



January 30, 2008

Ms. Julie Sonier
Director, Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier,

Prairie St. John's would like to take the opportunity extended to it by the Minnesota Department of Health to respond to the written and oral concerns the Department has received regarding our intent to build a Psychiatric Hospital in Woodbury. Since there is considerable overlap in the issues raised, we will structure this response by issue rather than by organization or individual commenting.

1. Prairie St. John's_Woodbury will take all funding sources

The responses to our application materials, along with the sentiments expressed at the public interest hearing on January 22, 2008, caused us to re-examine as carefully as possible our understanding of the extent to which the federal 'IMD exclusion' would limit Prairie St. John's_Woodbury's ability to receive funding for Medicaid eligible adults. Much to our surprise, since Minnesota may be unique in the nation in this regard, The Minnesota Department of Human Services has assured us that ALL of its health care programs including MA, MnCare, and GAMC pay for acute psychiatric hospitalization in IMDs. When the health care is paid by a managed care plan, such as PMAP, the IMD exclusion does not apply. When the health care is paid directly by the state through fee-for-service, individuals age 22 -64 who are in IMDs are moved to "Program IM" which is state-funded MA.¹ This means:

Functionally, the IMD exclusion has little effect in Minnesota and Prairie St. John's_Woodbury will operate on a level playing field with existing hospital psychiatric services for the vast majority of cases.

These reimbursement mechanisms are in place and working well for IMDs such as the Anoka Metro Regional Treatment Center (AMRTC)² and the Mayo Clinic's Genrose Hospital³.

¹ Prairie St. John's would receive initial Program IM DRG payments for Program IM patients, but as an IMD would not be eligible for the additional per diems available through special contracts (involving federal funds) to supplement reimbursement of extended hospital stays in the general hospital psychiatry units. These extended stay contract days currently account for just 7% of days paid by MA, GAMC and MinnesotaCare in calendar year 2006 (John Zalekj, Minnesota Department of Health).

² AMRTC receives separate appropriations and does not charge program IM, they are referenced only as it applies to prepaid Medicaid programs through Minnesota's Medicaid waiver.



This improved understanding leads to an important shift in our expected payer mix. Since we will be reimbursable for the identical population as existing hospitals, such as St. Joseph's, Regions, and Fairview, our projected payor mix will more closely approximate their collective average than it will the Prairie St. John's_Fargo facility extrapolation presented in our initial application materials.

A related question was raised in this vein about whether our location would prevent poorer patients from ever getting to our facility whether or not we could be reimbursed. The fact that ambulances are carrying patients every which way across Minnesota and all adjoining states in search of a bed proves that worry to be unfounded. If ambulances can find their way to Fargo, Duluth and Madison, we are quite sure they will be able to find their way to Woodbury.

2. The Need for Beds

The established hospital systems do not agree completely among themselves on whether more psychiatric beds are needed or not. All greater Minnesota hospitals responding to our application endorsed the need for more beds. Notably, these hospitals are not potential "competitors" of the proposed facility. In the metro, Regions and HCMC stated more beds are needed in the Twin Cities, while Fairview, HealthEast and the EMACS group maintain there is no bed shortage. HealthEast and EMACS rely primarily on a report called "Sg2 study" to argue the anomalous position that more beds are not needed, even as Regions and St. Joe's, as reported by Sg2, are adding beds. Fairview, on the other hand, has attempted to reframe the issue as a staffing shortage (See 11 below).

A. The Sg2 Study

The Sg2 study is a 2-page report commissioned by Joe Clubb, HealthEast's behavioral services director. The study compares psychiatric beds per 100,000 population in the Twin Cities, Denver, Seattle, San Diego and Madison. Table 1 shows the Sg2 data presented by EMACS along with responses to Prairie St. John's inquiries to the various local hospital associations. The Sg2 report itself demonstrates only that it is possible to find other cities at least as far below the national average for psychiatric beds as the Twin Cities, but doesn't even comment on whether these low bed rates provide adequate service availability to their communities. We contacted the hospital associations for the respective cities, and their emails detailing similar access problems to ours are attached to this letter.

