July 15, 2020

Chairman Vaupel & Members of the House Health Policy Committee,

My name is Alan Bolter. I am associate director of the CMH Association of Michigan. CMHAM is a trade association, representing the 46 CMH boards, 10 Prepaid Inpatient Health Plans (PIHP) and over 100 provider organizations. Our members provide mental health, developmental/intellectual disability and substance use disorder services for Michigan residents in all 83 counties in Michigan.

Our association supports the intent of SB 672 & 673, which is to increase the availability of psychiatric inpatient beds across the state. However, some of our members have concerns regarding the elimination of the Certificate of Need (CON) process and believe strengthening current CON practices would help more than simply eliminating CON all together.

Eliminating CON for psychiatric inpatient beds would detrimentally affect:

- A justifiable scientific approach for planning areas to more accurately predict, plan for, and respond to psychiatric bed need.
- A clearer, more targeted way to address the increase in need for psychiatric services which have increased at a much higher rate in the last five years than in the past.
- A greater emphasis on access for indigent and high acuity populations – a focus on access, quality, and cost would be compromised.
- Clearer requirements around minimum occupancy for hospital psych beds before a new entity could acquire, replace, or relocate beds.
- Elimination of the CON for psychiatric beds would eliminate careful planning, methodology, and guidance relative to availability of needed psychiatric beds in Michigan. This removal will worsen access to needed inpatient level of care where there are already issues in access to this level of care. Simple elimination will not stimulate competition to create beds, this will further harm timely access.

Again, thank you for your time and consideration of our remarks.

Respectfully submitted,

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Psychiatric Inpatient Denial
Data Collection Pilot

Introduction:

In 2015, MSHN received an increasing number of reports from Community Mental Health Services Program (CMHSP) participants of inappropriate, and sometimes lengthy boarding of consumers in inappropriate settings, such as hospital emergency rooms (ERs). In particular, there were barriers with securing access to inpatient psychiatric care for individuals with challenging behaviors, co-occurring conditions, as well as youth. The rate at which CMHSPs encountered significant barriers to psychiatric inpatient admission were alarming.

At the same time, the Behavioral Health and Developmental Disabilities Administration (BHDDA) and the Certificate of Need Commission (CON) experienced an increased volume of calls regarding inpatient psychiatric access barriers. These calls reportedly came from hospitals complaining of CMHSP inability to secure psychiatric inpatient access and from CMHSPs (in other regions) indicating severe wait times or other access barriers. MSHN took action to quantify these access barriers and collaborated with the BHDDA and the CON commission in the development of a data collection pilot to document the extent of these psychiatric admission barriers and to determine if there were systematic issues with psychiatric inpatient access. The purpose of this initiative was to document the scope of the problem, to ultimately reduce inpatient denials and for the State to investigate and resolve patterns of inpatient admission difficulties – which should lead to better access for individuals experiencing acute psychiatric distress.

Method:

MSHN, in partnership with BHDDA and CON created a pilot data collection instrument that included the following data elements necessary for the CON commission to conduct follow-up investigations of inpatient denials: consumer name, consumer identifier (Medicaid ID, EMR ID, etc.), date and time of denial, DOB, consumer diagnosis, comorbidities, hospital name and reason for denial. MSHN agreed to operate the pilot for about one year, after which time the Michigan Department of Health and Human Services (MDHHS) would determine the utility of expanding the pilot Statewide. This data was collected from the 12 CMHSPs in the MSHN region, and was logged into a web-based application developed by MSHN IT staff, for all consumers who were denied inpatient admission, regardless of payer type (i.e. Medicaid, Healthy Michigan, general fund). Raw data was extracted to produce the following findings.

