Integrated Behavioral Health Care in Michigan: A Policy Analysis

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Executive Summary

As the correlation between physical and behavioral health is becoming increasingly more recognized, policymakers and stakeholders are interested in addressing the health disparities of the Michigan population. Research continues to exemplify that those living with co-occurring physical and behavioral health conditions have higher health care costs while not experiencing better health outcomes. The COVID-19 pandemic has further exemplified the need for improvement in mental health services, empowering states to modernize current systems to address the co-occurrence of behavioral and physical health issues. Integrating physical and behavioral health care services at all levels of service delivery continues to be of interest to policymakers as a way to address the fragmentation of care that the population faces.

As co-occurring 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. Michigan's current system is siloed regarding coordinating and providing services for Medicaid beneficiaries requiring physical and specialty behavioral health services. Although innovative ways to address this problem continue to emerge throughout 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 statewide strategy to integrate care has yet to be enacted.

This policy analysis aims to assess current Michigan legislative action related to integrating physical and behavioral health care services, compare current legislation to other states' policies, and make recommendations on policy options after thoroughly disseminating information collected and presented. Michigan currently maintains the "status quo" regarding how Medicaid beneficiaries receive their bifurcated physical and mental health services. It may be of interest to policymakers to take a more gradual and incremental approach, collaborating with all stakeholders involved in a system change, to progress closer to the financial integration of physical and behavioral health services with the goals of improving health outcomes, lowering health care costs, and reducing fragmentation of care.

The co-occurrence of behavioral and physical health conditions, associated with higher health care costs and lower health outcomes, remains a significant issue for Michigan's population. Integrating physical and behavioral health care services can help reduce the fragmentation of care that this population is facing and improve health outcomes. As past efforts to integrate physical and behavioral health care at the financial level have yet to move past the planning process, it is proposed that policymakers use the lessons learned from previous efforts. It is recommended that a more gradual and incremental approach is taken to progress towards the financial integration of physical and behavioral health care services at this time. Collaboration among all identified stakeholders involved in this system change will be essential to implementing a comprehensive, integrated care system in Michigan.

Domain 1: Problem Identification

Introduction

As the COVID-19 pandemic swept through the world in 2020, rates of anxiety and depression were reported by the World Health Organization to have increased by 25% globally within the first year of the pandemic (World Health Organization (WHO), 2022). Many noted this increase associated with the pandemic. As many as 90% of countries surveyed reported incorporating mental health support along with psychosocial support within their COVID-19 response strategies (WHO, 2022). As attention to mental health care gains traction globally, innovative ways to concurrently address physical and behavioral health care needs are also emerging throughout the United States.

Integrated care is described as the coordination and provision of behavioral health services with physical health services (American Psychiatric Association, 2022). Although "integration" or "integrated care" can be associated with numerous definitions and aspects of both health and human services, the terms used in the context of this paper will focus solely on the integration of behavioral and physical health services. Integrated care models are critical to

increasing access to comprehensive and coordinated services (Goldman et al., 2022). 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 Counsil 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 before the COVID-19 pandemic, statewide 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. Although these bills were not passed, this paper will use a blended version of Bardach's: *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving* as well as the CDC's *Policy Analytical Framework* to continue guiding this policy analysis paper to make sound policy recommendations for a singular integrated care system in Michigan.

Significance to Population Health

As mentioned, many Michiganders have a mental or behavioral health condition, with 38% of that population not receiving care for these conditions. Emerging research continues to suggest that those living with co-occurring physical and behavioral health needs have higher healthcare expenses yet still experience worse health outcomes (National Counsel for Mental Wellbeing, 2022). SAMHSA further illustrates the effect of untreated behavioral health conditions on persons' lives as it has been found that those with any form of mental illness are more likely to have co-occurring chronic conditions when compared to their counterparts without behavioral health conditions. Some of these conditions include hypertension, asthma, diabetes, heart disease, and stroke (SAMHSA, n.d.). From a physical health standpoint, persons with chronic health conditions, such as diabetes or asthma, have also portrayed high rates of substance use disorders and psychological distress (SAMHSA, n.d.). After performing a population-based cohort study of those born in Denmark from 1900 to 2015, Momen et al. (2022) found that persons with co-occurring general medical conditions and mental illness were at an increased risk of dying. In England, the National Mental Health Intelligence reported that those with serious mental illness were more likely to die prematurely when compared to those without a serious mental illness, noting this specific population was “4.5 times more likely to die before the age of 75” (Office for Improvement and Disparities, 2023). Research by Chesney et al. (2014) concurs with these findings, observing that those diagnosed with a significant mental health condition have been found to die 7-24 years sooner than those without a significant mental health condition. Integrated care aims to improve health outcomes by addressing common, disabling, and costly health conditions (American Psychiatric Association, 2022).

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 statewide.

Background

Integrated care

It can be argued that the multitude of descriptions, meanings, and characterizations associated with "integrated care" can create difficulties pinpointing a specific definition. Integrated care definitions can differ depending on the driving factors related to professional points of view or from the observer's perspective. Despite many definitions, integrated care at its core can be described as an approach to reduce or overcome the fragmentation of care, resulting in a "commitment to improving the quality and safety of care services through partnerships" (Goodwin, 2016). As mentioned previously, this paper will focus on integrated care under the definition of the coordination and provision of behavioral health services with physical health services.

Attempts to coordinate behavioral health services with physical health have been noted in society starting in the mid-twentieth century. In North America and Europe, efforts to distinguish connections between psychiatric and medical illnesses focused primarily on scholarly endeavors rather than clinical integration during this time. In the 1950s and 1960s, integrating psychiatry and physical medicine entered the clinical setting within general hospital settings. The role of psychiatric consultation and liaison services aimed to follow a medical consultation model in which collaboration between physical and behavioral medicine ensued. It has been noted that in many settings, this psychiatric consultation represents a significant amount of the mental health services provided in a medical setting (Wulsin et al., 2006).

Historically, health services in the United States have been provided via a fee-for-service model, meaning that different components such as office visits, tests, laboratory work, or procedures are each paid for separately, resulting in incentives related to the number of services rather than as a measurement of the quality of care these services provided. In 2010, the Affordable Care Act was signed into law, resulting in a value-based payment model focusing

more on quality-of-care services than quantity. This act enabled providers and insurers the flexibility of value-based payment models so that they could develop solutions to improve access, coordination, and integration of services throughout different settings (Sandhu et al., 2021). This law intended to achieve universal healthcare coverage while also managing costs and improving the quality of care provided (Chernew et al., 2020).

It has been conveyed that many government agencies have played a significant part in progressing integrated health and psychosocial care. The Medicaid insurance program is a public insurance program covering 83.5 million people, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities, which is jointly funded by both state and federal governments (Medicaid, 2022.) It can be noted that those covered by Medicaid face increased socioeconomic challenges when compared to their privately insured counterparts and may be at higher risk for societal inequities. Nationally, Medicaid covers about 14% of the adult population, yet they manage approximately 26% of all adults with serious mental illness and about 21% of all adults with behavioral health conditions (United Healthcare, 2019). This statistic places the Medicaid program in a unique position related to integrating care for their covered population.

Medicaid is noted to be the leading payer for behavioral health services in the United States(Kelly et al., 2019). In 2020, findings reported that about 29% of Medicaid enrollees have a behavioral health diagnosis which is higher than those privately insured (21%) and those uninsured (20%) (Saunders & Rudowitz, 2022). Spending for these individuals is nearly four times that of those without a behavioral health diagnosis (Kelly et al., 2019).

Many states face significant barriers to advancing the integration of behavioral and physical healthcare as there is a separation of financing related to physical or behavioral healthcare. Traditionally, states provide Medicaid services through Managed Care Organizations (MCOs). Medicaid (n.d.) defines managed care organizations as “a health care delivery system organized to manage cost, utilization, and quality." Medicaid provides the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid

agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services." (Medicaid, n.d.). Many states who provide Medicaid managed care programs "carve out" or separate behavioral health benefits from physical health benefits. As managed care organizations coordinate enrollees' physical health benefits, behavioral healthcare services are usually managed by behavioral health organizations rather than the MCOs. This results in the coordination of a person's care being managed by multiple entities. Under the management of multiple entities, there may be diminished access to care and care coordination, resulting in poorer health outcomes for this specific population (Bipartisan Policy Center, 2019).

Michigan

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) has noted specific goals for improving its current system. These goals include 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) receives 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 (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.

Specialty Integrated Plans

Senate Bills 597 and 598 introduced the creation of Specialty Integrated Plans (SIPs), which are defined as "a separate entity that is either a managed care organization (MCO) or a person operating a system of health care delivery and financing as provided under Section 3573 of the Insurance Code" (Shirkey & Bizon, 2021). The actions and guidelines for a SIP operating as a community mental health services program were to be set by June 1st, 2022, if the bills had been passed. Michigan's Department of Health and Human Services (MDHHS) has noted the

difficulties related to the current bifurcated system within Michigan. The current system continues to separate physical and behavioral health services for Medicaid beneficiaries requiring specialty behavioral health services and is challenging to navigate. It was also addressed that the current system makes it difficult for providers to coordinate and integrate care. Providers and Managed Care Organizations lack incentives to integrate care to invest in keeping people well. It has been acknowledged that the current design of the system results in the lack of a single point of accountability concerning responsibility for the health of the whole person, resulting in challenges either related to communication, data sharing, cost shifting, and finger pointing between the current bifurcated system (MDHHS, 2019).