The only City on the list reporting reliable access to behavioral health beds is Madison. Madison has 144 beds per 100,000 when beds in standalone facilities are included. The Twin Cities has 22 per 100,000 according to Sg2's own data. Interestingly Seattle, with almost twice the beds as the Twin Cities at 40 per 100,000

³ Although part of the Mayo complex the Generose Hospital is separately licensed, in a building separate from the general medical services and is therefore legally an IMD (Institution for Mental Disease) under federal law.



still reports access problems. Adding the proposed 144 Prairie St. John's beds to the Twin Cities would raise the Twin Cities' bed rate to 27 per 100,000(ignoring dilution by greater Minnesota's population base), still less than the national average and substantially less than Seattle's. When the community effect of the comparison bed rates is taken into account, the Sg2 data source provides evidence for, rather than against, the need for more beds in the Twin Cities.

Table 1

April 2006 Twin Cities Population	2,820,000				
Total Psych Beds	620				
Psych Beds (excluding ded. MH facility)	450				
	Twin Cities	Madison	Denver	San Diego	Seattle
Psych Beds per 100,000	22	145	18	17	40
Psych Beds per 100,000 (excl. ded. MH facility)	16	15	10	12	7
Adequate access reported by Hospital Ass'n to Prairie St. John's		YES	NO	NO	NO

B. Is Integrated Care the Solution?

Prairie St. John's certainly believes that an optimally integrated behavioral healthcare system is the ideal. We believe that proper implementation can reduce bed pressure and reduce costs of properly caring for mental illness. Unfortunately, adequate training and adequate public and private funding for these programs do not exist. Proposals for adequate community based mental healthcare have been worked on since the de-institutionalization movement of the 1960's. We are still suffering a bed shortage in the Twin Cities, and the end is not in sight. If we fully funded and implemented an integrated care model tomorrow, the full effect of preventative care would not be realized for up to a decade.

The decision to go forward with more hospital beds is not an either-or decision. Minnesota can permit the addition of more beds, while at the same time working towards an integrated model of care. By pursuing both, there will be both increased preventative care and an improved safety net for those who need it.

We agree that inadequate provision of services at earlier stages increases the need for inpatient beds. However, we believe even more strongly that it is cruel to allow suffering patients to languish in Emergency Rooms while we admire the problem. We are offering a concrete way to serve more patients suffering from psychiatric crises. Until adequate early intervention programs are designed, funded, and implemented,



we need to serve the patients who might have been helped sooner if an integrated system of care were implemented.

Even when such programs become fully realized there will still be a need for hospitalization. Many cases do not declare themselves until a crisis emerges, and often multiple hospitalizations are required to fully stabilize a given person's disorders. Not all illnesses can be completely stabilized, even when optimally managed. More warning sign education and early intervention will help reduce, but never eliminate entirely, emergencies. Someday, when early genetic and neurophysiologic diagnosis and intervention are scientifically feasible, Prairie St. John's will be first in line to offer these technologies. In the meantime, we respond to the present reality.

3. EMTALA and unfunded patients

The Federal EMTALA law requires hospitals that

- 1) Have a licensed emergency department,
- 2) Hold out to the public that they treat emergency medical conditions without appointments, or
- 3) Provide at least 1/3 of their outpatient services in the previous year for the treatment of emergency medical conditions without appointments

provide care for all patients with Emergency Medical Conditions regardless of their ability to pay. 42 CFR 489.24 (b) (2007).⁴

Our proposed hospital will be bound by EMTALA, and will accept EMTALA transfers from other hospitals, as we have in Fargo for 11 years. We will not increase the number of unfunded patients needing care, so to the extent that we admit unfunded patients – as we must both legally and morally – pressure will be reduced on “other hospitals” to do so.

