PRIMMER PIPER EGGLESTON & CRAMER PC
Attorneys at Law

ANNE E. CRAMER
ADMITTED IN VT AND NH
acramer@primmer.com
TEL: 802-864-0880
FAX: 802-864-0328

March 3, 2017

VIA EMAIL AND FIRST CLASS MAIL
Judy Henkin, Esq., General Counsel
Green Mountain Care Board
89 Main Street
Montpelier, Vermont 05620

RE: Docket No. GMCB-010-15con, Proposed Ambulatory Surgery Center

Dear Judy:

Pursuant to Certificate of Need Rules 4.406(5)(c) and 4.407(2), the Vermont Association of Hospitals and Health Systems ("VAHHS"), as an interested party in the above-captioned Certificate of Need application, submits the enclosed Memorandum in Opposition to the Green Mountain Surgery Center Certificate of Need Application on Behalf of the Vermont Association of Hospitals and Health Systems. We believe the information in this Memorandum will assist the Green Mountain Care Board (the "Board") in determining whether to grant the Applicant's request for a CON. Also enclosed with this letter is a Verification Under Oath duly sworn by Jeffrey Tieman, President and Chief Executive Officer of VAHHS.

After the Board deems the above-captioned CON application complete, VAHHS asks the Board to convene a scheduling conference with all of the parties to this CON application in attendance by phone or in person. The purpose of this meeting would be to discuss the structure of the hearing, given the number of parties and potential witnesses, and to set when the hearing will be held. The opportunity for such a conference will enable all the parties and the Board to prepare for the public hearing and to facilitate a common understanding about the proceedings.

Thank you for your consideration.

Sincerely,

Anne Cramer, Esq.

Cc: Noel Hudson, Esq., Health Policy Director, Green Mountain Care Board
Donna Jerry, Senior Health Policy Analyst, Green Mountain Care Board
Lila Richardson, Esq., Office of the Health Care Advocate
Kaili Kuiper, Esq., Office of the Health Care Advocate
Eileen Elliott, Esq., Counsel for Applicant, Dunkiel Saunders
Drew Kervick, Esq., Counsel for Applicant, Dunkiel Saunders
Jill Berry Bowen, RN, Chief Executive Officer, Northwestern Medical Center
Jonathan Billings, Vice President, Planning and Community Relations, Northwestern Medical Center

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

IN RE:	)	
	)	
PROPOSED AMBULATORY SURGERY CENTER	)	**GMCB-010-15CON**
	)	

VERIFICATION UNDER OATH

Jeffrey Tieman, being duly sworn, states on oath as follows:

1. My name is Jeffrey Tieman. I am the President and Chief Executive Officer of the Vermont Association of Hospitals and Health Systems ("VAHHS"). I have reviewed the Memorandum in Opposition to the Green Mountain Surgery Center Certificate of Need Application on Behalf of the Vermont Association of Hospitals and Health Systems (the "Submission"), submitted herewith.

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in the Submission is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Submission is based upon either my actual knowledge of the subject information or upon information reasonably believed by me to be true and reliable and provided to me by the individuals identified below in paragraph 4. Each of these individuals has also certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact and does not omit to state a material fact.

4. The following individuals have provided information or documents to me in connection with the Submission and each individual has certified, based either upon his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the individual to be reliable, that the information or documents provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact:

   Michael Del Trecco, *Senior Vice President, Finance and Operations, VAHHS*
   Anne Cramer, *Attorney, Primmer Piper Eggleston and Cramer PC*
   Max Timm, *Assistant Vice President, Kaufman Hall*
   Walter Morrissey, *Managing Director, Kaufman Hall*
   Meg O'Donnell, *Director of Government Relations, Assistant General Counsel, UVM Medical Center*
   Christina Oliver, *Vice President, Clinical Services, UVM Medical Center*
   Jill Berry Bowen, *Chief Executive Officer, Northwestern Medical Center*

Jonathan Billings, *Vice President, Planning & Community Relations, Northwestern Medical Center*

5. In the event that the information contained in the Submission becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board and to supplement the Submission as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

Dated this 2 day of March, 2017.

Jeffrey Tieman, President and CEO
Vermont Association of Hospitals and Health Systems

On March 2, 2017, Jeffrey Tieman appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Notary public

My commission expires: 2/10/19

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

IN RE:	)	
	)	
PROPOSED AMBULATORY SURGERY CENTER	)	**GMCB-010-15CON**
	)	

MEMORANDUM IN OPPOSITION TO THE GREEN MOUNTAIN SURGERY CENTER CERTIFICATE OF NEED APPLICATION ON BEHALF OF THE VERMONT ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

The Vermont Association of Hospitals and Health Systems ("VAHHS"), on behalf of its sixteen member hospitals, submits the following memorandum in opposition to the application filed by ACTD, LLC d/b/a Green Mountain Surgery Center ("GMSC" or the "Applicant") for a Certificate of Need ("CON") to establish an ambulatory surgical center ("ASC") in Colchester, Vermont. Our opposition to the application, which is explained in more detail below, is premised on a number of factors:

- **Need.** This application does not demonstrate a "need" for new operating rooms or procedure rooms. The operating rooms ("OR") and procedure rooms ("PR") at both the University of Vermont ("UVM") Medical Center and Northwestern Medical Center have open times and the capacity to accommodate procedures for the foreseeable future.

- **Cost and duplication.** The GMSC will increase costs for the Vermont health care system and unnecessarily duplicate existing OR and PR capacity. The GMSC argues that its ASC would lower costs for their patients. That may be true for the subset of patients whose procedures can be done at the ASC. But building new ORs does not lower costs for Vermonters who need more complicated, higher-risk surgeries that have to be done at

places like UVM Medical Center. The ASC will not result in reduced costs, and the burden of those costs will fall to Vermonters in need of services not provided by the ASC.

- **Dependence.** The new ASC needs hospitals to be there for emergency and back-up care if complications arise, but they will not bear any of the costs associated with that back-up capacity.

- **Inconsistent with health care reform.** Vermont hospitals have been working closely with Vermont policymakers on key health care reform measures focused on moving from our existing fee-for-service system to one that aligns payment with desired health care outcomes. Our focus is on investments in prevention and community health to avoid unnecessary hospital stays and costly procedures. The for-profit ASC would be completely outside that transformation, as its financial success depends on maintaining the existing fee-for-service system and its attendant incentives.

- **Outside the regulatory structure.** The ASC would fall outside of most of Vermont's regulatory structures, like budget reviews, quality and serious medical error reporting requirements, and provider taxes.

- **Total costs will go up.** Building unneeded infrastructure will not control the health care system's costs, but will add to them. Those costs are ultimately paid for by all of us through increased public funding (Medicare and Medicaid) or through increased insurance premiums.

Vermont hospitals are committed to meaningful health care reforms that lower costs, provide universal coverage, and maintain access to doctors and hospitals. Our commitment is to

provide care to all Vermonters in need no matter what. The ASC is counter to Vermont's vision of reform and our goals because it is an unnecessary, unregulated, for-profit facility that could negatively impact access to care and drive up costs for Vermonters in need of critical health services.

Pursuant to the Green Mountain Care Board CON Rules, the Board is prohibited from granting a CON to a health care project that is inconsistent with the purposes and policies set forth in Chapter 221 of Title 18 of the Vermont Statutes Annotated and in 18 V.S.A. § 9372, or that does not meet the criteria set forth in 18 V.S.A. § 9437. *See* Green Mountain Care Board Certificate of Need Rule 4.402(1). Establishing an ambulatory surgery center in northwestern Vermont is inconsistent with the policies and purposes of these Vermont statutes. *See e.g.,* 18 V.S.A. § 9431 ("It is declared to be the public policy of this state that the general welfare and protection of the lives, health, and property of the people of this state require that all new health care projects be offered or developed in a manner which avoids unnecessary duplication and contains or reduces increases in the cost of delivering services…")

Further, on the merits, the application and subsequent filings by the Applicant fail to meet all of the statutory criteria required to obtain a CON under 18 V.S.A. § 9437. Critically, the application fails to provide evidence that there is an "identifiable, existing, or reasonably anticipated need" for an additional facility to provide outpatient surgery in northwestern Vermont as required by 18 V.S.A. § 9437(3). Also, the cost of the GMSC would be unreasonable because it would add the unnecessary expense of developing and maintaining unneeded OR and PR capacity, the cost of which is not outweighed by the application's suggested benefits to the health care system. 18 V.S.A. § 9437(2). Nor is the GMSC proposing to improve the quality of health care in the State or provide greater access to health care for

Vermont's residents as required by 18 V.S.A. § 9437(4). Lastly, granting this application will not serve the public good required by 18 V.S.A. § 9437(6), and as detailed in Green Mountain Care Board Certificate of Need Rule 4.402(3), because it will not help meet the needs of medically underserved groups, advance the goals of universal access to health services, further integration and coordination of health care services in northwestern Vermont, or advance Vermont's All-Payer ACO Model or other state and federal health care reform initiatives.

In addition, the GMSC will have an adverse impact on the ability of existing nonprofit hospitals to provide medically necessary services and address community health needs by diverting revenue and resources from them to a for-profit, physician investor owned facility.

The below information describes how Vermont law has been shaped to allocate health care resources to reduce or contain health care expenses, and to maximize fiscal resources to address the State's health care needs. Also set forth in this Memorandum are the ways the establishment of the GMSC is inconsistent with the policies and purposes set forth in Chapter 221 of Title 18 of the Vermont Statutes Annotated and 18 V.S.A. § 9372, and the reasons why this application fails to meet all of the mandatory CON criteria set forth in 18 V.S.A. § 9437.

