# Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

# Investigation of Michigan Residents Crossing Wisconsin Border to Seek Inpatient Mental Healthcare

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## Abstract

Reports from Michigan Community Mental Health Service Programs (CMHSPs) of Michigan residents seeking inpatient mental healthcare across the border in Wisconsin are becoming more frequent. While some have pointed to possible explanations being related to differences in per capita number of psychiatric beds between the states or Wisconsin hospitals taking initiatives to increase access to care, the following investigation offers an alternative perspective on the topic, with a focus on regional proximity to the nearest hospitals with psychiatric beds and the comparative isolation and inpatient psychiatric infrastructure of Michigan border cities with Wisconsin.

## Background

During the initial onset of the COVID-19 epidemic, states scrambled to adapt to the new restrictions and preventative measures. For Michigan's rural areas of the Upper Peninsula, this time was an ironic stopgap for a problem it had been experiencing for years - population loss. The first year of isolated quarantine forced the populations of the UP to remain in place, contrary to what had been occurring beforehand, although this did not last long and almost overnight populations began to decline once again. This was due to a number of factors, not least of which being Michigan's status as a post-industrial state, having lost its major mining and manufacturing industries in the 1970s and 80s. Since 1990, Michigan has ranked 49th in the country for population growth, only beating out West Virginia. Contrary to this, Wisconsin's population within its rural border counties have increased consistently since 2010, and shows no signs of slowing. Possible contributing factors to this phenomenon are Michigan border cities being much more isolated from major population centers, Wisconsin having superior healthcare infrastructure along the border, and Michigan Medicaid covering healthcare received in bordering counties of neighboring states.

While concerns have been raised by Medicaid providers in Michigan that this is an issue solely impacting their clients, over 1/3rd of Michigan residents who sought inpatient care in Wisconsin between 2022 and 2023 used private insurance or paid out-of-pocket, demonstrating that this issue extends beyond solely government-funded healthcare recipients.

**Table 1: Michigan residents seeking inpatient care in Wisconsin by payer 2022-23**

| Payer | 2022 | 2023 | Total | Percentage |
|---|---|---|---|---|
| Medical Assistance/Badgercare | 64 | 199 | 263 | 47.7% |
| Medicare | 11 | 70 | 81 | 14.7% |
| Private Insurance | 34 | 144 | 178 | 32.3% |
| Self-Pay | 3 | 15 | 18 | 3.3% |
| Other Government | 0 | 3 | 3 | 0.5% |
| Other/Unknown | 3 | 5 | 8 | 1.5% |
| **Total:** | 115 | 436 | 551 | |

**Source: Wisconsin Hospital Association**

Additionally, it is important to note that the Michigan Medicaid Provider Manual Section 7 discusses Borderland Providers, or providers that are in a county contiguous to the Michigan border. These areas are covered by Michigan Medicaid, and include the relevant Wisconsin border counties of Florence, Iron, Marinette,Forest, and Villas, as well as the cities of Ashland, Green Bay, and Rhinelander. This availability of cross-border access is likely a major contributing factor to this trend.

## Geographical Factors

Although the Wisconsin border counties of Iron, Villas, Forest, Florence, and Marinette are equivalently rural to their Michigan counterparts of Gogebic, Ontonagon, Iron, Dickinson, and Menominee, they are not as equally isolated from population centers. Looking at the largest cities on the Michigan-Wisconsin border, Menominee and Marinette, paints a very clear picture of this distinction. A Michigan resident living in Menominee seeking inpatient healthcare for mental health or Substance Use Disorder (SUD) has two choices: travel two hours and fifteen minutes to Marquette or cross the river into Marinette and drive fifteen minutes to the nearest Wisconsin hospital with a licensed psychiatric bed. In fact, no matter which city on the Michigan border someone lives in, the closest Michigan hospital with a psychiatric bed is always at least twice the distance away as the closest Wisconsin hospital.

