



## Reform (Footnotes)

<sup>1</sup> The Rhode Island Department of Health recently released a study that ranks states on a number of measures. To see this report, go to: [www.health.ri.gov](http://www.health.ri.gov).

<sup>2</sup> Federal law defines an IMD as a “hospital, nursing facility or other institution of more than 16 beds, which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” [42 U.S.C. 1396d(i)] Psychiatric units within general hospitals are not IMDs. Federal law prohibits states from providing Medicaid reimbursement to states for services provided to individuals over the age of 21 and under the age of 65. Vermont, as part of the 1115 VHAP waiver, has allowed payment for waiver-eligible adults to receive limited mental health services (up to 60 days per year). A new federal regulation, however, will eliminate all Medicaid payments to IMDs by CY 2006, regardless of state Medicaid waivers. (VSH Futures Report, pp. 2-3).

## Role of the State (Continued)

anticipated \$55 million Medicaid budget shortfall for FY06 and growing consumer needs, finding a balance in the coming year will be that much more difficult.

## Footnotes

<sup>1</sup> Vermont Health Care Expenditure Analysis Forecast : 2002-2006, Department of Banking, Insurance, Securities and Health Care Administration, p. 2 (December 2003)

<sup>2</sup> 2001 Vermont Health Care Expenditure Analysis, Department of Banking, Insurance, Securities and Health Care Administration, p.10 (December 2003)

<sup>3</sup> Id.

<sup>4</sup> Id.

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# Vermont Health Policy Perspectives

July 2004

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## WHAT PRICE FOR REFORM?

Just last year, the Vermont General Assembly passed Act 53, laying out an ambitious plan to assess our health care needs community by community and create a statewide “Health Resource Allocation Plan” (HRAP). In May, the legislature passed nineteen new health related studies, in addition to numerous measures that made incremental health policy changes. No doubt, this unprecedented focus on health care reform reflects growing concerns about rising health care costs and premium inflation.

Vermont’s health care worries are not unique. Concerns about rising health care costs, quality, and access continue to plague citizens and policymakers nationwide. Even though Vermont still ranks favorably on issues of efficiency, quality, and cost when compared to other states<sup>1</sup>, our system undoubtedly needs improvement.

To successfully re-engineer our health care system, we must understand the issues, align the system components and the stakeholders, and responsibly fund the solutions we agree upon. Without this alignment and leadership, our system will continue to flounder in a sea of disjointed initiatives, laws and reports.

We also must address the numerous sectors and services of the “health care system” one by one rather than en masse. One of them, mental health care, is a lens that can help us understand just how complex the notion of “health care reform” can be.

Last September, the federal government decertified the Vermont State Hospital (VSH). Since then, the administration and legislative focus on VSH and our entire mental health system has been constant – and rightly so. After the federal shake-up, ongoing investigations and a study, more questions than answers remain. As a member of one of the committees, the VSH Advisory Group, I am humbled by the magnitude of the changes needed and the process still ahead.

This year, the legislature established three committees: the Committee on Department of Developmental and Mental Health Services Designated Agency Provider System; the Vermont State Hospital Future Planning Advisory Group (designed to continue the work started by the VSH Advisory Group noted above); and the Mental Health Oversight Committee (a legislative committee that will meet to provide ongoing oversight and guidance when the legislature is not in session). In addition, the Department of Corrections must present a corrections mental health services plan to the Mental Health Oversight Committee no later than January 15, 2005.

Taken together, these committees and plans aim to rapidly create a strategy that will address both capacity and care concerns for the entire system. At the core of this effort remains the question of what to do with the VSH. The current thinking is to create two 16-bed “north & south” units. The 16-bed limit clearly intends to solve the pending loss of federal Medicaid funds for Institutes for Mental Disease (IMD),<sup>2</sup> but will it address the care needs of our aging population and the growing need for adolescent mental health services? The Brattleboro Retreat and five of Vermont’s acute care hospitals provide inpatient psychiatric services; but will their current capacity be enough if VSH’s current average census of about 50 patients is divided into two 16-bed units? In addition, how well do the community mental health centers, outpatient clinics and private offices meet patient needs throughout the state? How can providers and policymakers improve collaboration and patient flow between acute and community settings? Is there a need for additional mental health screening,

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- THE ROLE OF THE STATE IN HEALTH CARE: PAYER, REGULATOR, AND ADVOCATE





## THE ROLE OF THE STATE IN HEALTH CARE: PAYER, REGULATOR, AND ADVOCATE



*As we prepare for another round of political conversations on health care, it helps to have some perspective on the roles that the state of Vermont has carved out for itself on this front. In Vermont, state government plays three primary roles: payer, regulator, and patient advocate. Due largely to the Medicaid program, the role of payer has grown most dramatically in recent years. That role pressures the state to exercise its role as regulator to keep costs low. At the same time, as advocate of the public's health, it identifies health care problems that may incur additional costs.*

### State of Vermont as Health Care Payer

Total spending on health care in Vermont will likely reach over \$3 billion in 2004.<sup>1</sup> In 2001, the most recent year that actual numbers are available, Vermont health care cost \$2.5 billion.<sup>2</sup> The government sectors – state and federal – were the largest payers. Medicare, Medicaid, and other government programs accounted for \$1.2 billion, or 48% of the total.<sup>3</sup> Private payers such as commercial health insurance companies and employers paid 38% of the total bill, and consumers paying out-of-pocket picked up the remaining 14%.<sup>4</sup>

The state pays for health care primarily through the Medicaid program, funded approximately 40% by Vermont and 60% by the federal government. Medicaid makes payments to hospitals, nursing homes, physicians and other professional providers, and covers such services as developmental and mental health care, and home health care and personal services care. Vermont also pays for health care services outside of the Medicaid program, such as Adult Day Care and care provided at Vermont correctional facilities.

