POLICY BRIEF

The Role of Primary Care Practices and Providers in Increasing Access to Integrated Models of Primary and Behavioral Health Care in Rural and Urban Areas of Michigan

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Project Team

Jaque King, MPP
Wendy Hawkins, MPP
Nancy Baum, PhD, MHS

Background

Nationally, mental health needs increased over the last several years, exacerbated by the coronavirus disease 2019 (COVID-19) public health emergency that began in March 2020. A 2021 survey found that "...31.6 percent of adults in the U.S. reported symptoms of anxiety and/or depressive disorder, up from 11.0 percent in 2019." Studies have also shown an increase in behavioral health (BH) needs in Michigan, similar to national measures.

Primary care and BH providers offer a range of services to treat patients with BH conditions. These providers may work together to provide integrated primary care and BH services and may use telebehavioral health services to address BH needs. This study analyzed claims data to assess the types of BH providers delivering integrated services in rural and urban areas in Michigan for individuals with BH diagnoses who had BH claims. The analyses were conducted using Blue Cross Blue Shield of Michigan (BCBSM) preferred provider organization (PPO) and health maintenance organization (HMO) claims for commercially insured members from 2019 to 2021.

The study focuses on rural areas in Michigan. Rural populations generally have worse health outcomes than urban populations. The majority of health professional shortage areas are in rural areas, and residents may have difficulty accessing specialty services.

Methods

This study included a literature review for research and benchmarks about delivery of BH services by provider type and geography, as well as analysis of BCBSM PPO and HMO outpatient claims data. Members were included in the study cohort if they had any BH diagnosis in each individual year of the study (2019, 2020, and 2021), as well as 12 months of continuous enrollment and a Michigan ZIP code. ZIP codes were aggregated to counties and categorized by metro, micro, or rural designation, as defined by the 2010 U.S. Census and Office of Management and Budget.

We used the International Classification of Diseases, Tenth Revision (ICD-10) codes to identify BH-specific diagnoses. We then included relevant ICD-10, HCPCS, and CPT procedural codes to define telebehavioral health, integrated care, and medication-assisted treatment. Prescription drug claims, including regular medication refills, were not analyzed.

The BCBSM claims data did not adequately describe primary care settings or differentiate among primary care settings through a place of service variable. Furthermore, the outpatient place of service variable for doctor's offices did not denote whether the location is a primary care or a specialty provider clinic. As a proxy, we aggregated provider types into categories: BH providers, primary care providers, and both

primary care and BH providers. These definitions were informed by literature and documentation in the claims data, including information about the provider organization and specialty.

Key Findings

Our study found an increase in the use of BH services from 2019 to 2021, particularly for telebehavioral health and integrated care services. There were disparities in the use of these services among metro versus rural members, which may be due in part to lack of BH providers and broadband access in rural areas. Addressing these underlying access issues may help close this gap.

In the 2021 data, 12% of PPO members and 15% of HMO members had a BH diagnosis. There were **wide geographic disparities in the proportion of members who received BH services**. In metro areas, 40.6% of PPO members and 38.6% of HMO members received any BH service. In rural areas, only 26.9% of PPO members and 22.1% of HMO members received any BH service.

From 2019 to 2021, the use of telehealth services soared in all geographic regions. Telehealth has often been touted as a means to close the gap in use of BH services, yet geographic disparities remain. **In 2021, 28% of PPO members in metro counties had a telehealth visit, twice the rate of members in rural counties (14%).** This difference was greater for HMO members—28% in metro areas **compared with only 11% in rural areas.**

In 2021, **a larger proportion of PPO members from metro areas (36.4%) received a BH service from a BH provider than did those from rural areas (23.7%).** This difference was even greater for HMO members—35.2% received a BH service from a BH provider in urban areas compared with 19.2% in rural areas.

A very small percentage of all members with BH diagnoses had claims for integrated care services in 2021 (0.4% in both PPO and HMO populations). This proportion has been steadily growing in recent years, likely due to a growing awareness of integrated care billing codes among providers and the introduction of an additional integrated care code in 2021.

Conclusions

In contrast to survey data that showed a large increase in the prevalence of depression and anxiety from 2019 to 2021, the proportion of members in this study who had any BH diagnosis only rose 1 percentage point during the same time period. However, there was a 10% increase in the proportion of members with a BH diagnosis who received services for their BH conditions during this time period. This trend may be due in part to broad increases in the use of telebehavioral health services and the overall need for BH care as a result of the COVID-19 pandemic. Going forward, it may be key for policymakers to act to support telehealth as a necessary and effective form of providing care BH services even as COVID-19 becomes endemic.

Limitations

Claims data may have lags in billed claims, limited demographic information, and variables that do not offer clean distinctions among provider types. In addition, analyses of claims only assess services that were billed. We analyzed data from one large insurer for a commercially insured population, which may not be representative of all insured populations in Michigan. The study emphasized analysis of the use of integrated services in primary care among metro and rural areas in Michigan. Although some outpatient billing codes exist for BH integration, these codes are not widely used so likely do not represent the full use of integrated services.

Acknowledgements

This research is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.4 million. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

References

1. tbd