Findings:

Between March 1, 2016 and July 9, 2017, MSHN's 12 CMHSP's reported 31,107 instances of psychiatric inpatient admission denials impacting 1,676 consumers (table 1). This is an average of 19 denials per consumer. Of the total number of consumers denied admission, 13% were children/minors and 87% were adults (table 2). The most common reason for denial reported was *At Capacity* (81%) which could mean:

- all beds are full,
- gender specific bed capacity,
- beds are blocked in shared rooms for reasons such that a shared room is not deemed acceptable, or

- insufficient staff/staff training to address the needs of the consumer.

The next most common reason reported being *No Call Back/No Response* and *Patient Does Not Fit Milieu* at 5% and 4% respectively (table 3). All other reasons documented make up 10% of the denials. See charts on pages 3-9 for more details on reason for denial by hospital.

Table 1: Denials Reported by CMHSP

Reporting CMHSP	Instances of Denials	Unduplicated Consumer Count
Bay-Arenac CMH	1,915	193
CEI CMH	17,245	521
Central Michigan CMH	465	52
Gratiot CMH	105	22
Huron CMH	564	42
Lifeways	2,464	244
Montcalm Care Network	1,286	85
Newaygo CMH	184	14
Saginaw CMH	4,753	398
Shiawassee CMH	179	25
The Right Door for Hope, Recovery and Wellness	1,744	54
Tuscola CMH	203	26
Grand Total	31,107	1,676

average denials per consumer: 19

Table 2: Denials by Age

Age	Total
0-17	220
18+	1,454
Unknown	2
Grand Total	1,676

Table 4 below represents the number of consumers who are reported as being either an individual with a developmental disability (IDD), an individual with a substance use disorder (SUD), or an individual with autism spectrum disorder (ASD).

Table 4: Population Type

IDD	SUD	ASD
208	275	40
12%	*16%*	*2%*

Table 3: Reason for Denial

Reason Reported	Total
Ability to Pay	5
Age	60
At Capacity (All Licensed Beds At The Hospital Are Occupied)	25,256
Beds Available But Insufficient Staff	112
Beds Available But No Appropriately Trained Staff	42
Commitment Status	37
Gender	227
Handicap	15
No Call Backs/No Responses	1,665
Other (Specify)	1,711
Patient Comorbidities (Specify Medical Illness)	384
Patient Does Not Fit Milieu	1,198
Payment Rate Issues	22
Race	2
Religion	1
Sexual Orientation	4
Source of Payment	100
Violent/Disruptive behavioral Issues	262
Grand Total	31,107

Discussion:
Given a large majority of calls resulted in a denial due to capacity, MSHN, along with other parties, advocated with the CON commission to consider investigating patterns of denial that were inconsistent with existing CON commission rules. Another consideration was the development of a strategy in which real-time bed availability could be made available to CMHSP's to reduce the number of calls and time spent seeking admission. Trends in psychiatric admission difficulties for certain sub-populations were also noted. Census data, and the CON commissions own records showing bed availability and need showed there were enough beds available; however, they may not be available for specific populations. To address the needs of these specific sub-populations, the CON commission approved a statewide pool of 370 additional psychiatric beds to meet the needs of special population groups within the mental health populations: adult individuals living with Intellectual/Developmental Disabilities (110), children/adolescents individuals living with Intellectual/Developmental Disabilities (20), geriatric psychiatric patients (110), adult individuals with severe mental illness living with comorbid medical conditions (110), and children/adolescents living with severe emotional disturbances and a comorbid medical condition (20). These beds were designated to address inpatient access barriers by people in these sub-populations only and did not address the needs of persons in the severe mental illness category that do not experience these complicating conditions.

The MDHHS/BHDDA and the CON commission expressed interest in expanding the data collection state-wide and in expanding follow-up on patterns indicating psychiatric inpatient access barriers. MDHHS invited MSHN to submit a Health Innovation Grant request to provide ongoing support of the Statewide initiative. MSHN was awarded a small grant of $35,000 in November 2016. MSHN subcontracted with a vendor to enhance the web application that had been used by MSHN to ensure consistent, and standardized state-wide reporting capabilities. MSHN conducted web-based trainings for Emergency Services staff around the state, through webinars, in March, 2017 and went live with statewide data collection in July, 2017. The MSHN-specific pilot ended when the Statewide expansion began.

