Access to Behavioral Health Care in Michigan

Results for the Total Michigan Population | July 2019

Summary of Key Findings

▲ Millions of Michiganders experience mental illness, but less than two-thirds receive treatment. Of the 1.76 million Michiganders experiencing a mental illness, about 62% receive treatment, leaving 38%, more than 666,000 people, with unmet need.

▲ The majority of Michiganders with a substance use disorder go untreated. Of the 638,000 Michiganders experiencing a substance use disorder, only 20% receive treatment, leaving more than half a million people untreated.

▲ *Anxiety disorders* and *depressive episode* are the most common mental health conditions in Michigan, and those most likely to go untreated.

▲ *Alcohol use disorder* is the primary substance use disorder in Michigan, and the disorder most likely to go untreated.

▲ Across payer types, Medicaid enrollees are the most likely to remain untreated for a mental illness. About one-half of Medicaid enrollees, one-third of the privately-insured, and one-fifth of Medicare enrollees with a mental illness do not receive care.

▲ Across payer types, the privately insured are the most likely to remain untreated for a substance use disorder. About 87% of the privately-insured, 70% of Medicaid enrollees, and 60% of Medicare enrollees with a substance use disorder do not receive care.

▲ Barriers to behavioral health care access include shortages of providers, costs of care, and reluctance to seek care.

▲ Behavioral health provider capacity is especially 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 of Michigan could achieve the rates of care seen in best access areas of the state, another 236,000 people with a mental illness and 88,000 people with a substance use disorder would receive care. Statewide rates of treatment would rise to 75% of those with a mental illness and one-third of those with a substance use disorder.

▲ 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 brief presents study findings for the total Michigan population. Please see our companion briefs for summaries of findings for the Medicare population, the Medicaid population, and the privately-insured population. Study results and methods are documented in more detail in the 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 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 being received, as identified in 2016 administrative claims data. We use the IBM *MarketScan Research Database* for commercial claims, complete Medicaid claims data for Michigan, and Medicare Limited Data Set claims files for professionals and outpatient facilities to identify the share of individuals covered by each of these insurance types in Michigan who are currently receiving behavioral health services.

For the uninsured and the small share of the population with insurance coverage through the Veterans Administration (VA), Military Health System (MHS), Indian Health Service (IHS), or other source not reflected in our combined claims data, we used National Survey on Drug Use and Health (NSDUH) data to estimate the share untreated. 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 population counts by insurance type. Prevalence rates are from the NSDUH and the National Survey on Children's Health. Michigan population data by age, sex, insurance status, and location are from the U.S. 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 behavioral 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 Michiganders are not receiving treatment for their behavioral health conditions.

Of a total Michigan population of 9.9 million people, we estimate 1.76 million experience any mental illness (AMI). We find that 38% of those with AMI, more than 666,000 people, are not receiving care (Figure 1).

For SUD, the access gap is even larger; most Michiganders with SUD are not receiving care. Of the 638,000 Michiganders experiencing SUD, 80% of them, more than half a million 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]
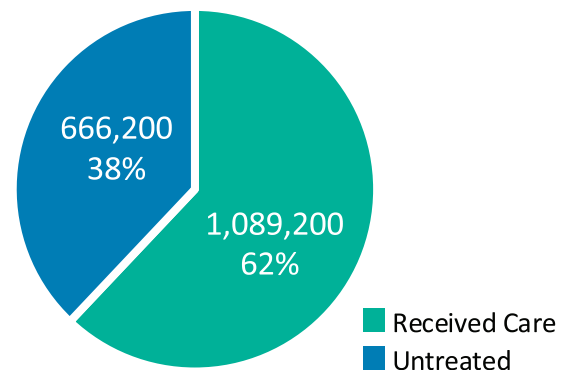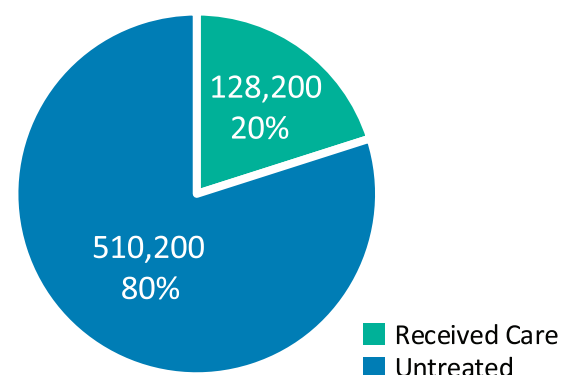

