HOUSE OVERSIGHT SUBCOMMITTEE
on Public Health & Food Security

MICHIGAN BEHAVIORAL HEALTH SYSTEM

— REPORT & RECOMMENDATIONS —

Executive Summary

Beginning in May, the Oversight Subcommittee on Public Health and Food Security launched an investigation into the underperforming behavioral health system in Michigan. Sixteen presenters from across the state testified at six different subcommittee hearings over two months to identify flaws in the system and voice their recommendations. The sixteen presenters included current and retired judges, county jail administrators, practicing physicians, behavioral health therapists, hospital executives, Michigan Department of Health and Human Services (MDHHS) physicians, behavioral health advocates, national nonprofit association board presidents and board members, and local community mental health (CMH) CEOs. Through our work, this subcommittee found a health system that is being held back by rigid administrative burdens, workplace shortages and insufficient inpatient capacity. These limitations are the central drivers reducing access to care and causing the behavioral health crisis to deepen across the state. This report walks through key findings and provides recommendations to develop solutions to those problems.

Background

The history of the root problem is not distant nor hard to trace. The "deinstitutionalization" movement, the closing of state behavioral health facilities, swept across the United States in the 1960s.[1] Michigan joined the movement late, but it joined in a strong way by immediately closing more than a dozen facilities in 1997 with insufficient infrastructure ready to support the released population. Emergency rooms, psychiatric units with limited beds, courtrooms, county jails, and constrained CMH facilities have been struggling to fill the gap since.[2] All of this has led to increased spending to address the behavioral health crisis without the state seeing measurable improvements in outcomes. Experts who came in front of our subcommittee consistently identified two policy approaches: **1)** reopening state psychiatric facilities for severe cases with a "step down" approach or **2)** reducing administrative

[1] Gutierrez, Andres, "The State of Mental Health Care in Michigan," CBS News, Oct. 10, 2022.

[2] See, Judge Richard L. Hillman's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (55th District Court Judge; Mental Health Treatment Court – Full Testimony from 9:45 to 50:41). May 20, 2025.; See also, Grand Traverse County Sheriff's Office: Sara Bush's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Jail Diversion Counselor – Full Testimony from 1:17:56 to 1:23:37). July 1, 2025.

burdens on local CMH providers through the PIHP, RFP, and Certificate of Need program to give providers increased flexibility. A move in either direction could meaningfully reduce Michigan's current behavioral health treatment backlog, which currently ranks 47th nationally in psychiatric bed space availability.[3]

Operation	Persons Waiting
Probate Process Admissions Adult	4
Forensic Process Admissions	269
Pediatric Admissions	25
Forensic Process Evaluations	480

Lack of Flexibility – PIHPs and Certificate of Need

Michigan providers currently offer about 19 psychiatric beds per every 100,000 residents, while the national average and most expert recommendations are for 30 psychiatric beds per 100,000 residents.[4] The Michigan Constitution deems public health of "primary public concern" and remains silent on how to carry that out – providing both flexibility and responsibility to state policymakers.[5] Michigan statutes give the Department of Public Health (now MDHHS) and local health departments broad authority to improve public health across the state.[6] One of the few limitations on the administration of public health is in MCL 500.3513(1), which simply requires the care be done "in a manner that ensures continuity and acceptable quality of health care."[7] The statutes that establish and govern CMH facilities were amended right before the shutdown of state facilities in 1997, because the Legislature intended local control to take a larger role after the 1997 shutdowns.[8] Despite the statutory preference for flexibility and local control, one consensus reached by all presentations and submitted written recommendations is that Michigan's behavioral health system lacks flexibility.

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[3] Michigan Health and Hospitals Association: Adam Carlson's and Taylor Alpert's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 52:17 to 1:15:04). May 20, 2025.

[4] Central Michigan University: Dr. Kai Anderson's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 29:00 to 45:40). June 24, 2025.

[5] Mich. Const. Art. IV § 51.

[6] MCL 333.2221; MCL 333.2433.

[7] MCL 500.3513.

[8] MCL 330.1204; MCL 330.1206.