As a companion activity, MSHN commissioned Health Management Associates (HMA) to conduct national research around public psychiatric inpatient bed registry (PBR) systems. Several states have implemented either mandator or voluntary systems for the purposes of maintaining real-time bed availability. The final report was shared with BHDDA and the CON commission and in June, 2017, was presented publicly to a group stakeholders to gauge interest and support for developing a PBR system in Michigan. With stakeholder support for moving forward to develop a PBR, the BHDDA established a workgroup to define the system requirements in addition to several other workgroups to address key issues related to inpatient access barriers.

Continued advocacy to address and remove barriers to psychiatric inpatient hospitalization are needed and will continue.

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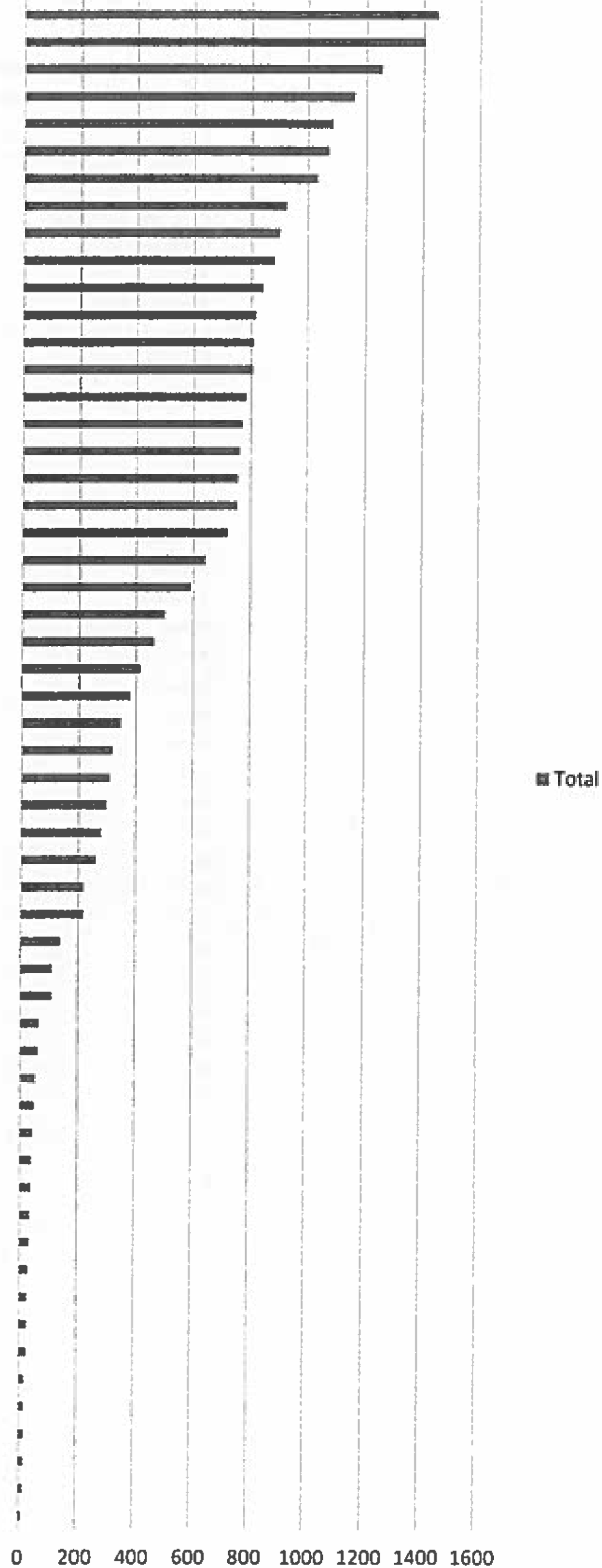