Figure 1: Unmet Need for AMI Care in Michigan

666,200
38%

1,089,200
62%

■ Received Care
■ Untreated

Figure 2: Unmet Need for SUD Care in Michigan

128,200
20%

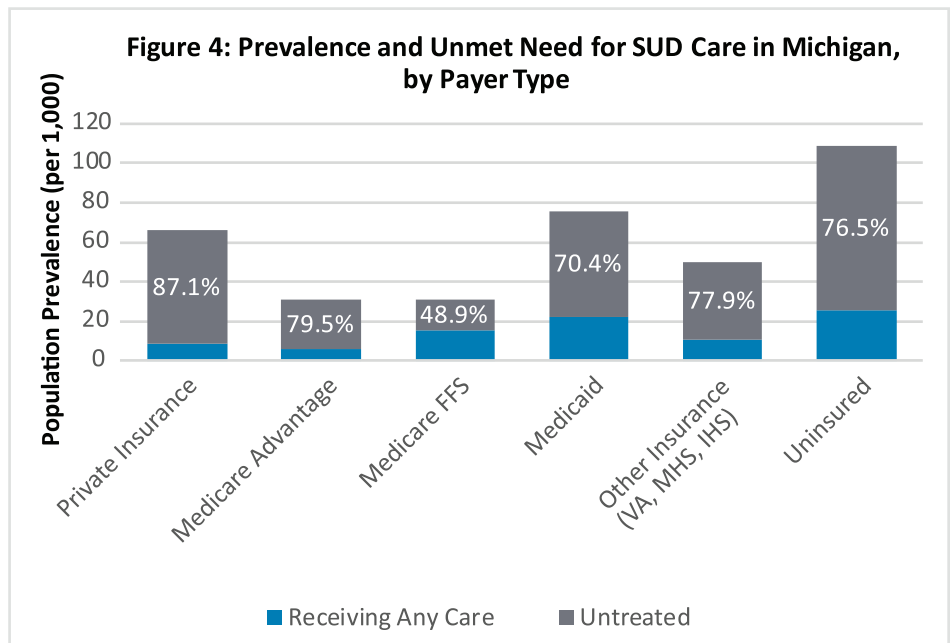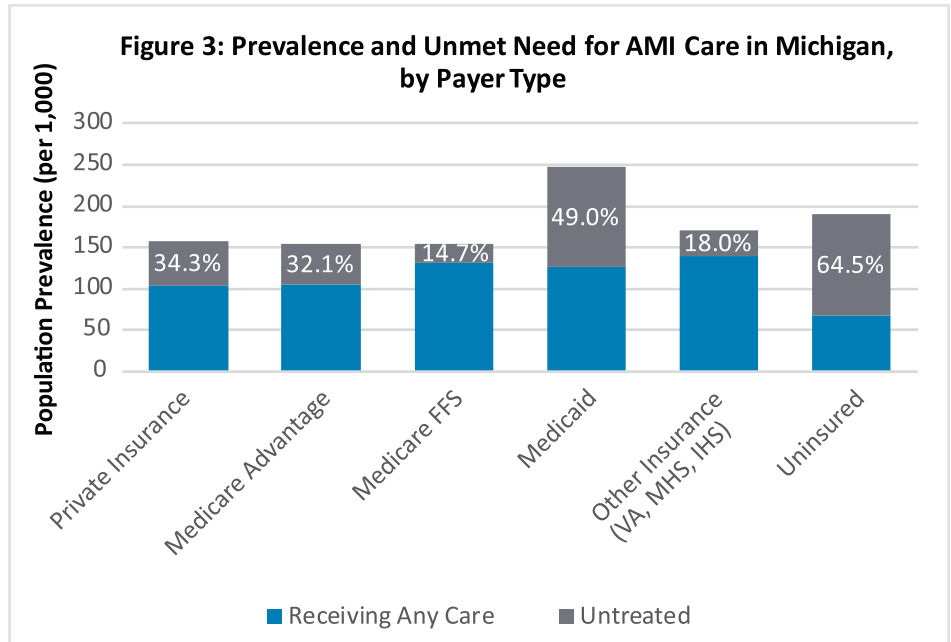510,200
80%

■ Received Care
■ Untreated

Results by Payer Type

Medicaid enrollees have a higher prevalence of AMI than Michiganders with other types of coverage, at about 250 people per 1,000. The uninsured experience the next highest rate, while those covered under private insurance and Medicare have AMI at a rate of about 150 people per 1,000.

Among the insured populations in Michigan, Medicaid enrollees have the largest share untreated for AMI at 49% (Figure 3). About one-third of those with an AMI covered under private insurance and Medicare Advantage are untreated. The best access to AMI care is experienced under Medicare fee-for-service (FFS), where only about 15% of those with AMI are untreated.

The highest prevalence of SUD is experienced by the uninsured population in Michigan, followed closely by the Medicaid population (Figure 4). The privately-insured have the largest share untreated, at 87%. The share untreated is between 70% and 80% for Medicaid, Medicare Advantage, the uninsured, and other insurance. The best access to SUD care is again under Medicare FFS, where 49% of those with SUD are untreated.

While population and claims data allow us to separate Medicare Advantage and Medicare FFS, it is important to note that the prevalence data are not available by Medicare plan type. If, for example, individuals enrolled in Medicare Advantage plans had lower rates of prevalence of behavioral health conditions than those enrolled in FFS, then the differences in the share of unmet need between the two Medicare populations shown here would be overstated.

Figure 3: Prevalence and Unmet Need for AMI Care in Michigan, by Payer Type

Population Prevalence (per 1,000)

- Private Insurance: 34.3%
- Medicare Advantage: 32.1%
- Medicare FFS: 14.7%
- Medicaid: 49.0%
- Other Insurance (VA, MHS, IHS): 18.0%
- Uninsured: 64.5%

■ Receiving Any Care ■ Untreated

Figure 4: Prevalence and Unmet Need for SUD Care in Michigan, by Payer Type

Population Prevalence (per 1,000)

