GMCB Public Comment

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Topic: UVMMC Enforcement Deliberations

Comment:

With respect to the UVMMC Enforcement deliberations, Member Walsh is to be applauded for resisting a perfunctory vote that ignores the historical dereliction of duty the state of VT has performed on behalf of it's mental illness population.

In UVMMC's possession are dollars the state of Vermont has deemed to be essentially – public goods. That they exist on UVMMC's balance sheet, commanding market rates for growth does not entitle it to retain these earnings, but instead, it is merely stewarding public goods which have yet to be realized in the form of increased access to inpatient psychiatric beds.

Public comment on the matter underscores well that the state should do more to provide well care upstream to prevent presentation at inpatient downstream for sick care. But member Walsh saliently underscores that even at 36 beds/100k the state of Vermont at 30/100k is woefully deficient, requiring at least 36 more beds. The rate of 36 beds/100k, however, assumes a robust presence of community based services. Such services are represented well by the Blueprint for Health and FQHC's performing integrated care in a PCMH model.

The direction of the board at this point should be twofold:

1. The prioritization of 36 new inpatient psychiatric beds downstream.
2. Utilizing the hospital and ACO budget processes to quickly and decisively expand community based mental health services upstream.

UVMMC claims a build cost/bed of $1mm and this was a pre-covid estimate endorsed by VT AHS. Protestations around inflation deny the reality that raw materials prices have returned to pre-Covid levels as tracked be Fed CPI data. While labor costs remain competitive, they certainly do not account for a 2-3x projected cost over similar builds across the country. A careful scan of current inpatient psychiatric builds demonstrates costs much closer to $300-500K/bed. If UVMMC was to allocate its $18mm + interest earned, at $500k/bed it could build an inpatient facility of 36 beds for $18mm.

This would be unusual for the AMC, however, because as has been underscored both by Rand and recently by UHC – UVMMC commands far greater reimbursement rates than any other AMC within 90 miles, thus their claim of $1mm/bed projected build. This is a function of GMCB historically not working more closely as a regulator after choosing a reform approach of collaboration rather than competition. Policy experts are very clear that such collaborative approaches risk monopolistic practices, and therefore require very granular regulatory participation.

At this time, GMCB, AHS and UVMMC must work closely and collaboratively together voting on statute that includes regulatory teeth to disburse the $18mm + interest in public goods sitting on the AMC's balance sheet since 2017. No imagination should be spared in canvassing available real estate stock, both extant and unbuilt to quickly deliver 36 desperately needed psych beds.

On the matter of upstream, community based well care GMCB would do well to take a much more granular look at the growing "Population Health Services Organization" (PHSO) UVMHN is building out. Its claims to many around the state is that its pouring millions into this PHSO and yet, I don't think a single member of this board or its staff could account for either the dollars spent or the outcomes of same. With UVMHN commanding nearly 2/3's of medical spending in VT, such a PHSO risks being duplicitous of the Blueprint for Health, FQHC PCMH's, its own ACO OneCare VT which claims it provides Complex Care Coordination services, as well as potentially its own MVP MA plan that normally includes care management services.

This budget season, the board would do well to decisively understand both he historical and projected spend for the PHSO and how it will complement the goal of reducing SUD, mental illness and particularly suicide prevalence rates which are growing at intolerable rates in VT, in excess of national averages. Moreover, these populations represent CMS quality score measures which through GMCB's ACO regulatory authority (currently its only ACO is 100% owned by UVMHN) must be again far more granularly collaborated around, with GMCB understanding clearly the value of analytics provided, their frequency and consistency of utilization and the evidence based insights they're providing to VT with cyclical QI cycles for which outcomes can then be measured and compared between HSA's and even practice level providers.

Anything short of this foregoing level or rigor risks a timely opportunity to correct VT's historically derelict role on behalf of its constituents struggling with SUD, MH, and suicide risk.