According to the MDHHS, the creation of Specialty Integrated Plans would combine traditional insurance companies' management skills with behavioral healthcare organizations' expertise and commitments. They envision that Specialty Integrated Plans will be provided by managed care organizations that will "maintain provider networks, conduct utilization management, manage claims, and provide individual care coordination for members" (MDHHS, 2019). MDHHS indicates that this plan would continue to offer all of the benefits currently offered through the Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans, as well as services related to support systems and social determinants of health, rather than only traditional medical services. MDHHS proposes that an integrated system is a way to decrease the current system's complexity and reduce barriers to care while also making it easier for persons to navigate their coverage.

As discussed previously, Michigan's current system "carves out" specialty behavioral health care coverage for those with behavioral health needs from their physical health coverage. This means that two separate entities are responsible for either the patient’s physical health needs or their behavioral health needs and do not work in combination to cover both at once. MDHHS suggests that under Specialty Integrated Plans, there would be only one entity paying and managing all of the individual's health needs, resulting in consistency, better coordination, ease of access, and easier navigation of the system statewide. They also clarify that individuals will

have a choice when deciding which integrated care management organization will handle their healthcare needs. MDHHS notes that they expect this plan to uphold "rigorous network adequacy standards," ensuring the same or greater access to physical and behavioral healthcare. They describe that within this plan, there will be stronger requirements and oversite by the state of Michigan. It appears that in 2019, MDHHS envisioned a plan that would change the overall funding and coordination of services provided related to the current system structure, resulting in greater investments for behavioral health services and supports, noting that savings could be captured from improvement in physical health outcomes with this improved coordination of care.

Senate Bills 597-598

Senate Bills 597 and 598 were introduced to the Michigan Senate on July 15th, 2021. The sponsors of these bills included Senators John Bizon and Mike Shirkey. SB 597 and 598 were referred to the Committee on Government Operations in July of 2021 and placed on order of a third reading with substitute (S-3) on March 2nd, 2022. Finally, on November 29th, 2022, substitute (S-8) was adopted, but the bills did not pass in the Senate then. Hence, the bills died and did not progress through the legislative process. Of note, Senate Bill 598 was tie-barred to Senate Bill 597, which required both bills to be passed together.

After final revisions, proposed Senate Bill 597 would have amended the Social Welfare Act by requiring the Department of Health and Human Services (DHHS) to create and launch implementation of a plan to integrate the management and provision of Medicaid physical health care services and behavioral health specialty services for behavioral health populations through a phased-in process. This process would be completed through the creation of Specialty Integrated Plans, otherwise referred to as SIPs, and the bill's timeline would require the complete integration and management of physical health care services and behavioral health specialty services through SIPs by 2030. This bill would require a Specialty Integrated Plan to contract services with community mental health service programs within its designated service area to provide specialty behavioral health services. This bill would also require community mental health service programs to provide behavioral health specialty services within its service area

through a contract with each SIP. A phased-in approach would be taken to transition all eligible Medicaid beneficiaries from their current prepaid inpatient health plans (PIHPs) into the timeline specified within this bill. The Department of Health and Human Services would also be required to consult with specified representatives to develop specific metrics to determine if an implementation phase has been successful. Another provision of this bill would require the Department of Health and Human Services to develop a plan to create a Behavioral Health Accountability Council, which would monitor each implementation phase, and complete an evaluation of each phase. This would be due within twenty months of the implementation of the phase. According to the bill, there would be a requirement that the current PIHP system and the CMHSPs must maintain all current provider contractual arrangements throughout the transition phases. The bill specifies that PIHPs would continue to deliver specialty services and supports for Medicaid-covered specialty services until SIPs were available to provide these services. Over two years, the bill also requires the Department of Health and Human Services to consolidate all 10 PIHPs into a single entity, managing Medicaid specialty services and supports. Lawmakers also would require the DHHS to seek a waiver from the federal government, allowing a SIP to manage and organize the delivery of both physical and behavioral health care services. There would also be a modification to the Social Welfare Act concerning the provisions of the bonus incentive pools to exclude or include SIPs.

Senate Bill 598 (S-3) would amend the Mental Health Code to specify that a SIP would not be responsible for defined in the bill until after the completion of a successful transition, as determined at each integration phase by the Behavioral Health Accountability Council. The Behavioral Health Accountability Council would be created after the passing of this bill along with a specified ombudsman. SB 598 specifies that a SIP would be a “separate entity supporting the CMHSPs and either a managed care organization or a specified health care delivery and financing system”. Practices and guidelines for SIPs were to be set by December 1st, 2022. Lawmakers envisioned that upon implementation that, the services provided by SIPs would be delivered in a manner that demonstrates recipient choice and involvement, as well as divert

specific populations, such as those with serious mental illness, serious emotional disturbance, or developmental disability (DD) from possible incarceration. Specialty Integrated Plans would also be required to guarantee the availability of services for those persons with substance use disorder through the allowance of contracts with community entities to provide these services rather than being required to coordinate the provision of those services. The bill would require multiple changes to the Mental Health Code to make both SIPs and local behavioral health entities eligible to be providers for publicly funded behavioral health services. There would be requirements to direct a SIP to participate in developing school-to community transitions services for those with serious mental illness, serious emotional disturbance, or developmental delay. As mentioned in SB 597, the creation of a Behavioral Health Ombudsman and a Behavioral Health Accountability Council is indicated as a requirement of these bills. The bill also describes the establishment of a multidisciplinary council for selecting a Director of the Office of Recipient Rights concerning the date of a SIPs implementation. Of note, this bill also calls for a repeal of Section 269 of the Mental Health Code, which currently allows designated community mental health entities and its CMHSP network to contract and spend funds related to counseling, treatment, and as well as the prevention of substance use disorders.

Problem Statement/Issue

The work of this project is guided by the following: 1) How does the recent integrated care legislation under consideration in Michigan compare to similar legislation in other states? 2) What are the strengths, weaknesses, and gaps in Michigan's proposed legislation? 3) What actions are necessary to improve the state of integrated care in Michigan?

The purpose of this project is to 1) conduct a comprehensive policy analysis of current legislation related to integrated care in Michigan, 2) evaluate this legislation in relation to recognized best practices and similar legislation in other states, and 3) develop recommendations for the implementation of a single integrated care delivery model in Michigan through policy reform. This policy analysis will address the gaps in current legislation. Given the recent movement of integrated care legislation in Michigan, our findings will inform this process by

providing timely, critical, and actionable information for Michigan policymakers. A thorough investigation of integrated care delivery systems and subsequent recommendations will be valuable in guiding ongoing discussion and policy efforts. The enactment of laws to support an effective and sustainable integrated care model in Michigan would directly impact the delivery of behavioral health care services in Michigan.

Domain 2: Policy Analysis

Step 2A: Identify and Describe Policy Options

Domain 2 of this policy analysis consists of reviewing the literature on integrated care, surveying best practices, and conducting an environmental scan to determine and understand what other jurisdictions are doing. Bardach's: *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem-Solving,* in conjunction with the Center for Disease Control's *Policy Analytical Framework*, will be used to guide this policy analysis project. Both models have been widely used to analyze policy. In Phase I of our project, the first three steps were conducted, which focused on the collection and assessment of data. **Step 1**: Defining the problem. A thorough assessment of integrated care policy issues in Michigan was undertaken to define and formulate a detailed description of the problem. A fiscal analysis of the current proposed bills will also be discussed further in this paper. **Step 2**: Assembling some evidence. This step consists of obtaining baseline descriptive information about integrated care in Michigan; information was collected to examine the nature and extent of the issues surrounding integrated care policies in Michigan and characterize the features of legislation currently being considered. Data sources included but were not limited to, federal and state government resources, published scientific literature, online materials, and healthcare policy experts and organizations.

Additionally, information was collected on the facilitators and barriers to implementing integrated care policies. This process consisted of an extensive review of "best practices" and exemplar cases of successfully integrated care models in other states, as well as lessons learned and factors impeding success. The information collected allowed for the compilation of

necessary and sufficient factors relating to implementing state-based, integrated care policies. These steps coincide with Domain 1 of the CDC's *Policy Analytical Framework*, which includes identifying the problem or issue. **Step 3**: Constructing the alternatives. Alternative strategies or solutions for improving integrated care in Michigan were constructed during this step. In this paper, two alternative scenarios will be specified using best practices exemplars. Examples of integrated care policies enacted in other states and a "status quo" and no purposeful change or movement in policy are discussed during this step and fall into Domain 2 of the CDC's *Policy Analytical Framework*. The development of alternative scenarios summarizes potential political, fiscal, and public health implications, which will be compared to the public health impact, feasibility, and budgetary/fiscal impacts of SBs 597 and 598 as well as maintaining the "status quo" in Michigan. Combinations of various components of different scenarios will be considered when appropriate.

Phase II of the project includes the remaining steps in Bardach's approach, which reflect value-driven evaluative steps. **Step 4**: Selection of criteria. This step will determine the criteria needed to evaluate the alternatives, including policy objectives, political acceptability, available and necessary resources, efficiency, effectiveness, sustainability, equity, ethics, and public values. In addition, existing metrics for access and utilization of behavioral health care services and the provision of integrated health care services in Michigan will be examined. **Step 5**: Project outcomes. This step involves projecting the outcomes for each alternative that may interest all stakeholders. Based on the analyses, predictions of plausible immediate and long-term outcomes that may result directly or indirectly from each policy alternative will be discussed. **Step 6**: Confronting the tradeoffs. The status quo, or unchanging condition (i.e., no passing of integrated care law in Michigan), is considered to be the "base case" of this policy analysis.

A constructed matrix of the projected favorability for each alternative will be presented below to evaluate tradeoffs. These will be compared and contrasted against those of the status quo. These steps also coincide with Domain 2 of the CDC's framework, which focuses on policy analysis. Domain 3, the final Domain within the CDC's framework consists of Strategy and Policy

development which coincides with Steps 7 and 8 of Bardach's framework for policy analysis. **Step 7** of Bardach's framework entails "stopping, focusing, narrowing, deepening, and deciding". This step will discuss the selection of the most promising alternatives and the synthesis of findings. **Step 8**: Telling the story. Finally, preparation of this policy analysis for dissemination in various venues and assessment for further analysis will be performed.