Vermont CON Law, Hospital Budget Regulation and Provider Assessments

a. CON Law

Vermont has long chosen to pursue and maintain a highly regulated health care market. The certificate of need law was established in 1979 when federal capital funding was made available for building health care facilities subject to the review and approval of the project by a State health planning agency, among other requirements. Vermont's CON laws have from the inception promoted cost-containment through avoiding unnecessary spending:

> It is declared to be the public policy of this state that the general welfare and protection of the lives, health and property of the people of this state require that

> all new health projects be offered in a manner which avoids unnecessary duplication and contains or reduces increases in the cost of delivering services, while at the same time maintaining and improving the quality of and access to health care services, and promoting rational allocation of health care resources in the state.

18 V.S.A. § 9431.

State health planning documents, which have guided CON decisions for decades, have reflected this policy goal. Instead of promoting competition, these state health plans – the precursor to the current Health Resource Allocation Plan – have repeatedly promoted "the rational allocation of health resources" by focusing on the health care system as a whole. *See*, for example, the State Health Plan developed in 1990:

> The statute that sets out the requirements for the [State Health] Plan puts an emphasis on systems planning for health services and facilities, rather than for specific diseases or conditions.

Vt. Health Policy Council, State Health Plan 1990-1993, at 1 (1990).

Similarly, in the Health Resource Allocation Plans adopted in 2005 and 2009, State and health care leaders continued to recognize that the small and rural nature of Vermont make it difficult to sustain a free health care market in Vermont. Vermont Department of Health, "Vermont State Health Resource Allocation Plan", 6-7 (July, 2009) *citing* Vermont Department of Health, "Vermont State Health Resource Allocation Plan", 27 (August, 2005). Absent regulation, health care resources would likely be concentrated in the more urban areas of the State where there is the most demand, leaving rural areas without necessary services and threatening patient care.

Overall, the effect of Vermont's CON laws over the past forty years has been to deter and reduce competition among health care facilities in the State and to guarantee Vermonters access to health care facilities throughout the State.

Although the Applicant has submitted substantial argument and materials touting the benefits of competition and the convenience of surgery at an ambulatory care center, Vermont has deliberately chosen to maintain its intensive CON review of all significant health facility capital expenditures and new services and has not encouraged the establishment of ASCs, regardless of trends in other states. As noted in the Certificate of Need Guidelines published by the Health Care Administration of the Department of Banking Insurance Securities and Health Care Administration ("BISHCA") in March 15, 1999,

> Although ambulatory surgical centers increase convenience for some patients [...], the centers raise concerns about the potential for stimulating unnecessary demand, reducing the efficiency of the existing system, and adding risk management concerns when cases have complications. It is also important to point out that hospital-based surgical services need to be retained and locally accessible for more complex cases and for 24-hour service so that having an ASC in an area instead of a hospital-based service is not a realistic option. As a result, the potential for adding new costs to the existing system by the establishment of an ASC are quite high.

Vt. Dept. of Banking, Insurance, Securities and Health Care Administration, *CON Guidelines, Ambulatory Surgical Center Guideline, Policy Issues*, at 9 (March 15, 1999).

Vermont's CON laws have been explicitly designed to reduce duplication of services and capital investments. *See e.g.*, Vermont Department of Health, "Vermont State Health Resource Allocation Plan", xxxiv (August, 2005) ("Principle 6. Equity...Subprinciple 6(B). Vermont should ensure that resource allocation decisions are based on principles of population-based need in order to achieve cost-effective and high quality health facility operations...") On balance, they have worked well and allowed Vermont to maintain a strong health care system. There is little to no duplication of acute care services due to very well defined hospital service areas with limited overlap. At the same time, patients have access to care even in rural areas. The CON laws have required rigorous and transparent planning resulting in high-quality services, good

access and comparatively lower health care costs. VAHHS and its members agree that growth in health costs must be contained. Allowing more competition is not a solution to containing or limiting system-wide costs, however. Instead, in an effort to contain costs, our State has maintained and strengthened a robust CON review program, has embraced strict hospital budget regulations and has embarked on initiatives focusing on population health and provider payment reform culminating in the 2016 Vermont All-Payer ACO Model Agreement between the State of Vermont and the Centers for Medicare and Medicaid Services ("CMS").

b. Hospital Budget Regulation

Soon after the enactment of the Certificate of Need law, in 1983, the legislature established a hospital budget review structure to oversee hospital expenditures. It began as a nonbinding public review process that evolved into the current review and "establishment" of each hospital's budget by the Green Mountain Care Board ("GMCB" or the "Board") under 18 V.S.A. § 9456. The Board now annually sets key parameters for the hospitals to meet – including setting a system-wide net patient revenue ("NPR") growth cap, which in FY 2017 was 3% over prior year's budget, prior to adjustments.

Vermont's hospital budget law and state policy favor providers working together as a system, not as competitors, to contain and reduce health care expenditure state-wide. Hospitals are encouraged to engage in health reform work and to collaborate to create a "system of care" that shifts expenditures away from acute care services to primary care and Blueprint initiatives. Further, as part of the hospital budget review process, hospitals submit Community Health Needs Assessments, which are required by federal law for 501(c)(3) hospitals, to demonstrate how they plan to prioritize expenditures to address community health needs and invest in population health improvement.

Prior to June 30 each year, hospitals submit extensive budget information, including utilization information, prior period budget performance, financial indicators, staffing needs, capital expenditure needs, and budget operating surplus to the Board. The Health Care Advocate and the public submit comments on proposed budgets for the Board's review. The Board may also compare a hospital's key indicators with its Vermont, regional and national peers. The Board reviews and establishes each hospital's average overall rate increase in order to stay within an allowed net patient revenue increase for the fiscal year as set forth in the Board's Hospital Budget Order. Hospitals then file monthly actual year-to-date operating result reports and information on the rate of return realized on each approved investment in a health care reform initiative. Any material changes to the fiscal year revenue, expenses or assumptions used in determining its budget, must be reported to the Board. As a result, there is enormous transparency and accountability to the public regarding hospital revenue and expenditures.

Unlike hospitals, ambulatory surgery centers are not subject to any annual budget reporting review or required cost containment efforts. The proposed ASC's budget, rates and actual operating expenditures will not be subject to public review and Board approval.

c. Provider Assessments

In the early 1990s, the legislature established the Health Care Improvement Program which imposes an assessment, or tax, on hospitals (as well as on certain other health care providers, but not on independent physicians) for the express purpose of attracting additional federal financial participation in the State's health care program. 33 V.S.A. § 1950. Currently, hospitals pay an annual 6% assessment on net patient revenues. 33 V.S.A. § 1953(a)(i). This assessment revenue for State fiscal year 2016 has been estimated at $129,647,755 as noted in the Vermont Agency of Human Services Department of Vermont Health Access Budget Document

for State Fiscal Year 2017, at page 119. Each dollar of this funding is provided to the State Health Care Resources Fund where it is matched at an FMAP rate of $1.20. Vt. Agency of Human Services, Dept. of Vt. Health Access, *Budget Document for State Fiscal Year 2017*, at 119 (2016). Consequently, after this match, the hospital assessment revenue for FY 2016 will provide the State Health Care Resources Fund approximately $285 million in funding. *Id.* It should be noted that for every $10 million of health care expenditure that is removed from hospital net patient revenue, about $600,000 in hospital tax is lost, resulting in a loss of $1,320,000 in total revenue to the State Health Care Resources Fund. *Id.*

Ambulatory surgery centers are not subject to any State assessment to support the State's medical assistance programs.

d. Licensure

VAHHS member hospitals are licensed by the State Board of Health pursuant to 18 V.S.A. Chapter 43. Hospitals are also required to report adverse patient events to the Department of Health and to notify the Department of any intentional unsafe acts. 18 V.S.A. § 1915-1916.

The State of Vermont does not license ambulatory surgical centers, and there are no State laws or regulations requiring ASCs to make any adverse patient event reports to the Department of Health, like hospitals are required to do. The Applicant has indicated that it will be regulated by and report free care, charity care and total patient revenues to Vermont's Agency of Human Services Department of Disabilities, Aging and Independent Living ("DAIL"). We are aware that DAIL's Survey and Certifications Unit, pursuant to federal authority, regulates ASCs in accordance with federal regulations. DAIL does not, however, request or receive reports on free care, charity care or patient revenues. *See* Letter from Suzanne Leavitt, Director State Survey

Agency and Assistant Division Director, Vermont Department of Disabilities, Aging and Independent Living to Donna Jerry at the Green Mountain Care Board (February 24, 2017) (on file with the Green Mountain Care Board).