- Private Insurance: 87.1%
- Medicare Advantage: 79.5%
- Medicare FFS: 48.9%
- Medicaid: 70.4%
- Other Insurance (VA, MHS, IHS): 77.9%
- Uninsured: 76.5%
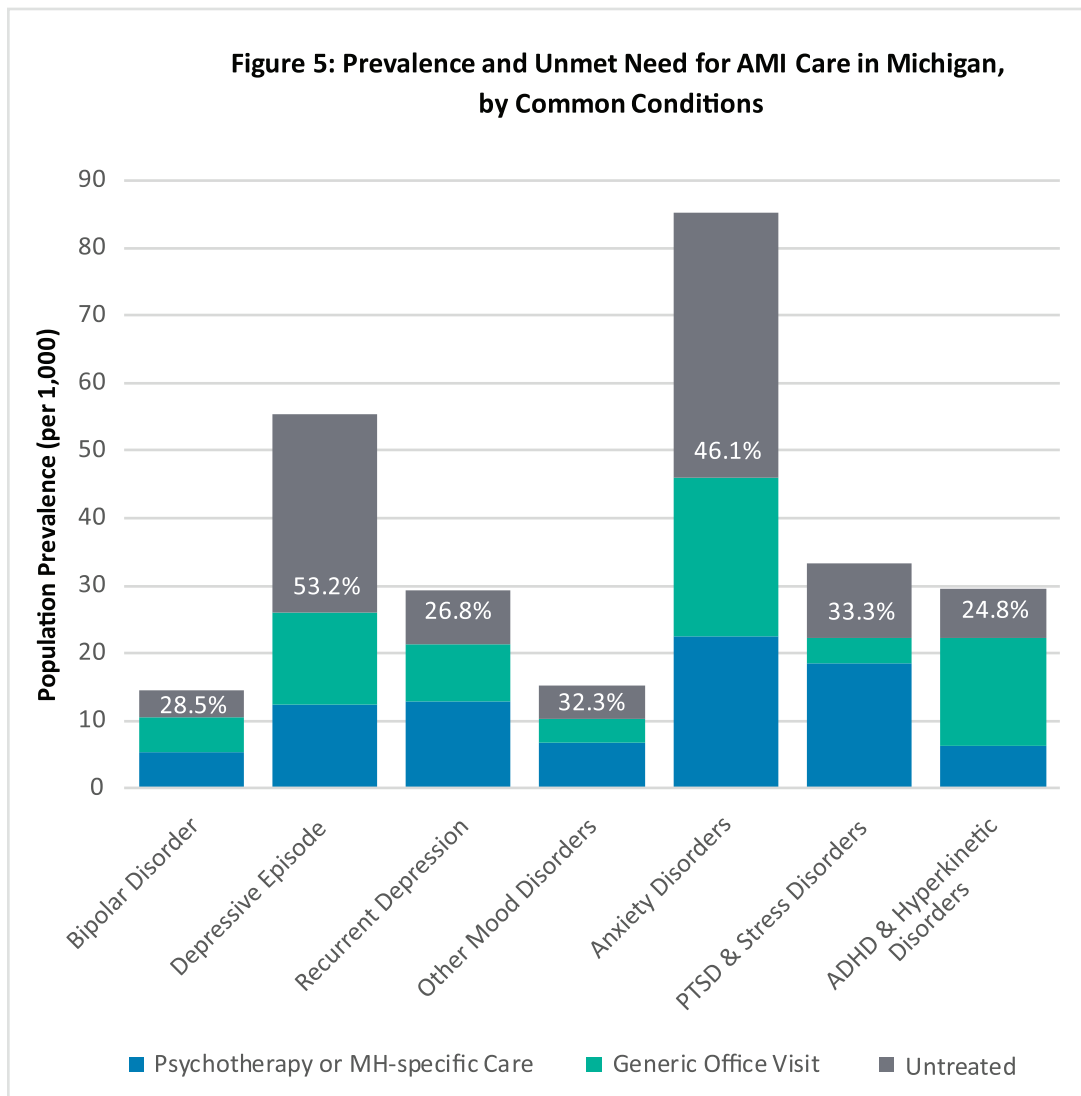
■ Receiving Any Care ■ Untreated

Results by Condition

We examined results by common mental health and substance use disorder conditions for the combined Medicaid, Medicare, and privately-insured populations in Michigan. The smaller populations of uninsured and those covered under other insurance are not included in these results.

Common Mental Health Conditions

Unmet need for AMI in Michigan is greatest for the more prevalent, mild-to-moderate conditions. Figure 5 shows the variation in estimated prevalence and unmet need for some of the most common mental health condition diagnostic categories. The conditions with the largest shares going untreated are *anxiety disorders* and *depressive episode*. More serious conditions such as *bipolar disorder, recurrent depression*, and *post-traumatic stress disorder (PTSD) and other stress disorders* are less prevalent among Michiganders and show lower shares going untreated.

For those treated, Figure 5 also distinguishes between individuals 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). Michiganders with *anxiety disorders*, a *depressive episode*, and *attention-deficit hyperactivity disorder (ADHD) and hyperkinetic disorders* are most likely to receive care coded as a generic office visit.

