Department of
HUMAN SERVICES

Inpatient Bed Tracking Study Committee Report

December 2021

2021 Iowa Acts Senate File 524: Inpatient Bed Tracking Study Committee Report

Executive Summary

2021 Iowa Acts Senate File 524 directed the Department of Human Services (DHS) to convene a study committee to develop recommendations for improving Iowa's existing bed tracking system. Recommendations shall include but not be limited to:

- Expanding the acuity of disabilities a hospital or facility is able to accept in its program to include but not be limited to persons with certain mental disabilities, behavioral disabilities, and sexually or physically aggressive behaviors;
- Increasing reimbursement rates based on the level of care provided; and
- Implementing enhancements to the inpatient psychiatric bed tracking system to accept and report real-time electronic data from the state mental health institutes, hospitals, and subacute mental health care facilities participating in the system.

The Committee's membership included representatives from DHS, the Iowa Hospital Association (IHA), managed care, Iowa Department of Public Health (IDPH), law enforcement, a private payor of inpatient services, MHDS Regions, and a county mental health advocate. (Appendix A) The Committee completed the tasks as identified in the legislation during four open public meetings on July 27, August 24, September 28, and October 22, 2021. At the first meeting, it was asked if future meetings would include time for public comment. The Committee agreed this was a good idea and that item was added to future meeting agendas.

Committee members identified the primary issue of concern to be availability of specialized, high acuity inpatient psychiatric care, not the quantity of available psychiatric beds. By federal law[1], hospitals must serve, within their capabilities, all individuals seeking treatment at their facility. Committee members described the experiences of patients with complex care needs who presented in emergency rooms or engaged with law enforcement and then waited for an extended period of time before securing inpatient treatment. In some cases, Committee members identified that inpatient treatment was not secured and the patient instead left the emergency room. Further, while patients are waiting in the emergency room, Committee members describe the significant level of effort extended by care team members or administrative support staff who make multiple calls seeking a hospital to accept the patient for admission. It was noted that a hospital can deny an admission if it lacks the capacity to care for a patient despite having open inpatient beds. The hospital does not need to

[1] 42 U.S. Code section 1395dd

identify reasons for the lack of capacity. This makes it difficult to gather data to inform solutions.

Current inpatient psychiatric bed tracking data shows Iowa has consistent, sufficient availability for adult inpatient psychiatric care within the State. However, anecdotal information indicates that inpatient psychiatric providers willing and able to meet the specialized physical, environmental, and clinical demands of adults with complex comorbidities including complex medical conditions, intellectual/developmental disability, and/or display of aggressive behavior are limited. Both current bed tracking data and anecdotal evidence indicate limited availability for inpatient psychiatric care for youth. Further anecdotal information indicates gaps in the behavioral health care continuum that, at times, slow discharge from existing specialized inpatient care causing further limitation on availability.

The Committee identified three recommendations for further work. However, it was noted by some members of the Committee that the identified recommendations will not immediately address concerns discussed. Instead, the recommendations center on developing, utilizing, and reporting data to equip decision makers with the tools they need to make informed decisions to strategically invest in support of systemic capacity.

Recommendations

1. DHS will partner with the Iowa Hospital Association to further analyze options related to 2018 recommendations.[2] Options to establish and define patient criteria for a distinct level of specialized care, such as intensive psychiatric inpatient or tertiary care, targeting the treatment needs of Iowans who display outlier levels of need such as highly complex medical, behavioral, functional, and/or psychiatric care needs will be analyzed. Based on the feedback from this Committee the target population as described in the *Expanding Acuity Hospitals Can Treat* section of this report will serve as the definition of the target patient population for this component of work. Findings of this analysis, including comparison to other states, options to be considered for the development of specialized care units, potential code changes, reimbursement requirements and fiscal impact will be reported by DHS to the Legislature and Governor's office by June 30, 2022.
2. DHS's Medicaid division will analyze the creation of a tiered reimbursement structure that accounts for different levels of acuity for inpatient psychiatric care. Medicaid will partner with providers and payers on submission of pertinent data to help identify distinct levels of patient acuity to inform tier development. Once acuity tiers are identified, at least three models of potential reimbursement adjustments utilizing tiers will be outlined based on cost of patient care in each

[2] Tertiary-Care-Psychiatric-Hospitals-Report.pdf (iowa.gov)

tier. At least one model will reflect a cost neutral adjustment for the implementation of tiered reimbursement. Other models may reflect options for additional investment for consideration as identified by the Medicaid team in its analysis. Findings of this analysis, including fiscal impact and any possible changes in code, will be reported to the Legislature and the Governor's office no later than June 30, 2022.