There is No Need for Additional Operating and Procedure Rooms in Northwestern Vermont

VAHHS members, with the exception of the White River Junction VA Medical Center, are nonprofit hospitals whose missions are focused on delivering high quality care to their communities while ensuring continued accessibility and availability to all individuals. Thirteen of the VAHHS member hospitals, spread out in eleven of Vermont's fourteen counties, maintain operating rooms available on a 24/7 basis. In response to questions asked by the GMCB by letter dated April 5, 2016, the five hospitals located in northwestern Vermont – Northwestern Medical Center, Central Vermont Medical Center, UVM Medical Center, Copley Hospital, and Porter Medical Center – submitted information on the number, capacity and utilization volume of their ORs and PRs. Response of Vermont Association of Hospital and Health Systems to the Green Mountain Care Board's Request for Information (May 6, 2016). The information filed last spring shows that each of the five hospitals currently has substantial excess staffed capacity and the ability to extend hours to increase staffed capacity. *Id.* For example, both the UVM Medical Center and Northwestern Medical Center can open ORs and PRs on Saturday and Sunday to accommodate an increase in demand, and can expand OR and PR hours during the week. *Id.*

VAHHS engaged KaufmanHall ("KH"), a national consulting firm with substantial expertise in healthcare resource allocation assessment, to analyze the operating and procedure room capacity in northwestern Vermont and assess if there is a need for more capacity over the next twenty years. Its report, attached hereto in PowerPoint format as Exhibit 1, shows that the

Vermont health care system currently has plenty of OR capacity. KaufmanHall, "The Green Mountain Surgery Center (GMSC): Need Assessment" (March 1, 2017) at Exhibit 1. The report also indicates that current OR capacity will be sufficient for the next twenty years, given how slowly the population of northwestern Vermont is growing. *Id.* at 8, 20. A 2016 analysis based on data from the 2010 Census projects a population growth rate in Chittenden County of less than 0.5%, resulting in Chittenden County's population being less than 180,000 by 2035. *Id.* at 12. In contrast, GMSC's utilization projections are based on an outdated 2000 census that overestimates population growth by 35%, projecting Chittenden County's population to exceed 250,000 by 2035. *Id.* Hospital data shows that the current median utilization rate (used operating room minutes compared to available operating room minutes) of ORs in those five northwestern Vermont hospitals – Copley Hospital, Porter Medical Center, Central Vermont Medical Center, UVM Medical Center (Main and Fanny Allen Campuses), and Northwestern Medical Center – is only 66% while the national benchmark median utilization rate is 75%. *Id.* at 22. None of the hospitals other than the UVM Medical Center even approaches this 75% utilization rate. Northwestern Medical Center, located only about twenty miles from the proposed GMSC location, is currently operating at a 43% utilization rate. *Id.* at 22. Kaufman Hall concluded from this analysis that there is sufficient OR and PR capacity to accommodate the population that the GMSC is seeking to serve for at least the next twenty years. *Id.* at 20.

The Applicant has taken the position in its CON application and responses to the Board that "the need the GMSC would fill is offering to Vermonters...the option to have certain surgical procedures performed at a location that is not a hospital." Response of ACTD LLC to Green Mountain Care Board's Request for Additional Information (Q003), 8 (July 15, 2016). The intent of the CON laws was to avoid unnecessary duplication of services. *See* 18 V.S.A. §

9431. As a result, an "identifiable, existing or reasonably anticipated need" does not include a patient's desire to obtain, or a provider's desire to provide, a service outside of a hospital outpatient operating or procedure room setting when there is plenty of hospital outpatient surgery and procedure room capacity. This "need" criterion is further framed in terms of better quality or enhanced access. *See* 18 V.S.A. § 9437(3)-(4). CON laws were never intended to allow one facility to duplicate the same procedures and services available at another facility in order to provide a competing service site.

"Wait Time"

The five northwestern Vermont hospitals were also asked by the GMCB in its April 5, 2016 letter to provide information on "wait time." VAHHS's members are unaware of any industry standard regarding wait times for surgery or for specific procedures. (For instance, who determines what the starting event for calculating a wait time is?) As presented in the May 6, 2016 responses, the timing of surgery procedures is a function of numerous factors apart from the availability of operating room facilities and staff, including:

- Patient availability and preference;
- Insurance approval;
- Pre-operative procedures;
- Medically necessary patient preparation; and
- The surgeon's work schedule and availability.

Response of Vermont Association of Hospital and Health Systems to Green Mountain Care Board's Request for Information (May 6, 2016).

The Applicant reports a range of procedure wait times in its July 15, 2016 Responses to Questions posed on February 10, 2016 that were reported by physicians performing these

procedures. Response of ACTD LLC to Green Mountain Care Board's Request for Additional Information (Q003), 10 (July 15, 2016). The Applicant did not, however, provide any basis for how the above variables affected those wait times. The Applicant also references a Burlington Free Press Article by Dan D'Ambrosio, which it attaches as Exhibit 5 to its January 25, 2017 Responses to 006 Questions. Response of ACTD LLC to Green Mountain Care Board's Request for Additional Information (Q006), Exhibit 5 (January 25, 2017). But that article is predominantly focused on the wait times for a patient to get an appointment to see a provider in certain medical specialties, which is very different than the variables involved with a physician scheduling a surgery or procedure. The Applicant's claim of long wait times does not account for variables controlled by the physician or by the personal needs of the patient in preparing for the procedure.

The five northwestern Vermont hospitals work closely with all physicians, independent and employed, who have hospital medical privileges to arrange the OR and PR schedules using "block time" reservations with open times for scheduling urgent or additional cases. The hospitals are constantly monitoring the use of their ORs and PRs and adjusting as needed to best accommodate patient demand and physician schedules. All of the hospitals report that operating rooms and staff are made available for patients needing emergency and urgent care.

UVM Medical Center, with seventeen ORs on its main campus and an additional five ORs on its Fanny Allen Campus, has a committee, the OR Operating Committee, that receives requests for block times and works with the providers to reserve the blocks. Both UVM Medical Center-employed and independent community physicians are members of the OR Operating Committee and participate in this scheduling process. UVM Medical Center has dedicated one of the seventeen operating rooms exclusively to handling urgent and emergent cases. The room

is fully staffed but it is not scheduled in block times reserved by physicians. Rather, urgent or emergent cases and cases that might otherwise be delayed as a result of a scheduled prior surgery exceeding its allotted time can be addressed in this dedicated OR. This obviates the need to "bump" a patient in a scheduled block in one of the other sixteen ORs.

The UVM Medical Center OR Operating Committee consistently monitors use of the block times and providers' releases of reserved block time. This regular evaluation was implemented five years ago to ensure that UVM Medical Center is a good steward of OR and PR resources, allocating hospital funds and staff time in accordance with need. For example, if a provider is regularly using less than 65% of the reserved block time – indicating a lack of need – this time will be reallocated (after a three-month and six-month notification to the provider) to another provider who is either newly requesting time or who needs additional time as demonstrated by volume of procedures performed. If, through these consistent assessments, UVM Medical Center were to become aware of regular backlogs or delays (*e.g.*, block times were regularly scheduled at greater than 80% or there was a lack of open time in the schedules for additional cases), the hospital could expand capacity by extending its weekday hours or opening on Saturdays and Sundays.

Providers are also made aware of the shifts in schedules in demands. The hospital sends an open time report out daily by email to credentialed surgeons with the current OR schedule for the month showing all the blocks of time "released" by other surgeons and the open operating times. This allows doctors to schedule patients in blocks or open times who cannot be treated during reserved block times.

The hospitals are very thorough in their monitoring of use and demands for their ORs and PRs in order to operate them as efficiently and cost effectively as possible while delivering high quality care on a 24/7 basis.

Excess, Unneeded Capacity Will Increase Cost

By creating excess outpatient surgery capacity in the Vermont health care system, the GMSC will drive up overall health care costs, making it more expensive in the aggregate and more difficult for the medically-underserved to access health care. As the KaufmanHall report concludes, adding two more operating rooms and four more procedure rooms to Chittenden County will result in an oversupply of operating room space in the area. KaufmanHall, "The Green Mountain Surgery Center (GMSC): Need Assessment", 8 (March 1, 2017) at Exhibit 1.

Should this CON application be granted, the costs associated with the construction and operation of the proposed new ORs and PRs will be collectively borne by all of us who pay for health care in Vermont: taxpayers who support Medicare and Medicaid, businesses and individuals who pay insurance premiums, and individuals who pay out-of-pocket costs. The individuals who are served by the new ASC might pay a bit less for the services they receive there, but hospitals will not avoid any costs. They will still need to generate the revenues necessary to provide the full range of services. That means that people who do not have "the option" to get services outside of the hospital are likely to pay proportionately more for those services. That is precisely the type of consequence that Vermont's CON laws were designed to avoid.

Nor will excess OR capacity help to resolve pressing community health issues, because when hospitals lose system-supporting revenue, it is harder for them to address community needs, let alone pay for services that are not fully funded, such as obstetrics or mental health.

In fact, creating excess capacity will drive increased utilization without a corresponding increase in patient satisfaction or quality. The State highlights in the 2009 Health Resources Allocation Plan that more health care delivery capacity leads to the delivery of more services, without improved outcomes for patients. *State of Vermont Health Resource Allocation Plan*, pg. 9 (July 1, 2009) *citing* D.C. Goodman, et al., "Hospital and Physician Capacity Update," *Dartmouth Atlas of Health Care* (March 30, 2009) *see also* "Hospital and Physician Capacity", *Dartmouth Atlas of Health Care*, at: http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=24 (last visited on February 23, 2017). This supports the proposition that by adding unnecessary outpatient surgical capacity in northwestern Vermont, the GMSC could drive up utilization. The fee-for-service payment structure and the for-profit status of the proposed ASC are strong financial incentives for the GMSC providers, particularly the investors, to increase utilization. The ASC will operate without accountability, as it is not subject to annual budget review by the Board, and it will be outside of the Board's jurisdiction to contain costs.

