Challenges of Maintaining Adequate Medicaid/IRPS Reimbursement for Emergency Services

Unpredictable Consumer Flow and Flexible Service Schedule

Emergency Service (ES) for mental health is like any community emergency service…the service must be staffed to respond immediately to the crisis situation regardless of when the crisis occurs or even if any crisis occurs…like the fire department. However, given the economic realities of community mental health funding, having trained and experienced staff merely 'on-standby' for a possible emergency is not feasible; ES staff must help generate revenue by maintaining a caseload of active clients for providing reimbursable activities. Due to the unpredictability of urgent and emergent occurrences, ES staff cannot maintain a fully productive schedule with their assigned clients and simultaneously provide timely ES service. The national standard for staff reimbursable activity in community mental health is 25 hours per week. To adequately respond to crisis events, the expected scheduled activity for an ES worker would be about 12.5 hours per week…leaving 12.5 hours for emergency service, of which an estimated 50% (or 6.25 hrs) may be billable. The net result is approximately 18.75 billable hours compared to 25 billable hours in a non-emergency setting. Even by building in daily ES time, additional time for each ES event is often necessary as many crises consume an inordinate amount of time for satisfactory resolution; for example, an involuntary commitment may take up to 6 hours for placement. With new (and lower) Medicaid and IPRS definitions and rates, one FTE (full time equivalent) position can generate approximately $97,500 in annual charges. Just considering the above figures, one ES FTE position would generate only $73,125 in annual charges…a decrease, or loss, of $24,375 due to ES activity, and this assumes no additional ES time is needed beyond the allotted percent. Obviously, additional ES time required for adequately resolving emergency situations would further diminish the capacity of the ES worker to provide reimbursable services.

Psychiatric Services

A salient component of any ES system is adequate psychiatric coverage and consultation on a 24/7 basis. It has been well chronicled over the past few years that the Medicaid/IPRS rates for physician services are inadequate to fully cover physician services, and especially when including 24/7 on-call coverage. Larger service entities offering primarily Community Support activities can utilize excess CS funds to assist with paying for physician services; smaller service units that now exist in Henderson County will have less ability to leverage CS dollars. Excellence in emergency services requires timely response to crisis situations, and to ensure high quality and responsive emergency services, Parkway Behavioral Health employs a fulltime psychiatrist. Annual cost of a physician employee, to include wages, on-call fees, benefits and indirect costs, averages $320,000; annual average earnings of a psychiatrist working with the public-funded clientele is approximately $235,000…resulting in a shortfall of $85,000. With ES demands, allotting 15% of physician time to non-reimbursable ES activity equates to an additional subtraction from earnings of around $35,000…resulting in a total shortfall of approximately $120,000. Henderson County's share of this revenue shortfall relative to psychiatric services is approximately $18,000, or 15% of the total (Buncombe = 50%; Transylvania = 15%; Henderson = 15%; Polk = 5%; Rutherford = 15%).

Limited IRPS Funds

State/IPRS funds historically have been depleted prior to the end of the fiscal year. During funding shortfalls, non-emergency services can be reduced or eliminated. However, reducing emergency services would pose potential substantial negative consequences both for Parkway Behavioral Health and Henderson County. The ES payer mix includes a higher percentage of IPRS consumers than typically found in public-funded general outpatient agencies due to more options for the Medicaid consumer. Limited IPRS funds pose considerable risk of having those emergency services that are billable to be fully reimbursed, further exacerbating a fragile reimbursement system for emergency services.

Non-Target Pop Residents

Individuals who do not meet the criteria for receiving Medicaid or State-funded mental health/substance abuse services must be offered services by Parkway if they present in a condition of crises or emergency. For other agencies offering public-funded, non-emergency outpatient services, this is not the case. Projecting at least three ES events per week in Henderson County, and conservatively estimating 15% of ES consumers will lack a funding source, then about 23 Henderson County consumers will be served by Parkway Behavioral Health without any reimbursement. Again, conservatively estimating 3 hours of service per crisis consumer and with 50% of ES activity generally reimbursed, then serving the consumers without a funding source will equate to an annual loss of 37.5 billable hours or $5,175.

Costs of No or Inadequate ES system

Perhaps the most relevant costs of having no emergency services or inadequate emergency services will be the costs experienced by the residents and community service entities of Henderson County. Common sense, and research literature, point to the increase demand upon a community's 'safety net' infrastructure (DSS, Health Dept, law enforcement, hospitals, etc) as structured mental health crisis interventions decrease. Without the benefit of a system for stabilizing the mentally ill consumer in crisis, the consumer will continue to escalate, eventually leading to a host of actions involving other community resources, such as refuge in the local hospital ER, family intervention by DSS, crisis intervention by local law enforcement, criminal behavior resulting in jail and commitment process requiring law enforcement transportation to Broughton Hospital. The costs associated with these 'community interventions' is beyond simple dollars as the increased instability of the consumer extracts an emotional price from the family, friends and the County's 'helping infrastructure'.

Summary

Like other community emergency services, mental health crisis services require available and responsive qualified staff regardless of the time or frequency of crisis events. Due to the required staffing model and to the low Medicaid/IPRS reimbursement rate for physician services, financial self-sufficiency of emergency mental health services is not achievable. Without a viable mental health ES system in the community, the consequential financial and emotional costs are shared by the community's infrastructure and residents.