An extensive literature search was conducted using various databases such as Policy File, CINHAL, PUBMED, and the Michigan State University Health Policy Resource Center. Relevant literature was identified using the key search terms to accomplish the second step of this review. Key search terms included integrated care AND (policy or policies or law or laws or legislation) AND (mental health or mental illness or mental disorder or psychiatric illness or behavioral), integrated care AND (health care reform OR health policy). Limiters to this search also included literature specified to be in English, published between the years 2017 to 2022, full-text articles, and locations within the United States or studies that included the United States.

The initial research resulted in 1,059 relevant studies, reports, reviews, and gray literature. The writer then filtered these results to further assess the relevance to the topic of integrated care. After a thorough review of the resulting studies, further assessment of the resulting literature abstracts was performed to remove any literature that lacked relevance specific to integrated care. Furthermore, articles were also removed if they lacked a focus on policy procedures, implications, and recommendations. Studies and literature that specified they were incomplete or were not pertinent to United States policymaking were also excluded from this review.

The final step of this literature review process was selecting the relevant studies. A total of 11 forms of literature were selected that met the above criteria. These articles were analyzed and reviewed to disseminate information related to the research questions mentioned earlier. Table 3 in Appendix D details the specifics of each literature source chosen, associated factors related to integrated care noted in the literature identified, and the extent to which the specified literature may impact the policy process. Table 3 also organizes the literature discovered by the

type or method used to disseminate the author's findings, i.e., policy reports, systematic reviews, uncontrolled clinical trials, scoping reviews, and policy analysis.

A synthesis of the selected relevant works was performed. Public health impact, feasibility, and economic and budgetary impacts related to the works specific to integrated care policy were considered during this literature review according to the CDC's framework. Due to the varying types of literature discovered during this review, not all sources discussed public health impact, the feasibility of integrated care policies, or budgetary impacts in their findings. This literature review revealed key findings related to integrated care models, foundations, stakeholder perspectives, and implementation models. It can be noted that there is no defined form of literature review recommended for policy analysis and further compilation of gray literature is also disseminated throughout this paper to answer the questions defined above.

Identify

According to the CDC's Policy Analytical Framework, a review of literature on integrated care, a survey of best practices, and an understanding of what other jurisdictions are practicing takes place during this step. Policy options relevant to integrating physical and behavioral health care can be collected as evidence for potential strategies used in other areas. A literature review and a search of grey literature will help describe potential policy options and implications in this step.

Of the literature disseminated through this review, only two papers discussed specific policy changes implemented in other states involving integrated care. In a briefing paper by Bachrach et al. (2017), the authors discuss consolidating Arizona's physical and behavioral health services agencies into their single Medicaid agency, allowing the Medicaid director to facilitate care integration. On a broader note, Sandhu et al. (2021) also discuss efforts and policy changes that have been put in place nationally and at a state-wide level to address the integration of health and social care. Both sources highlight innovative and practical ways in which changes in state policies or program reforms have begun to test ways to improve population health and decrease disparities among the Medicaid population in the United States. These authors

exemplify how to progress, and investments have been made to integrate behavioral, social, and physical healthcare in ways that are meant to improve population health. Bachrach et al. (2017) suggest that there is no "one-size fits all" approach to integrating services for Medicaid beneficiaries. The authors note that consolidation of Arizona's behavioral and physical health services under the state's Medicaid director poised the ability to facilitate progress towards integrated health care at the state level. Although the paper produced by Sandhu et al. (2021) focuses more so on the integration of health care and social care rather than specifically physical and behavioral health, their paper exemplifies three federally enacted programs that have been found to progress the integration of behavioral, social, and physical health needs. These authors focus on three federal policy initiatives that were put in place to expand integrated care efforts and improve the health of the Medicaid population (Sandhu et al., 2021). The authors comment that there is considerable variation between state strategies to implement these programs. The authors found that the federal reports on 1115 waiver programs noted increased collaboration between providers, supporting physical and behavioral health integration with implementing these waivers (Sandhu et al., 2021). A briefing by Edwards (2017) also discusses federal regulations that were found to be encouraging an integrated care approach. This author notes that in 2016 the Medicaid Managed Care rule and the Medicaid managed care mental health parity rule could further facilitate the shift to integrated care models. The Medicaid Managed Care rule was passed to promote efficient information sharing and encourage greater accountability to Medicaid, aligning with integrated care principles which include quality care coordination (Edwards, 2017).

Bachrach et al. (2017) discuss the consolidation of physical and behavioral health services in Arizona, which is similar to the model Michigan's Department of Health and Human Services describes as their vision for integrating care in this state. Before Arizona consolidated services, responsibilities were split between the Arizona Health Care Cost Containment System (AHCCCS), a Medicaid agency, and the Division of Behavioral Health Services (DBHS), which can be compared to Michigan's current bifurcated system. By consolidating these two separate

entities in 2015, one new AHCCCS agency was formed by integrating the DBHS with the AHCCCS to address Arizona's Medicaid enrollees' physical and behavioral health needs. In this specific policy paper, the authors report that the consolidation of services has broadly impacted the integration of behavioral and physical services. They report that there has been increased attention to the integration of behavioral health with physical health, creating strategic purchasing of physical and behavioral health services, streamlined regulation and consistent policy, and enhanced communication and collaboration among sectors (Bachrach et al., 2017). In 2019, the Bipartisan Policy Center also endorsed the integration of physical and behavioral health moves to align incentives and increase accountability, making the policy recommendation to eliminate "carve out" behavioral health services.

Three other articles from this literature review focused on the integration of behavioral and physical health care related to specific populations. Rosales and Calvo (2021) found from their study an increase of funding for policies related to the adoption of integrated health services at Hispanic-Serving organizations may help to decrease the disparities that this specific population faces related to access to mental health care. Shippee & Vickery (2018) also concurred that improving access to integrated care and social services in Minnesota's Medicaid population may be the greatest way to help their specific population of study. Keitzman et al. (2018) also studied the specific population of older adults in California and how their mental health delivery system serves this population. Their study found that there were many unmet needs for this population with mental illness in the public mental health delivery system. They noted recommendations for bridging these unmet needs with the designation of a distinct leadership structure for this population, increasing integration efforts between health services, and instituting standardized data-reporting requirements among some of their recommendations.

Of the literature review, three studies also focus on the integration of behavioral and physical health services into either community mental health homes or centers (Wells et al., 2019; McClellan et al., 2020; Aby, 2019). Wells et al. (2019) found that through the integration of Primary Care Centers in Texas, providers, and patients perceived improvements in the

integration of primary care into community mental health centers. McClellan et al. (2020), also determined that integrated models within Medicaid Health Homes could be a promising model for improving overall health for this population. The creation and negotiation of funding for such programs was also a topic of concern exemplified within many of the reports found through this review exemplifying the need for further research in regards to enacting these programs or initiatives (Aby, 2019 & Wells et al., 2019; Wakida et al., 2018). Although these studies focused on the local and community levels of care integration, each provided insight into the challenges, strengths, and barriers to integrating behavioral and physical health care at this level.

Although integrated care has become a larger talking point over the past decade, the amount of research currently available that outlines the effect that policy changes at a state level needs to be improved. Through this literature review, the expansive range of information presented on integrated care makes it difficult to make concrete conclusions on the effectiveness of state-level integrated care policies with connected data metrics. Further studies and high-quality data are needed to determine the public health impact, feasibility, and economic impact of specific state-wide policies that have helped to reduce fragmentation of care and improved disparities noted among the Medicaid population. Further research was performed on gray literature outside of this formatted literature review to obtain a better understanding of other state policy options in order to obtain information on "best practice" or current practices in other states that may be comparable to Michigan's current proposed legislation in regards to SB 597 and 598.

Arizona

As mentioned previously in the above literature review, Arizona is a state that has successfully integrated these systems of care 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 with 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).

A policy brief by Soper (2016) also 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 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.

New York

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. Examples of other states who have used varying models to approach the integration of physical and behavioral health care are Florida, Kansas, Texas, Oregon, and Washington. 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.

Describe

After reviewing available literature on integrated care and surveying what other jurisdictions are doing, according to the CDC's *Policy Analytical Framework*, the next step is to describe each policy option identified from the above background work. Each of these policy options is described by three interconnected criteria: the public health impact, feasibility, and economic and budgetary impacts of each of the following identified policy options. Public health impact disseminates the potential for the policy to impact disparities and quality of life factors. The feasibility criteria determine the likelihood of the specified policy being enacted and implemented. Finally, the economic and budgetary impacts criteria compare the costs to implement, enact, and enforce the following policy options and compare the benefits of each. Following the CDC's Policy Analytical Framework, the policy analysis key questions of this framework were used to assess each identified policy option.