Further, hospitals subsidize ASCs. The GMSC states in its application that it will rely on UVM Medical Center to provide emergency and inpatient treatment to GMSC patients as need arises. *ACTD, LLC Certificate of Need Application*, Docket No. GMCB-010-15con, pg. 55 (July 2, 2015). The GMSC also states that it will rely on 911 services for emergency transportation. *Id.*, at 56. That hospital and emergency backup is essential. An ASC cannot operate without hospital emergency and inpatient services, but ASCs do not pay for the overhead inherent in that service. Nor does an ASC pay for the emergency transportation to the hospital for its patients. Thus, in a very direct way, hospitals – here, all non-profit entities – subsidize the operations of ASCs, which are primarily proprietary or for profit. *See* Spitz, Bruce and Boyd Collman, "Analysis of the Impact of an Ambulatory Surgical Center on the Health Care Delivery System

in Vermont," *Final Report to Vermont Department of Banking Insurance, Securities and Health Care Administration*, 1-3, 5-11 (May 10, 2002).

The proposed GMSC also ignores its potential direct negative impact on hospitals outside of Chittenden County, such as Northwestern Medical Center (an Interested Party in this matter), where any material loss of surgery cases will affect their ability to pay for existing infrastructure and community health services. Revenue from outpatient surgery at a nonprofit hospital is used to defray the cost of services in programs where reimbursement does not cover overhead, such as mental health and substance abuse treatment and primary care. The proposed ambulatory surgical center will siphon cases from the surrounding hospitals. As set forth in Northwestern Medical Center's submission, dated March 3, 2017, the Vermont Eye Surgery and Laser Center ("VESLC"), which opened in 2008, drew more than 600 patients away from it over the course of an 18-month period between November, 2012 and May, 2014. See Northwestern Medical Center, *Memorandum in Opposition to the Green Mountain Surgery Center Certificate of Need Application* (March 3, 2017) (on file with the Green Mountain Care Board), *and* Vermont Eye Surgery and Laser Center Implementation Reports, 2012-2014 (May, 2014) (on file with the Green Mountain Care Board). That had a material impact on Northwestern Medical Center's revenues, which are used to support the broad range of services it offers in its community. By contrast, the Applicant will focus its services on healthy patients who are primarily classified as ASA I and II. Response of ACTD LLC to Green Mountain Care Board's Request for Additional Information (Q006), 8 (January 25, 2017). A loss of elective outpatient surgery and procedure patients to the proposed ASC, similar to the loss Northwestern Medical Center experienced with the VESLC, reduces Northwestern Medical Center's ability to provide these essential community services and invest in community health programs. *See* Northwestern Medical Center,

Memorandum in Opposition to the Green Mountain Surgery Center Certificate of Need Application (March 3, 2017) (on file with the Green Mountain Care Board).

The Proposed ASC Will Not Improve Quality or Access

The mandatory criteria for the issuance of a CON include the requirement that "the project will *improve* the quality of health care in the State or provide *greater* access to health care for Vermont's residents, or both." 18 V.S.A. § 9437(4) (emphasis added). The Applicant is not proposing to provide services that would improve the quality of health care in the State – it is simply seeking to offer services outside of a hospital setting. The supposed convenience offered by the GMSC does not equate to improving the quality of health care. Nor will the GMSC provide Vermonters with greater access to care. The GMSC is not proposing to provide services to individuals who cannot access the health care system. It will be located in Chittenden County, an already well-served area. The proposed location of the GMSC is within fifteen minutes of both UVM Medical Center campuses and within fifty minutes of four other hospitals with outpatient surgery facilities. Chittenden County is so well served that 20% of UVM Medical Center's ambulatory surgical volume comes from outside the county, while only 2% of Chittenden County residents "out-migrate" to other counties for ambulatory surgical care. KaufmanHall, "The Green Mountain Surgery Center (GMSC): Need Assessment", 10 (March 1, 2017) at Exhibit 1.

An Independent Fee-for-Service, Investor-Owned ASC in Northwestern Vermont Does Not Serve the Public Good

Rule 4.402 of the GMCB CON Rule sets forth the following factors for the Board to consider in determining if a CON application will serve the public good, as required by 18 V.S.A. § 9437(6):

(a) Whether the project will help meet the needs of medically underserved groups and the goals of universal access to health services.

(b) Whether the project will help facilitate the implementation of the Blueprint.

(c) Whether the Applicant has demonstrated it has analyzed the impact of the project on the Vermont health care system and the project furthers effective integration and coordination of health services.

(d) Whether the project is consistent with current health care reform initiatives at the state and federal level.

(e) [Non-applicable]

(f) Whether, and if so to what extent, the project will have an adverse impact on the ability of existing facilities to provide medically necessary services to all in need, regardless of ability to pay or location of residence.

18 V.S.A. § 9437(6).

As noted above, the Applicant will not provide improved access to care or help meet the needs of medically-underserved groups. The ASC is not oriented to facilitating the Blueprint initiative or integrating with the regional health system. Nor will an ambulatory surgery center contribute to meeting the goals of universal access to health services. The GMSC will actually be detrimental to health care reform efforts.

Vermont is in the midst of a bold health reform initiative that is moving in the opposite direction of what the GMSC proposes to establish: a for-profit, fee-for-service ambulatory service center. In addition to a decades-long history of regulating Vermont's health care system so as to reduce or eliminate the unnecessary duplication of services (and the resultant unnecessary costs), policymakers in Vermont have been working for several years to develop

payment models that transform how health care is delivered in the State. That includes an emphasis on moving away from the fee-for-service reimbursement model that has for decades dominated American health care. That model has been repeatedly recognized by policymakers across the country as a major factor in the exponential growth in health care costs.

Act 48, which established the Green Mountain Care Board in 2011, tasked the Board with developing and implementing payment and delivery system reforms to control the rate of growth in health care costs while maintaining or improving health care quality. Act 48 then defined "payment reform" as including "modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals." Act 48 (2011), § 3 (codified at 8 V.S.A. § 9373(12)).

The Legislature has also explicitly acknowledged the potentially perverse incentives of fee-for-service payment models on health care costs. Act 54, passed in 2015, directed the GMCB to consider "the benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service models." Act 54 (2015), § 23(a)(1). While that law focused on primary care, one can infer that the negative consequences of fee-for-service payments would be even greater for specialty-care services, which are typically paid at a much higher rate than primary care services.

The GMCB itself pointed to fee-for-service payments as a "significant driver" of health care spending growth as recently as last October, when it included the following statement in its written explanation of its vote to sign the All-Payer ACO Model Agreement:

> The fee-for-service reimbursement model, which compensates health care providers and facilities for each health care service and care component delivered, is the most prevalent form of provider compensation in our country today, yet is widely recognized as a significant driver of health care spending growth. By creating incentives for the health care system to perform a high volume of health care services, fee-for-service reimbursement does not compensate providers for

> important time spent coordinating care with other providers or community services, sending e-mails, making phone calls, or talking with patients and their families about factors that may be negatively impacting a patient's health status. The fee-for-service model rewards the quantity of work done, not its quality; it does not incentivize providers based on improved health care outcomes.

In re Vermont All-Payer Accountable Care Organization Model Agreement, Green Mountain Care Board, 1-2 (Oct. 31, 2016) (citation omitted, emphasis added).

In short, the GMSC's proposed new ambulatory surgery center is inconsistent with the stated direction of health care reform in Vermont, as it would perpetuate – rather than shift away from – a reimbursement model that rewards the quantity of services delivered, not the quality. The GMSC's fee-for-service payment structure will be an impediment to achieving the State's health care payment reform goals. The Applicant acknowledges that "overutilization" is an "unfortunate side-effect" of its fee-for-service payment structure. Once granted a Certificate of Need, however, the GMSC will have no incentive to move away from fee-for-service payments toward longer-term payment reform efforts that are designed to contain costs.

The Applicant fails to demonstrate that the proposed ambulatory surgery center will serve the public good, a required CON criterion. Establishing an independent ASC is, in fact, contrary to the public good as it is a for-profit corporation that depends on a fee-for-service payment structure, will be unlicensed, will operate outside the GMCB's jurisdiction, and will duplicate the existing resources of nonprofit hospitals while diverting revenue from them. And because the GMCB lacks authority to oversee ASCs' budgets, it will have no ability to reign in GMSC's potential excesses, as it does with hospitals.

Conclusion

The GMSC has failed to demonstrate that an additional surgery facility is needed in northwestern Vermont, that its cost to the Vermont health system is reasonable, that it will improve quality or provide greater access to health services than currently available, or that it

will serve the public good. 18 V.S.A. § 9437. Further, the establishment of the GMSC is not consistent with the statutory policies and purposes set forth in 18 V.S.A. § 9372 and Chapter 221 of Title 18 of the Vermont Statutes. Green Mountain Care Board Certificate of Need Rule 4.4.02. Because the CON law's requirements have not been met, its Application must be denied.

Dated in Montpelier, Vermont this 2 day of March, 2017.

