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WHA Presents State Capitol Briefing on Wisconsin's Psychiatric Safety Net

Data helps identify both problems and solutions

State Sen. Jesse James and state Rep. Rob Summerfield hosted on May 23 a Wisconsin Hospital Association (WHA) briefing for state policymakers and staff at the state capitol focused on challenges facing inpatient psychiatric services across Wisconsin.

Broadcast on WisconsinEye, the hearing reviewed utilization data for mental health services in hospitals and the enormous challenge of sustaining mental health services when Medicaid volumes are high and Medicaid reimbursement is well below the cost of providing the service.

WHA President and CEO Eric Borgerding and WHA General Counsel Matthew Stanford were joined in the briefing by Stoughton Health Chief Financial Officer Michelle Abey who discussed challenges for rural critical access hospitals that have inpatient psychiatric units, and Jessica Small, president of Aurora Psychiatric Hospital and Aurora WI Behavioral Health Operations, who shared challenges for inpatient psychiatric services in urban settings.

The crowd at WHA's capitol briefing on May 23

Borgerding highlighted a long list of what has already been accomplished in a bipartisan way in Wisconsin to address mental health needs, such as working to address Wisconsin's psychiatrist shortage through the creation of a graduate medical education matching grant program that now supports 36 new psychiatric residencies.

"This is a great example of identifying problems along the way and not waiting for one silver bullet, but working together with lawmakers and elected officials in a bipartisan way to find solutions," said Borgerding.

But Borgerding said that serious challenges are facing psychiatric hospital services, including acute shortages of mental health professionals, closure and cancelling of inpatient psychiatric units and projects, and many units across the state struggling to sustain the inpatient psychiatric operations and capacity beds they have. Reimbursement and payer mix is a major factor, with Medicaid reimbursement to hospitals on average about 65% of the cost of delivering care.

"46% of our members' behavioral health inpatients are covered by Medicaid, and that number has only been growing. That is a significant challenge from a reimbursement perspective," said Borgerding.

Stanford reviewed hospital discharge claims data collected and reported by the WHA Information Center (WHAIC) to reveal trends

and distributions of hospital emergency department and inpatient behavioral health services.

In addition to data sets, publications, and custom reports on hospital and ambulatory surgery center utilization, service, staffing and finance produced by WHAIC, Stanford pointed to interactive behavioral health data dashboards created by WHAICthat can be queried by region, facility type, and date to help inform behavioral health needs and planning assessments. Those dashboards are free of charge and can be accessed at https://www.whainfocenter.com/Analytics/Behavioral-Health-Visits.

Some key highlights of hospital behavioral health utilization in 2022 included:

- 75,550 emergency department visits occurred in which a behavioral health diagnosis was coded as the primary reason for the visit.
- Winnebago Mental Health Institute had 3,742 inpatient psychiatric admissions, accounting for 7% of all inpatient psychiatric admissions statewide.
- Private sector hospitals had 40,605 psychiatric inpatient admissions representing 84% of all inpatient psychiatric admissions statewide. The remainder of admissions statewide - 3,570 - occurred in county-operated psychiatric hospitals.
- 46% of all inpatient psychiatric admissions at private sector hospitals were Medicaid patients.
- Utilizing the most conservative evidence-based study estimating psychiatric beds needed to meet population needs, Wisconsin's 18 inpatient psychiatric beds per 100,000 population indicates Wisconsin has a shortage of roughly 600 staffed beds to meet its population's needs.

In addition to high Medicaid volumes and reimbursement well below the cost of care, Stanford also reviewed unique Medicaid funding policies that create additional challenges for access to inpatient psychiatric services. For example:

- Recognizing the unique patient population, Wisconsin's readmissions penalty program does not apply to psychiatric only hospitals. However, the readmission penalty program does apply to acute care hospitals that have inpatient psychiatric units.
- Differences in cost-based, per day vs. fee schedule per patient Medicaid reimbursement for the same inpatient psychiatric service provided in a psychiatric only hospital vs. a general community hospital.
- To help sustain low patient volume rural critical access hospitals, those hospitals receive a special cost-based Medicaid reimbursement that approximates the cost of providing inpatient care. However, critical access hospitals that operate distinct part unit inpatient psychiatric beds are excluded from the special cost-based Medicaid reimbursement for those beds and receive the lower fee schedule rate paid to higher-volume acute care hospitals.
- Psychiatric hospitals with more than 16 beds receive no Medicaid reimbursement for Medicaid patients between age 18 and 64 that are not enrolled in a managed care plan. This payment limitation is known as the Institute for Mental Disease or IMD exclusion.