Enactment of Senate Bills 597-598

Criteria 1: Public Health Impact

Coordination of care within Michigan's current system for providing separate physical and behavioral health services among the Medicaid population has been an area of concern among the mental health community in Michigan. It has been noted that Michigan's current system does not coordinate care effectively for those requiring physical and specialty behavioral health services as they are provided services between two different systems with two separate payment modalities. This can result in confusion, fragmentation of care, and increased disparities regarding how, when, by whom, and where services are provided. Managed care programs have demonstrated care coordination as a strength within their approach (Michigan Senate Fiscal Agency, 2021 & United Healthcare, 2019). Ralls (2021), concurs with these findings, describing

that prioritization of integration through managed care programs has to opportunity to improve outcomes as they focus on a whole-person approach. Upon review of a bill analysis of SB 597 and 598, it was determined that transferring responsibility to a single entity could help improve the coordination of care in Michigan (Michigan Senate Fiscal Agency, 2021). Powers et al. (2020) note that the aforementioned creation of SIPs within SB 597 and 598 appears to be very similar to Arizona's RBHAs, which would create a lead agency or organization that would be empowered to provide holistic services and care coordination. In 2020, reports from Arizona's AHCCCS found many improvements across various outcome measures for those impacted by their serious mental illness integration efforts. Improvements were noted in ambulatory care, preventative care, and chronic disease management measures, as well as with indicators related to patient experience improvements and hospital-related measures (ACCCHS, 2020). Notable improvements from their findings included medication management for people with asthma, comprehensive diabetes care, and adult access to preventative/ambulatory health services increased by 32%, 4%, and 2%, respectively (ACCCHS, 2020). ACCCHS (2020) also noted patient improvement experiences related to health plan ratings, ratings of all healthcare, coordination of care, and shared decision-making. Hospital-related measure improvements associated with SMI integration also showed a decrease in emergency department utilization rates by 10%, a readmission rate decline, and 30-day post-hospitalization for mental illness follow-up increasing by 10% among other improvements (AHCCCS, 2020). Financial integration of physical and behavioral health services within Medicaid-managed care has been found to improve Oregon enrollees' access to care (Charlesworth et al., 2021). Nevertheless, other studies from states such as Washington found that this type of integration was disrupting to behavioral health professionals and did not outwardly appear to motivate clinical change (McConnell et al., 2023).

Several potential public health impacts can be identified while looking at the goals and provisions of this bill package, including improvement in access to care, enhanced care coordination, improved quality of care, and potential cost savings. Integrating physical and

specialty behavioral health services under a single entity, particularly for those with complex or co-occurring conditions, could improve access to care. These bills could also improve care coordination by promoting a single entity taking on the responsibility of services provided for the specific populations mentioned by these bills. These bills also propose a focus on quality measures related to the implementation of SIPs and coordination with those who specialize in behavioral health care. Quality measures were fundamental for the initiation of specialty plans in Arizona and are a strength within this bill package. The creation of incentive programs based on quality measures could also improve the quality-of-care persons are provided.

Regarding the specific populations that would be affected by the passing of SB 597 and 598, these bills specify that Medicaid beneficiaries will be transitioned into SIPs according to a "phased-in" timeline. Within these specifications, different populations will be affected by the changes these bills propose at different times. The bills would require MDHHS to fully integrate physical and specialty behavioral services and develop a plan to transition “all eligible Medicaid beneficiaries with a serious mental illness, developmental delay, serious emotional disturbance, or substance use disorder and eligible Medicaid beneficiaries who were children in foster care” by January of 2023 (Shirkey & Bizen, 2021) .

In 2019, approximately 325,000 persons were served by the 10 PIHPs in Michigan (Casemore & Sedlock, 2019). These persons and their caregivers/families would be the initial persons impacted by the passing of these bills, which are noted to be "phased-in" at different periods after the successful transition of the previous populations. The populations significantly impacted by these bills would include individuals with serious mental illness (SMI), individuals with serious emotional disturbances (SED), individuals with substance use disorders, and those with intellectual/developmental disabilities. The bills also called for fully integrating physical and specialty behavioral health services through SIPs by 2026. It is unclear as to exactly when each of these populations would be affected by the proposed change as a provision of the bills was to designate the task of an implementation timeline to MDHHS. Under these bills, those not considered any of the above populations would continue to receive physical health care through

Medicaid health plans. As noted from previous states who have made progress towards integrating physical and behavioral health care, issues have arisen with the enrollment of beneficiaries and reimbursement of services, which could negatively impact the populations mentioned above (Powers et al., 2020). Depending on the timeline determined by MDHHS, the above-mentioned populations would be affected at different times. The possible public health impacts could be similar to those noted in Arizona's efforts such as improvements in ambulatory care, preventative care, and chronic illness management measures.

Gaps in the evidence-base, such as the exact number of persons whom would be affected by each phase of this change need to be extrapolated from current PIHP data. Although the PIHPs currently serve approximate 325,000 persons, it is unclear how many people fall into each separate designation for the phased in process. There is the possibility that the population of those requiring specialty behavioral health services may be negatively impacted if the planning of implementing a Specialty Integrated Plan is not well organized or is unable to maintain sustainability for this vulnerable population. Other gaps in evidence could include lack of specified metrics that will be measured prior to the implementation of a SIP. Although other states have successfully begun implementing the integration of physical and behavioral health services, many are still in their infancy, resulting in limited data and evidence-based measures to compare the public health impact of these bills.

Criteria 2: Feasibility

As Powers et al. (2020) noted, Arizona's change to how they manage the coordination of behavioral and physical healthcare through agency and policy change was highly supported by both the Governor's budget and backing from the legislative perspective as a whole. In Michigan, conversations regarding integrating behavioral and physical health services have been discussed many times. However, most plans in Michigan to progress toward an integrated care model have been met with resistance. Support for a policy change must have financial and stakeholder backing, neither of which are currently noted within Michigan's political climate toward integrating physical and behavioral health services.

Developing, enacting, and implementing these bills will require significant engagement from multiple stakeholders. Stakeholders could include healthcare providers, insurance providers, Medicaid beneficiaries, community mental health services, schools, and advocacy groups. The time and resources needed to engage stakeholders are significant to the feasibility of these bills as they will allow all stakeholders to give their input and feedback on the bill package implementation. Further discussion of the political history and perspectives regarding similar policy options will be discussed to address the likelihood of these bills being successfully implemented and adopted.

Past efforts to integrate physical and behavioral health services have been discussed in Michigan with the Section 298 Initiative. In 2016, This was an effort to address ways to improve the coordination of physical and behavioral health care services for these publicly funded services. Of note, the facilitation workgroup associated with this initiative met with stakeholders and submitted a final report to the State which included policy recommendations to include financing recommendations and targets for implementation. Although pilot sites were determined in 2018 to attempt a new model of integration in three regions of the state, these pilots were never implemented due to stakeholder disagreement on funding and structure of this program. Other bills have been proposed in Michigan to integrate physical and behavioral healthcare at the financial delivery level have met resistance and have not passed in the legislature in the past as well.

It is also important to note that implementation of SB 598 and 598 could take several years based on the timelines provided. Within the language of these bills, MDHHS was required to develop and begin implementing physical and specialty behavioral health services by June 2022. The timeline also supported the complete integration and administration of these services and supports by 2026. Of note, the language of these bills also required the DHHS to monitor each implementation phase and provide an evaluation of each phase within 18 months of the effective date. Due to the phased-in process that these bills propose, there could be more flexibility on the timelines initially introduced. Through the creation of this evaluation process,

areas for improvement and best practices could also be implemented in future phases. Arizona demonstrates the strengths of a gradual and evolving process for integrating behavioral and physical health services. A strength of these bills is that they require a steadier implementation process, as Arizona has continued to advance its programs since 2015.

Some negative impacts that could be associated within these bills could include the disruption of current systems, the possibility for uneven implementation strategies, inadequate or disagreement on funding, and privacy concerns. Through the creation of a SIP, changes in provider networks, billing systems, and referral processes may also undergo significant changes depending on the implementation of these bills. There may also be concerns related to privacy as sensitive information sharing among different healthcare providers and systems during this transition which has been a concern among stakeholder in the past. SB 597 and 598 do not directly address how these issues would be addressed as these bills require MDHHS to create a plan for the SIP rather than mapping out a strategy for how these plans will unfold. As noted from New York's effort, problems with members enrollment were faced. Arizona's implementation also noted issues with reimbursement after their system change. SB 597 and 598 also describe a complex integration process of services which could result in variations in how these bills would be implemented in different state regions.

SB 597 and 598 have met resistance from multiple community members and legislators upon the proposal of these bills. 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. As there has been much opposition to the passing of both of these bills and

prior pilot studies related to integrating these services meeting resistance, the feasibility of enacting these specific bills is low at this time. The lack of support for these bills is further exemplified by this particular set of bills not being passed in the Senate and no current knowledge of reintroducing this bill package with the changing of legislative leaders.

Criteria 3: Economic and Budgetary Impacts

From a budgetary perspective, the costs and benefits of SB 597 and 598 are complex and may depend on varying factors. According to the Senate Fiscal Agency (2021), minor costs would be associated with implementing these bills, including costs for creating a Behavioral Health Ombudsman. It was noted that the exact fiscal impact of these bills could not be precisely determined as changes are directly related to choices made by the new entities which cannot be foreseen prior to implementation (Michigan Senate Fiscal Agency, 2021). The Senate Fiscal analysis notes that SIPs will likely have greater reserves than the current PIHPs. This could result in less costs to the state if the entity managing the SIP is able to cover the costs of unexpected expenses.

As there is potential for cost savings in providing care to underserved persons, there may also be an increase in costs related to the extent to which these persons are underserved. These cost increases may alternatively lead to improvements in health outcomes. The bills specify that any savings procured through this plan would be used to expand services, resulting in no overall savings to the state. Arizona's implementation of an integrated system for those with serious mental illness showed improvement in health outcomes but costs related to their program are unclear at this time. There were also concerns related to these bills' impact on payments to local government units. Other policy changes independent of the introduced bills would have to be considered; hence adjustments to local governments cannot be presumed at this time (Michigan Senate Fiscal Agency, 2021).

There is also a potential for cost savings through the integration of behavioral and physical health services as duplication of services may be reduced. The advancement of more efficient use of resources under a unified system rather than the current bifurcated system could

also have the potential to decrease costs to the State. From the examined fiscal analysis, no clear data defined cost savings specifically related to these bills. As noted with Arizona's outcome improvements from their evaluation, decreased readmission rates, emergency department utilization, admissions for chronic conditions, and increase in follow-up rates there is the potential for positive cost savings for the state over time.