By: _____

Jeffrey Tieman, President and CEO
Vermont Association of Hospitals and Health Systems
148 Main Street
Montpelier, Vermont 05602

Exhibit 1

KaufmanHall

The Green Mountain Surgery Center (GMSC):
Need Assessment

Vermont Association of
Hospitals and Health Systems

March 1, 2017

Table of Contents

1 Background

Regional OR Performance and Supply/Demand Analytics Are Subject to Varying Market Definitions

Chittenden County

Counties included:
- Chittenden

Burlington MSA

Counties included:
- Chittenden
- Franklin
- Grand Isle

NW Vermont

Counties included:
- Chittenden
- Franklin
- Grand Isle
- Addison
- Lamoille
- Washington

★ **The Green Mountain Surgery Center Proposed Location**

Green Mountain Surgery Center (GMSC) CON Application Overview

GMSC Proposed Location

Source: GMSC CON Application

Key Figures

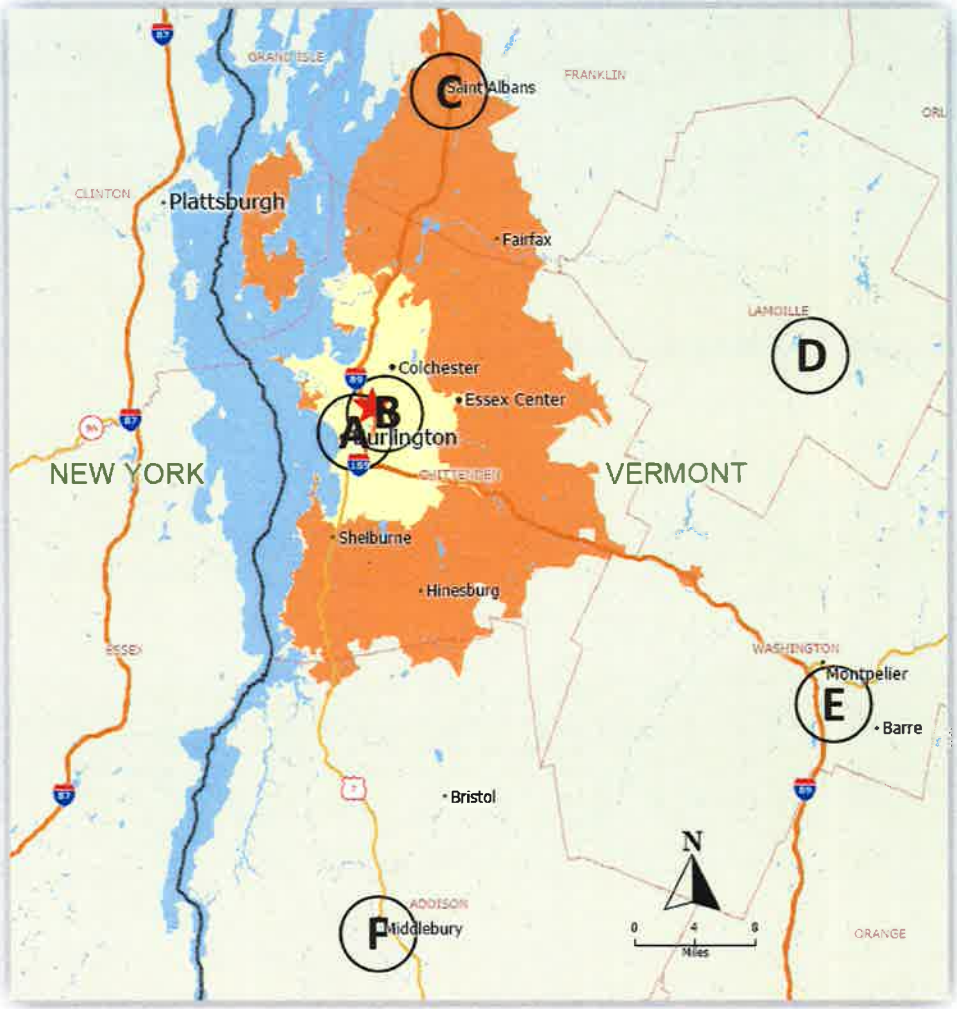
12.8K	Building size, in square feet
$1.6M	Construction budget for interior outfitting
2	Number of operating rooms
4	Number of procedure rooms
14	Number of pre-/post-operative beds

Key Facts

- **Owner / Operator:** ACTD, LLC
- **Initial service lines:** Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, and Pain Medicine
- **Primary service area:** Chittenden County
- **Operating hours:** M-F from 6am to 5pm

The Proposed GMSC is Located 50 Minutes (or Less) Away From 5 Other Outpatient Surgery Facilities

Drive Time Accessibility to Proposed ASC



Drive Time Commute to GMSC from…

• Colchester	10 minutes
• Burlington	15 minutes
• Saint Albans	30 minutes
• Montpelier	40 minutes
• Middlebury	50 minutes
• Morrisville	50 minutes

A, B — University of Vermont Medical Center

E — University of Vermont Health Network Central Vermont Medical Center

C — NMC Northwestern Medical Center

F — Porter Medical Center, Inc.

D — Copley Hospital

★ Proposed GMSC Location

Drive Time Commute to Proposed GMSC Location

15 min. or less

15 min. to 30 min.

Sources: Calipers Maptitude software, 2015 and Google Maps

2 | Summary of Findings

Summary of Findings

- The construction of two additional operating rooms in Chittenden County would result in an oversupply of OR space in the market in the near term, which would lead to an increase in price for all other service lines to cover potential losses
- The cost implications of an oversupply of OR space across the local healthcare economy contradicts a movement toward value-based care
- Current OR supply can meet the demand generated in NW Vermont for the next 20 years
- Chittenden County is well served by outpatient, ambulatory surgery facilities evidenced by the fact that 20% of the University of Vermont Medical Center (UVMMC) ambulatory surgical volume comes from outside the county while only 2% of Chittenden County residents "out-migrate" to other counties for ambulatory surgical care
- Technological innovation and changing practice patterns could limit the need for operating room or procedure room space for some service lines identified by GMSC
  - Example: Alternative options in lieu of screening colonoscopies that do not require an operating room or procedure room setting

3 | Market Overview

Market Overview | Key Points

A. Population Growth Trends (Chittenden County)

- Chittenden County's population is expected to grow 0.5% annually; annual population growth rates used in GMSC's application are nearly 3x greater

B. Surgical Demand Trends (Vermont)

- Inpatient surgical usage rates in Vermont have decreased over time while outpatient surgical usage rates in Vermont have increased over time
- Surgical demand aligns with surgical usage rate trends, due to relatively stagnant population growth statewide

C. Surgical Demand Migration Trends

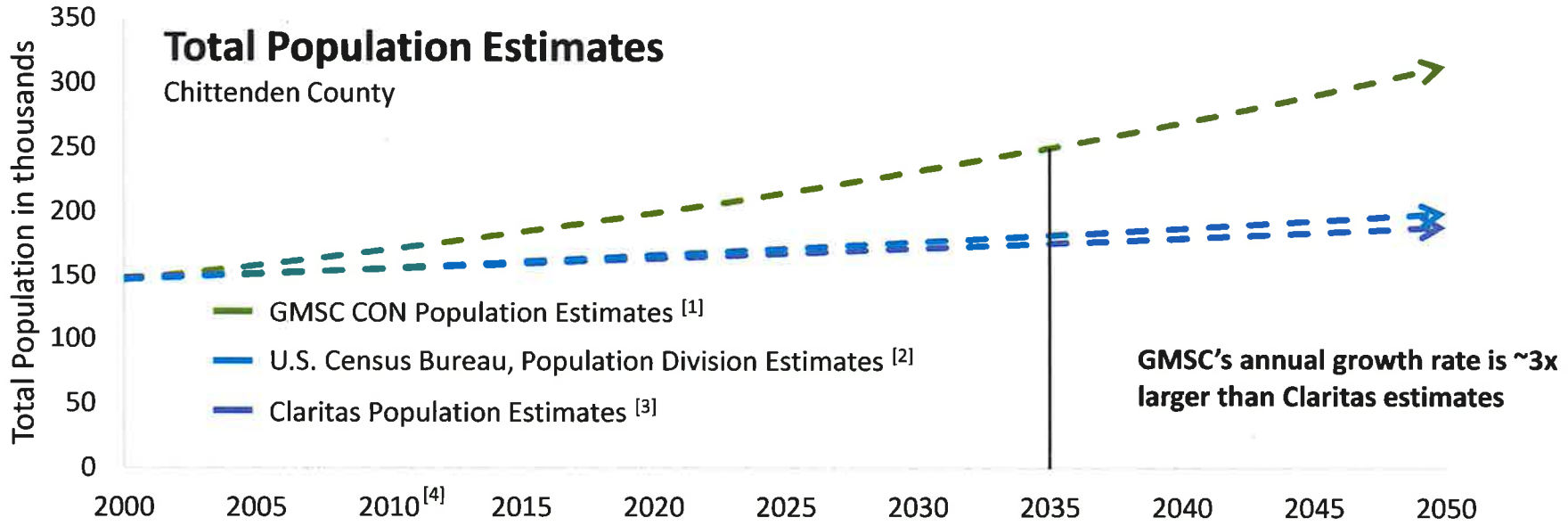
- UVMMC campuses in Chittenden County receive a substantial amount of their outpatient surgical volume (~20%) from outside the Burlington metro area[1], while only 2% of Chittenden County residents "out-migrate" to other counties for ambulatory surgical care

Note: [1] Burlington Metropolitan Statistical Area (MSA) is defined as Chittenden County, Franklin County, and Grand Isle County