Figure 5: Prevalence and Unmet Need for AMI Care in Michigan, by Common Conditions
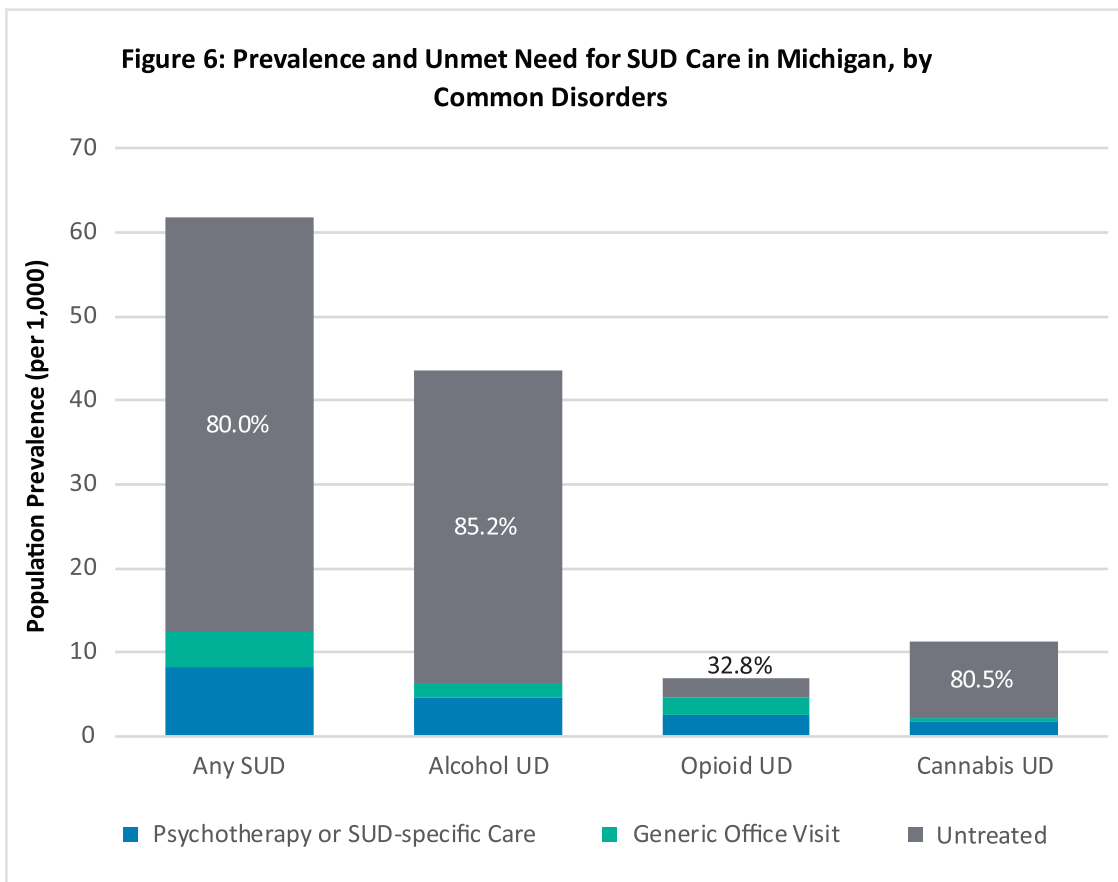
Common Substance Use Disorders

Among common SUDs, the prevalence and the unmet need is greatest for alcohol use disorder. Michiganders are experiencing alcohol use disorder at about four times the rate as cannabis or opioid use disorder, and more than 85% of those with alcohol use disorder are not receiving care. While lower in prevalence, unmet needs are still large for the other major disorders; more than 80% of those with a cannabis use disorder are not receiving care, as are one-third of those with an opioid use disorder.

Compared to the 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 those with a SUD received a service specific to SUD treatment or a psychotherapy visit.

Figure 6: Prevalence and Unmet Need for SUD Care in Michigan, by Common Disorders

Variation by Age & Sex

Mental Health Conditions

Male children have nearly three times the rate of AMI (including attention deficit disorder) as female children (Figure 7). For every other age group, females have significantly higher rates of AMI than males.

Unmet needs are similar across age/sex categories, ranging from 30% to 40% untreated. For example, 38% of females age 25 to 54 with AMI are untreated, while 43% of males in this age group are untreated.

Substance Use Disorders

For SUDs in Michigan, prevalence is highest among young men ages 18 through 24, followed by young women ages 18 through 24, and then men ages 25 through 54 (Figure 8). Prevalence of SUD drops significantly for older adults age 65 and older.

Unmet needs for all age groups are much higher for SUD than for AMI. At any age, most individuals with a SUD do not receive care. The percent of individuals not receiving SUD care is between 70% and 90% for all age/sex categories.