The state's role as payer has grown significantly over the past 20 years. The Medicaid program alone ballooned from \$96 million in 1984 to an estimated \$750 million in 2004. Many factors contributed to this growth, but key among them has been the expansion of both the types of services covered and the eligibility requirements. Examples of this expansion include:

- **Dr. Dynasaur:** Provides Medicaid coverage to children up to age 18 and to pregnant women who meet income guidelines

- **Vermont Health Access Plan (VHAP):** Provides health insurance to adults not covered by employer health plans and who can't afford insurance on their own.
- **Pharmacy coverage:** Programs such as VScript and VHAP Pharmacy provide prescription drug coverage to low-income, elderly, and disabled Vermonters.

### State of Vermont as Regulator

The State of Vermont actively regulates health care delivery, cost, and quality. The chief regulatory arm of the state is the Health Care Administration (HCA), located within the Department of Banking, Insurance, Securities & Health Care Administration (BISHCA). The State's primary regulatory roles include:

The **Certificate of Need (CON)** program establishes a process and a set of statutory criteria to guide the approval of new health care facilities and services in Vermont. The program seeks to ensure reasonable access to needed clinical services throughout the state without unnecessary service duplication while reviewing the cost, type, level, quality, and feasibility of new projects.

The **Health Resource Allocation Plan (HRAP)** is a four-year plan prepared by HCA and submitted to the Governor that identifies Vermont needs in health care services, the resources available to meet those needs, and the priorities for addressing those needs on a statewide basis. Established by Act 53 in 2003, the first plan is due on July 1, 2005.

HCA annually administers **binding budget review** of all Vermont hospitals in an effort to monitor and control increases in hospital costs.

HCA **collects and analyzes health and market data** to assist the Commissioner in identifying, evaluating and distributing resources as well as evaluating need, effectiveness, utilization, and cost.

The **Vermont Program for Quality in Health Care (VPQHC)** is a private non-profit organization that aids the state on quality issues. VPQHC seeks to determine that health care services rendered were professionally indicated and with the applicable standard of care.

### State of Vermont as Advocate

In the last decade, the state's role as regulator has placed greater emphasis on patient advocacy. Since 1996, HCA has examined key aspects of access to and delivery of health services on a yearly basis. The Vermont Legislature has adopted various other programs to expand the state's role as consumer protector:

- The **Health Care Ombudsman** helps consumers choose health insurance plans and provides information to consumers about their rights and responsibilities. The Ombudsman also provides information to the public, agencies, and legislators about problems facing health insurance consumers, and makes recommendations for resolving those concerns.
- **Mental Health Care Services Review** is provided by an independent panel that reviews decisions in which insured consumers are denied access to mental health treatment.
- Individual Vermonters have the right to **External Appeals:** an independent review of denial, reduction or termination of health coverage or payments when the insured has exhausted all applicable internal review procedures provided by the health benefit plan.

The state strives to provide what Vermonters want: affordable, accessible, responsible, high-quality health care. To address each aspect of the system, it must assume each of the three roles described above. Inevitably, conflict arises. With an

*(Role of the State continued on back cover)*



### Reform *(continued from front)*

care and diagnosis in primary care offices? These are just some of the questions that must be answered in short order.

As complex as these questions are, there is still the issue of alignment. (See Perspectives, April 2004 available at [www.vahhs.org](http://www.vahhs.org)) How will improvements to our mental health system comport with the Agency of Human Services re-organization that the legislature just approved? Will the HRAP provide additional guidance to mental health changes or will BISHCA and the HRAP Advisory Committee take mental health off their "to-do" list?

Last but not least remains the issue of funding. When all is said and done and a coordinated plan has been compiled for the various mental health sectors, there will be a price tag. Will the proposed changes be affordable? With an anticipated \$55 million Medicaid gap anticipated for FY 2006, I worry that any proposed improvements will remain "on the wall," leaving us with great effort, thoughtful studies, good plans and no implementation.

With Medicaid funding gaps, legislators have five basic short-term choices:

- They can raise taxes.
- They can cut existing benefits.
- They can raise eligibility thresholds.
- They can cut payments to providers.
- They can cut spending in other programs (e.g. education, transportation).

None of these choices are easy – but given the forecast of worsening deficits, I'm betting all five options will be in play next year. So how does one reconcile ambitious plans, such as those proposed for mental health care, with a \$55 million budget gap? The balance will not be easy and will require some painful re-allocation of resources.

I hope the HRAP and other studies will provide legislators with meaningful guidance as they face tough choices next year in an effort to improve our health care system. If not, then these time-consuming, expensive efforts will only serve to add more costs to an already unaffordable system.

*Mami B. Gramer*

*(Reform footnotes are located on back cover)*