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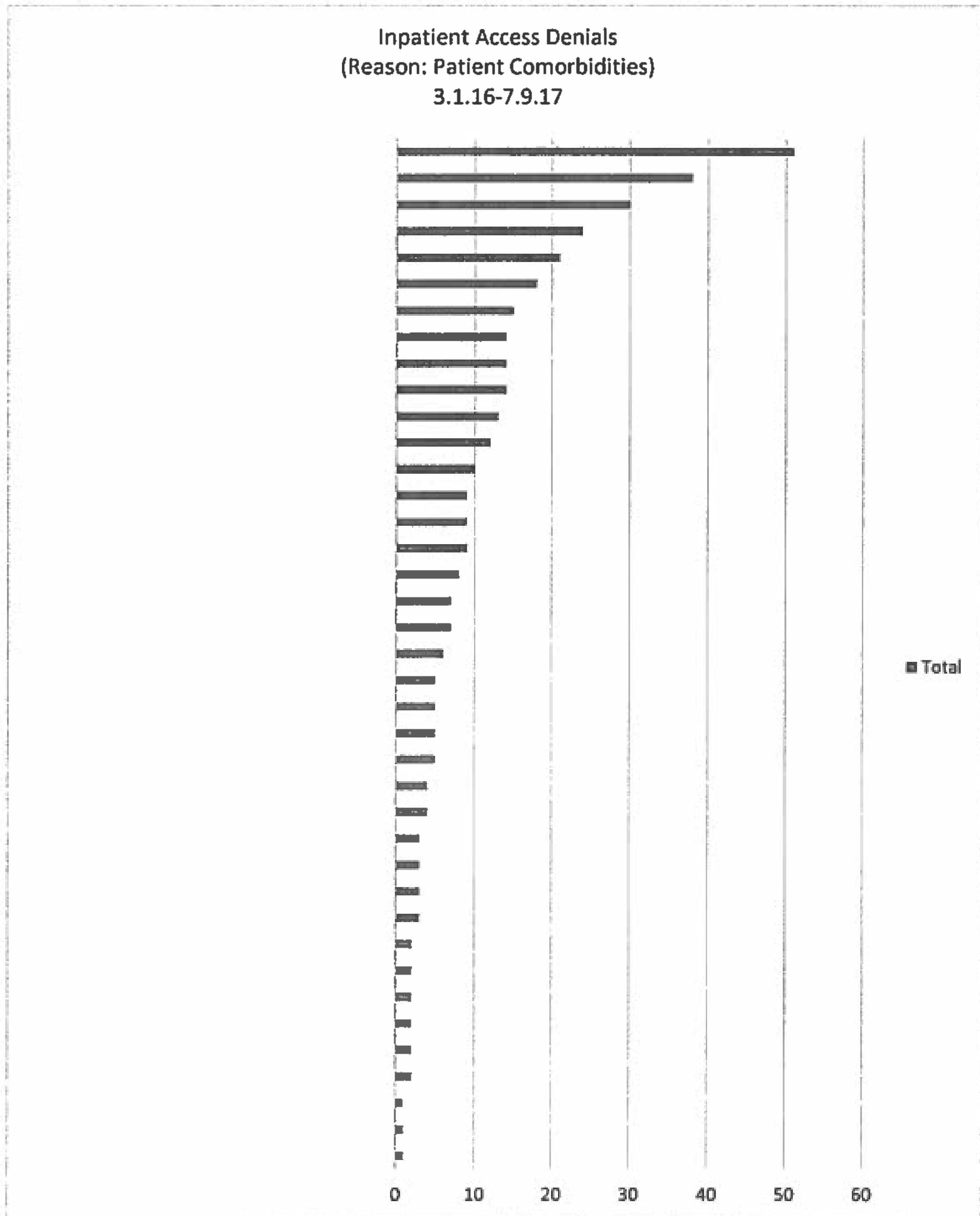

