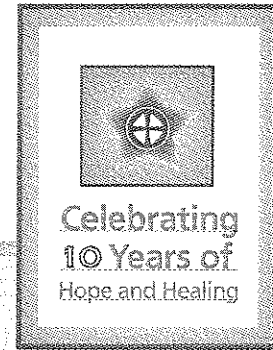




## PRAIRIE ST. JOHN'S



February 4, 2008

**Corporate**

Phone  
651.259.9700  
Fax  
651.259.9740

**Child/Adolescent  
Partial Hospital Program  
Day Treatment**

Phone  
651.259.9750  
Fax  
651.259.9790

7616 Currell Boulevard  
Suite 100  
Woodbury, MN 55125

[www.prairie-stjohns.com](http://www.prairie-stjohns.com)

Robert K. Meiches, M.D., M.B.A.  
Chief Executive Officer, Minnesota Medical Association (MMA)  
Minnesota Medical Association  
1300 Godward St. N.E., Ste. 2500  
Minneapolis, MN 55413

Roger G. Kathol, M.D.  
Co-Chair, Psychiatric Bed/Patient Diversion Task Force  
Minnesota Medical Association  
1300 Godward St. N.E., Ste. 2500  
Minneapolis, MN 55413

Steve P. Sterner, M.D.  
Co-Chair, Psychiatric Bed/Patient Diversion Task Force  
Minnesota Medical Association  
1300 Godward St. N.E., Ste. 2500  
Minneapolis, MN 55413

Dear Drs. Meiches, Kathol and Sterner:

We are writing in response to your January 17, 2007 letter to the Minnesota Department of Health delineating conditions for MMA's support of our proposed Woodbury psychiatric hospital. We appreciate the opportunity to clarify questions raised and certain factual misunderstandings.

To begin with, allow us to express our full appreciation of MMA's role in advocating for judicious allocation of healthcare resources and its efforts to encourage systemic solutions to the overall psychiatric services shortage. In addition, we are grateful for your very explicit statements that more psychiatric beds are in fact a needed part of solving Minnesota's psychiatric services shortfalls. Surprisingly to us, this obvious need – by all accepted national standards – has been challenged by some stakeholders in the discussion.

Your letter lists three criteria that Prairie St. John's proposed facility would need to meet in order to receive MMA's support. The discussion that follows explains how we meet all three conditions.

1) *"Prairie St. John's must accept all patients regardless of insurance status or type."*



Contrary to the speculation that EMTALA regulations may not apply to the proposed hospital, *freestanding psychiatric hospitals are in fact obligated* under COBRA/EMTALA regulations to provide emergency psychiatric stabilization to *all patients presenting with an urgent condition regardless of financial situation* (Title 42 U.S.C. 489.24(b)). The broad definition of emergency department at U.S.C. 489.24(b) clearly includes the proposed hospital's Needs Assessment Department due to its 24-hour, 7-day-a-week availability for unscheduled assessments. This is indeed how CMS has treated the Prairie St. John's\_Fargo Needs Assessment Department during several reviews.

Furthermore, the question whether the federal "IMD exclusion (Institution for Mental Disease(42 U.S.C. §1396d(i))" precludes our eligibility for Medicaid reimbursement for adults ages 22-64, does not in any way absolve our responsibilities under EMTALA.

*Specifically regarding Minnesota Medicaid reimbursement for adults:*

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 prior 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 Medicaid based programs, including PMAP, MnCare, UCare and Minnesota MA effectively circumvent the IMD exclusion, whether through Medicaid "waiver" mechanisms, or direct state funding sources such as GAMC or "Program IM." 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.*

The only difference is that while as an IMD Prairie St. John's *would* receive initial Program IM DRG payments for Program IM patients, it *would not* be eligible for the additional per diems available through special contracts (involving federal funds) that existing general hospitals hold to supplement their reimbursement for extended hospital stays.

These reimbursement mechanisms are already tested and functioning for the Mayo Clinic's Generose Hospital. Although part of the Mayo complex, the Generose Hospital is separately licensed, in a building separate from other general medical services, and is therefore legally an IMD (Institution for Mental Disease) under federal law.



This improved understanding leads to an important shift in our expected payer mix. Since we will be reimbursable for the identical population as existing general hospitals with psychiatry services, our projected payer 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.