Figure 7: Prevalence and Unmet Need for AMI Care in Michigan, by Age & Sex
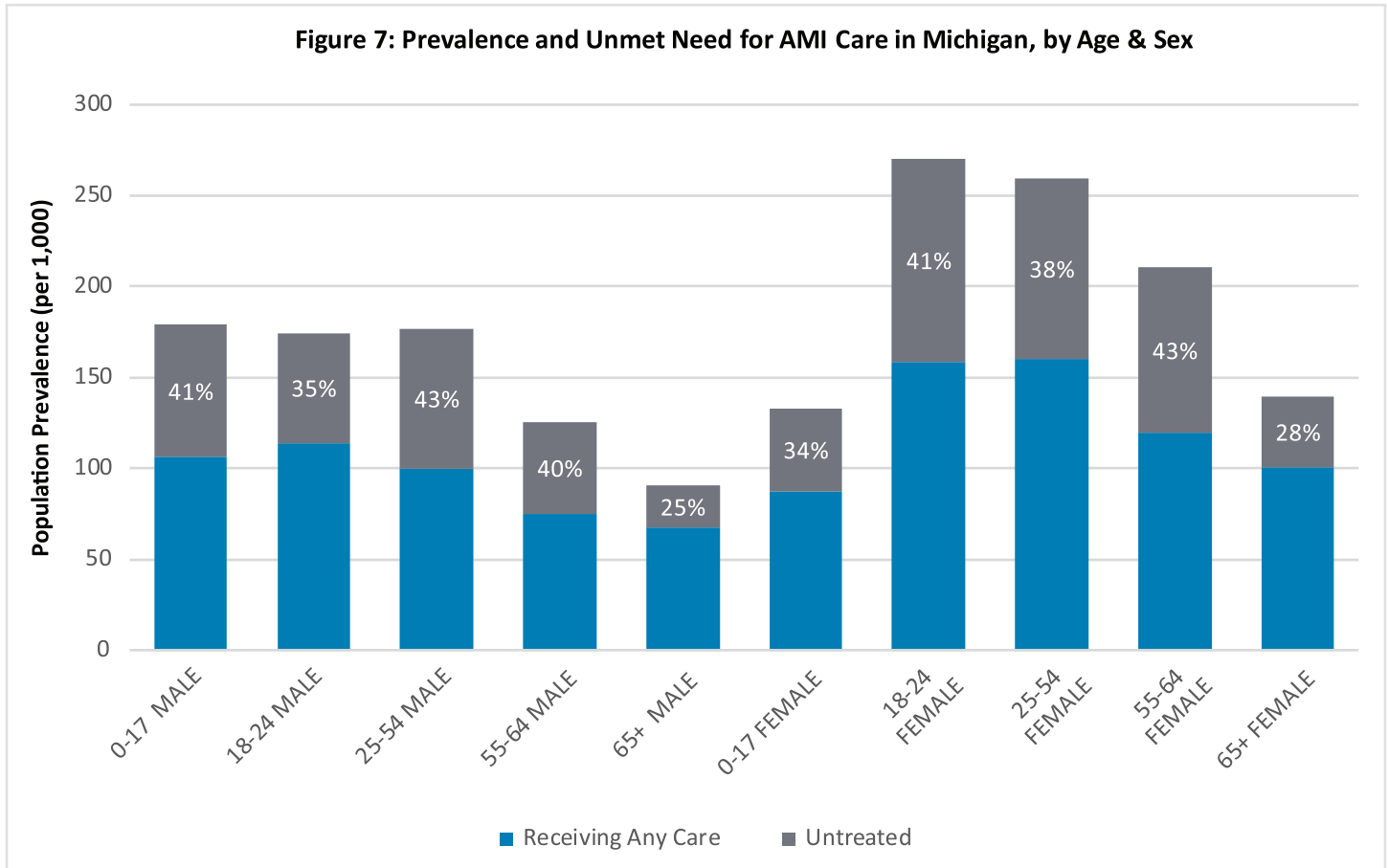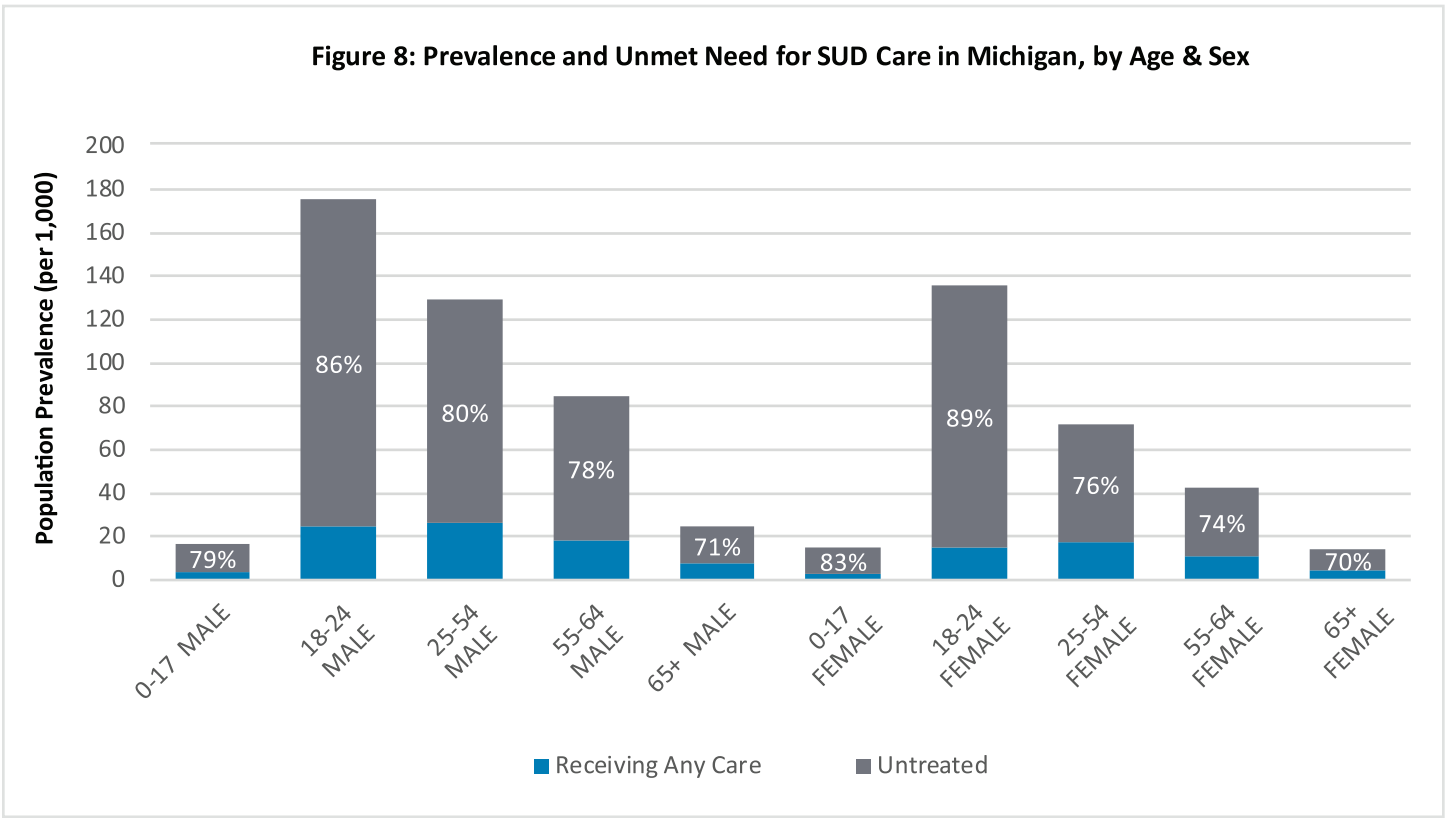
Figure 8: Prevalence and Unmet Need for SUD Care in Michigan, by Age & Sex

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 individuals with AMI not receiving care ranges from 29.4% in Region 9 (Southeast Michigan) to 41.4% in Region 5 (Central Michigan) (Figure 9). While large numbers of Michiganders not receiving mental health services reside in the more populated regions of the state (West Michigan, Region 4 and Detroit Metro, Region 10), relative access gaps are greater in the more rural parts of the state.

