NAMI
National Alliance on Mental Illness
MINNESOTA

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To: Minnesota Department of Health

NAMI Minnesota believes that there are not enough inpatient psychiatric beds in Minnesota to meet the needs of children or adults struggling with their mental health. People wait days, sometime weeks, and are either sent home without being connected to appropriate care or sent hundreds of miles away from home making it difficult to stay connected to their community of supports.

The downsizing and soon closure of the 110 beds at St Joseph's hospital and the closure of the 18 inpatient beds at Southdale have had a devastating impact on the mental health system in Minnesota. At St. Joe's alone, there were over 1,800 inpatient psych admissions every year. The beds at these two hospitals represent about 16% of the inpatient psychiatric beds in the metro area.

There is broad agreement that early intervention and community services are important; however, inpatient hospital services will always be needed. In previous communications NAMI Minnesota has stated cleary that inpatient capacity should not be reduced until the early intervention and community services are in place. But those beds were closed anyway by Fairview.

Over and over again we have heard from hospitals that the low payment rates for inpatient psychiatric care, especially under Medicaid, are the reason that more hospitals do not add beds and why hospitals close beds. Hospitals across the country note that providing inpatient psychiatric care causes them to lose money – millions of dollars.

While inpatient psychiatric hospital beds are needed, NAMI Minnesota has concerns with M Health Fairview's proposal to build a free-standing psychiatric hospital. Our concerns are as follows:

1. Your head is connected to the rest of your body. President Eisenhower, in his seminal mental health report, believed that every community hospital should have a psychiatric unit to ensure that people had access to comprehensive care close to home. Conversely, we believe that psych only hospitals that provide acute - and not long-term care - are not providing comprehensive care close to home.

   When you are having an acute psychiatric episode or a mental health crisis of some kind, you deserve to be cared for in a regular hospital with access to any other health care you might need. People end up needing psychiatric care after a suicide attempt, self-harm, intoxication, or an overdose. People with serious mental illnesses are more likely to have other health care conditions such as diabetes, COPD, heart disease, liver, or kidney issues. People experiencing homelessness who also have a mental illness may end up

needing hospitalization for their mental illness but also health care conditions associated with being unhoused such as frostbite or fungal infections.

It is hard to treat the whole person when you are only focusing care for their mental health. A study by Hendrie et al found that older adults with mental illnesses had "higher rates of emergency care, longer hospitalizations, and increased frequency of falls, substance abuse, and alcoholism." They went on to recommend that this population be provided an integrated model of care.

We also believe it is less than ideal for someone who finally gets a psychiatric bed to be transferred to another facility when they need other types of health care. It is unsettling to be tied down to a gurney and be transported.

This passage is from an article in the San Diego Business Journal: "Despite a hit to one area of the bottom line, hospitals have more incentive to invest in psychiatric care, said Lindsay Scollin. Payment models increasingly emphasize patient outcomes. 'Organizations are starting to think about care of the patient more holistically' said Scollin, a senior manager with consulting firm Deloitte. 'They see mental health as an area they really need to invest in or they're going to have longer-term implications.' They aren't only pouring money into facilities. Scollin said hospitals have turned to telepsychiatry and other technology, despite reimbursement being slow to catch up. Dr. Michael Plopper agreed that **it makes business sense to treat the whole patient**, and he said it's the right thing to do. He's the chief medical officer of Sharp HealthCare, which among San Diego hospitals carries the greatest load in behavioral health with 200 inpatient beds."

2. This hospital will not have an emergency room. That means that they decide which patients will be admitted. Will there be an incentive to not admit people with the most serious mental illnesses or people who have other health care conditions? Will then not admit people who have more complex needs?

3. Medicaid limits payments to what is called an IMD – Institute for Mental Disease. IMD hospitals cannot bill Medicaid if people are on fee-for-service Medicaid. They can bill for limited days for people on managed care Medicaid but if they exceed the limit on the number of days, the state pays 100% of the capitation rate. When all the other hospitals in Minnesota and across the country are reluctant to add beds due to the low reimbursement rates, particularly under Medicaid, we are worried that the only way this hospital is profitable is if they limit the number of admissions of people who are on Medicaid. People with more serious mental illnesses tend to be insured by Medicaid and have longer stays than is allowed under the IMD exclusion for managed care.