So, with more information, it is clear that the worry that "other hospitals in the region will be forced to take a disproportionate share of uninsured and/or publicly funded patients with greater risk of financial insolvency and bed closure" is simply unfounded:

1. The IMD exclusion does *not* apply:
  - a. Under federal law to:
    1. Medicare funding for people at any age,
    2. Medicaid funding for those under 22 and over 64 years of age,
  - b. Under Minnesota specific programs to:
    1. PMAP recipients ages 22 – 64, (Minnesota Statute 256B.69 (2007)),
    2. *All* other Medicaid eligible Minnesota adults according to Minn. Stat. 256B.055, Subd. 13 (2007), or
    3. GAMC funding for involuntarily committed adults (county managed funding).
2. Since our presence will not increase the actual number of psychiatric patients needing help, to the extent that we admit unfunded or publicly funded patients – as we must do both legally and morally – pressure will be *reduced* on "other hospitals" to do so.
3. Prairie St. John's legal situation with the uninsured is identical to other hospitals', including the COBRA/EMTALA obligation to accept such patients on transfer when other hospitals are full and we are not.

Furthermore, we dispute the implied premise that government funded patients represent nothing more than a financial burden for area hospitals. This is taken as a given in this debate, but results from an oversimplification of the actual (but generally unrecognized) economics involved.

First, the overhead allocations typically attributed to psychiatry units in general hospitals are inflated relative to the actual overhead in an objective cost center analysis of the services. Although Medicare "cost reporting" rules no longer reward most hospitals for these cost exaggerations, general hospitals often continue to view psychiatry services in this way, e.g., attributing global institutional costs,



including costs of equipping high tech services, by proportion of square footage in the facility rather than matching actual costs to actual revenues by service.

Second, Medicare rules do continue to substantially offset general hospital expenses related to government funded or indigent patients with "disproportionate share" Medicare rate adjustments. The adjustments attributable to psychiatry patients alone may add millions of revenue dollars per year to hospital systems "losing money" on psychiatry. We know from prior confidential negotiations that for at least some area hospitals, when these "disproportionate share" adjustments are taken into account their "money losing" psychiatry services have in reality a net positive effect on the organization's bottom line.

2) *"Prairie St. John's must provide 24-hour emergency access for psychiatric evaluations and admissions."*

Your letter acknowledges that our application details our 24 hour, 7 day a week, 365 day a year triage service that we call Needs Assessment, but states that it is inadequate because it is not bound by EMTALA, so "ambulances and families will not be directed to Prairie St. John's." The citations noted above, especially U.S.C. 489.24(b), demonstrate our EMTALA obligation to accept ambulance transfers. JCAHO and CMS require "24/7" emergency access as well in order to be deemed a hospital and Prairie St. John's\_Fargo has passed and excelled at multiple reviews by both entities over the last eleven years.

3) *"Prairie St. John's must make provisions for availability of medical services for psychiatric patients with stable medical illness at the Prairie St. John's facility and for acute care psychiatric services to patients with unstable medical illness in collaborative adjacent medical facilities."*

This again is exactly consonant with CMS and JCAHO regulations and the Prairie St. John's policies submitted with our application materials have passed multiple CMS and JCAHO reviews without any reservations expressed in this regard. 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.

The discussion related to this criterion 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 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 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.

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 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?

We trust that these clarifications, especially concerning our obligations under EMTALA and COBRA, which were not correctly understood when formulating the questions raised in your letter, will allow you to withdraw formally your reservations concerning our proposed psychiatric hospital and to provide an update concerning your support for our project to Julie Sonier at MDH. We regret not entering into dialogue with MMA sooner on our proposal as these misunderstandings may have been avoided.

Since your January 17<sup>th</sup> letter, premised upon an incorrect understanding of our EMTALA/COBRA obligations, was summarized on the MMA webpage and circulated in its e-newsletter, we would respectfully request that you



arrange to have this letter posted on the MMA webpage and included in the e-newsletter so members have the opportunity to understand our responses.

We appreciate the invitation to discuss our proposal further with the Task Force at its February meeting, and look forward to any feedback on how we might integrate better with the broader ongoing initiatives.

Respectfully Yours,

John Ryan  
Special Projects Liaison

Stephen R. Setterberg, M.D.  
Co-Chairman

Cc: Julie Sonier, Minnesota Department of Health