Policy brief
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Integrated Behavioral Healthcare in Michigan

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Executive statement

As the correlation between physical and behavioral health is becoming increasingly more recognized, policymakers and stakeholders are interested in addressing the health disparities related to the co-occurrence of these conditions in the Michigan population. Research continues to exemplify that those living with coinciding physical and behavioral health conditions have higher health care costs while not experiencing better health outcomes. As the co-occurrence of behavioral and physical health conditions are becoming more prevalent among Medicaid beneficiaries, policymakers and healthcare advocates are looking for alternative measures to address the needs of this population. Although innovative ways to address this problem continue to emerge throughout Michigan and the United States, past efforts to financially integrate physical and behavioral health services among Michigan's Medicaid population have failed to move into law. A singular state-wide strategy to integrate care has yet to be enacted. This policy brief aims to discuss past Michigan legislative action related to integrating physical and behavioral health care services, compare Michigan efforts to other states' policies, and concludes with policy recommendations.

Problem statement and recommendations

Problem: Michigan has *no common legislative strategy* to support an integrated care delivery system state-wide

- Recommendation 1: Pilot a singular regional SIP in Michigan
- Recommendation 2: Consolidation of agencies
- Recommendation 3: Maintain “status quo” in Michigan with continued efforts to integrate care at local level

Introduction

Integrated care is described as the coordination and provision of behavioral health services with physical health services (American Psychiatric Association, 2022). According to Goldman et al. (2022), integrated care models are critical to increasing access to comprehensive and coordinated services. However, a singular integrated care model has yet

to be adopted in Michigan. In Michigan, approximately 1.3 million residents have a mental or behavioral health condition, 38% of whom are not receiving care (National Council for Mental Wellbeing, 2022; Ryhan et al., 2019). Among Michigan residents enrolled in Medicaid, almost half (49%) have unmet needs for mental health conditions (Ryhan et al., 2019). These statistics exemplify the urgency required to address the disparities Michigan's population is facing.

Although initiatives to address mental health care needs have been prevalent for some time, state-wide policies to integrate physical and behavioral health have failed to make it through the legislative process thus far in Michigan. In 2021, Michigan Senate Bills 597 and 598 were introduced to address the structural problems within the state's healthcare system and improve coordination between physical and behavioral health care specifically for the populations significantly impacted by the current fragmented system (Shirkey & Bizon, 2021). These bills proposed reforming Michigan's Medicaid system to integrate medical and behavioral health services for Michigan's Medicaid population. At the beginning of this project, Senate bills 597 and 598 had been introduced to the Senate and were referred to the Committee on Government Operations. Upon passing these bills, the Social Welfare Act would be amended to compel the Department of Health and Human Services to develop and implement a plan to integrate Medicaid medical health care with behavioral health care services by creating Specialty Integrated Plans (SIPs). These bills would allow a SIP to manage the comprehensive behavioral and medical care services for Medicaid beneficiaries requiring specialty behavioral health services (Shirkey & Bizon, 2021). As of November 29th, 2022, these bills were not passed in the Senate. Two additional bills, House Bill 4576 and House Bill 4577, are currently referred to the Committee on Health Policy as of May 16th, 2023, mirroring the two former senate bills.

"THE SOLUTION LIES IN INTEGRATED CARE – THE COORDINATION OF MENTAL HEALTH, SUBSTANCE ABUSE, AND PRIMARY CARE SERVICES. INTEGRATED CARE PRODUCES THE BEST OUTCOMES AND IS THE MOST EFFECTIVE APPROACH TO CARING FOR PEOPLE WITH COMPLEX HEALTHCARE NEEDS." - Substance Abuse and Mental Health Services Administration (SAMHSA)