The isolation of Michigan cities on the border is also demonstrated by their proximity to the nearest industrial areas and the capitol. The table below shows this stark contrast:

| **City:** | **Distance to nearest Michigan Population Center (Marquette)** | **Distance to Michigan Capitol (Lansing)** | **Distance to Nearest Wisconsin Population Center (Green Bay)** | **Distance to Wisconsin Capitol (Madison)** |
|---|---:|---:|---:|---:|
| Menominee, MI | 2 hours, 15 minutes | 6 hours, 30 minutes | 1 hour | 3 hours |

## Infrastructural Factors

When compared to Wisconsin, Michigan's infrastructure is much more concentrated, especially within the Lower Peninsula. The waterway divide between the Upper and Lower Peninsulas of Michigan creates an interesting isolation for those in the UP, as it is not physically connected to the section of Michigan containing most of its major population centers and the capital. This has led to the number of beds per capita comparatively being misleading in Michigan's favor, as it does not discuss the distribution of beds across the full length of the state.

As an example, when we compare Michigan's total psychiatric beds per capita (33.8) with Wisconsin (15.5), one would come to the conclusion that Wisconsin is far behind in all areas.

However, when we look at this same figure and localize it to beds within one hour of the border, the gap swings in the other direction with Wisconsin having 3.5 beds per 100,000 and Michigan having none.

## Discussion

When considering solutions to these problems, the arbitrary nature of state borders becomes a significant issue. Inpatient healthcare for mental health and SUD is often of a critically urgent nature, and citizens being forced to make these decisions due to state border concerns is likely an added source of stress. Recipients of inpatient psychiatric and SUD care should be reassured that the state border is not a major barrier to receiving care, and that Medicaid provides coverage in those previously mentioned counties.

While the provisions within the Michigan Medicaid Provider Manual are likely to address this exact issue, it doesn't solve the problem entirely. During the initial onset of the Covid-19 crisis,

Wisconsin and Michigan both enacted emergency orders that allowed residents to seek telehealth from out-of-state providers. This was highly successful, and although a push was enacted in the Wisconsin legislature to update the regulations to the order to keep it enacted, it was shot down due to concerns of difficulty in malpractice claims across state borders (though that issue did not arise during covid-19). Improving telehealth in this way would improve Michigan's already impressive outpatient care for psychiatric health and SUD, thus reducing the need for as many inpatient beds through preventative care.

Increasing accountability of providers by creating networks that extend across state borders could help increase the amount of healthcare providers that hold dual licensure in both states, which would increase both the mobility of and access to the providers themselves, as well as make it easier to hold providers accountable for issues of malpractice.

## Conclusion

Michigan residents seeking healthcare out-of-state is a multifactorial issue with a complex interplay of geography, healthcare infrastructure, and state investments shaping these behaviors. Wisconsin's hospitals and major industrial centers' proximity to the border, combined with Michigan's declining rural populations, provides a compelling case for Michigan to reassess its investment strategies regarding inpatient psychiatric and SUD healthcare. By expanding access to local inpatient psychiatric care and substance use services, Michigan could continue to improve its outpatient services, reducing the need for residents to seek inpatient psychiatric and substance use healthcare in neighboring states, ultimately enhancing accessibility and outcomes in its rural communities.

For Michigan Medicaid providers of psychiatric and SUD health care services, including CMHA member organizations, the CMHA recommends the following:

1. Ensure recipients are aware of Medicaid's out-of-state/borderland providers to reassure them of their access to inpatient psychiatric and substance use healthcare services.
2. Increase efforts to promote more inpatient beds in Michigan border counties.
3. Continue to improve Michigan's outpatient psychiatric and SUD services to prevent the need for as many inpatient beds.

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*The Center for Healthcare Integration and Innovation (CHI$^2$) is the research and analysis office within the Community Mental Health Association of Michigan (CMHAM). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.*

*The Community Mental Health Association of Michigan (CMHA) is the state association representing Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at [www.cmham.org](http://www.cmham.org) or by calling (517) 374-6848.*