Small echoed the Medicaid payment challenges, including the IMD exclusion which particularly impacts larger facilities and communities. She noted the significant number of Medicaid enrolled patients that Aurora Psychiatric Hospital and other freestanding psychiatric hospitals receive no reimbursement for due to Medicaid managed care company disenrollment policies that often impact patients with mental health challenges, shifting those patients to non-reimbursable fee-for-service Medicaid.

In addition to these payment policy challenges, higher acuity trends in inpatient psychiatric units were noted by Small.

"What we are seeing with patients on inpatient psychiatric units is a shift to very ill, psychiatrically complex patients," said Small. "We are having to address things that we didn't have to address in inpatient behavioral health 5-10 years ago when we had much more worried well type issues. These are now very complicated psychiatric patients in very vulnerable situations."

Staffing has always been challenging, explained Small, but is becoming a bigger challenge for inpatient psychiatry units as work-from-home telehealth companies and other lower acuity services are more attractive to staff than high acuity, in-person inpatient services.

Further, staffing and costs are only increasing for inpatient psychiatric services as acuity increases.

"With the acuity that we are now seeing in our patient population, we are having to have more staff members per patient," said Small. In the past year, Small shared that Aurora Psychiatric Hospital added 2 FTE per 15 patients to adjust to the higher acuity patient trends they are seeing in order to "continue to have a safe environment for patients and to address the legal and paperwork processes associated with emergency detention patients."

Small also noted Milwaukee area health systems and Milwaukee County coming together to build and operate the new Mental Health Emergency Center in Milwaukee to meet community needs, but also discussed the significant costs and ongoing operating shortfalls incurred by the partners.

The Mental Health Emergency Center is seeing almost 9000 emergency visits annually, where "law enforcement or community members can walk into without having to go to a medical emergency room," said Small. "But the cost to run a facility to meet those

patients' needs is significant. It was an $18 million start-up cost that the partners put together to build the bricks and mortar and then another $12 million estimated annual operating loss to staff the facility and meet the needs of the community."

While rural and urban inpatient psychiatric services face many of the same staffing and unsustainable reimbursement challenges impacting access to inpatient services, Abey shared a unique reimbursement parity issue impacting Stoughton Health and other rural critical access hospitals that pays and treats general inpatient services and psychiatric inpatient services very differently.

As a critical access hospital, Medicaid and Medicare provide a reimbursement rate that approximates 100% of our cost for delivering care. However, Medicaid and Medicare exclude distinct part unit inpatient psychiatric services provided in a critical access hospital from the cost-based reimbursement rate that applies to all other inpatient services in a critical access hospital," explained Abey. "Instead, just for inpatient psychiatric services like our geriatric psychiatric unit, those rates are paid at the same low fee schedule rate applied to high-volume hospitals."

L to R: Matthew Stanford, Eric Borgerding, Michelle Abey, Jessica Small, State Rep. Rob Summerfield and State Sen. Jesse James

"This results in a negative reimbursement impact to our organization of $1.3 million dollars per year on average," said Abey. "The financial strain placed on small organizations like ours is the reason, I believe, why there are only a handful of critical access hospitals left in Wisconsin who have inpatient psych units."

Abey also shared that those losses are only exacerbated by increasingly common scenarios where post-acute facilities are not willing to take individuals with a mental health history that are ready to be discharged from Stoughton Health's inpatient psychiatric unit.

Abey described a situation where a patient's Medicare managed care plan will no longer provide any reimbursement for the patient's care on their inpatient psychiatric unit because she is now medically and psychiatrically stable, but Stoughton is unable to discharge the patient because there is no post-acute facility willing to accept the patient due to their mental health history.

"This patient is stuck in a hospital bed, taking up a specialized geriatric psychiatric bed needed in the community, receiving care that Stoughton Health isn't being reimbursed for by the patient's Medicare Advantage managed care plan," said Abey. "These losses add up quickly."

"Inpatient behavioral health is a huge part of the behavioral health continuum," said Small. "There has been a lot of investment in the upstream part of the continuum. The investment we now need to look at is how do we take care of the patients that are going to need inpatient care because that number isn't going to change and is becoming more complicated to manage."

Other Articles in this Issue

- More Than 100 Wisconsin Hospitals Ask State Budget Committee to Increase Funding
- WHA Presents State Capitol Briefing on Wisconsin's Psychiatric Safety Net
- WHA Testifies in Support of Two More Bills to Expedite Health Care Licensure at Assembly Committee Hearing
- Health Care Rapidly Adopting Registered Apprenticeships
- WHA Expresses Concerns with Congressional Subcommittee's 340B, Site-Neutral Proposals