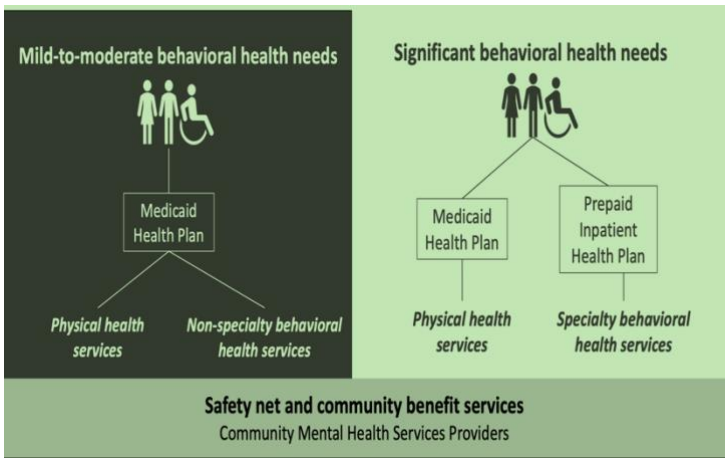
Policies that support the implementation of integrated care models are highly promoted to reduce fragmented and gaps in care for individuals with behavioral health conditions (Bachrach et al., 2014; Goodwin, 2016). Prior studies have demonstrated that integrated care laws and policies have favorable effects on access to care, clinical outcomes, patient satisfaction, and quality of care while reducing unnecessary and duplicate services

(Baxter et al., 2018; Coates et al., 2022). Despite the apparent benefits of integrated care models, Michigan has yet to execute a common legislative strategy for supporting an integrated care delivery system state-wide.

Background

According to Mental Health America, in 2022, Michigan was ranked 25 out of 50 states for access to mental health care. Access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability were measured regarding this ranking (Mental Health America, 2022). Concerning Michigan's vision for integrated care among its Medicaid population, the Michigan Department of Health and Human Services (MDHHS) had noted specific goals for improving its current system. These goals included broadening access to quality care, improving care coordination, and increasing behavioral health investment and financial stability. These goals are accompanied by core values, including "person-centeredness, self-determinedness, family-driven, youth-guided, community-based, recovery-oriented, culturally competent, and evidence-based" (Michigan Department of Health and Human Services (MDHHS), n.d.).

When discussing Michigan's current public behavioral health system, there is a difference between the care provided to those with mild-to-moderate behavioral health needs and those with significant behavioral health needs (i.e., those with significant mental health disorders, substance use disorders, and those with intellectual or developmental disabilities). The first population mentioned (individuals with mild-to-moderate behavioral health needs) receive all of their physical health and non-specialty behavioral health benefits from a Medicaid Health Plan (MHP). The second specified population, or those with significant behavioral health needs, receives behavioral and physical health benefits from a bifurcated system. This system is separated by a Medicaid Health Plan (MPH), which provides physical health care and care management, and Prepaid Inpatient Health Plans



Michigan's Current System for Medicaid Beneficiaries. Retrieved from Michigan Department of Human Services" *Strengthening Michigan's Behavioral Health System"*

(PIHPs), responsible for behavioral health benefits and case management. Michigan's Department of Health and Human Services has noted that this specific bifurcated system has caused challenges for this specific population and the current system

Prepaid Inpatient Health Plan is a term found in federal regulation from the Centers for Medicare and Medicaid Services, which can be defined as an entity that "1) provides medical services to enrollees under contract with the State Medicaid agency on the basis of prepaid capitation payments, 2) includes responsibility for arranging inpatient hospital care, and 3) does not have a comprehensive risk contract." (Community Mental Health Association of Michigan, n.d.) Michigan PIHPs manage Medicaid resources concerning specialty behavioral health services for Michigan Medicaid enrollees. There are currently ten regional PIHPs in Michigan responsible for managing specialty behavioral health benefits. In Michigan, Community Mental Health Services Programs (CMHSPs) and those they contract with provide a widespread assortment of behavioral health services in all 83 Michigan Counties (Community Mental Health Associations of Michigan, 2019). Prepaid Inpatient Health plans contract with the CMHSPs and associated providers to deliver services within their specified region. There are currently 46 CMHSPs in the state of Michigan. Of the ten regional PIHPs, seven of these entities partner with multiple CMHSPs within their region to provide necessary services.

Strengths of Current System
•Locally Based Systems
•Strong commmunity partnerships
•Serves All Residents in Crisis
•Does not limit crisis interventions to only those with Medicaid
•Locally Driven Innovated Care Delivery Models
•Investsments in schools, jails, prisons, and local social services
Challenges of Current System
•Complex Care Coordination
•Navigation of Two Systems
•Inconsistency in Services
•Lack of Primary Care Coordination

Table A: Strengths and Challenges of Current System in Michigan

Upon proposal of SB 597 and 598, significant resistance from multiple community members, PIHPs, and legislators was noted. Community Mental Health Association of Michigan (2022) lists 125 groups opposing SB 597 and 598. Advocacy groups, educational organizations, human rights organizations, mental health organizations, and payer organizations were some of the groups noted to oppose these bills. Supporters of this bill did include private health insurers such as Blue Cross Blue Shield of Michigan and Meridian Health. Opponents of these bills expressed concerns related to the privatization of funds as well as considerations that private insurers may focus or specialize in medical care and profits rather than service outcomes. Those in

opposition also argue that these bills focus solely on financial integration and do not address integration at a service delivery level. Please see Table A for both reported strengths and challenges of Michigan's current system.