4. In a letter to many of the advocates in January of 2020, M Health Fairview, in defense of it closing St Joe's, wrote that "the hospital is operating at a significant loss of roughly

$45 million a year due to reimbursement changes and because of its age it now requires more than $35 million in infrastructure upgrades." Which is interesting since the capitol costs for this new proposal is between $57-65M. We are struggling to understand the financing of this new hospital.

5. We are also concerned that if M Health Fairview admits far fewer Medicaid patients, it could upend the payor mix at other hospitals in the metro area. If other hospitals serve a higher percentage of Medicaid patients, they may face greater losses.

   Typically, hospitals providing psychiatric services rely on providing other services to cross subsidize mental health care. In a research paper by Sachs, studying psych bed closures in CA she found that "Neighboring hospitals experience negative financial spillovers as a result of closures. Care at nearby hospitals shifts towards the most severe and least profitable patients, individuals with schizophrenia and Medicaid beneficiaries. As a result, loss margins double at nearby psychiatric units."

   A story in the San Diego business journal noted the following: "Earthquake regulations with a 2030 deadline led Scripps Health to reimagine its Hillcrest campus. They also forced a reckoning in behavioral health. Scripps is planning a 15-story tower to replace Scripps Mercy Hospital, including a locked psychiatric ward with 36 beds. It was estimated a replacement behavioral health facility attached to Scripps Mercy would cost $3 million to $4 million per bed, according to Scripps, a costly proposition. And operations lose money. Scripps lost $4.7 million on psychiatric services in 2017, similar to the two prior years. Making behavioral health pencil out has become a greater challenge for San Diego hospitals like Scripps, Sharp HealthCare, Palomar Health, and UC San Diego Health. Partly for fiscal reasons, Tri-City Medical Center last year suspended inpatient beds…Rather than the $3 million to $4 million per bed plan, Scripps Health decided partnering would be the best route. Under a deal announced in February, the health system, and Acadia Healthcare plan to develop a 120-bed psychiatric inpatient unit by 2023…Scripps would have a 20-percent ownership stake in the new hospital, which would be in Chula Vista due to land constraints in Hillcrest. Van Gorder said not only would the deal free up funds for other construction projects, but also aims to eliminate Scripps' annual losses in behavioral health. Acadia would have the scale, expertise and patient mix to make the venture profitable, he added. He noted that Acadia will honor Scripps' charity care policy, namely taking low-income patients with Medi-Cal. Tennessee-based Acadia, a for-profit provider, is a powerhouse with 586 behavioral health facilities. In 2016, the company embarked on a strategy of partnering on facilities with not-for-profit hospitals like Scripps, attracting them with the promise of allaying patient backups in emergency rooms. But Acadia has come under scrutiny in several communities, including lawsuits in Oklahoma over patient injuries, highlighted by The Oklahoman newspaper. ' As it happened, the city council rejected the proposal due to concerns about the distance from a hospital and thus limited access to EMS, neighbors' concerns, and concerns with Acadia. Read the article here.

NAMI Minnesota is curious as to how nearly every other hospital providing inpatient psychiatric care loses money, but Acadia finds it profitable. They are also a for profit company which would be unusual for this state. We are concerned that a national company will have control over patient care, and that it will be difficult to obtain responses to concerns and problems. In looking at their current board of directors they have people from a private equity company, Financial Advisory North America, Maxum Petroleum, Deloitte, Guidon Partners, Arcadia Strategies, LLC, Jo-Ann Stores, and one psychiatrist. There is nothing on their website as to where to share any concerns or complaints. In other hospitals in Minnesota there are patient advocates whose job it is to listen to complaints and concerns. Many hospitals also provide a comment form, such as on Regions Hospital's website, where people can email comments and concerns.

NAMI Minnesota has struggled with the need for more inpatient psychiatric beds and this proposal. If M Health Fairview were proposing additional beds on the campus of any of their hospitals - St John's, Woodwinds, West Bank, Southdale – we would be wholeheartedly supporting it. But we have valid and serious concerns about their proposal for a free-standing psychiatric hospital that does not have an emergency room.

Sincerely,

Sue Abderholden, MPH
Executive Director