3. In partnership, the Departments of Public Health and Human Services will assess the capabilities of both the current DHS inpatient bed tracking system and the IDPH hospital reporting system that was utilized as part of the State's required response to the COVID-19 Public Health Emergency. Together, the Departments will determine if the systems can be aligned, integrated, or expanded to include: real-time reporting for inpatient psychiatric availability; features for identification of patient acuity; and referral tracking that would capture the time between patient referral and admission and aggregate information reflecting the diagnoses and acuity of referred patients. In addition, expansion to include tracking availability of other service settings such as community-based crisis services, residential substance use treatment, and Psychiatric Medical Institutions for Children (PMIC) will be explored. The committee identified specific data elements reflected in *Appendix B* of this report that should also be taken into consideration in development. The Departments will include proposed functionality for the enhanced system such as: relief of administrative burden of manual entry requirements for providers, public dashboards to monitor Iowa's behavioral health system capacity and use of data to distinctly identify gaps in the care continuum including geographic access concerns, and specific patient profiles and counts of populations underserved by the current systems. Findings of this assessment, including fiscal impact and any potential changes in code, will be reported in a joint Departments of Health and Human Services report to the legislature and the Governor no later than June 30, 2022.

Discussion

Recommendation 1: Expanding Acuity Hospitals Can Treat

- The group discussed that Iowa's existing bed tracking system, CareMatch, displays a sufficient supply of inpatient psychiatric beds. However, hospitals are not always staffed to treat patients with high acuity needs. Patients with higher intensity of need related to complex comorbidities or their display of symptomology, especially those with intellectual/developmental disability and those who display currently or have a known history of sexually or physically aggressive behavior, are often difficult to place for treatment, services, and support of all types.
- Emergency departments in community hospitals cannot turn patients away but, don't have the resources necessary to treat highly complex patients who present to the emergency room experiencing a significant behavioral health crisis and in need of inpatient treatment. Hospital staff are then mired in making phone calls

across the state seeking placement, often with little success. There is no "list" or means of identification of hospitals equipped to provide inpatient psychiatric care for patients with high acuity, high complexity needs.

- Some Committee members also participated in a 2018 workgroup formed to discuss the creation of tertiary care psychiatric hospitals. It was decided in review of the work done by the 2018 committee, that it would be helpful in defining the psychiatric space for the level of care described in the bill. Dr. Jodi Tate from UIHC shared a refined definition with the committee members and the committee members agreed that the population described below captures that target population of this committee's conversation.

The patient must have a serious mental illness and have a current, severe, imminent risk of serious harm to self or others as exemplified by, but not limited to:

- *Have complex comorbidities including intellectual/developmental disability, autism spectrum disorder, substance use disorders, and traumatic brain injuries;*
- *Have a history of violence that is secondary to mental illness or mental illness in individuals with the above noted comorbidities;*
- *A request for patient transfer has been rejected by inpatient level of care due to severity of symptoms; or*
- *Is nonresponsive to typical intervention or is treatment refractory.*

Recommendation 2: Increasing Reimbursement Rates Based on Level of Acuity

- Prior to this meeting Committee members surveyed their respective peers to determine if other states or payers had success in addressing concerns about availability of inpatient psychiatric care. The two main takeaways were that there is not a lot of information and the problems discussed by the Committee are not unique to Iowa.
- The Committee discussed that payer data is needed to determine an appropriate amount or level of additional reimbursement for high acuity inpatient psychiatric beds. Representatives from Wellmark, Iowa Total Care, and Amerigroup stated they could provide data within confidentiality guidelines. Dr. Jodi Tate created a list of data points that could help inform data-driven decisions. (Appendix B)
- Iowa Medicaid Director, Liz Matney, and Provider Cost Audit Principal, Jeff Marston, joined the Committee's conversation to share how Medicaid reimburses psychiatric hospital services. Diagnostic Related Groupings (DRG) are used to reimburse psychiatric units that are not certified and per diems are used to reimburse certified psychiatric units. Neither of these methods account for variance in patient acuity levels.

- It was suggested that reimbursement could be based on levels of acuity, similar to reimbursement for Neonatal Intensive Care Units (NICU). Director Matney indicated Medicaid could model wrapping reimbursement around what additional resources are required but did indicate that Iowa hospitals may not prefer to change reimbursement structures in that fashion.
- The Committee recommended that the Medicaid division perform an analysis to determine appropriate tiers, associated rates, and project associated fiscal impact to implement a tiered reimbursement methodology based on patient acuity.

