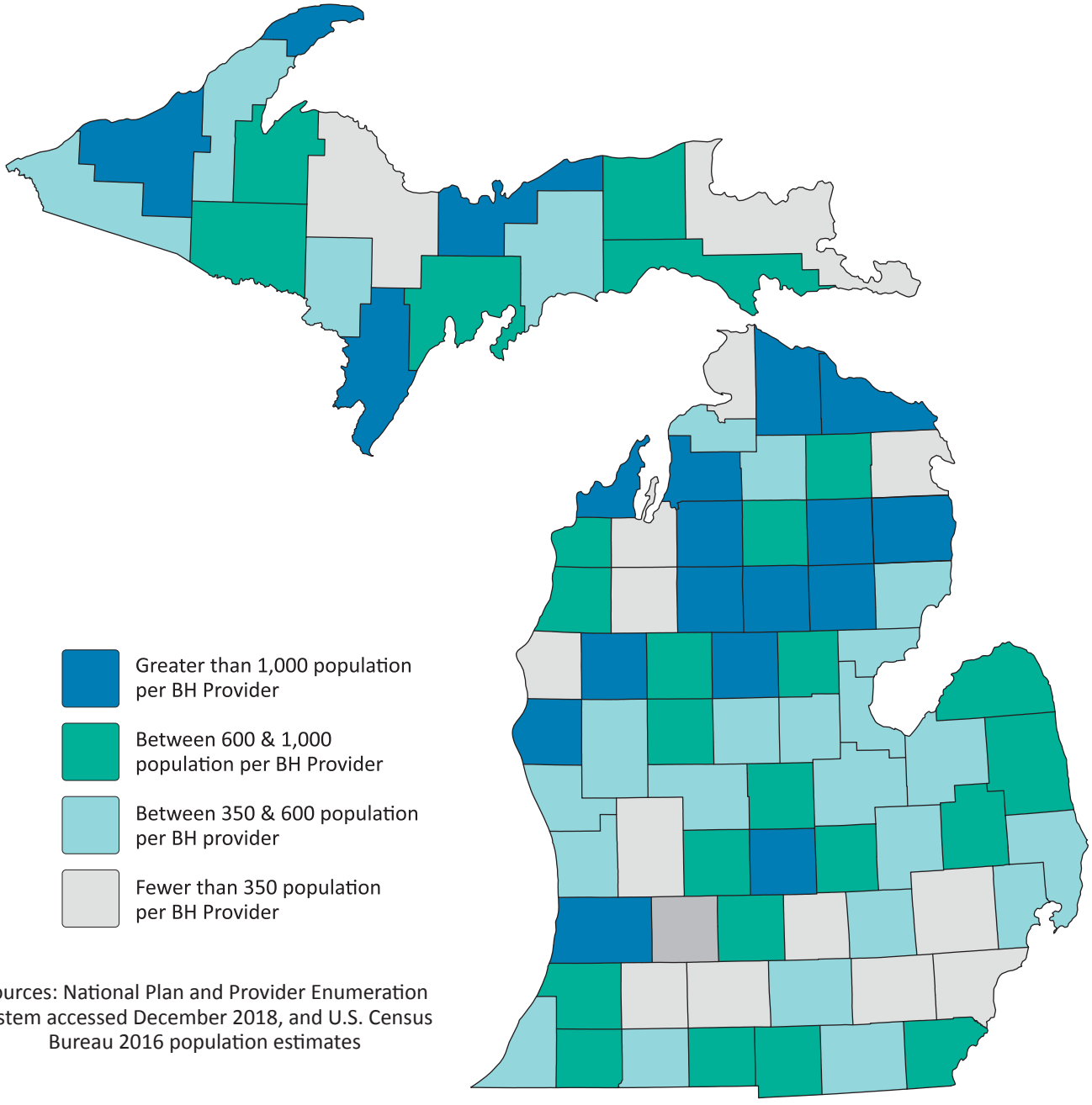


Source: SAMHSA Behavioral Health Treatment Facility Locator, https://findtreatment.samhsa.gov/locator, which uses data from the National Survey of Substance Abuse Treatment Services and the National Mental Health Services Survey

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

Figure 14: 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 insurance, there are financial barriers to access. This study finds large shares of those with behavioral health conditions who have coverage under Medicare or other public or private plans do not receive treatment for their conditions. One reason may be that psychiatrists are more likely than any other specialty to opt out of participation in Medicare, and many do not take insurance at all, greatly increasing patient exposure to costs.[2]

Survey data confirm that cost is a strong barrier to access. In the 2016 National Survey on Drug Use and Health (NSDUH), the Medicare population reported cost concerns as among the top reasons for not receiving treatment for mental illnesses, with 23% saying affordability was a factor, 12% citing not enough insurance coverage, and 9% saying insurance didn't cover the care needed (Figure 15).