Integrated Care Initiatives in Other States

Arizona is a state that has successfully integrated these systems of care. A policy brief by Soper (2016) acknowledges Arizona's integrated model for creating a specialty plan for those with serious mental illness. Arizona awarded a competitive contract to serve as an integrated RBHA for Maricopa County in 2015 prior to launching this state-wide initiative. From Soper's (2016) briefing, it was noted that state officials found that creating a competitive process among bidders for new contracts caused bidders to think more creatively regarding the state's vision for integrated service delivery. Soper (2016) also defines Arizona's approach as a Specialty Plan for beneficiaries with SMI. Michigan's Department of Health and Human Services 298 Facilitation Workgroup (2017) places this structure in the Modified Managed Care Approach category. Although positive outcomes were noted from this agency reform, challenges were noted concerning provider reimbursements and delays in prior authorizations (Powers et al., 2020). Arizona continues to implement integration efforts at the state-wide level for its Medicaid population to this day.

Forward progress was also made in Arizona through the consolidation of its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), and the state's Division of Behavioral Health Services (DBHS). Before consolidating these two separate entities, Arizona used a "carve out" method in which behavioral health care was managed and provided by Regional Behavioral Health Authorities (RBHAs.) Prior to the merger of these two divisions, DBHS was an agency beneath the AHCCCS, which managed the regional entities. With the merging of the DBHS and AHCCCS, Arizona initially started integrating behavioral health care for those with serious mental illness. Their model focused on adding primary care services to the state behavioral health contracts and services (Powers et al., 2020). In 2018, Arizona's Medicaid program continued integrating behavioral and physical health care through their AHCCCS Complete Care plans, which included those with mild to moderate behavioral health needs (Powers et al., 2020). Under these changes, adult and child members of the AHCCCS with serious mental illness, intellectual/developmental disability, and foster children are managed through the RBHA. In contrast, members with mild to moderate behavioral health needs are provided care through the AHCCCS Complete Care

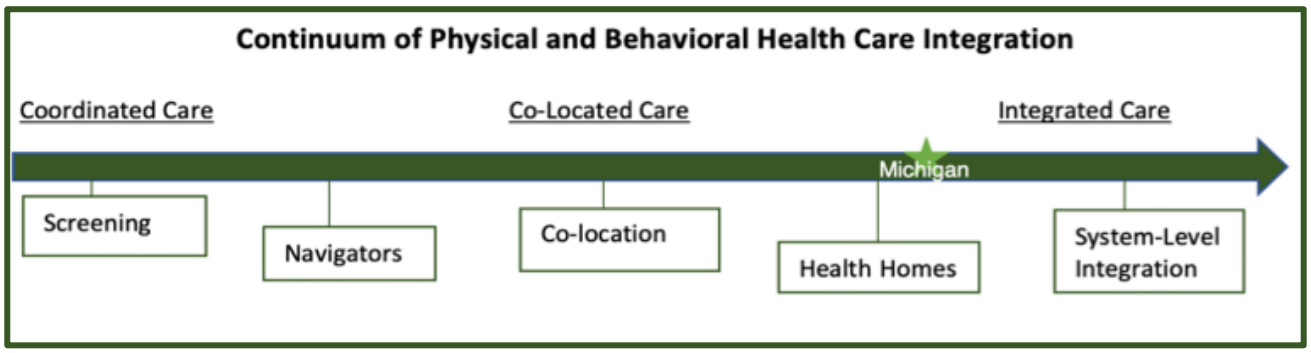
providers. These two divisions are then divided into regional service areas to provide care for these individuals.

Powers et al. (2020) note that Arizona has proven to stand out as it advances care integration through entire agency reform state-wide. They determined this reform has not affected the state's long-term system members. As this consolidation had political support through the Governor's budget and was unanimously endorsed among legislators, it has been found that this consolidation has streamlined communication and collaboration and unified the culture and goals of the agency (Powers et al., 2020).