A. Population Growth Trends

Chittenden County

The GMSC CON Utilizes Aggressive Population Estimates for Chittenden County

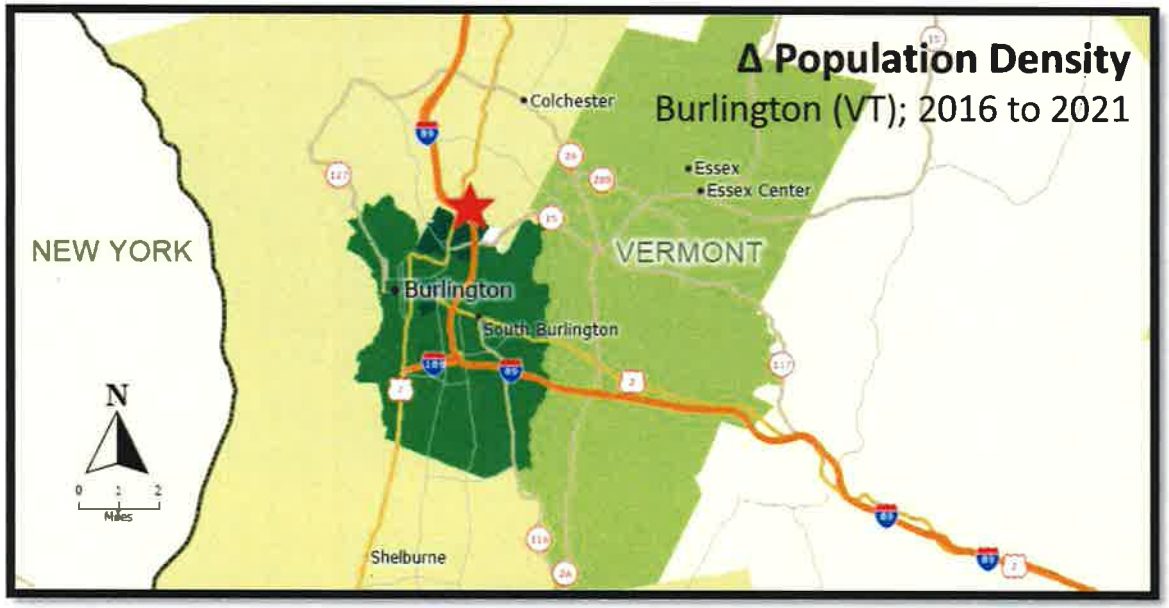


- In its application, the GMSC uses an aggressive population growth rate (based on 2000 Census data) that overestimates Chittenden County's 2035 population by more than 35%
  - At current annual growth rates, more recent evidence projects Chittenden County's population to be less than 180K by 2035
  - GMSC's application states that Chittenden County's population is expected to exceed 250K by 2035, citing a report released in 2000

Note: GMSC's 2035 population estimate assumes a 69% increase from 2000 Census figures, which is equivalent to ~1.5% annually

Sources: [1] GMSC CON population estimates cite a Economic & Policy Resources, Inc. report entitled "Economic and Demographic Forecast: Northwest Vermont and Chittenden County 2000 to 2035 and Beyond" (2000) [2] Annual Estimates of the Resident Population; U.S. Census Bureau [3] Claritas population estimates, 2016 [4] GMSC CON does not incorporate 2010 U.S. Census results since the cited study was released in 2000

Population Estimates That Incorporate 2010 Census Data Project Chittenden County's Population to Remain Stagnant



Δ Population Density per sq. mile
2016 to 2021

- 1.6 and below
- 1.6 to 10
- 10 to 25
- 25 to 40
- 40 to 100
- 100 and above
- Proposed ASC Location

Total Population & CAGR by Age Cohort
Chittenden County

Age Cohort	2016	2021	CAGR
0-17	30,026	29,274	(0.51%)
18-64	109,278	108,587	(0.13%)
65+	22,566	27,614	4.12%
Total	161,870	165,475	0.44%

- **Chittenden County's population is expected to increase at an annual growth rate <0.5%**
- The county's 65+ age cohort is expected to grow at a relatively quicker pace than the rest of the county at a rate of >4% annually

Note: GMSC CON population estimates cite a Economic & Policy Resources, Inc. report titled "Economic and Demographic Forecast: Northwest Vermont and Chittenden County 2000 to 2035 and Beyond" (2000)

Source: Claritas population estimates, 2016

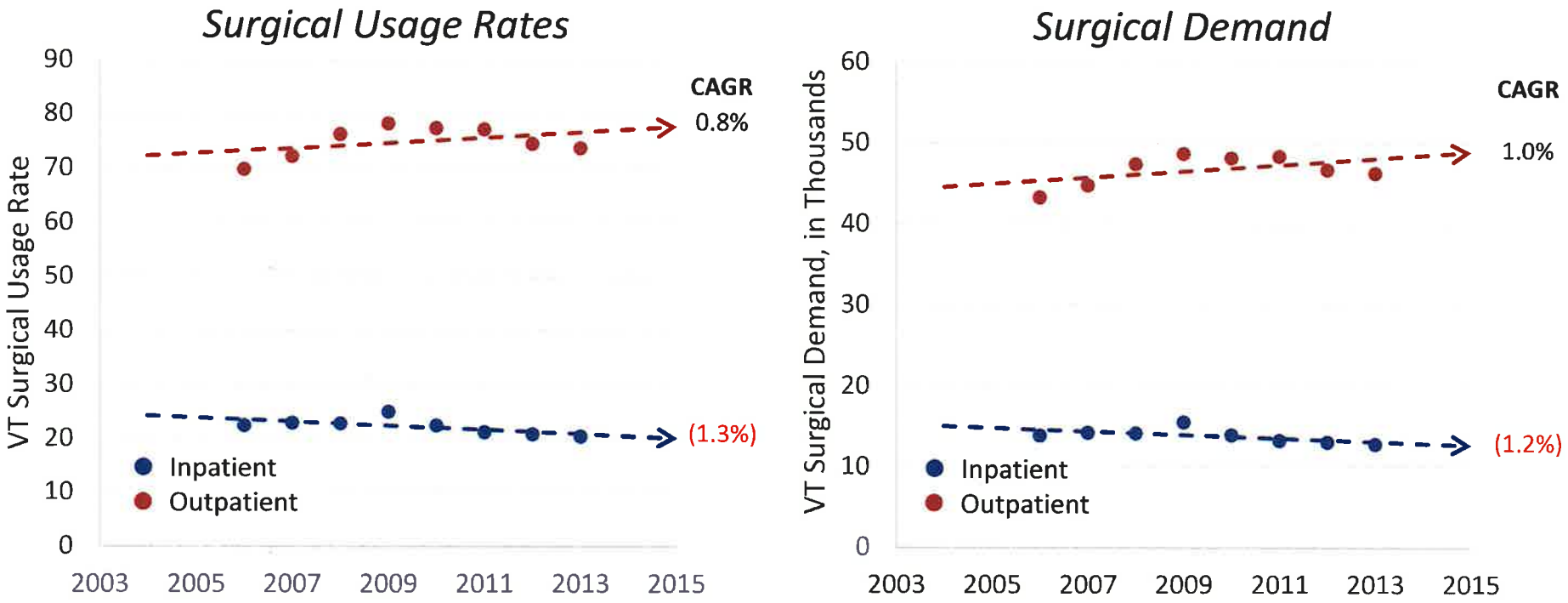
B. Surgical Demand Trends

Vermont

Surgical Usage Rate Trends Applied to Relatively Small Population Growth Generates Stagnant Surgical Volumes

Vermont Surgical Usage Rates & Surgical Demand by Patient Type (2006 - 2013)

Surgical usage rates are not reflective of independent, freestanding ASCs (i.e., Eye Surgery Center)



- Outpatient surgical usage rates are increasing while inpatient surgical usage rates are declining over time
- Due to relatively small population growth, trends in surgical volumes align with surgical usage rate trends (i.e., OP surgical demand is increasing whereas IP surgical demand is decreasing)

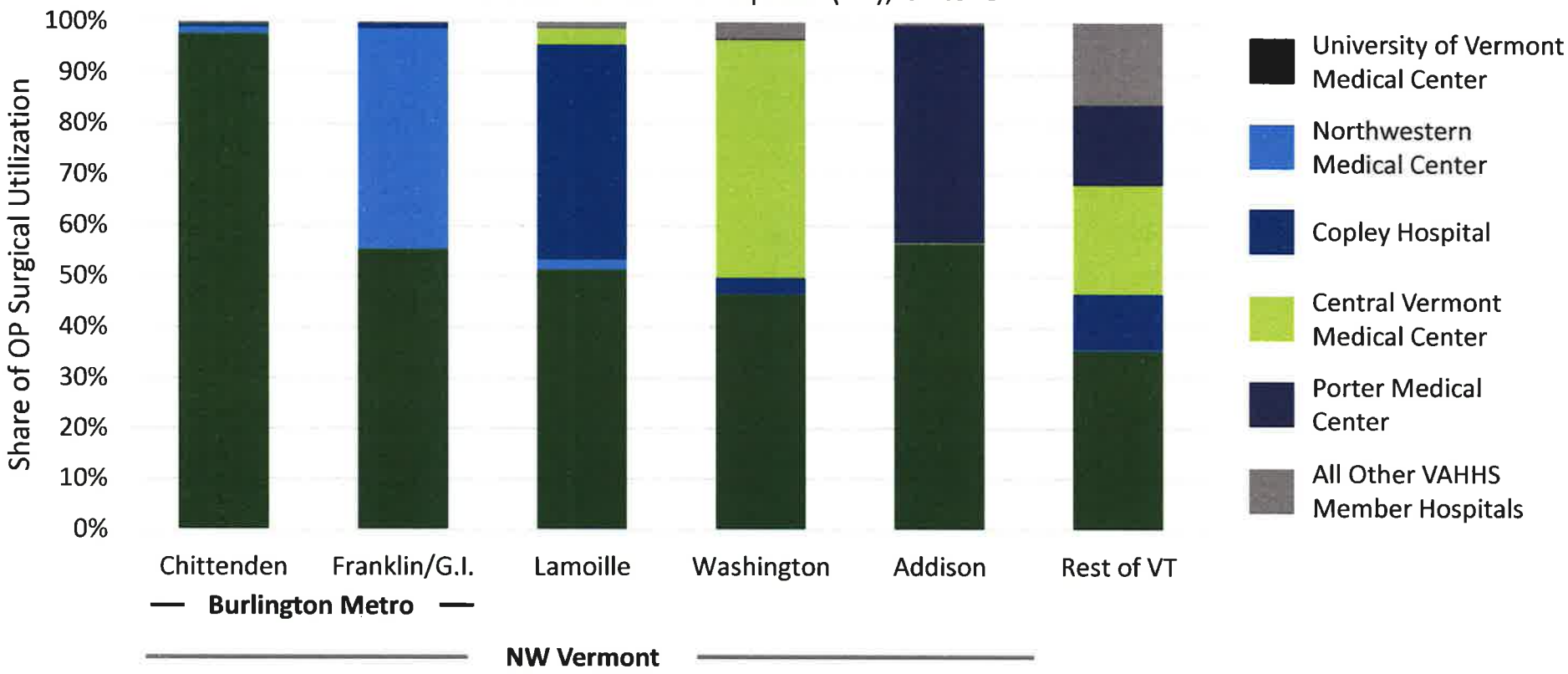
Source: The American Hospital Association (AHA) 2015 statistical survey, published by Health Forum