We have identified through subcommittee hearings that MDHHS has delegated much of its duty to provide behavioral health care to regional CMH CEOs who administer Medicaid-funded Pre-Paid Inpatient Health Plans (PIHPs). Because private insurance coverage for behavioral health care can be limited, many providers in Michigan rely on Medicaid as their primary funding source. Michigan's CMHs are organized into 10 regions, each with a PIHP CEO responsible for all policies, guidelines, Medicaid funding, and administrative support. This results in inconsistencies across regions with different PIHPs issuing different criteria to qualify for their plans and utilize them to the best possible extent. Testimony further indicated that planned changes may further increase variation in criteria across regions going forward. The department originally planned to open up bids for PIHPs to for-profit and out-of-state administrative organizations.[9] After months of work exploring the drawbacks of that potential decision in our committee, those plans are now on hold. We listened to behavioral health specialists, patient advocates, and local healthcare professionals urge the state to halt the plan, and it has now been tabled.[10]

On top of the limited flexibility afforded under the current PIHP structure, MDHHS also requires a Certificate of Need (CON) for health facilities to do anything outside of their annual treatment plans submitted for PIHP approval in Michigan. MDHHS states that the purpose of the CON program is to ensure that only necessary services are provided in Michigan.[11] While the CON program is often cited as a strong candidate for additional flexibility and reform, it does help to prevent excess low-quality care in its current form. Under the CON program, any psychiatric hospital or unit needs to submit a proposal to be reviewed by an 11-member board before doing any of the following: **1)** increasing the number of beds or relocating beds from one site to another; **2)** acquiring an existing facility; **3)** operating a new facility; **4)** initiating, replacing, or expanding covered clinical services; or **5)** changing an extended care services program. The extent of these requirements limits flexibility for shifting beds to use a "step-down" approach, something most of the professionals with whom we spoke argued would work best.[12] Under the current format, CMH providers get one chance per year to perfectly guess the number of beds that they will need for each population of patients, or else they are stuck in an imperfect situation. Several presenters used a common example to explain this issue: The need for adolescent psychiatric beds is high in the summer, while the need for adult beds is low. However, CMHs are unable to shift available beds in their facility to accommodate on an as-needed basis due to the combination of the PIHPs' policies and the CON requirement. In addition to the rigidity of the policy, these issues raise questions regarding how 'need' is defined and evaluated within the CON process and by the current makeup of the CON board.

[9] MDHHS Seeking Proposals to Improve Specialty Behavioral Health Care for Medicaid Beneficiaries. (Aug. 5, 2025)

[10] Ret. Probate Judge Steven Burnham's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (32:20 – 58:26). July 1, 2025.

[11] MDHHS Certificate of Need Informational Sheet (2022).

[12] Universal Health Services: Steve Vernon's (CEO of Cedar Creek Hospital) and Jamie White's (CEO of Havenwyck Hospital) Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 6:10 to 28:14). June 24, 2025.

Lack of Staffing

Another consistent message from concerned presenters was that the "shortage of psychiatric beds" does not necessarily mean beds are not physically there, but a lack of staffing creates an effective shortage. A graduate student studying to enter the behavioral health field, among many others, illustrated well the gravity of the growing shortage of behavioral health professionals.[13] Michigan is running short on physicians in every field, and the behavioral health field is no different. Unfortunately, many presenters have suggested that the PIHP model, lack of viable student loan programs, and other administrative burdens play a large role in staff not entering the field or staying in the field long-term.

The lack of flexibility in bed space also makes it difficult to hire the right staff. Some CMH CEOs discussed that certain staff are needed for high-risk patients, while other staff can work for lower risk patients that just need to be monitored, but Michigan's system does not allow operational flexibility. Instead, CMHs must submit their annual plans and hire staff accordingly under the assumption that nothing changes. They must hope they lose no one along the way in an incredibly taxing and high turnover field and that their specialized needs do not change materially throughout the year. Of course, those needs do change, thus creating shortages. The staffing shortages have resulted in emergency room doctors and corrections officers in jails and prisons being forced to serve as fill-in psychiatrists and treat populations for which they lack the expertise necessary to help.

Lack of Administrative Support – Overall, and Especially in Northern Michigan

Inconsistencies in administration and guidance in a difficult field with dynamic challenges make the staffing shortage worse. One useful example of a lack of administrative support came through in testimony before our subcommittee: one patient attacked a fellow patient, and the offender was locked in a room to cool off while being monitored. This resulted in a fine from MDHHS for locking the door. When the same incident happened again, the facility called instead of locking a door, and then MDHHS fined them for not doing anything. The lack of clear guidance and inconsistent enforcement punished the already-stretched staff and left the organization unclear on how to proceed in the future.