While the unmet need for SUD care is greater, the variation between regions is narrower. The share of unmet need for SUD care ranges from 75% in Region 2 (Northwest lower peninsula) to 83% in Region 4 (West Central Michigan).

Variation by Metropolitan Statistical Area

There is more variation in unmet need across the state's Metropolitan Statistical Areas (MSAs) than by the Prosperity Regions. The share of unmet need for AMI care ranges from lows of 26% in the Ann Arbor MSA to a high of 50% in the Saginaw MSA (Figure 10). The Detroit-Dearborn-Livonia and Niles-Benton Harbor MSAs also show high rates of unmet need for AMI care. The non-MSA areas of the state (rural areas outside of any city's metropolitan region) have a share of unmet need near the state average, at 37% untreated. This is unexpected, as gaps in access in rural regions were expected to be near the top of the state's range.

The unmet need for SUD care shows a slightly different pattern by MSA as that seen for AMI care (Figure 11). The share of unmet need ranges from a low of 75% in the Monroe MSA to a high of 86% in the Midland MSA. The rural non-MSA areas have unmet need of 80%, again in the middle of the range of access gaps by MSA.

Figure 9: Unmet Need by Michigan Prosperity Region

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

Region 1:
AMI Gap: 19,800 (37.1%)
SUD Gap: 13,900 (77.4%)

Region 3:
AMI Gap: 12,900 (34.3%)
SUD Gap: 8,400 (75.1%)

Region 2:
AMI Gap: 19,600 (33.0%)
SUD Gap: 13,300 (75.0%)

Region 5:
AMI Gap: 44,600 (41.4%)
SUD Gap: 34,300 (81.5%)

Region 4:
AMI Gap: 108,200 (38.4%)
SUD Gap: 88,900 (83.3%)

Region 6:
AMI Gap: 65,700 (38.8%)
SUD Gap: 48,200 (78.7%)

Region 7:
AMI Gap: 29,200 (33.0%)
SUD Gap: 29,000 (82.0%)

Region 10:
AMI Gap: 268,000 (41.0%)
SUD Gap: 192,200 (79.1%)

Region 8:
AMI Gap: 49,500 (35.5%)
SUD Gap: 37,700 (79.4%)

Region 9:
AMI Gap: 48,600 (29.4%)
SUD Gap: 42,400 (76.5%)

Figure 10: Prevalence and Unmet Need for AMI Care by Michigan MSA

Population Prevalence (per 1,000)

MSA	Untreated %
Non-MSA	37%
Ann Arbor, MI	26%
Battle Creek, MI	35%
Bay City, MI	44%
Detroit-Dearborn-Livonia, MI	48%
Flint, MI	44%
Grand Rapids-Wyoming, MI	42%
Jackson, MI	40%
Kalamazoo-Portage, MI	34%
Lansing-East Lansing, MI	35%
Midland, MI	39%
Monroe, MI	31%
Muskegon, MI	33%
Niles-Benton Harbor, MI	47%
Saginaw, MI	50%
Warren-Troy-Farmington Hills, MI	40%

■ Received Care ■ Untreated

Figure 11: Prevalence and Unmet Need for SUD Care by Michigan MSA

Population Prevalence (per 1,000)

MSA	Untreated %
Non-MSA	80%
Ann Arbor, MI	79%
Battle Creek, MI	78%
Bay City, MI	82%
Detroit-Dearborn-Livonia, MI	81%
Flint, MI	80%
Grand Rapids-Wyoming, MI	84%
Jackson, MI	80%
Kalamazoo-Portage, MI	81%
Lansing-East Lansing, MI	83%
Midland, MI	86%
Monroe, MI	75%
Muskegon, MI	82%
Niles-Benton Harbor, MI	84%
Saginaw, MI	82%
Warren-Troy-Farmington Hills, MI	81%

