Sheppard Pratt

Written Testimony

House Bill 632 – Certificate of Need – Psychiatric Health Care Facilities and Psychiatric and Mental Health Services - Exemption

House Health Committee

February 18, 2025

On behalf of Sheppard Pratt, Maryland's largest nonprofit behavioral health system and a primary provider of inpatient psychiatric hospital services across the state, we respectfully submit this testimony in opposition to House Bill 632.

House Bill 632 would eliminate the Certificate of Need (CON) requirement for psychiatric health care facilities and psychiatric and other mental health services. While framed as a measure to increase access and reduce regulatory barriers, this legislation would significantly destabilize Maryland's fragile behavioral health continuum of care at a time of unprecedented workforce shortages and financial strain.

Maryland's Behavioral Health System is Uniquely Vulnerable

Unlike many states, Maryland does not operate a broad network of state-run psychiatric hospitals for civil patients. Instead, the state relies heavily on private nonprofit hospitals and general hospital psychiatric units to serve as the backbone of the inpatient behavioral health safety net.

These nonprofit providers, including Sheppard Pratt, serve Medicaid beneficiaries, uninsured individuals, high-acuity patients, and individuals with complex comorbidities. Many of these services operate on razor-thin margins or at a loss due to chronically low reimbursement rates and rising workforce costs.

Removing CON protections in this environment would not create new clinicians, increase Medicaid reimbursement, or address the true drivers of limited access. Instead, it would create incentives for market entry into the few profitable niches of behavioral health care while undermining the financial stability of essential safety-net providers.

The Behavioral Health Market Requires Oversight

Behavioral health does not function like a traditional market. High-need services such as acute inpatient psychiatry, crisis stabilization, and long-term residential treatment are often low-margin or negative-margin operations.

Without CON oversight, new entrants may “cherry-pick” commercially insured or lower-acuity patients, siphoning revenue from existing hospitals that rely on cross-subsidization to support uncompensated and high-acuity care.

Maryland’s CON framework specifically evaluates impact on existing providers and community need to prevent destabilization of the broader delivery system. HB 632 would remove that safeguard entirely for psychiatric services.

Reimbursement Rates and Workforce, Not Regulation, Are the Limiting Factors

The primary constraints on behavioral health capacity in Maryland are inadequate reimbursement rates and severe workforce shortages, not regulatory oversight.

Behavioral health reimbursement rates, particularly under Medicaid, have historically failed to cover the true cost of providing high-acuity inpatient psychiatric care, crisis services, and intensive outpatient treatment. Psychiatric services require high staffing ratios, 24/7 clinical coverage, security infrastructure, and specialized interdisciplinary teams. Yet Medicaid inpatient per diem rates and outpatient behavioral health rates often lag significantly behind actual operating costs.

Hospitals across Maryland continue to absorb substantial losses on psychiatric units. Many rely on cross-subsidization from other service lines to sustain essential behavioral health programs. Removing CON without addressing reimbursement would further destabilize providers already operating under chronic financial strain.

At the same time, Maryland faces profound workforce shortages. More than half of U.S. counties lack a psychiatrist, and rural regions experience significantly lower psychiatric workforce supply. Even where CON approvals have been granted to expand psychiatric capacity, some beds remain unstaffed due to pipeline constraints and competition for licensed clinicians.

Expanding facilities without improving payment rates does not create psychiatrists, nurses, social workers, or psychiatric technicians. Instead, it intensifies competition for a limited workforce pool, often drawing clinicians away from existing safety-net hospitals that provide comprehensive, high-acuity, and Medicaid-heavy care.

If policymakers seek to meaningfully expand access to psychiatric services, the solution lies in strengthening reimbursement structures, supporting workforce pipeline development, and ensuring financial sustainability for providers, not eliminating planning safeguards designed to protect system stability.

Risk to Rural and Underserved Communities

CON plays a critical role in ensuring services align with documented community needs and geographic access considerations.

Without planning oversight, new psychiatric facilities are far more likely to be in commercially favorable suburban or urban markets rather than in Western Maryland, Southern Maryland, or other historically underserved regions. This could widen geographic disparities in access rather than close them.

Quality and System Coordination Concerns

Maryland's CON review process incorporates financial viability, quality standards, equity considerations, and system impact review.

Eliminating CON for psychiatric services would remove these accountability mechanisms. There would be no structured evaluation of whether new providers can sustainably operate, serve Medicaid populations, coordinate with emergency departments, or integrate with the state's broader crisis response and continuum-of-care infrastructure.

Behavioral health is not a stand-alone service line; it is an interconnected system involving emergency departments, inpatient hospitals, residential treatment, outpatient clinics, and community supports. Uncoordinated entry into one segment can have cascading effects across the entire continuum.

Conclusion

Maryland's behavioral health system is at a tipping point. Demand is rising, emergency departments continue to experience psychiatric boarding, and nonprofit hospitals are carrying disproportionate responsibility for high-need populations.

HB 632 would:

- Undermine safety-net providers,
- Encourage cherry-picking of profitable patient populations,
- Exacerbate workforce competition,
- Risk geographic maldistribution of services, and
- Remove critical planning safeguards designed to protect access and quality.

For these reasons, Sheppard Pratt respectfully urges an unfavorable report on House Bill 632.

We remain committed to working with the Committee on sustainable, evidence-based solutions that strengthen Maryland's behavioral health infrastructure while preserving equitable access for all Marylanders.