C. Surgical Demand Migration Trends

UVMMC Attracts Patients from Outside Chittenden County, Driving In-Migration Patterns

Proportion of Outpatient Surgical Utilization by Patient Origin

VAHHS Member Hospitals (VT), CY2015



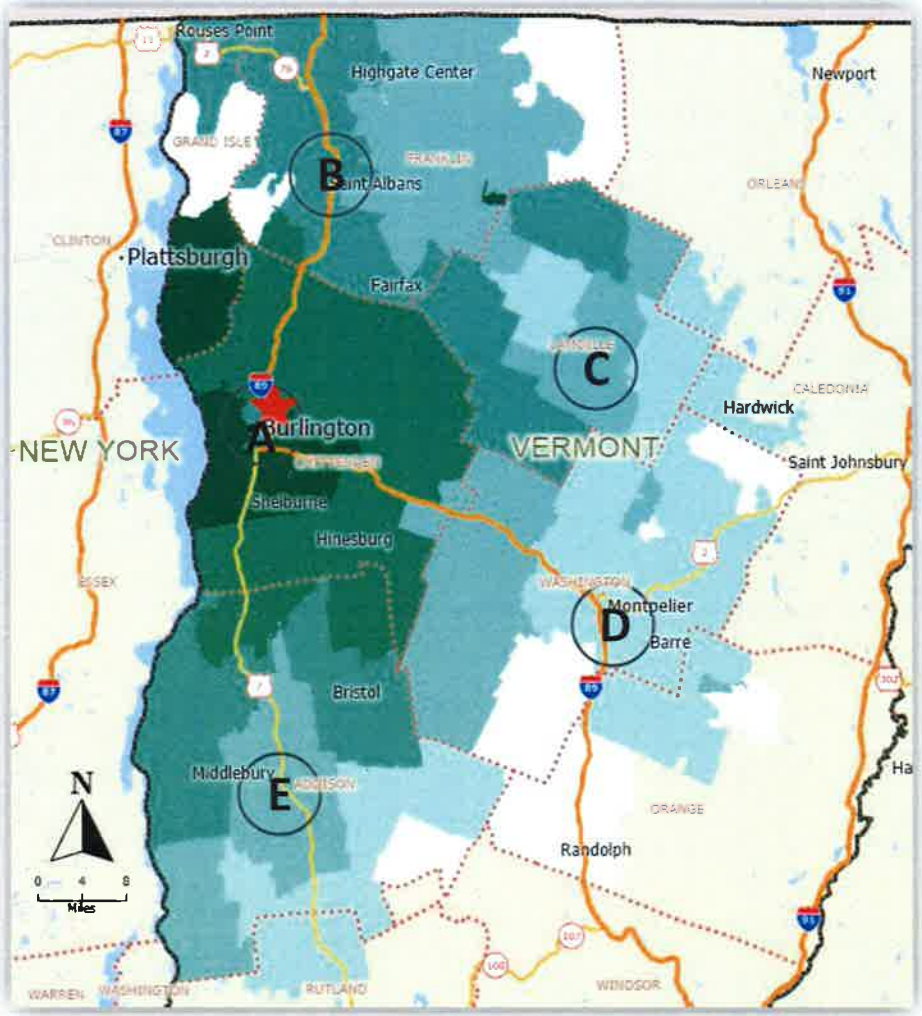
- Chittenden County observes low levels of outmigration (<2%) while all other VT counties surrounding Burlington experience outmigration to UVMMC >35%

Note: G.I. is Grand Isle County

Source: Outpatient surgical utilization dataset (CY2015) provided by VAHHS and details Vermont cases only. Ambulatory surgical cases were determined based on whether an outpatient case was associated with revenue code 036X (Operating Room Services) or 049X (Ambulatory Surgical Care).

20% of UVMMC's OP Surgical Population from Vermont Originate from Outside the Burlington Metro Area

UVMMC OP Surgical Patient Origin (CY15)



UVMMC OP surgical cases
Per 1,000 pop. (CY2015)

- 25 and below
- 25 to 56
- 56 to 90
- 90 to 140
- 140 to 190
- 190 and above

VAHHS Hospitals

- (A) UVMMC Campuses
- (B) Northwestern Medical Center
- (C) Copley Hospital
- (D) Central Vermont Medical Center
- (E) Porter Medical Center

UVMMC OP Surgical Case Count
By County (CY2015)

County	#Cases	% of Total	
Chittenden	27,755	67.5%	Burlington Metro
Franklin	3,958	9.6%	
Grand Isle	1,044	2.6%	
All Other VT	8,344	20.3%	
Total	41,101	100.0%	

Source: Outpatient surgical utilization dataset (CY2015) provided by VAHHS and details Vermont cases only. Ambulatory surgical cases were determined based on whether an outpatient case was associated with revenue code 036X (Operating Room Services) or 049X (Ambulatory Surgical Care).

4 | Summary of Regional OR Needs

Summary of Regional OR Capacity | Key Points

A. Current OR Supply

- Capacity is available within the current OR supply based on current utilization rates and average case times
- There is procedure room capacity at UVMMC campuses that can accommodate the case volume the GMSC is seeking to serve

B. OR Need Assessment

- The relationship between OR demand and supply is sensitive to population estimates and market sizing
- Projected OR utilization suggests current OR supply could meet demand for the next 20 years

A. Current OR Supply Operations

OR Suites in the NW Vermont Region Have Available Capacity Based on Current Utilization Rates…

VAHHS Member Hospitals | OR Utilization Rates (FY2015)

Hospital	OR Room Count	Available Op. Minutes	Used Op. Minutes	Utilization Rate
UVMMC Main Campus	17	3,098,160	2,288,753	74%
UVMMC Endoscopy Suite	8	1,095,120	780,960	71%
UVMMC Fanny Allen Campus	5	764,400	483,948	63%
Northwestern Medical Center	5	587,250	251,343	43%
Central Vermont Medical Center	5	720,360	368,838	51%
Copley Hospital	3	396,420	206,138	52%
Porter Medical Center	3	451,920	301,968	67%
Total	**46**	**7,113,630**	**4,681,948**	**66%**

- National surveys indicate that the median prime-time utilization rate is 75% [1]
- Other than UVMMC's Main Campus and Endoscopy Suite, there is not an OR suite that approaches 75% utilization even with limited hours of operation

Notes: [1] OR Benchmarks Collaborative (ORBC) accessed via *OR Manager* Vol. 28 No. 1 (Jan 2012). 87% of the participants in the ORBC analysis were hospitals; 'prime-time' defined as 7am to 3pm [2] NMC's hours of operation are M-F 7:30AM to 5:30PM [3] OR room counts and operating capacity based VAHHS Response to Request for Data from Member Hospitals, provided 5/6/2016 [4] Available operating minutes are based on current hours of operation and implicitly assume that existing surgical suites are able to staff appropriately

...and Based On the Average Duration of Cases

VAHHS Member Hospitals | OR Utilization Rates (FY2015)

Hospital	OR Room Count	#Cases	Used Op. Minutes	Avg. Case Time (min.)
UVMMC Main Campus	17	11,983	2,288,753	191
UVMMC Endoscopy Suite	8	13,016	780,960	60
UVMMC Fanny Allen Campus	5	4,481	483,948	108
Northwestern Medical Center	5	2,664	251,343	94
Central Vermont Medical Center	5	3,305	368,838	112
Copley Hospital	3	1,940	206,138	106
Porter Medical Center	3	2,796	301,968	108
Total	**46**	**40,185**	**4,681,948**	**117**

- Average case times – in conjunction with low operating room utilization rates – indicate available capacity as current throughput does not present a temporal constraint on the current OR supply to operate efficiently
  - Average case duration benchmarks are dependent on service mix

Note: The number of cases reflect services that were rendered in an operating room. There are additional ambulatory cases not included in the case counts above that were performed in a procedure room or another ambulatory setting.