Additional costs need to be considered as these bills propose the establishment of the Behavioral Health Accountability Council and an Office of Behavioral Health Ombudsman. The Michigan Department of Health and Human Services may also have to address the capacity in which they can implement these changes to the current system in Michigan. Formation of a new agency could result in hiring new staff or creating new procedures within the department, all of which should be considered from a budgetary standpoint. No clear data identifies what the costs of the creation of these new jobs would entail.

Due to the complexity and varying components associated with the plans introduced in these bills, it is difficult to calculate the exact budgetary and economic impact these bills would have on Michigan. Overall, the costs and benefits of these bills appear to be distributed across different entities and populations after enactment in which further data is needed. The timelines associated with these costs and benefits are unclear due to the uncertainty of the potential changes related to expenditures and policy decisions made after the enactment of these bills. Gaps in evidence are directly related to the inability to precisely estimating the fiscal impact of these bills and would need to be thoroughly assessed after more concrete evidence has presented itself concerning the funding and budgetary needs related to these policies.

"Status Quo"- No Policy Change

Criteria 1: Public Health Impact

As discussed, Michigan's current Medicaid program is administered through two separate managed care systems: PIHPs, which manage specialty behavioral health services, and Medicaid Health Plans, which manage physical health services. This separation has led to a reported fragmented care system, resulting in separate payment models and uncoordinated care between

the two systems. The National Alliance on Mental Illness (2021) reported that there are 355,000 Michigan adults living with serious mental illness. Their statistics show that Michiganders are five times more likely to be forced out of network for mental health care when compared to primary care, resulting in difficulties finding care and increased costs (National Alliance on Mental Illness, 2021). Many patients continue to experience challenges accessing coordinated and comprehensive care under the current system, especially those with co-occurring physical and behavioral health conditions or complex needs. Lack of integrated care can result in reduced access to care as patients under the current system must navigate multiple systems and providers to receive the care they need. Some effects include delays in treatment, decreased quality of care, and increases in healthcare costs.

Furthermore, suppose Michigan is to maintain the current "status quo" regarding no change in policy. In that case, negative consequences related to fragmented care and lack of coordination for patients requiring physical and specialty behavioral health services will continue to ensue. An article by Ralls (2021) found that "carving out" methods often led to duplicative billing and oversight issues, fragmentation of care, and the misalignment of incentives which could be associated with worse outcomes for patients. Policy recommendations from the Bipartisan Policy Center (2019) also recommend phasing out "carve out" methods to improve the alignment of agency incentives. MDHHS (2019) noted that Michigan's current system is difficult for people to navigate, creates extra hurdles for providers, and does not incentivize providers or managed care organizations.

If Michigan is to maintain the current "status quo" regarding the lack of an integrated care model. In that case, there may be no direct benefits to the population of those having to navigate the current siloed system. The state will continue to experience fragmentation and lack of care coordination, especially among those necessitating specialty behavioral health services with co-occurring physical health needs. Maintaining the “status quo” also does not align with MDHHS’ vision for an integrated care system as previously discussed. Without effective integration of

care, these populations may continue to face worsening health outcomes, further widening health disparities.

Criteria 2: Feasibility

Michigan is currently maintaining the "status quo" due to the lack of legislative and other stakeholder support concerning policy changes related to financial reform for integrated care for Medicaid beneficiaries requiring specialty behavioral health services. The feasibility, or the state of something being easily or conveniently done, for Michigan maintaining the "status quo" appears to be high as it has maintained this current system for quite some time. Although the practicality of maintaining this current system may not be entirely feasible in the long run, it continues to operate as is. While the state has maintained this "status quo", other efforts have been made regarding expanding the integration of behavioral and physical health services. One key initiative addressing integrated care efforts in Michigan is the Medicaid Health Home program. Other states have pursued similar programs to improve outcomes and reduce costs by eliminating barriers to care. These Health Homes allow states the option to develop "innovative, integrative, and sustainable care management/coordination programs for high-need, high-cost Medicaid beneficiaries with chronic health conditions" (Michigan.gov, n.d.). Program benefits include “comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referrals to community and social support services” (Michigan.gov, n.d.). MDHHS contracts with a lead entity (PIHP) to administer Health Homes, which then contracts with health home partners, such as Community Mental Health Partners and other centers, providers, and clinics. Under this program, providers are required to use a multidisciplinary approach.

In 2022, the expansion of this program has led to five PIHP regions/counties being able to offer Behavioral Health Home benefits to Medicaid enrollees with serious mental illness or serious emotional disturbance. These expansions are recent and current data on the public health impact of this expansion may need to be disseminated in the future. As mentioned previously, the feasibility of maintaining the "status quo" of no changes in state-wide policy to integrate

specialty behavioral health and physical health services may continue to be a feasible option if programs such as Medicaid Health Homes are found to have a positive impact on the population, state budget, and coordination of care efforts that the state of Michigan envisions. Programs such as these may also be more appealing to stakeholders as there could be fewer disruptions to the current systems, which was a noted concern related to other introduced legislative actions.

Criteria 3: Economic and budgetary impacts

The current economic and budgetary impacts of maintaining the "status quo" regarding integrating physical and behavioral healthcare are complex and difficult to estimate. As mentioned previously, fragmentation and lack of care coordination could lead to increased costs to the state. Implementation of Medicaid Health Homes has been shown to reduce healthcare costs by $103-$366 per member per month, yet these programs are not yet fully integrated throughout the state of Michigan and are only serving specifically approved regions at this time (Michigan.gov, n.d.). There are also concerns related to solvency issues that Michigan's current PIHPs have faced, which may also negatively impact Michigan's economic and budgetary outcomes at this time. Further investigation of the economic and budgetary impacts of maintaining the “status quo” would need to be performed to determine the exact extent of the cost of maintaining the current system.

Consolidation of Agencies

Another policy option that could be considered is the consolidation of Michigan's Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA). Both agencies function under the Michigan Department of Health and Human Services (MDHHS) but oversee separate plans that manage physical or behavioral health. As noted with Arizona, integrating two systems helped streamline services, improve coordination of behavioral and physical healthcare services, and align agency goals.

Criteria 1: Public Health Impact

The consolidation of the Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) in Michigan can potentially have a significant public health impact. Currently, in Michigan, both of these agencies serve under the MDHHS. MSA oversees the care and coordination of Medicaid Health Plans, while BHDDA oversees services as determined in the Michigan Mental Health Code and Michigan Public Health Code. Combining these two agencies may improve coordination between physical and behavioral health services in Michigan. By consolidating the MSA and BHDDA, Michigan can create a more integrated healthcare system that addresses individuals' physical and mental health needs. By addressing these needs, better health outcomes and reduced healthcare costs could arise. A similar approach was noted in Arizona when they combined their DBHA with the AHCCCS, leading to complete oversite by their director of Medicaid.

Consolidating the MSA and BHDDA could also ensure that individuals have access to the care they need, regardless of whether it is related to their physical or mental health. This consolidation could help reduce health disparities and improve health outcomes if agency alignment reduces duplication of services and administrative functions. As mentioned above, many individuals with chronic conditions, such as diabetes or heart disease, also have mental health conditions that can impact their overall health. By integrating physical and behavioral health agencies, Michigan can better manage chronic conditions and improve overall health outcomes by creating a more cohesive and coordinated administrative oversite.

By creating a more integrated healthcare system, Michigan can improve the quality of care provided to individuals. An integrated system would help to provide individuals with evidence-based treatments and ensure that care is coordinated across multiple providers. An increase in efficiency may be noted through the consolidation of the MSA and BHDDA, ensuring that resources are used effectively and that individuals receive timely access to the care they need.

Overall, the consolidation of the MSA and BHDDA in Michigan has the potential to have a positive public health impact. Improving access to care, better management of chronic conditions, improvement in the quality of care provided, and increasing efficiency are all possible

outcomes associated with the consolidation of agencies. By creating a more integrated healthcare system, Michigan can better meet the needs of its citizens and improve health outcomes. This option may also cause less disruption to the current system as it would not require an initial dismantling of how current local systems are run at this time. This recommendation may take considerable time to implement, which could give government agencies time to consider other options for integrating behavioral and physical healthcare.

Criteria 2: Feasibility

The feasibility of consolidating the Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) in Michigan depends on several factors but appears to be low at this time. Considerations that should be assessed are the legal and regulatory requirements, stakeholder buy-in, technical considerations, and political considerations.

Consolidating the MSA and BHDDA may require changes to state laws and regulations, as well as approval from state legislators. Changes to these laws and regulations need to be carefully reviewed and considered before implementation as there may be a need for policy changes on multiple different system levels. As BHDDA services are regulated by Michigan's Mental Health Code and Public Health Code, consideration has to be taken that changes to these codes may have to be made to consolidate these services. In Arizona, the Governor and policymakers' support helped consolidate their two separate agencies. In 2015, Arizona amended sections of Senate Bill 1480 which included the transfer and administration of the division of behavioral health services to the Arizona Health Care Cost Containment System (Arizona Senate Bill 1480, 2015).

Consolidating the MSA and BHDDA may require additional funding and resources, such as staff and technology. The cost of this consolidation effort would need to be carefully evaluated, and funding sources would need to be identified by the state. This consolidation effort would depend on the support of key stakeholders, which could include providers, consumers, advocates, and other state agencies..

It should be taken into consideration that consolidating the MSA and BHDDA may require developing a unified system and confirming that data can be shared between systems. The feasibility of creating this type of system would need to be evaluated before implementation. Political considerations, such as the current political climate, competing priorities, and potential stakeholder opposition, would also need to be considered prior to consolidation of these agencies or the polices it may change.