In 2016, New York also restructured its historical "carve-out" method for managing behavioral health services within their Medicaid population. According to Powers et al. (2020), New York fully integrated these services into its Medicaid health plans in 2016. New York's Health and Recovery Plans (HARPs) are responsible for the coverage of Medicaid beneficiaries with SMI or serious behavioral health needs. Of note, eligibility under HARPs is determined through an algorithm and only covers individuals 21 years or older with SMI or a substance use disorder (Powers et al., 2020). This program does not specifically cover children or those with intellectual/developmental delays, with both populations being addressed by separate initiatives. The policy brief from Powers et al. (2020) noted that Health Plans are required to meet particular standards to apply and become HARPs. Under this integration of services, HARPs contract directly with providers who deliver complimentary services and function as separate entities within health plans (Powers et al., 2020 & Soper, 2016). Soper (2016) describes New York's implementation as a hybrid model, noting that all previous fee-for-service behavioral health services were integrated into the Medicaid managed care plans. Michigan's Department of Health and Human Services 298 Facilitation Workgroup (2017) places this reform in the "State-wide Behavioral Health Managed Care Organizations" category. They have noted that other states with similar models include Washington, California, and Pennsylvania. There were noted savings among those enrolled in Health Homes in New York and positive program outcomes, but challenges were faced regarding enrolling members in these services (Powers et al, 2020).

These are just two examples of states that have integrated physical and behavioral health care within their Medicaid Populations. In a recent report analyzing deliverance and administration among the states regarding integrated healthcare, the authors found many planned changes as well as data on how different states are addressing integrated care in their

area. It was interesting to note that only two states, Arizona and California, currently have an organizational structure of Medicaid and Behavioral Health Authorities under a single agency in the same division (Guth et al., 2023). The majority of other states reported having a single agency with different divisions and Michigan was described as “Other Organizational Structure”. As each state's population, finances, disparities, and policies differ, no two efforts to integrate these services at a state-wide level appear to be the same. Regarding Michigan's Senate Bills 598 and 597, Arizona's current system may most closely exemplify what these bills are proposing. Continued research and attention to data and metrics reported by other states should continue to be disseminated to determine if a "best practice" can be applied to any state looking to integrate these services.



Recommendations

The most feasible option for implementing and coordinating a legislative integrated care strategy may be implementing a Specialty Integrated Plan in a singular region of Michigan prior to a state-wide reform. Although the public health impact would be smaller at first, piloting a single regional SIP would allow the state of Michigan to test this type of financial integration without necessitating state-wide policy change. As similar pilots have been attempted in the past, this is the most practical option at this time if financial integration is a top priority of policymakers. This policy recommendation would address the current bifurcated system without significantly impacting the entire population of those requiring specialty behavioral health services at once. It should be noted that a focus on a singular group that requires specialty behavioral services should also be prioritized first. Specified populations could be those with SMI or another specific population, such as those with D/I DD.

Although remaining "status quo" appears to be the most realistic option for Michigan at this time, it does not address the current bifurcated system that MDHHS noted as a priority issue in previous years. Movements towards integrating care at the service delivery level continue to expand in Michigan but, again, do not address the financial integration of these systems at a state-wide level or for the entirety of the populations affected. It is recommended that MDHHS designs a plan to pilot a singular SIP in one region of Michigan to address the current bifurcated system. As fear of change and stakeholder resistance have been noted regarding previous legislation proposing a change to models in which the entire state integrates care at the financial level, this recommendation provides a more incremental and gradual approach, without complete disruption of the current system. A more gradual process can monitor efforts at a smaller and more controlled level without needing state-wide policy change.

As SB 597 and 598 have low feasibility of being enacted due to stakeholder resistance, other policy options should be considered, such as implementing a SIP in a singular region before state-wide implementation efforts. Future efforts and analysis can be constructed to further expand Specialty Integrated Plans after improvements to public health and reduction of health disparities have been noted during the piloting of this program.

Although the consolidation of agencies may also be a relevant policy recommendation to address coordination of care and align state and agency goals regarding integrated care, this recommendation may not have an initial significant impact on public health and does not appear to be of interest to policymakers at this time. While the consolidation of agencies was a catalyst to other states' efforts towards integrating behavioral and physical health services, this recommendation should be further analyzed in the context of Michigan's political climate and the agreeability among stakeholders regarding agency consolidation.