One CMH CEO outlined the daily struggle he has with having to report to his CMH Board while also having to report to a PIHP CEO and work through MDHHS policy all at the same time.[14] That official noted that he was able to deviate from policy to provide better care and keep his job after, but that most CMH CEOs would be unlikely to take that risk and unlikely to survive it if they did. A consistent theme with all who

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[13] See, Licensed Professional Counselor and Behavioral Health Master's Student Sarah Lee Sullivan's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 14:40 to 19:50). July 22, 2025.; See also, Licensed Child and Family Services Counselor Megan Morrissey's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 20:15 to 32:20). July 22, 2025.; See also, Former State Representative Felicia Brabec's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 1:14:09 to 1:28:04). July 22, 2025.

[14] Bay Arean Bay Arenac CMH CEO Chris Pinter's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 20:15 to 32:20). July 1, 2025.

provided presentations or written recommendations to this subcommittee is the feeling of being trapped by administrative burdens with very limited avenues for administrative guidance or escalation. Additionally, the administration – whether MDHHS or local hospital administrators – have failed to invest in a robust Electronic Health Records (EHR) system.[15] This makes communication across regions arbitrarily divided by PIHP and between private hospitals delayed, difficult, or impossible. Several presentations urged for more EHR investments to clear up the confusion.

Michigan's 47th place ranking and below-average psychiatric bed availability is bad enough, but countless presenters also highlighted the particular needs of Northern Michigan and the Upper Peninsula. Experts and staff in these regions feel left behind by the administration with many presenters referring to "deserts" for psychiatric care in Northern Michigan with patients even having to drive 100 miles at a time to reach a facility. The Traverse City Group has presented their need multiple times and even brought county jail administrators to point out that over 30% of their inmates were suffering from severe behavioral health and/or substance abuse disorders.[16] The National Alliance on Mental Illness even went as far as submitting a written business proposal for a new facility in Northern Michigan to raise the state up to the national average of 30 beds per 100,000 residents.

Recommendations

1. Amend PIHP policy requirements to allow providers greater operational flexibility in treating severe behavioral health crises.
2. Authorize CMH providers the flexibility they need to reallocate and reorganize bed capacity within facilities within the current Certificate of Need program administered by MDHHS.
3. Enhance local control and flexibility in behavioral health business decisions in future department regulatory and business-side decision-making.
4. Create a Northern Michigan Behavioral Health Campus to treat all populations and address the gap with the service deserts in Northern Michigan and the UP.
5. Target state funding more specifically toward staff training, staff safety, and educational incentives to grow and help keep the field of behavioral health professionals stable across the state.
6. Invest in Electronic Health Record systems so hospitals across Michigan can modernize their systems and better share data/records with each other.

[15] Universal Health Services: Steve Vernon's (CEO of Cedar Creek Hospital) and Jamie White's (CEO of Havenwyck Hospital) Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 6:10 to 28:14). June 24, 2025.

[16] NAMI President Kate Dahlstrom's Testimony to Michigan House Oversight Subcommittee on Public Health & Food Security (Full Testimony from 54:37 to 1:13:44). July 22, 2025.

Conclusion

The state of behavioral health care in Michigan is far past its own crisis point. With one in five adults across the United States experiencing some level of mental illness every year and over 1.4 million Michiganders having a behavioral health condition, timely intervention is needed.[17] Shutting down over a dozen state psychiatric facilities in 1997 without enough local CMHs in place or flexibility allowed to cover the gap has left a lasting impact. Our jails and courtrooms are now spending limited resources on behavioral health patients who need real psychiatric treatment, not incarceration. Too many patients are falling through the cracks due to facilities with limited bed space or a full capacity jail. Public health is a primary concern under our Constitution, and it is incumbent upon the state to give behavioral health professionals the resources they need to address the problem. Addressing these challenges will require coordinated action across state agencies, providers, and the Legislature. The Subcommittee believes the recommendations outlined above provide a practical framework for improving access, flexibility, and outcomes in Michigan's behavioral health system. In short, enable providers to deliver care, support them along the way, and cut the administrative burdens.

Chair Matthew Bierlein
Michigan House of Representatives
Oversight Subcommittee on Public Health & Food Security

[17] NAMI, "Mental Health in Michigan Fact Sheet," Feb. 2021.