Source: VAHHS Response to Request for Data from Member Hospitals, provided 5/6/2016

There Is Procedure Room Capacity

VAHHS Member Hospitals | PR Utilization Rates (FY2015)

Hospital	PR Room Count	Volume Capacity	Actual Volume	Utilization Rate
UVMMC Main Campus	5	7,421	3,046	41%
UVMMC Fanny Allen Campus	2	5,364	169	3%
Northwestern Medical Center	4	26,529	3,726	14%
Central Vermont Medical Center	2	4,379	2,923	67%
Copley Hospital	2	4,877	1,542	32%
Porter Medical Center	1	2,088	866	41%
Total	**16**	**50,658**	**12,272**	**24%**

- The GMSC intends to offer services that are eligible for a procedure room setting, including arthroscopic surgery, screening scopes and gynecology services
- UVMMC has procedure room capacity within Chittenden County to accommodate ambulatory case volumes eligible for a procedure room

Note: Each member hospital determined volume capacity from the avg. length of procedure (minutes) based on historical experience dating back to FY2013

Source: VAHHS Response to Request for Data from Member Hospitals, provided 5/6/2016

B. OR Need Assessment

OR Need Assessment | Key Assumptions

OR need projects surgical demand forward based on current utilization and recent trends observed in market. Key assumptions include:

- Increasing outpatient surgical usage rates [1]
- Decreasing inpatient surgical usage rates [2]
- Stagnant population growth [3]
- Efficient utilization of available operating room capacity [4]
- Declining surgical case times due to increased operational efficiencies driven by increased volumes, technological innovation, and a service mix that is proportionally more outpatient [5]

Market Definitions

Counties included:
- Chittenden

Chittenden County

Counties included:
- Chittenden
- Franklin
- Grand Isle

Burlington MSA

Counties included:
- Chittenden
- Franklin
- Grand Isle
- Addison
- Lamoille
- Washington

NW Vermont

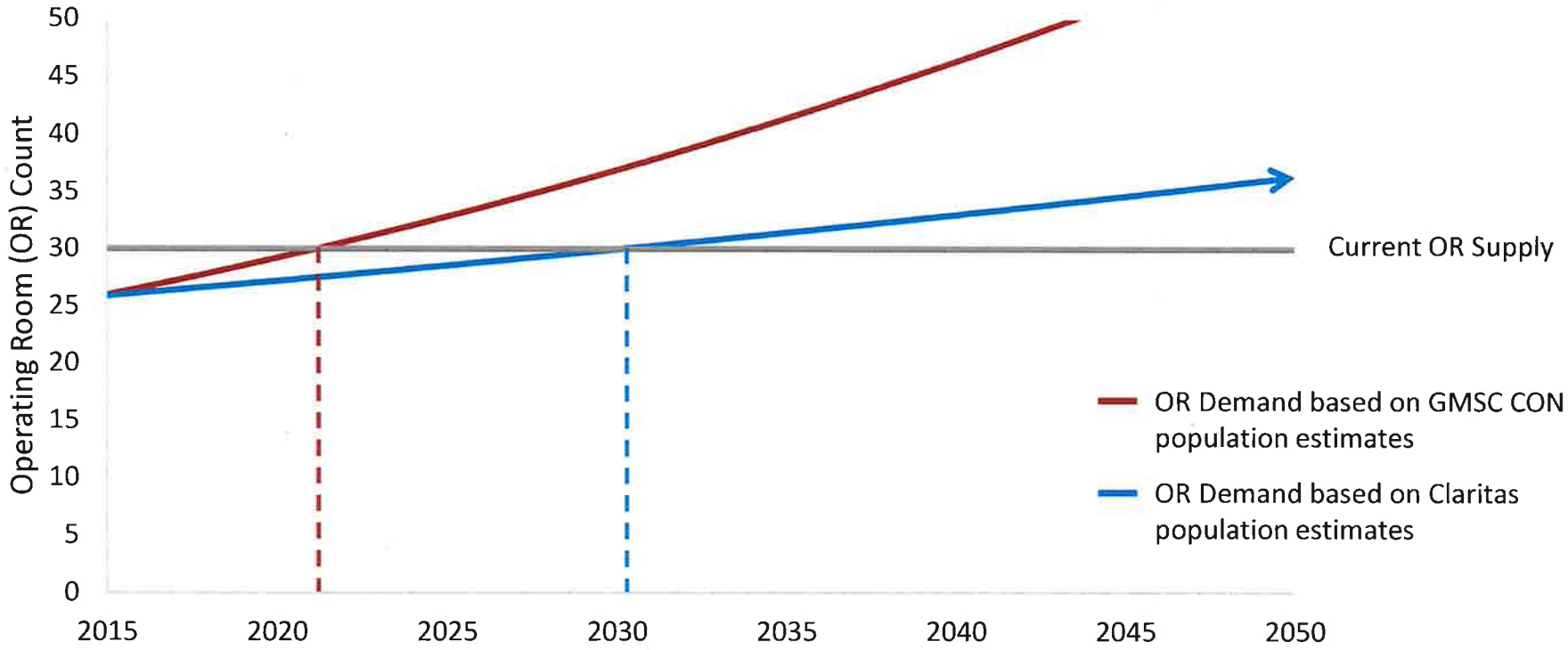
Notes: [1] OP surgical usage rates increase 0.8% annually [2] Mixed (IP & OP) surgical usage rates increase 0.3% annually [3] Projected population varies by market definition but does not exceed 0.5% annually [4] Efficient OR utilization rate assumed to be 80% [5] Average case time for ORs that render IP & OP procedures decline 0.3% annually

Source: Current utilization based on VAHHS Response to Request for Data from Member Hospitals, provided 5/6/2016

Chittenden County's OR Supply Meets Demand Past 2030 Based on More Recent Population Estimates

OR Demand Projections v. Current Supply

Chittenden County (VT)



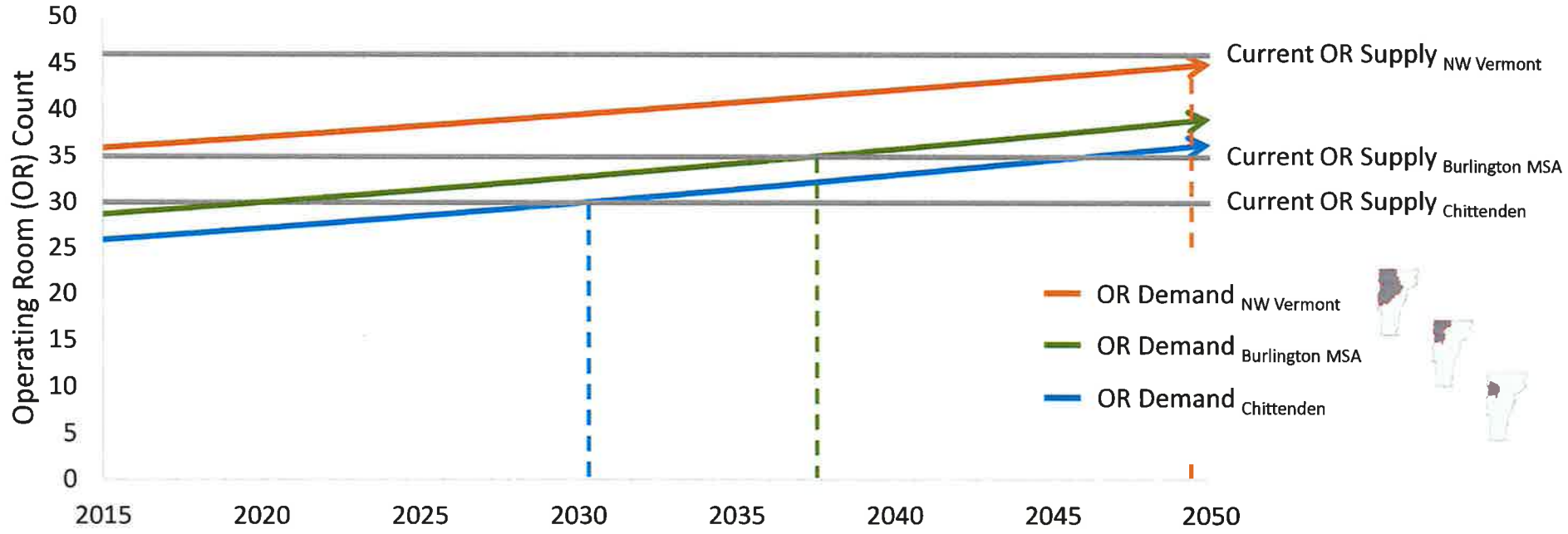
GMSC's population estimates generate demand that meets current supply ten years sooner than demand generated by more recent Claritas population estimates

Note: Current OR Supply is based on the number of operating rooms at UVM Medical Center Main Campus (17), Endoscopy Suite (8) and Fannie Allen Campus (5)

Broader Market Definitions Extend the Time In Which Projected Operating Room Demand Meets Current Supply

OR Demand Projections v. Current Supply

By market definition



- Current OR supply is more than adequate to meet projected demand for the foreseeable future, regardless of market definition
- As the market definition expands, the longevity of current supply meeting demand lengthens past 2050 assuming efficient utilization

Note: Current OR Supply is based on the number of operating rooms at VAHHS member hospitals in Addison County, Chittenden County, Franklin County, Grand Isle County, Lamoille County and Washington County

Conclusion:

There is no need for additional surgical capacity in NW Vermont for at least 20 years

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, Inc. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

KaufmanHall

2101 Rosecrans Avenue, Suite 6200, El Segundo, California 90245
310.227.8988 phone | 847.965.3511 fax
www.kaufmanhall.com