Recommendation 3: Enhancements to the Inpatient Bed Tracking System

- Representatives from FivePoints Technology Group presented information and a demonstration of CareMatch, Iowa's current bed tracking system to Committee members.
- Date / time stamping, staffing and level of acuity are not currently captured in CareMatch but, the technology can support all these items.
- Currently, hospitals providing inpatient psychiatric care are required to report bed availability via CareMatch twice daily. Compliance with reporting is fair with a small handful of non-compliant outliers. Currently, compliance is requested but not enforced. Reporting effort is manual data entry and, although the effort is minimal, has some degree of administrative burden for providers.
- IDPH shared information about the hospital bed reporting system that is used to track non-psychiatric hospital beds. Hospitals have been required to use this system during the COVID-19 public health emergency but are not otherwise required to report.
  Two of Iowa's larger health care systems have established automatic data feeds to IDPH (real-time data). The Committee agreed that leveraging technology and avoiding manual data entry is desirable. CareMatch is capable of this type of data integration.
- The Committee determined that Iowa needs improved inpatient psychiatric care capacity to treat patients with highly complex comorbidities including individuals displaying interfering behavior, such as aggression.
- It was noted by Committee members that throughout the committee meetings, although problems were described, it was difficult to define the scope due to a lack of available data.
- The Committee determined that Iowa does have inpatient psychiatric care available but not the right kind and not in the right places.
- Improving inpatient bed tracking systems to seamlessly capture and analyze data regarding patients in need of care who are unable to access the care they need, such as diagnoses, geography, and time spent waiting or in transit (including transport by law enforcement) would help decision makers to direct system

investments in a meaningful way and would enable monitoring of the State's return on investment.

Conclusion

The Committee appreciates the Legislature's recognition of the need to address access to behavioral health care for all Iowans. This Committee afforded stakeholders a forum in which to discuss the depth and complexities of access concerns from all angles and determined that, although there are sufficient inpatient psychiatric beds available for adults in Iowa, specialty care, especially support for children and adolescents, high acuity or complicated, co-morbid patients, is difficult to secure. In partnership with multiple stakeholders and Departments, DHS is committed to completing the work contained in the three recommendations in this report as part of the overall ongoing effort improve access to high quality behavioral health care for Iowans. Committee members also emphasized that the concerns discussed in the Committee and outlined in this report are urgent. The Committee encourages all Iowa stakeholders to continue to progress toward more equitable access to high quality behavioral health treatment for all Iowans. We look forward to continuing the conversation with all stakeholders and will keep the Legislature apprised of the results of the ongoing analyses.

Appendix A – Committee Participants

Organization	Name and Title
DHS	Marissa Eyanson, Division Administrator – MHDS, Community ***Co-Chair**
DHS	Theresa Armstrong, Bureau Chief, Community Services & Planning
DHS	Julie Maas, Program Planner
DHS	Carrie Malone, Legislative Liaison
DHS	Victoria L. Daniels, Project Manager
Iowa Hospital Association	Erin Cubit[3] ***Co-Chair**
Iowa Total Care (managed care)	Marissa Crawhorn, LPCP, Director, Behavioral Health Clinical Operations
Amerigroup (managed care)	Leslie Cardoza, Regional Director, North Central Region
Iowa Department of Public Health (IDPH)	Rebecca Curtiss Chief, Bureau of Emergency and Trauma Services
Iowa State Sheriffs' and Deputies' Association	Sheriff Jared Schneider, Washington County
Wellmark Blue Cross and Blue Shield of Iowa (private payer)	Brandon Geib, Government Relations Counsel
University of Iowa Hospital and Clinics	Dr. Jodi Tate, Senior Vice Chair for Clinical Services
University of Iowa Hospital and Clinics	Heidi Robinson, Director, Behavioral Health Nursing
Knoxville Hospital & Clinics	Kevin Kincaid, FACHE, CEO
MHDS Regional CEOs	Jennifer Robbins, South Central Behavioral Health Region CEO
County Mental Health Advocate	Ashley Gray, Southwest Iowa Judicial Mental Health Advocate

[3] Initially Kimberly Murphy was the Co-Chair representing IHA. However, when Ms. Murphy left IHA to take another position, Erin Cubit replaced her as the representative from IHA.

Appendix B – Data Elements

Below are the data elements discussed by the Committee to help identify the population of patients described as stuck in emergency departments secondary to lack of available inpatient care with capacity to address high acuity and/or co-morbid conditions.

1. Payer

2. Patients with following ICD-10 diagnoses
    a. Mental illness
    b. Intentional self-harm
    c. Substance use disorder
    d. Intellectual disability
    e. Dementia

3. Time from ED arrival to ED departure for admitted ED patients with above diagnosis codes. From this data calculate the median time from ED arrival to ED departure for admitted ED patients with above ICD-10 diagnoses

4. Identify outliers of median time from ED arrival to admission.
    a. Patient Characteristic
        i. Age
        ii. Sex
        iii. Payer
        iv. ICD-10 diagnosis
        v. Geography / Location
    b. Barriers to admission
        i. lack of capacity secondary to staff
        ii. lack of capacity secondary to expertise
        iii. lack of capacity secondary to no open beds
        iv. other
    c. Outside parties involved with trying to obtain admission
        i. DHS
        ii. Region
        iii. MCO
        iv. Other