Consolidating the MSA and BHDDA in Michigan is a feasible option but would require careful consideration of legal and regulatory requirements, funding and resources, stakeholder support, and procedural considerations. Assessment of these factors would need to be conducted before any action is taken to implement the consolidation effort. As there appears to be no effort on the consolidation of agencies at this time, the feasibility may remain low until the risk and benefits of this change can be weighed among stakeholders. Consolidation of agencies could lead to innovative and collaborative ways in which the MDHHS might approach the integration of physical and behavioral health at the financial service level. This option may be more feasible than initially requiring a transition to Specialty Integrated Plans and shifting local funding, which has met much resistance in the past.

Criteria 3: Economic and budgetary impacts

Consolidating the Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) in Michigan could have marginal economic and budgetary impacts. Consolidation of the MSA and BHDDA could save costs by reducing administrative expenses associated with managing two separate agencies. Consolidation could also help Michigan allocate its resources more efficiently resulting in overall cost savings for the state. Improvement in the current systems efficiency should also be considered a cost saving possibility as there could be a reduction in duplicative efforts noted between the separate agencies. Alignment of agency goals and values could also help Michigan deliver services more effectively and efficiently under a consolidated system.

An upfront investment to merge systems and ensure that data can be shared between systems would also be a budgetary impact that would need to be assessed. These costs need to be considered in the context of Michigan's overall budget and funding priorities. In Arizona, funding and legislative support for the consolidation of their bifurcated agencies was supported by the Governor's budget and plan.

Workforce impacts, such as staff reductions or reassignments for current employees of each agency also need to be assessed as a budgetary consideration. As noted during Arizona's consolidation of agencies, some members left the DBHS after the consolidation was announced. Other employees were transferred into new roles in the new system. In Michigan, these impacts must be carefully considered and managed to minimize service and agency disruption. In Arizona, it was noted that some members of the DBHS left prior to the consolidation of these agencies which could be a possibility with this recommended consolidation. One hundred fourteen persons from the prior separated system were integrated and given positions within the new agency (Bachrach et al., 2017).

Overall, the economic and budgetary impacts of consolidating the MSA and BHDDA in Michigan is complicated at this time and also not a priority policy option as noted by lack of past efforts or current efforts to combine these agencies. The possible benefits of consolidating these agencies may outweigh the risk of significant economic impact. There is limited data on what the economic and budgetary impacts of this recommendation and further stakeholder input should be considered prior to the consolidation of these separated agencies. A detailed cost-benefit analysis would need to be conducted to evaluate this recommendation's economic and budgetary impacts fully.

Pilot Program a SIP in One Region

In regards to the past political climate related to the opposition in passing SB 597 and 598, it may be more feasible to first implement a pilot program in a specific region with a focus on the serious mental illness population of Michigan rather than requiring the entirety of the state to move current payment models from the status quo. In Arizona, a pilot of their RHBAs was initiated in a

single county before implementation went state-wide. This action allowed the overseeing agencies to address problem areas in a controlled environment. Other previously proposed bills in Michigan centered around changing the current bifurcated system at a financial integration level have also faced opposition or did not pass in the House during past legislative efforts. Past efforts to pilot financial integration in Michigan failed to be implemented due to disagreement among stakeholders and vetoing from the Governor. Reported struggles among stakeholders consisted of disputes relating to startup costs and scaling of the model (Wilson, 2019).

Criteria 1: Public Health Impact

The policy recommendation to establish a Specialty Integrated Plan (SIP) for individuals with serious mental illness in a singular region in Michigan may have a marginal public health impact. Because this would be piloted in a single region, there is the opportunity to avoid changes to policy at the state-wide level and reduce the number of persons initially impacted by this change. Implementing a regional SIP in Michigan through a gradual and collaborative method, such as piloting the program in one state region, could have several potential public health impacts. This Pilot program would provide an opportunity to test the effectiveness of this care delivery model in a smaller controlled setting, resulting in the ability to identify any challenges or barriers to implementation and opportunities for improvement. If successful, the program could be scaled up to other state regions. This pilot SIP could also improve health outcomes for individuals with complex health needs by providing integrated and coordinated care in the specified region resulting in a smaller initial public health impact than implementing a statewide change. The piloting of a regional SIP can lead to better health outcomes and a reduction in healthcare costs over time if improvements are seen in this region. Although the public health impact may be considered low during initial implementation, the state can take into consideration the impacts of this pilot program and be able to scale the effects it may have at the statewide level.

Strengths to draw upon from SB 597 and 598 are the phased-in processes that these bills introduced. As this approach is incremental and gradual, a phased-in method could be used to implement the SIP in one region. Downfalls related to this approach include a slower

implementation and evaluation period, which leaves a considerable amount of the targeted population out of the initial phases.

Past efforts to implement pilot programs with managed care organizations had almost reached implementation in the past. It would be helpful to use those past piloting plans to attempt to implement a pilot program again in the previously suggested regions. Arizona saw improvement in many areas within the serious mental illness population and integration efforts which began with the implementation of a pilot program prior to expanding statewide. As improved access to coordinated care can help to prevent adverse health outcomes and reduce hospitalizations, emergency department visits, and patient readmissions, these factors can be a starting point for initiating a plan to implement a pilot SIP in a singular region. It would be helpful to collaborate with other states' officials to determine the efforts that also helped to catalyze their efforts, creating the ability for supporters of this pilot to disseminate learned information to key stakeholders.

The piloting Specialty Integrated Plans in one region of Michigan could initially have marginal to low public health impacts by improving health outcomes, reducing healthcare costs, and providing valuable insights into the feasibility and effectiveness of this care delivery model to the specified region's population. This model may have an initially smaller impact on the target population of those requiring specialty behavioral health services at first but has the opportunity to expand and adjust over time if quality measures and feasibility of phases are being taken into consideration, leading to improved future implementation processes.

Criteria 2: Feasibility

The feasibility of this policy option depends on several factors, including the availability of funding and resources, the willingness of healthcare entities to participate, and stakeholders' engagement in the plan's development and implementation. The Governor's budget at this time does not account for a pilot program such as the one presented above. This factor needs to be considered if state dollars or federal grant funds are planned to be used with the implementation of this pilot. Past efforts to implement a similar pilot program have been supported in the past

during the planning phase. These efforts ended in 2018 when stakeholders could not agree on startup costs and model scaling (Wilson, 2019).

Piloting a singular regional SIP in Michigan would require political will and support from policymakers and stakeholders, such as health plans, providers, and consumers. As past efforts have met resistance, a reevaluation of stakeholders' agreeability to integration at the financial level will need to be assessed. At this time, financial integration is not a priority among policymakers. It appears a focus on expanding Medicaid Health Homes is at the forefront of physical and behavioral health integration at this time.

Piloting this singular SIP would require addressing legal and governing barriers related to integrating physical and behavioral health services at the financial delivery level. Reimbursement and licensure issues for the entity providing these services would need to be further investigated. From past efforts, it appears that the piloting of similar programs did not require regulatory or changes to laws initially. Implementing a singular regional SIP would require ongoing evaluation and monitoring to ensure the program meets its goals and objectives. Past efforts outlined specific metrics that would be measured during similar pilot programs, which included improved coordination of behavioral and physical health services, improved health outcomes, customer satisfaction, provider network stability, treatment, service efficiencies, use of best practices, financial efficiencies, and other relevant factors. These measures could be translated into the implementation of this suggested pilot program.

Given these factors, it is possible that implementing SIPs in Michigan through a gradual and collaborative method, such as piloting the program in one region of the state, may be feasible. However, it would require careful planning, consistent monitoring, and evaluation of the implementation process to ensure the program's success. It would also require engagement and collaboration with stakeholders across the healthcare system to ensure that the program

meets the needs of Michigan's population. Strengths of this policy recommendation include stakeholder agreeability to begin planning financial integration efforts in the past, which can be drawn upon for future implementation strategies.

Criteria 3: Economic and budgetary impacts

This policy option may have a positive economic impact in the long term by reducing healthcare costs associated with preventable hospitalizations and emergency department visits. Value-based payment models should be incorporated within the piloting of this program as they can incentivize providers to deliver high-quality care and reduce unnecessary utilization, leading to cost savings. Arizona encouraged using value-based payment models within their integration efforts to encourage improvements in the care providers offer and deliver. Investment in health information technology could also improve care coordination and reduce administrative costs and was a budgetary impact that Arizona highlighted in its efforts to integrate their services. It is unclear what the cost of investing into an improved health technology information system in Michigan is at this time, but should be taken into consideration when piloting this program.

This policy option may require an initial investment to establish the SIP and the necessary infrastructure needed to support the implementation of this program. However, the long-term budgetary impact may be positive due to the potential cost savings associated with improved health outcomes and reduced healthcare utilization. It is important to conduct a cost-benefit analysis to determine the specific budgetary impact of the policy option. Associated funding from local or state budgets should be assessed to determine the exact extent of the budgetary and economic impact of this policy recommendation. There is no current funding set aside for this type of program which makes it difficult to assume the economic impact. Shifting

of costs from the current local agencies to a managed care organization would need to be assessed to determine an exact impact to the specified regions budget.

The piloting a SIP in one region of the state would make it possible to evaluate the program's impact on healthcare utilization and costs after a more detailed plan has been formulated. Measuring these impacts could help to inform decisions about the feasibility and cost-effectiveness of scaling up the program to other regions of the state, especially in the context of the uncertainty of the actual costs of implementing SBs 597 and 598 state-wide. Policymakers should also take careful consideration to assess the fiscal impacts related to changing payment models to local community services, as there is the possibility that the managed care organization taking over these payment models could disrupt the current systems. Changing regulations regarding local payment systems and models would need to be further investigated to determine whether or not other statutes would need to be changed to adjust for financial changes.