4. Charity Care Comparison with Twin Cities Hospitals

Our Charity Care percentage is beyond reproach. We have attached comparisons of our Fargo facility's charity care with that of Twin Cities hospitals for 2004 through 2006. This 3 year time period clearly shows Prairie St. John's commitment to ministering to the poor, unfunded, and underfunded. In fact our rates of charity and uncompensated care exceed most area hospitals. It should be noted that the apparent drop-off in charity care during 2006 is simply an artifact of staff changes in our finance department at that time resulting in less attention to the formal processes required to designate uncompensated care as charity care. You will note that the rate of uncompensated care did not drop-off in that same year, consistent with this explanation.

⁴ The idea that we are not bound by EMTALA appears to come from legal research that overlooked the regulations that enforce the law. The EMTALA law itself (located at 42 U.S.C. 1395dd) only states hospitals with emergency rooms must provide treatment, but the Code of Federal Regulations (CFR) expands the law to include the 3 definitions listed above. We have attached the pertinent law and regulation for your review.



We have one of the most relaxed debt collections policies in the Midwest, taking into account how psychiatric conditions may affect a patients' ability to pay, and taking seriously our Mission and Values statements. We realize that we deal in the scarce resource of the mental health dollar. To that end, we are careful stewards of that resource, spending it only where we believe it will do the most good. We reinvest mental health dollars into mental health services. We do not require the grand edifices⁵ that have become standard for general medical facilities; we design functional, warm, and inviting spaces that are cost-effective for the children and adults we serve. And we don't have other more capital intensive 'product lines' that we need to siphon money into from mental health revenue.

5. Exploring Collaborative agreements with other health systems

We have explored opportunities to partner with other Health Systems in the Twin Cities for more than a year. We continue to explore opportunities with health systems that are genuine in their desire to increase the quality and capacity to care for behavioral health patients. To date, some of these talks appear to have been thinly veiled attempts to gain competitive information or to slow our attempts to negotiate with others. Yet we remain open to partnering with any hospital system that has a good faith interest in partnering with us. We are currently exploring with area health systems ways in which we could partner to enhance patients' access to care, even in light of the fact that we are not bound by the IMD exclusion as we previously believed and even though we will operate under EMTALA regardless.

6. Medical Capabilities

Our psychiatric hospital will be operated in accordance with CMS and JCAHO regulations. Prairie St. John's policies submitted with our application materials have passed multiple CMS and JCAHO reviews without any reservations expressed. This is objective verification that we meet this criterion. All patients will receive physical exams as part of the admission process, phlebotomists will be on site daily for lab testing, and primary care physicians will round daily on patients with ongoing concerns. Specialty consultants will also be on staff.

A. Prairie St. John's CMS and JCAHO standards for psychiatric hospitals

The discussion related to our proposed standalone facility appears to go a step further, however, and suggests holding Prairie St. John's to a stricter standard than does CMS or than is any other psychiatry service in the state, namely that we should be able to provide all the care of a general medical hospital in a standalone facility. In fact when psychiatric patients become medically unstable on psychiatry units in general hospitals, the community standard is to transfer them off the psychiatry unit to a general medical or surgical service. We will (and are

⁵ Fairview Health Services recently broke ground on a \$175,000,000 renovation to its riverside campus. The 180,000 square foot building will cost \$945 per square foot, while Prairie St. John's proposed 93,000 square foot hospital will cost approximately \$17 million, or \$182 per square foot.



required to by JCAHO and CMS) establish transfer agreements with nearby facilities to accomplish analogous access to appropriate care. We dispute the logic that it is a financial disadvantage to a general medical facility to be asked to provide general medical care. Furthermore, a transfer from our facility to a receiving general medical facility could create a reimbursement advantage for that facility in a DRG environment, compared with treating both conditions during one admission.