Public Awareness and Perceptions

The NSDUH survey data also show that lack of information and attitudes are barriers to receiving treatment for behavioral health conditions. Respondents with Medicare coverage reported "didn't know where to go," and "thought could handle" as top reasons for not receiving mental health care.

Figure 15: Self-Reported Reasons for Not Receiving Behavioral Health Treatment

TOP REASONS FOR NOT RECEIVING TREATMENT	% Citing Each Reason, AMI Care
Couldn't Afford Costs	23%
Thought Could Handle/Not Ready to Get Treatment	17%
Not Enough Insurance Coverage	12%
Didn't Know Where to Go	12%
Health Insurance Didn't Cover	9%
Some Other Reason	28%

Source: 2016 National Survey on Drug Use and Health. Respondents could select multiple answers.

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 Medicare enrollees in Michigan, computed as the average of the top quintile of Metropolitan Statistical Areas, an additional 40,600 Medicare enrollees would receive mental health services each year, and an additional 7,800 would receive treatment for SUDs. Achieving this goal would increase the share of Medicare enrollees receiving mental health services from 79% to 95%! It would increase the share of Medicare enrollees receiving substance abuse treatment from 40% to 56%, leaving less than half untreated. Figures 16 and 17 display counts and shares of Medicare 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 16: Unmet Need for Medicare AMI Care if Best MI Access is Statewide

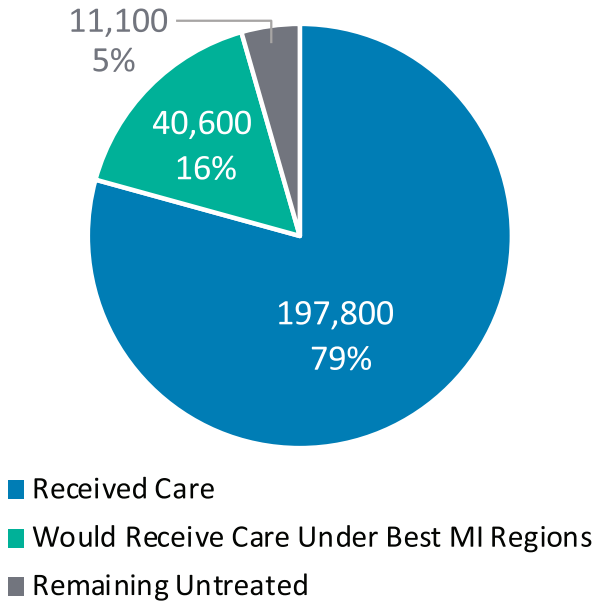
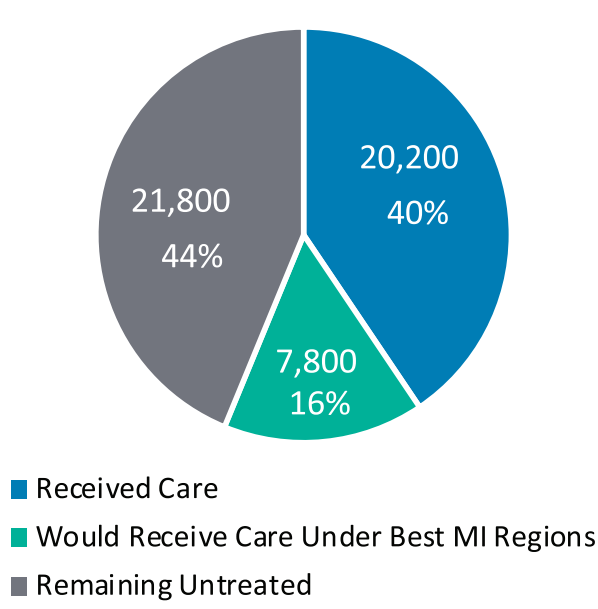


Figure 17: Unmet Need for Medicare SUD Care if Best MI Access is Statewide



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 → →

↑ ↑ Additional Cost ↑ ↑	Low	Medium	High
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

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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
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