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SB673 > oppose

The State of Michigan Certificate of Need process is not the barrier in access to behavioral health services. The lack of true parity in behavioral health reimbursement, a shortage of psychiatric providers and the many facets of human safety in psychiatric settings more directly contribute to the challenges of access in our communities.

Acute psychiatric inpatient services are a small part of treating patients with severe mental illness. Most treatment, and unfortunately the long waits in access, are found in the outpatient arena. Several Michigan families wait months for psychiatric outpatient appointments due to the lack of providers in the community. The longest waits are for child psychiatry.

There are enough licensed psychiatric beds in Michigan. The behavioral health access problems run deeper than the need for more beds. Eliminating the psychiatric CON would be a disappointing remedy to the lack of inpatient access. Without more access to the people who care for people with mental illness, more beds will only mean more frustration. At Pine Rest we cannot admit a patient simply because we have an empty bed. We must have the capacity to give appropriate, meaningful care to the person who needs that bed. The lack of providers and adequate reimbursement directly contribute to the underutilization of these beds.

Presently there are 215 adult and 66 child and adolescent available beds in the state's psychiatric pool for organizations to apply for and put into use. There are 500 available in the specialty pool of psychiatric beds, intended to help alleviate the waits in emergency departments with high acuity psychiatric patients. In total nearly 800 beds sit today available across Michigan for existing and new psychiatric providers. These available beds, the result of the Certificate of Need department working with psychiatric providers and advocates across the State, were increased six months ago when the CON standards were reviewed. To date, only a handful have been applied for and primarily by existing providers.

The often cited 200-person waiting list for an inpatient bed is unlikely to change by licensing more psychiatric beds. Many of those on the waiting list cannot be served by hospitals with open beds. The wait list issues can be addressed through staffing strategies (psychiatric coverage, nursing, direct care), and the creation of a psychiatric ICU rate that would dramatically reduce the waiting list. Last spring Pine Rest opened its Psychiatric Urgent care center to offer another creative solution to open access and help reduce unnecessary emergency room visits and waits. To date we had over 6,600 psychiatric evaluations in the urgent care. Over 65% of those patients were brand new to Pine Rest suggesting this type of service helped avoid the ED and offer immediate access to psychiatric resources to people in crisis.

The regulations put in place by Certificate of Need require that at least 50% of psychiatric beds need to be available to Medicaid patients. An unintended consequence of CON elimination could be further restriction to access for those most vulnerable. Psychiatric reimbursement is much lower and often below cost requiring most acute care settings to subsidize behavioral health care units.

Eliminating psychiatric CON is contrary to the principle of Parity for mental health. As other specialty services maintain CON status, eliminating psych perpetuates the lack of parity. There are other examples of markets that have gone from psychiatric CON to non-CON status. These provide cautionary tales about the net negative impact of eliminating psychiatric CON. In Milwaukee, after a few for-profit organizations opened children psychiatric facilities, the market was decimated. Several hospitals were forced to close as Psychiatric providers, both physician and nursing, constantly moved to the for-profit facilities. Reimbursement didn't improve and operations became too much to sustain.

I hope we will all learn from the experience in Wisconsin and find better, more innovative solutions in Michigan.