It should be noted that the Mayo Clinic's psychiatric facility, the Generose Hospital is also legally an IMD, separately licensed and located in a building across the street and across town from Mayo general medical facilities. We are not aware of any criticism leveled towards Mayo's psychiatry service concerning its "separation" from general medical care, or aspersions cast on the quality of its care. Prairie St. John's_Woodbury will have the same physical proximity to a separately licensed general medical facility, namely Woodwinds Hospital, as does the Generose Hospital. It is also our hope, once granted moratorium exemption, to establish a mutual affiliation with the Woodwinds Hospital exactly to address the medical support issues and to bolster their psychiatric consultation resources.

There is of course a genuine need for specialty medical-psychiatry units, where gravely medically ill psychiatric patients may receive the full gamut of medical interventions, such as IVs, ventilators, cardiac telemetry and the like while their psychiatric conditions are addressed equally as vigorously. Yet not one of the existing general medical facilities already treating psychiatry patients has taken the initiative to start such a unit. How then in fairness could Prairie St. John's be denied permission to serve any patients because it won't provide a highly sub-specialized form of care, that would be impossible for it to provide, when the existing systems that could easily provide such care choose not to? Not only would that be blatantly unfair, the whole proposition is illogical:

Med psych units are needed.

Prairie St. John's does not have med psych units.

Therefore, Prairie St. John's is not needed.

That syllogism wouldn't pass in logic 101⁶.

⁶ As stated earlier, Prairie St. John's continues to pursue collaborative agreements with general hospitals to provide psychiatric expertise in a number of possible ways, including medical-psych beds attached to a general hospital. Prairie St. John's is capable of entering into such a venture while at the same time adding bed capacity for the vast majority of MI patients at the proposed standalone facility



Regions Hospital's assertion that any new inpatient bed expansion for mental health services should serve persons with medically complex conditions is especially curious. Regions is currently expanding their behavioral services from 80 to 96 beds. As part of a general medical hospital, they are in the best position to add medical psych beds without the need to invest in more medical equipment or staff, and yet to our knowledge their expansion does not include the service they have identified as the most needed.

7. Why not more residential beds instead?

This argument contains the same flaw in logic as the med psych bed argument above. If hospital beds do not address all of deficiencies in the current system, are they not needed? Prairie St. John's proposes to add capacity to a service clearly lacking in the state. We also have a demonstrated commitment to providing the full continuum of care – including residential treatment at our Fargo location. In our experience, receiving permission for residential licensure rivals that for hospital beds in time and regulatory complexity; mixing that into our hospital proposal would have been extremely impractical. While residential treatment is not contained within the scope of the current proposal, it is something we may pursue in the future

8. Admissions must be taken 24/7/365

We can and do take admissions 24/7/365 utilizing appropriately certified staff and the consultation of an on-call psychiatrist.

9. Impact on Woodwinds and other Emergency Rooms

Prairie St. John's_Fargo typically refers less than 1% of patients presenting for a needs assessment to a local Emergency Room for a general medical condition⁷. We will not create more patients simply by building a hospital in Woodbury, and, from the data just cited, it is clear that we will not be a burden on local Emergency Rooms. We will do a great service to local Emergency Rooms by accepting transfers of patients who present to the Emergency Room and must wait for an available psychiatric bed. We will result in patients being given the appropriate care at the appropriate time by the appropriate provider.

10. Fairview's claim that we only refer unfunded patients

We have contacted Fairview and asked that they provide data to support their allegation. This is not consistent with our data or our experience. In fact, as recently as January 25th, we attempted to transfer an adolescent patient who was fully funded and in need of inpatient hospitalization. Unfortunately, Fairview, as well as every other adolescent inpatient provider in the Twin Cities, was full. We would ask that the Minnesota Department of Health require proof of such an arguably defaming allegation before it accepts it as true.

⁷ Of the 1,156 needs assessments conducted in September 1 through December 31, 2007, only 9 were referred to a local Emergency Room for General Medical Care.