Step 2B: Assessment of Policy Options

Please see Table 1 for this writer's assessment of policy options adapted from the CDC's *Policy Analytical Framework*. Each policy option was scored within the matrix, comparing the public health impact, feasibility, economic and budgetary impacts as discussed in the previous domain. As SB 597 and 598 were not passed in the Senate even after amendments were made during this policy analysis, this option is not feasible at this time. Although the public health impact would have been high for those requiring specialty behavioral health services, the economic and budgetary impacts were neutral. Maintaining the "status quo" appears to be the most feasible option with Michigan's current political climate, as there have been no further measures to integrate physical and behavioral health services at the financial level. The consolidation of separate agencies may have a marginal public health impact regarding the integration of physical and behavioral health services. The political climate regarding this policy

option is also unclear, and further research would need to be done to assess for feasibility and acceptability of consolidating the separate agencies. Piloting a SIP in a single region of Michigan can potentially have a small public health impact. However, it would benefit the assessment and implementation of the integration of these services at a financial level. The economic and budgetary impact is not completely clear at this time because costs would most likely need to be negotiated among stakeholders before implementing this recommendation. As past recommendations have consisted of limiting change to state policy regarding integration efforts, this may be the most feasible option regarding acceptability among policymakers. Of note, although these ratings are grounded in the data and evidence provided in Step 2 of this policy analysis, they are subjective to the writer of this paper.

Step 2C: Prioritize Policy Options

For this policy analysis, 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 rather than 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. After a thorough comparison of the above-mentioned policy recommendations, implementing a singular Specialty Integrated Plan in one region of Michigan is the writer's recommendation regarding creating a strategy to further progress an integrated care model at the financial level in Michigan. 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 feasible option for Michigan lawmakers 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. 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 soon, 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 consolidations 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.

Domain 3: Strategy and Policy Development

For this domain of this policy analysis, a strategy will be defined regarding the enactment and implementation of the prioritized policy solution. This domain includes clarifying operational issues related to implementing a Specialty Integrated Plan. This domain also details the writer's plans to share information with key stakeholders who would be affected or interested in this recommended policy solution.

Clarifying Operational Issues

The first operational issue that would need to be addressed is the agreeability of policymakers and stakeholders, such as community mental health organizations, PIHP groups, and the population affected by implementing an integrated specialty plan. If stakeholders are not agreeable to the proposed change related to the financial integration of these services, it would not be feasible to implement a change at this time. Education related to this specific change's impact should be provided to all stakeholders before implementation. Engagement in the recommended change should be an initial strategy to align the priorities, goals, and values of this recommended change. These elements should be established through a workgroup consisting of stakeholders. The proposed workgroup should include policymakers, local community health systems, the specific PIHP group for that region, and patients and families functioning under the current system. One important thing to identify would be a consensus on the definition of integrated care under this workgroup. Collaboration and alignment of goals, values, and the definition of integrated care should be determined prior to the implantation of this pilot. Funding

and grant opportunities should also be investigated during this time. As this recommendation is a pilot program, there should be no need for a specific change to legislation during this time. It should be taken into consideration other legislative policies and laws that may need to be adjusted in the future if this pilot program was to be implemented state-wide.

Next, the specific region of Michigan where this pilot program will be implemented should be determined. In 2018, Muskegon County CMH, Genesee Health System, and Saginaw County Community Mental Health Authority were selected and approved for a similar piloted program. It may be a feasible option to trial a pilot in these regions again, as they had been approved in the past for similar pilot programs addressing the financial integration of services. A needs assessment should be considered before implementation in any of these regions to determine the exact extent of disparities and population that would be served regarding current public health and integrated care factors. A needs assessment would also provide a baseline for the outcome measures looking to be improved. Workgroup members should be agreeable to the outcome measures they want to see improved throughout this pilot. Members should agree upon which specific population requiring specialty behavioral services they would like to target (SMI, D/IDD). A timeline for implementing this pilot should also be determined at this time. Past pilots required a two-year commitment to monitoring the pilots, which may also be feasible.

Once goals, values, funding, and an implementation plan have been agreed upon, MDHHS should send request for information (RFIs) to interested parties who want to provide the specialty integrated plans. RFIs have been a helpful method used in other states to gauge perspective managed care organizations or other entities and determine the best fit for the specific population. It would be helpful to include all stakeholders in choosing who will take on the role of the Specialty Integrated Plans to ensure that the values of all parties involved are

considered. To facilitate the implementation of a SIP, stakeholders will need access to timely and accurate information about program goals, requirements, and outcomes. Clear communication channels and data-sharing platforms must be established during this time. To hinder fears related to loss of providers or dismantling of the system, considerations should be taken to ensure that the affected population can continue receiving care from established providers or provide a plan to ensure that there is no disruption of services provided as this has been a significant concern among stakeholders in the past.

Implementing a SIP within a single region of Michigan will require a commitment to sustainability which should include ongoing monitoring and evaluation to ensure that the pilot program is meeting its goals and objectives. Adjustments to address emerging issues and challenges should be taken into consideration and addressed among stakeholders throughout the implementation process. Stakeholders should attempt to forecast possible challenges and create a strategic approach to addressing these issues.

In conclusion, the implementation of a SIP within a single region of Michigan will require careful planning, collaboration, and coordination among different stakeholders. The operational issues addressed in this section are only a catalyst to initiating steps forward to integrate Michigan's physical and behavioral health services financially. After a workgroup has been formed, more detailed plans can be made to begin the implementation of a Specialty Integrated Plan in Michigan. By addressing these operational issues, the program can potentially improve the quality of care for individuals requiring specialty behavioral health services in this region and enhance healthcare outcomes for the designated region with the ability to expand statewide.

Sharing Information

As a significant part of policy development, the dissemination of information from this analysis will be provided to interested parties. Products will be presented to describe and publicize the information of this policy analysis to share the information presented in this paper. For this analysis, a briefing paper will be provided to Michigan State University's Institute for Public Policy and Social Research (ISPPR) for distribution to their intended audience. This paper will discuss policy recommendations made by the writer for use by stakeholders and policymakers alike. A blog post will also be created to disseminate the results found in the analysis to be distributed to interested parties. Findings and recommendations from this policy analysis were also presented at the Midwest Nursing Research Society conference and Michigan State University's College of Nursing Research Day in March of 2023. These opportunities allowed interested parties to review the writer's work and discuss this policy analysis. This policy analysis will also be presented at Michigan State University's Doctor of Nursing presentation day and during a webinar for the Mental Health Association of Michigan in May of 2023 to share the findings of this project with key stakeholders and interested parties in attendance. Information sharing will continue after the completion of this project, with the ability of the writer to continue to accomplish future analyses of the findings of this paper.

Conduct Additional Analyses

The CDC's Policy Analytical Framework denotes conducting additional steps if the current policy recommendation is not prioritized. Lack of policy prioritization could be due to low feasibility or insufficient stakeholder support, which are both concerns related to the recommendation of implementing a single regional SIP. As mentioned, a more incremental policy recommendation has been created to better address the current problem related to care integration in Michigan's current political climate. Further research should continue to monitor

stakeholder acceptability of proposed recommendations. Continued monitoring of legislation related to integrating these services at the financial level is ongoing. At this time, there is no current new legislation that is being proposed to Michigan's Senate or House of Representatives. This work will continue to guide current public health topics of interest. This specific policy analysis can continue to be helpful for information distribution and sharing if policymakers begin to reconsider strategizing ways to continue financially integrating care in Michigan for their underserved populations.

Timeline

The project timeline began in September 2022 and included the following activities (Table 2). For the policy audiences, a plan to request a meeting with Michigan policymakers considering the current legislation to discuss this work will take place after this analysis has been completed. Two update reports and a briefing paper will be submitted to IPPSR for review and publication to their institute as they find fitting. Abstracts were submitted for our healthcare professional audiences, particularly behavioral health providers. This work was presented at the annual conferences of Michigan State University College of Nursing Research Day and the Midwest Nursing Research Society (MNRS). The findings of this analysis will be presented to faculty and students at a research seminar at the Michigan State College of Nursing. Two blog posts or news stories will be delivered to the public audience to share this work. Future analyses can ensue once the initial steps of implementation of this policy recommendation have commenced. At the time of the completion of this analysis, integration efforts at the financial level of service have halted, therefore recommendations to once again begin the planning process for integrating physical and behavioral health services at the financial level are being provided.

Conclusion

As Michigan struggles to implement a state-wide integrated care model, this policy analysis introduces a more gradual and collaborative approach to reaching that overarching goal. 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 integrating physical and behavioral health through a more comprehensive approach to care coordination and reducing 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 are widely adapted to improve noted health disparities.

From the policy analysis, it does not appear that MDHHS's previous vision for a financially integrated system is at the forefront of integrated care efforts. As noted from past attempts, stakeholder involvement, and collaborative efforts are necessary with regard to such a significant change to how Michigan’s current system is functioning. It appears that a vast agreement among all parties and state funding is necessary to ensure change is made regarding this topic.

As many financial 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 will present itself regarding the positive impacts of these strategies on a state's population health and cost savings. This policy analysis looks to educate and give recommendations to policymakers and stakeholders alike on how an integrated care model can be adopted into Michigan's current healthcare 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. Drawing from the strengths and weaknesses of bills proposed in Michigan and policy changes in other states, this analysis 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 payment system for these Medicaid beneficiaries. Whether attempting to consolidate agencies or through the creation of Specialty Integrated Plans for their Medicaid population, Michigan policymakers have the potential to improve health outcomes for struggling populations. 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.