■ Received Care ■ Untreated

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.
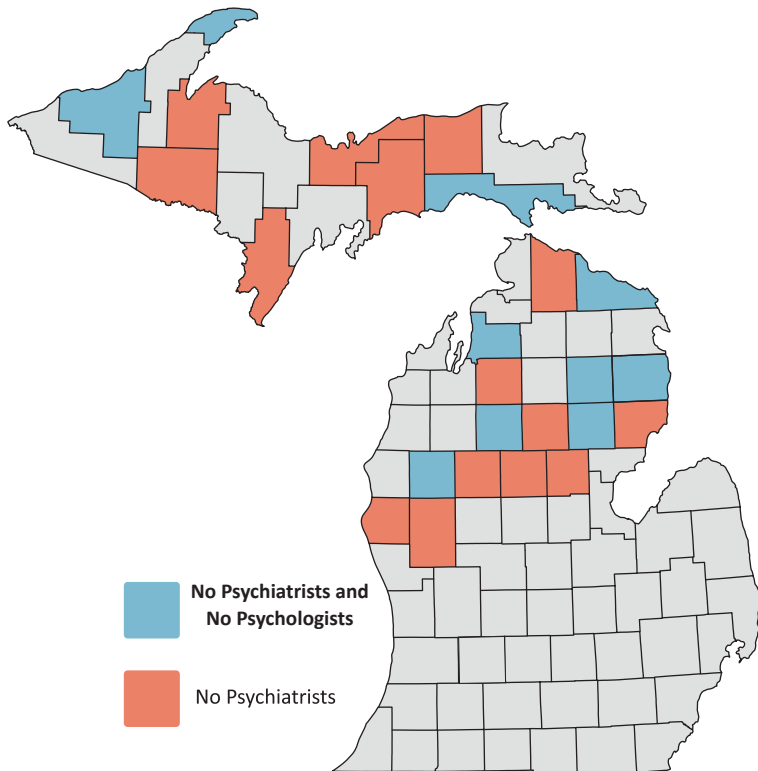
There are 292 mental health treatment facilities in Michigan, a density comparable to the U.S. average of one for every 34,000 people. Mental health facilities offering residential services are in shorter supply; with 17 such facilities, there are 590,000 people per facility in Michigan compared to the 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.
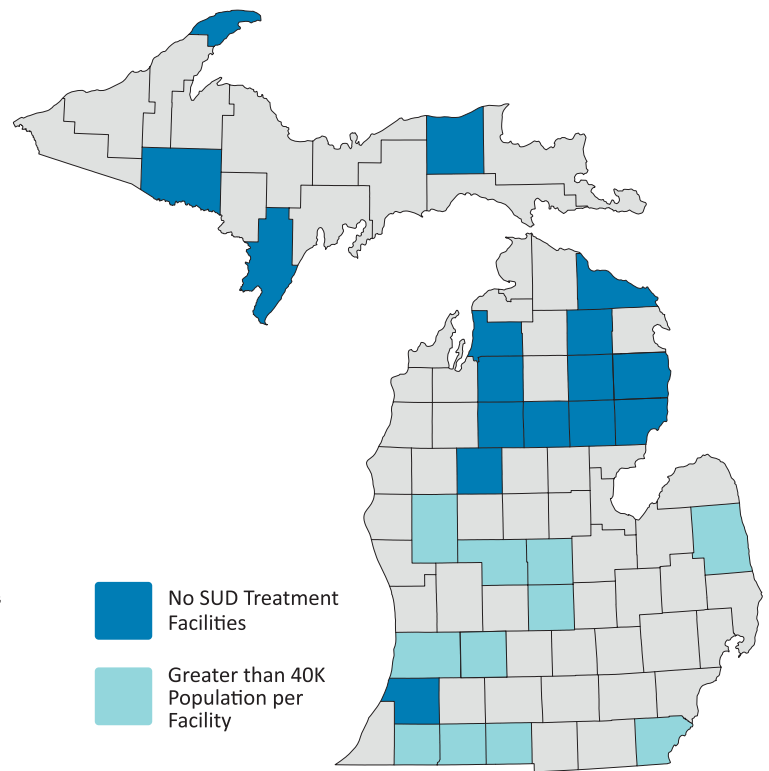
While the total number of facilities relative to the population in Michigan is consistent with the national average, there is considerable geographic variation within the state. There are 16 counties in Michigan with no SUD treatment facility (Figure 13, shaded dark blue) and an additional 11 counties (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 12: Counties Lacking Behavioral Health Clinicians

No Psychiatrists and No Psychologists

No Psychiatrists

Source: Altarum analysis of National Plan and Provider Enumeration System data, accessed December 2018
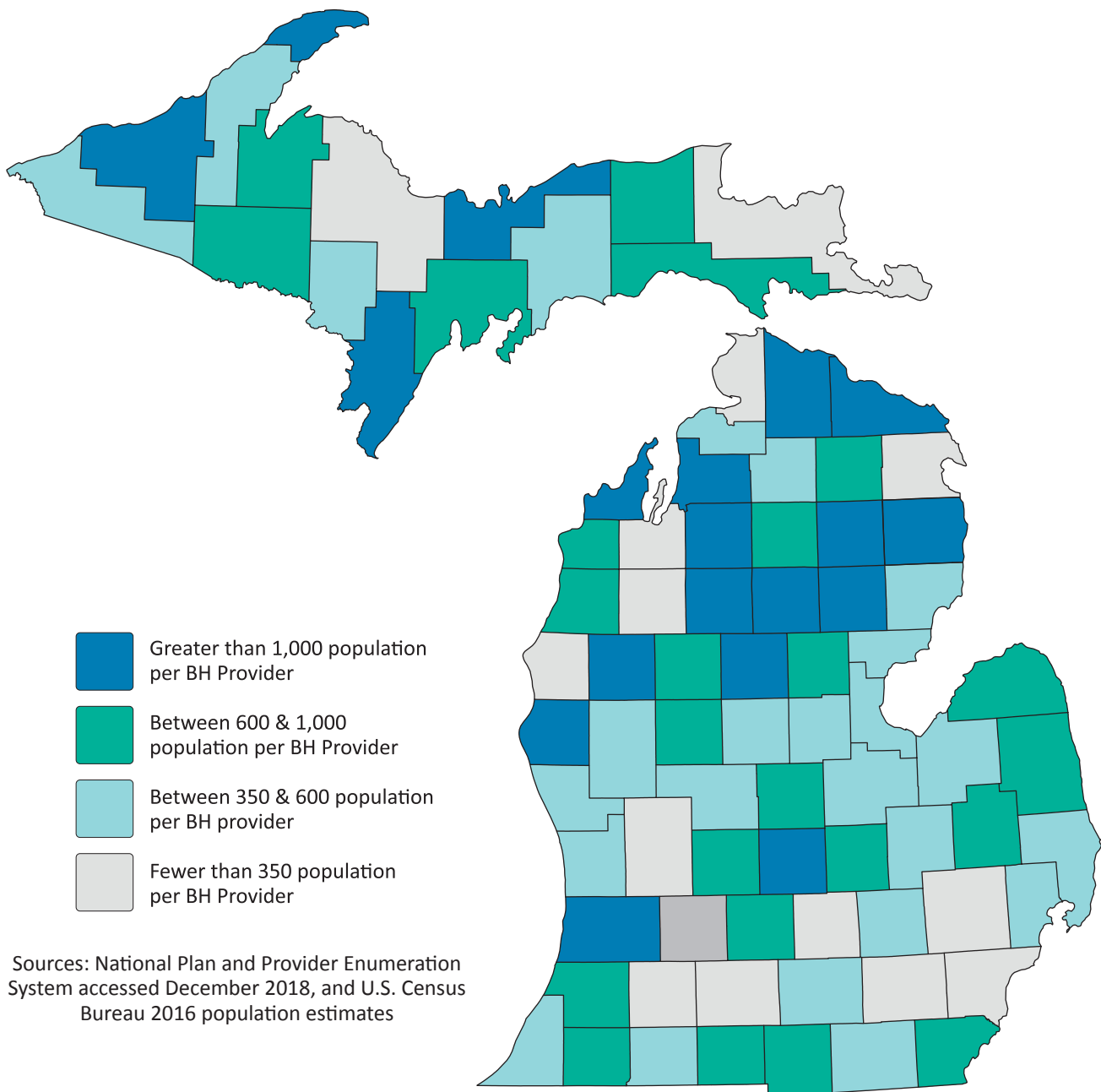
Figure 13: Counties Lacking SUD Treatment Facilities