11. Recruiting Doctors away from other programs.

Prairie St. John's is a very attractive place for mental health professionals to work. We are led by psychiatrists, and as such we value behavioral health workers more than others might. Specific concerns raised by Health East, in both their written comments as well as Joe Clubb's verbal comments are without merit. Prairie St. John's met with Mr. Clubb on November 1, 2007 to discuss our plans and any concerns HealthEast had. One of the concerns Mr. Clubb expressed was the fear that a Psychiatrist specializing in chemical dependency would leave St. Joseph's when Prairie St. John's opened its doors. The Doctor in question, as well as Prairie St. John's representatives, have attempted numerous times to reassure Mr. Clubb that the psychiatrist does not plan on leaving St. Joseph's and that he will have time to perform his services at both locations. An Email is attached to this document that was dated 11/5/07 attempting to reassure Mr. Club. The real context here is that Susan Criger, CEO at St. Joseph's refused in May 2007 to contract jointly with Prairie St. John's for this psychiatrist's time. But for this stonewalling, St. Joseph's would have contractual assurance of our commitment to support their chemical dependency service. Since there was no dispute on fees, duties, or time, we can only conclude that this refusal related to turf and a disinclination to collaborate.

Because we are an attractive employer for mental health professionals, we do have more success than most general hospitals at recruiting. We currently are in contact with a Psychiatrist practicing in Hawaii that is interested in returning to the Twin Cities (where she trained) to raise her family. She is not actively looking at other hospitals, but is very interested in working for Prairie St. John's. This is just one example of the many Psychiatrists, counselors, and nurses that can choose to work anywhere, but choose to work for Prairie St. John's. The example also speaks to our assertion that we will create a net increase in professionals for the state.

This concern is especially puzzling coming from Fairview with the most intensity. Fairview currently trains the majority of psychiatrists in this state in conjunction with the University of Minnesota psychiatry residency and fellowships. As such it has an unmatched recruiting opportunity, day in and day out. In most academic psychiatry settings, young doctors are honored to have the opportunity to stay on in the hospital systems where they trained. Fairview should have the easiest recruitment situation in the state with little need to look outside its own unending stream of trainees. At the recent public interest hearing the reason given by a Fairview administrator for their staffing woes was that the draw of "outpatient practice" was too powerful. Outpatient practice is indeed attractive to many psychiatrists, in the way some surgeons may prefer a general surgery practice over trauma surgery. However several UofM /Fairview trainees have told us that while they wouldn't have considered an inpatient career based upon their training experiences, they would like to hear more about inpatient options at Prairie St. John's_Woodbury. We expect to comprise much of our staff with doctors who wouldn't have otherwise done inpatient work, so in effect from an expanded pool, not the zero sum game area providers are used to. To be frank, it is preposterous for Fairview to point to



us as a threat to their staffing while they fritter away an unsurpassable opportunity to foster a steady stream of recruits from within their own halls. Minnesota would lose fewer psychiatrists “to outpatient” if inpatient settings were less aversive. This is not an economic issue. Inpatient psychiatrist billings are reimbursed at a higher rate per hour than are outpatient billings. It comes down to how the staff is treated and how their work is valued within the organization as a whole.

12. Summary

The Minnesota Department of Health is charged with evaluating whether our proposed psychiatric specialty hospital would be in the public interest. There is no defensible factual or logical basis to conclude anything other than a need for more psychiatric and dual diagnosis hospital beds exists. We have also pointed out how illogical it would be to recommend against our proposal because it doesn't meet *every* behavioral healthcare need. Given the established need that Prairie St. John's_Woodbury is intended to fill; MDH must then weigh meeting that need against potential negative effects on existing systems and caregivers. We have explained in detail that our obligations under EMTALA are the same as any other hospital with psychiatric services and that we are open to any mutually beneficial collaboration with other systems. In addition it is now clear that the potential payor mix imbalances posed by the federal IMD exclusion will not exist under Minnesota law. We trust that MDH officials know fear mongering, turf protection and disingenuous rhetoric when they see it and look forward to their objective assessment and recommendation.

Respectfully submitted,

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