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Appendix

Appendix A

Table 1

Policy Options Assessment Table

CRITERIA	PUBLIC HEALTH IMPACT	FEASIBILITY	ECONOMIC AND BUDGETARY IMPACT	
Scoring Definitions	**Low:** small reach, effect size, and impact on disparate populations **Medium:** small reach with large effect size or large reach with small effect size **High:** large reach, effect size, and impact on disparate populations	**Low:** No/small likelihood of being enacted **Medium:** Moderate likelihood of being enacted **High:** High likelihood of being enacted	**Less favorable:** High costs to implement **Favorable:** Moderate costs to implement **More favorable:** Low costs to implement	**Less favorable:** costs are high relative to benefits **Favorable:** costs are moderate relative to benefits (benefits justify costs) **More favorable:** costs are low relative to benefits
			BUDGET	*ECONOMIC*
Enactment of SB 597 & 598	o Low o Medium • **High** Concerns about the amount or quality of data? (Yes / **No**)	• **Low** o Medium o High Concerns about the amount or quality of data? (Yes / **No**)	o Less favorable • **Neutral** o More favorable Concerns about the amount or quality of data? (**Yes** / No)	o Less favorable • **Neutral** o More favorable Concerns about the amount or quality of data? (**Yes** / No)
"Status Quo" No change in policy	o Low • **Medium** o High Concerns about the amount or quality of data? (Yes / **No**)	o Low o Medium • **High** Concerns about the amount or quality of data? (Yes / **No**)	o Less favorable o Neutral • **More favorable** Concerns about the amount or quality of data? (**Yes** / No)	o Less favorable o Neutral • **More favorable** Concerns about the amount or quality of data? (Yes / **No**)
Consolidation of separate agencies	o Low • **Medium** o High Concerns about the amount or quality of data? (**Yes** / No)	o Low • **Medium** o High Concerns about the amount or quality of data? (**Yes** / No)	• **Less favorable** o Neutral o More favorable Concerns about the amount or quality of data? (**Yes** / No)	• **Less favorable** o Neutral o More favorable Concerns about the amount or quality of data? (**Yes** / No)
Pilot of a SIP in one region of Michigan	• **Low** o Medium o High Concerns about the amount or quality of data? (Yes / **No**)	o Low • **Medium** o High Concerns about the amount or quality of data? (**Yes** / No)	o Less favorable • **Neutral** o More favorable Concerns about the amount or quality of data? (**Yes** / No)	o Less favorable o Neutral • **More favorable** Concerns about the amount or quality of data? (**Yes** / No)

The above table was adapted from the CDC's Policy Analytical Framework and measure were adjusted to fit within the context of this specific policy analysis (CDC, n.d.)

Appendix B

Table 2

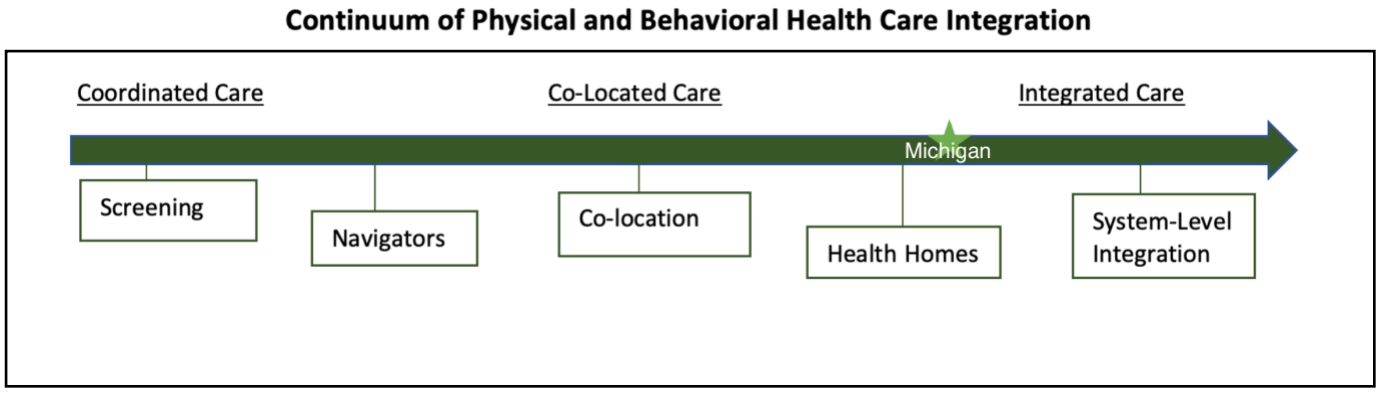
Simplified Project Timeline

Table 3: Project Timeline	**Month**											
Activity	1	2	3	4	5	6	7	8	9	10	11	12
Data acquisition and cleaning												
Policy analyses- Phase I (Bardach's steps 1-3)/ CDC Domain's 1-2			R									
Policy analyses- Phase II (Bardach's steps 4-8)/ CDC Domain 3									R			
Research seminar presentation for College of Nursing												
Manuscript preparation											P	
Blog post/news story												
Abstract submission and conference presentation: MNRS												
IPPSR briefing paper preparation												P
R: Denotes submission of a brief updates report on progress to IPPSR. P: Denotes submission of paper.												

Appendix C

Figure 1

Continuum of Physical and Behavioral Health Care Integration Adapted from SAMHSA-HRSA Center for Integrated Health Solutions



Appendix D

Table 3

Literature Review Table

Title/Author	Journal/Organization	Country	Type	Data Source	Characteristics/Factors related to Integrated Care	Effect on Policy Process
Assessing Changes to Medicaid Managed Care Regulations: Facilitating Integration of Physical and Behavioral Health Care Edwards, Elizabeth	The Commonwealth Fund	United States	Health Policy Report- Grey literature	Government Press release, reports, previous research	-Not one defined integrated care model -Focuses mainly on those with co-occurring chronic conditions, older adults, moderate or severe mental illness populations -Importance of quality care coordination	Unclear
California Mental Health Older Adult System of Care Project Deliverable 4 Report: Focus Groups Kietzman, Kathryn G; Dupuy, Danielle; Damron-Rodriguez, Jo Ann; Palimaru, Alina; Frank, Janet C; del Pino, Homero	UCLA Center for Health Policy Research	United States-California	Report	Key informant interviews/ Focus groups	-Used individual values as to guide mental health services for older adults -Mental health service delivery systems alignment with consumer and family needs	Some
How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services Bachrach, Deborah; Boozang, Patricia M; Davis, Hailey E.	The Commonwealth Fund	United States-Arizona	Report	Published research, Arizona Medicaid agency materials, interviews	-Attentiveness to behavioral health services and integration efforts increased -Allowed for strategic buying - Streamlined of regulatory processes -Enhanced collaboration, communication, and mutual trust	Yes

Integrating Clinical and Mental Health: Challenges and Opportunities Bipartisan Policy Center	Bipartisan Policy Center	United States	Report	Federal policy options, government reports, legislation	-Discussion points for improvement in coordination of care as well integration of care	Yes
The Complex Needs of Medicaid Expansion Enrollees with Very Low Incomes Shippee, Nathan D; Vickery, Katherine D.	The Commonwealth Fund	United States-Minnesota	Report	Minneapolis-St. Paul region Medicaid Enrollee data 2011-2013	-Providing access to integrated health and social services could be beneficial to this specific population	No
A Case Study of Implementing Grant-Funded Integrated Care in a Community Mental Health Center Martha Aby	The Journal of Behavioral Health Services & Research	United States	Case Study	Interviews and Document Data Collection	-Focus on integrating primary care and behavioral health services within a CMHC or behavioral health setting -Discusses challenges associated without ongoing federal financial support -Focus on obtaining a shared definition of integrated care -Highlights need for further research on insurance payment strategies	Some
Barriers and facilitators to the integration of mental health services into primary health care: a systematic review Edith K Wakida , Zohray M Talib , Dickens Akena Elialilia S Okello , Alison Kinengyere [5] Arnold Mindra , Celestino Obua	BMC Systematic Reviews	Global	Systematic Review	6 Databases and internet platforms searched	Key factors related to integration of mental health services into primary care: “acceptability, appropriateness, credibility, knowledge and skills, motivation to change, management and/leadership, and financial resources” (Wakida et al., 2018)	Little
The Affordable Care Act: policy predictors of integrated care between Hispanic- serving and mainstream mental health organizations Robert Rosales and Rocío Calvo	BMC Health Services Research	United States	Analysis of National Mental Health Services Survey (NMHSS).	Organizational responses from the National Mental Health Service survey	-Federal funding for organization transitions to integrated care services increased delivery of these services to this population (Hispanic-serving organizations) -Focus on integrating primary care with addiction treatment	Some
Integrated Health and Social Care in the United States: A Decade of Policy Progress	International Journal of Integrated Care	United States	Descriptive policy paper	Academic journals, articles, and Medicaid /Medicare fact sheets	-Focus on state and policy initiatives in US over last 10 years -Details policy changes to integrate health and social care for American Medicaid population at federal level	Yes

Sahil Sandhu, Anu Sharma, Rushina Cholera, Janet Prvu Bettger						
Integrated care models and behavioral health care utilization: Quasi-experimental evidence from Medicaid health homes Chandler McClellan ,Johanna Catherine Maclean, Brendan Saloner, Emma E. McGinty, Michael F. Pesko	Health Econ	United States	Quasi-experimental Evidence	Analysis of National Survey on Drug Use and Health (2010-2016)	-Enrollees self-reported health improvements post-HH implementation -Self reported health improvements post Medicaid Health Home implementation -First population level effects of this service on behavioral health service use	Some
Integrating Primary Care Into Community Mental Health Centres in Texas, USA: Results of a Case Study Investigation Rebecca Wells, Ellen D. Breckenridge, Sasha Ajaz, Aman Narayan, Daniel Brossart, James H. Zahniser and Jolene Rasmussen	International Journal of Integrated Care	United States	Case Study	Interviews and study groups	-Perceived improvements with integrated care model -Funding was short term -Adequate and predicable funding needed for longevity	Little