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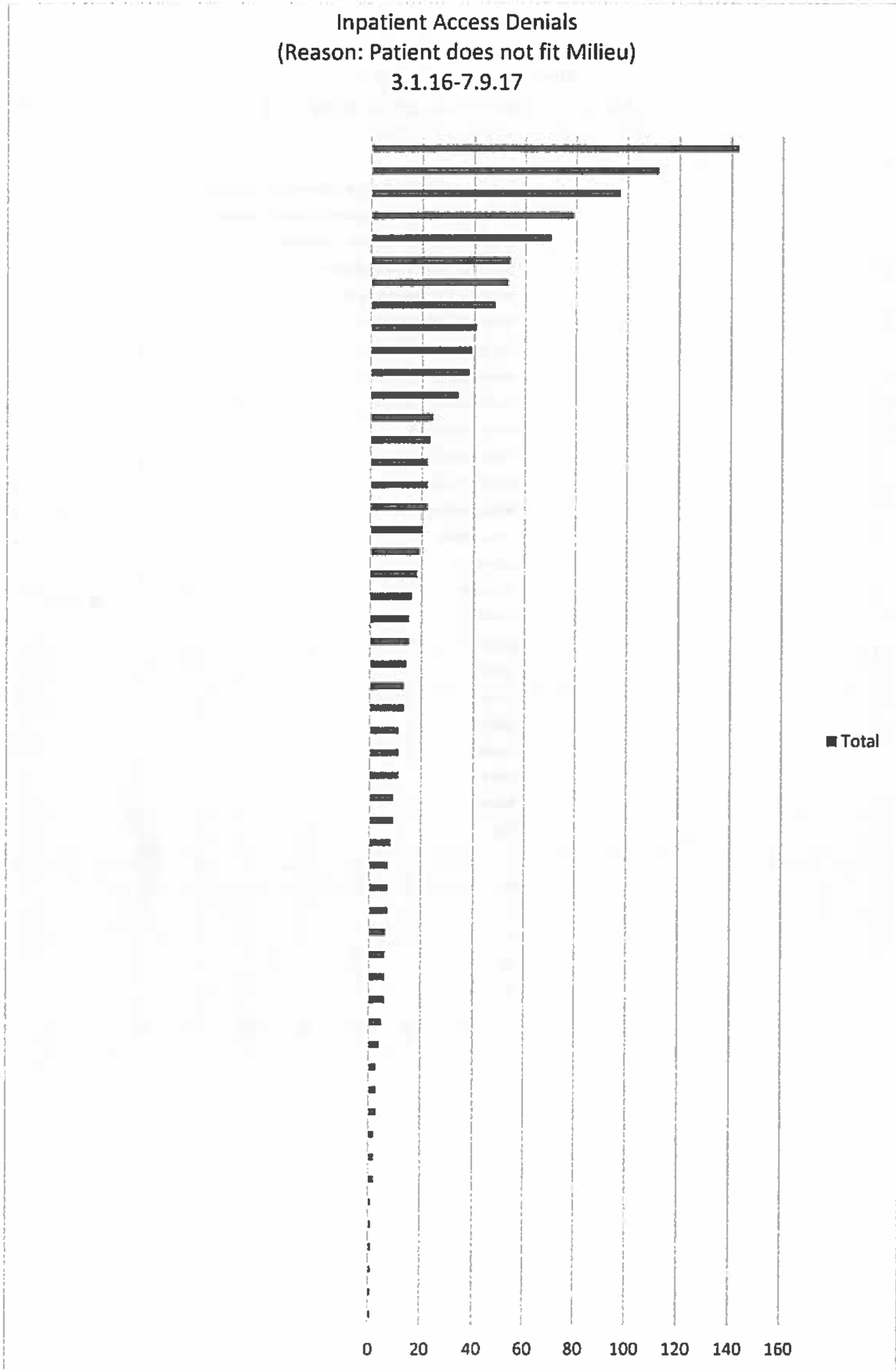