Conclusion

As Michigan struggles to implement a state-wide integrated care model, this policy brief introduces a more gradual and collaborative approach to reaching that overarching goal. Diminished access to care, lack of care coordination, and poor health outcomes for vulnerable populations can result from multiple entities managing a person’s care. It can be determined that integrated behavioral and physical healthcare benefits populations suffering from co-occurring physical and behavioral health issues. The research exemplifies the benefits of integration as it can provide a more comprehensive approach to care coordination and

reduction in fragmentation. As Michigan continues to take the initiative toward improving population health locally, further steps can be taken to continue integration at the financial level. Other states are continuing to successfully move away from "carve out" models that bifurcate physical and behavioral healthcare payments with good results. Although each state differs in its approach to best fit its targeted population, it is encouraging to see that financial integration models as well as agency consolidations are being implemented to improve noted health disparities. As noted from past attempts, such as the 298 Initiative and SB 597/598, stakeholder involvement, agreeability to change, and collaborative efforts are necessary with regard to such a significant adjustment to Michigan's current system functioning.

As many integrated care models in other states are still in their infancy, more time is needed to measure quality improvement metrics and cost-saving data. When additional information on these metrics is obtained, further evidence may present itself regarding the positive impacts of these strategies on a state's population health and cost savings. This policy brief looks to educate and give recommendations to policymakers and stakeholders alike on how an integrated care model may be adopted into Michigan's current system.

Past efforts have met continued resistance or failed, resulting in a stall in the movement toward the financial integration of physical and behavioral health services in Michigan. Drawing from the strengths and weaknesses of the bills proposed in Michigan and policy changes in other states, this research can continue to help inform others on the implications and necessary steps that should be considered before financially integrating physical and behavioral health services for Medicaid beneficiaries. Further research on these policy considerations' public health, economic, and budgetary impact should continue to ensue. As there is no "one size fits all" method for integrating physical and behavioral healthcare at the clinical or financial level, stakeholders should continue to monitor both the political climate surrounding this topic and the impact of continuing to separate these services at the financial level.

Overall, Michigan has the ability to provide comprehensive care to its populations requiring specialty behavioral health services by enacting changes to the current system for these Medicaid beneficiaries. Michigan policymakers continue to have the potential to improve health outcomes for struggling populations through the integration of physical and behavioral health. These efforts also can align state goals and reduce the fragmentation of the current system. Additional policy analyses on future legislative action should continue to ensure that practical and feasible methods are being taken to address the current public health needs of those requiring both physical and behavioral health services in Michigan.

Conclusions and Recommendations

Integration of physical and behavioral health services into a comprehensive plan has the ability to:

- Provide a comprehensive and collaborative approach to care coordination
- Improve patient and provider experiences
- Reduce administrative complexity and costs
- Reduce fragmentation of care
- Provide alternative delivery system and payment models with a focus on care quality improvements

Integration of physical and behavioral health services have been found to be an effective way to address co-occurring physical and behavioral health concerns and reduce health disparities. Stakeholders address opposition to a large system change that removes control from local entities as proposals of state-wide system change continues to meet resistance. It is promising to see that progress is being made with the expansion of behavioral health homes and local initiatives towards integration efforts. Policy reform regarding integrated care is also in its infancy and rapidly changing in many states with a myriad of methods being noted throughout the country. Future long-term data gathering is necessary to determine "best practices" at this time. A more gradual and incremental approach towards integration may be necessary rather than a system-wide change due to the current political climate surrounding care integration in Michigan at this time.

Recommendation 1: Pilot a Singular Regional SIP in Michigan

- Use past efforts to guide workgroup or pilot program design
- Involve all stakeholders (PIHPs, health plans, beneficiaries)
- Would not require state-wide policy change
- Gradual and incremental approach
- Would not cause disruption to entire system
- Design a metrics measurement plan for future implementation strategies

Recommendation 2: Consolidation of Agencies

- Arizona's DBHA and AHCCCS merger serves as a successful model
- Integration can address physical and mental health needs under one agency
- Alignment of separate agency goals
- Improvements with coordination of services
- Reduces number of entities involved
- Enhance communication and collaboration among sectors

Recommendation 3: Maintain "Status Quo" with continued efforts to integrate care at the local level

- Enables local communities to harness their strengths
- Efforts can be tailored to the community's specific needs
- Does not require a complete system change
- Data metrics should continue to be monitored within all new initiatives
- Less opposition among stakeholders

Acknowledgements

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