No SUD Treatment Facilities

Greater than 40K Population per Facility

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 more people per provider, 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 parts 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 greater share of the population going untreated, particularly among the privately insured and Medicare populations. Conversely, counties in the more populated areas of the state, such as southeast Michigan, have the greatest supply of providers and tend to have lower shares untreated.

Figure 14: Population Per Behavioral Health Provider by County in Michigan

Greater than 1,000 population per BH Provider

Between 600 & 1,000 population per BH Provider

Between 350 & 600 population per BH provider

Fewer than 350 population per BH Provider

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 that large shares of those with behavioral health conditions who had health insurance did not receive treatment for their conditions. For those covered under high deductible plans, the out-of-pocket costs required to pay for treatment may be prohibitive. In addition, psychiatrists are more likely than other specialties to opt out of participation in public and private insurance networks, and many do not take insurance at all, increasing patient exposure to costs.[2] In Michigan, outpatient behavioral health care was four to six times more likely to be out-of-network than medical/surgical care.[3]

Survey data confirm that cost is a strong barrier to access. In the 2016 NSDUH, individuals reported "couldn't afford costs," and "not enough insurance coverage" as among the top reasons for not receiving treatment for AMI (Figure 15). For SUD treatment, high shares also cited cost and insurance coverage as barriers.

Lack of Transportation

Respondents to the NSDUH survey also report transportation issues as a barrier to receiving care. For AMI, 11% of Medicaid enrollees report transportation as a factor (not shown in Figure 15). For SUD care, 8% of all respondents cite transportation as a factor.

Public Awareness and Perceptions

The NSDUH survey data also show that lack of information on how to access care, lack of acceptance that care is needed, and reluctance to seek care due to discomfort with stigma are barriers to receiving treatment for behavioral health conditions. Respondents reported "didn't know where to go," and "thought could handle" as top reasons for not receiving care. Less often cited, but still among the top reasons were "concerned about neighbors' opinion" and "didn't want others to find out."

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

TOP REASONS FOR NOT RECEIVING TREATMENT	% Citing Each Reason, AMI Care	% Citing Each Reason, SUD Care
Couldn't Afford Costs	40%	27%
Thought Could Handle/Not Ready to Get Treatment	28%	38%
Didn't Know Where to Go	22%	19%
Didn't Have Time	20%	5%
Not Enough Insurance Coverage	13%	12%
Concerned about Neighbors' Opinion	11%	14%
Didn't Want Others to Find Out	9%	4%

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 if all areas of the state achieved the current best access for Michigan, computed as the average of the top quintile of MSAs, an additional 236,400 Michiganders would receive mental health services each year, and an additional 87,500 would receive treatment for SUDs (Figures 16 and 17). Achieving this goal would increase the share of Michiganders with AMI receiving care from 62% to 75%. The share of Michiganders receiving care for SUDs would increase from 20% to one-third (34%) of those with a SUD.

Figure 16: Unmet Need for AMI care if Best Michigan Access is Statewide
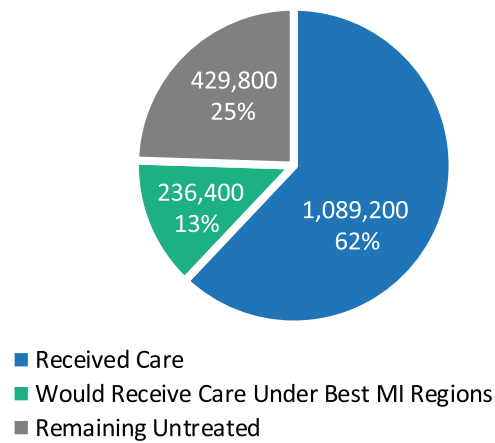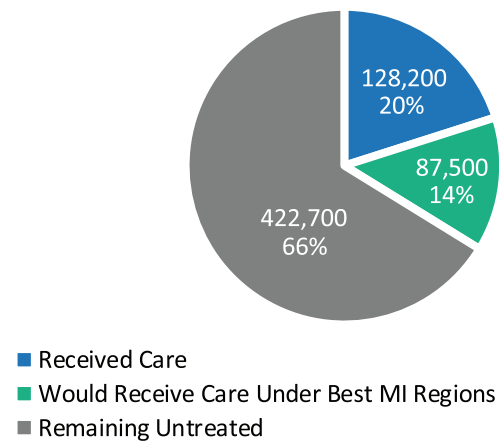

- 429,800 / 25%
- 236,400 / 13%
- 1,089,200 / 62%

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

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

- 128,200 / 20%
- 87,500 / 14%
- 422,700 / 66%

■ 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.[4]

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.[5]

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%.[6] 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.[7] 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.[8] 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 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

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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