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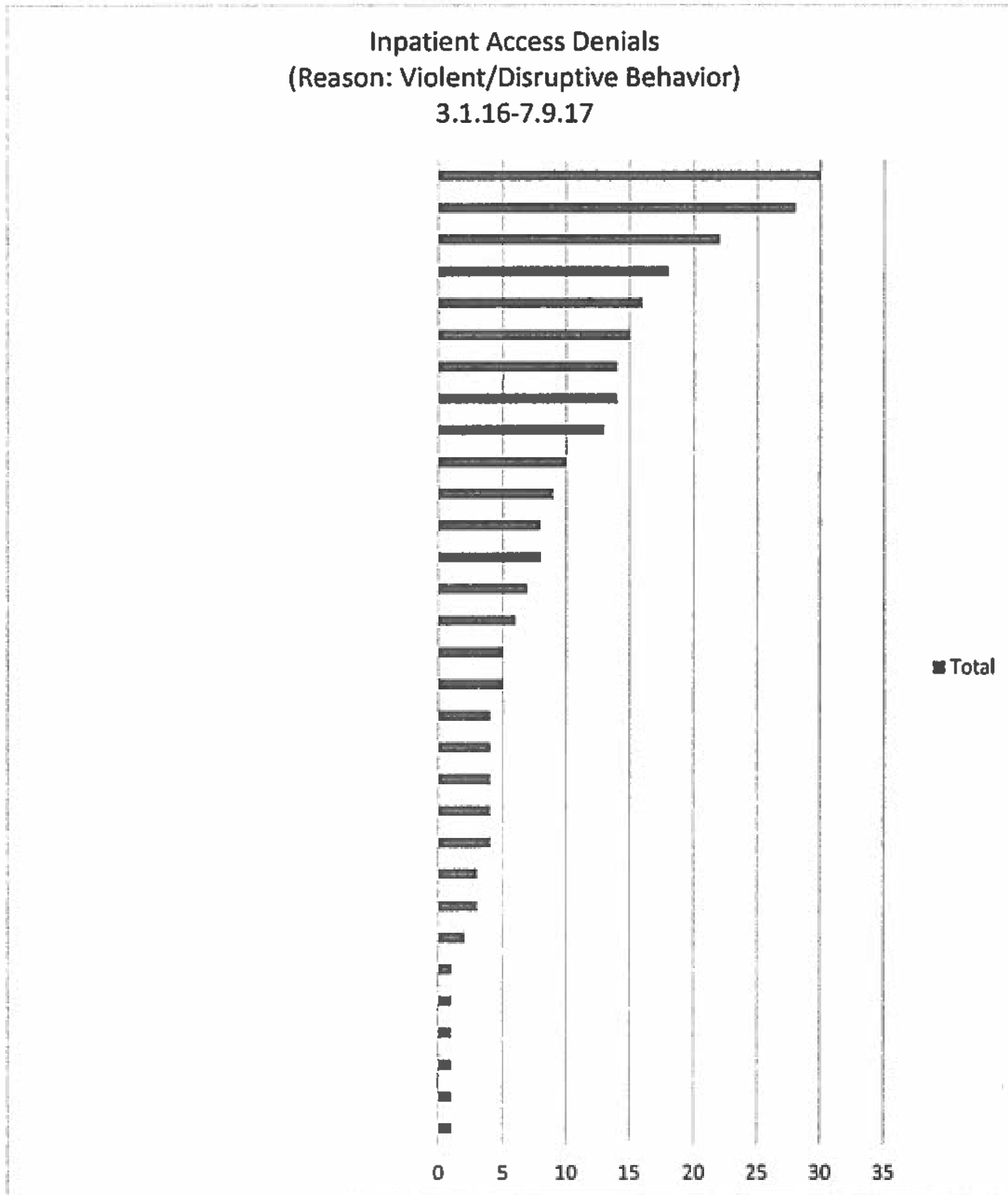

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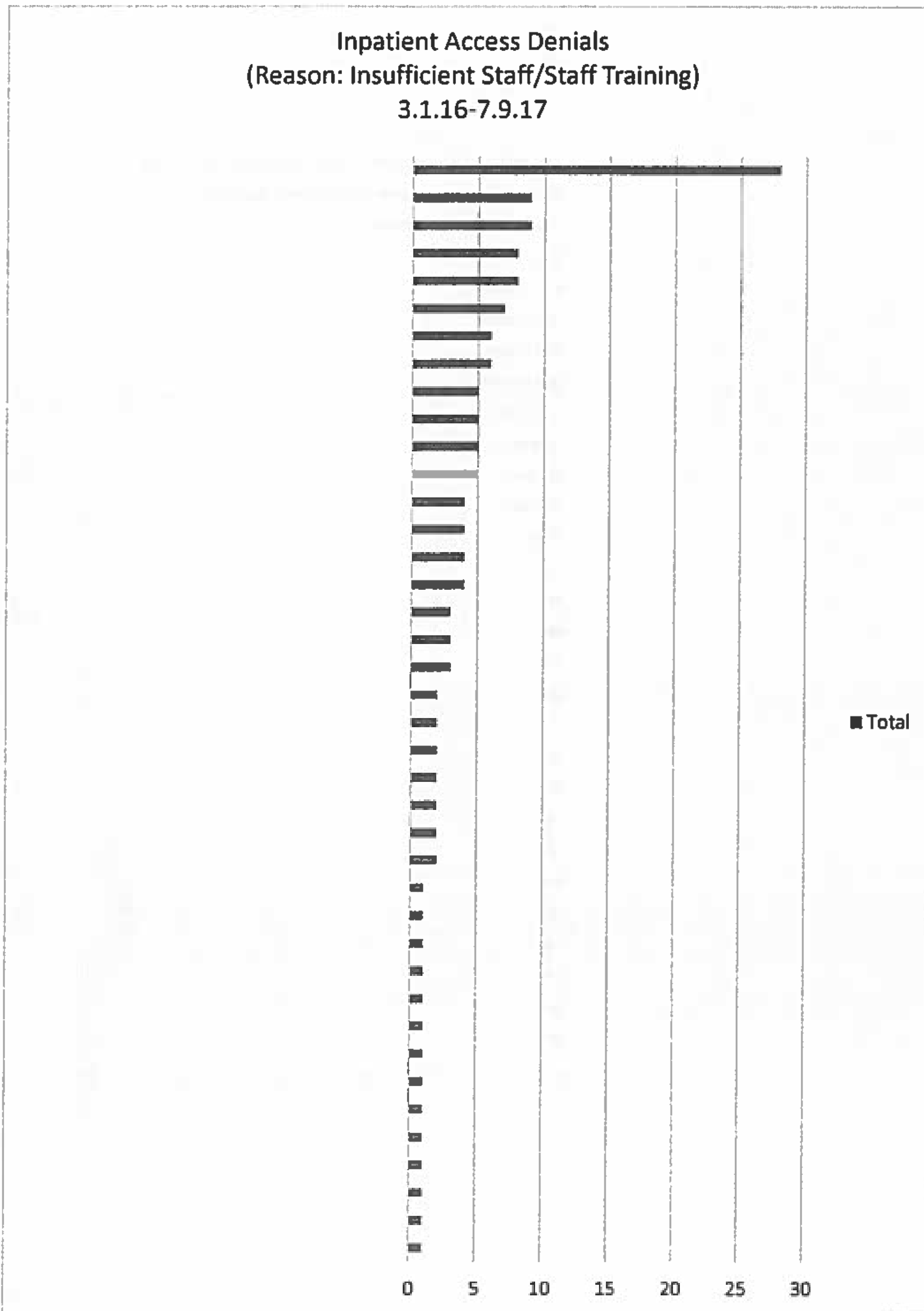

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