

**STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD**

In re: ACTD LLC, d/b/a The Green Mountain)
Surgery Center) GMCB-010-15con
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STATEMENT OF DECISION

Introduction

We today issue a certificate of need to ACTD, LLC (the applicant) to develop a multi-specialty, ambulatory surgery center in Chittenden County. Our decision, though not unanimous, was guided by our statutory charge and informed by input from many Vermonters—businesses and individuals, hospitals, physicians and insurers. In making today’s decision, we underscore that the applicant is bound to conditions that directly reflect the information and assurances it provided the Board and to members of the public throughout the review process; specifically, that the surgery center will provide low cost, accessible and medically appropriate care for Vermonters and will join in Vermont’s efforts for system-wide payment and delivery reforms.

Procedural Background

After filing a letter of intent with the Board in June 2015, ACTD, LLC (the applicant) filed a certificate of need (CON) application on July 2, 2015 to develop Green Mountain Surgery Center (GMSC), a for-profit, multi-specialty ambulatory surgical center in Colchester.¹ On July 17, 2015, the Vermont Office of the Health Care Advocate (HCA), representing the interests of Vermont health care consumers, intervened in the proceeding. *See* 18 V.S.A. § 9440(c)(9); GMCB Rule 4.000 (*Certificate of Need*) § 4.406. Northwestern Medical Center (NMC) and the Vermont Association of Hospitals and Health Systems (VAHHS) filed separate motions for interested party status on July 31, 2015; on that same date, the HCA filed Proposed Questions to the Applicant. The Board granted interested party status to NMC and to VAHHS, in separate orders, on August 13, 2015.

Beginning August 28, 2015, the Board requested, through a series of eight sets of interrogatories, that the applicant provide additional or clarifying information to assist the Board with its review.² Additionally, on April 5, 2016, the Board requested data from VAHHS relating

¹ The full certificate of need record, other than any materials deemed confidential, may be accessed at <http://gmcboard.vermont.gov/con>. The documents may also be obtained by request to the Board.

² Under Vermont law, the Board has 90 days from the date of filing to review a CON application, which the Board can extend for 60 additional days, or longer with the consent of the applicant. 18 V.S.A. § 9440(c)(4). The statutory clock is tolled, however, during the time when an applicant is responding to requests for information from the Board. Here, the applicant took approximately four months to respond to the Board’s first information request; for a later request, the applicant took five months. *See* Responses

to member hospitals' surgical capacity. VAHHS responded to the request on May 6, 2016. At the request of the interested parties (on January 25, 2017) and the applicant (on January 27, 2017), the Board on February 6, 2017 extended the period of review. On March 6, 2017, the applicant requested that the Board refrain from closing the docket until March 24, 2017, pending its review of materials submitted by VAHHS.

The Board closed the application on March 10, 2017 and scheduled a hearing on the matter. Public notice of the hearing was published, in accordance with statute, on March 14, 2017.

Meanwhile, at the close of 2016, Chair Al Gobeille was chosen by Vermont's newly elected governor to head the Agency of Human Services, and resigned from the Board effective January 2017. Member Rambur resigned in January 2017 for personal reasons. As the hearing date approached, both positions were unfilled.

The hearing was held on April 13, 2017, before the three remaining Board members, Con Hogan, Jessica Holmes, and Robin Lunge. The applicant was represented by attorneys Eileen Elliott, Karen Tyler, and Drew Kervick of the law firm Dunkiel Saunders Elliott Raubvogel & Hand. Amy Cooper (Member Manager, ACTD, LLC), Joan Dentler (President and CEO, Avanza Healthcare Strategies), and Dr. Paul Reiss (Chief Medical Officer, HealthFirst) testified on the applicant's behalf.³ VAHHS and NMC were represented by attorney Anne Cramer of the law firm Primmer Piper Eggleston & Cramer PC. Jeffrey Tieman (President and Chief Executive Officer, VAHHS), James Medendorp (Vice President, Kaufman Hall & Associates), Chris Oliver (Vice President of Clinical Services, University of Vermont Medical Center), Michael Del Trecco (Vice President of Finance and Operations, VAHHS), and Dr. Walter Morrissey (Managing Director, Kaufman Hall & Associates) testified on behalf of VAHHS. Jill Berry Bowen (Chief Executive Officer, NMC), Jane Catton (Senior Vice President, Chief Operating Officer, and Chief Nursing Officer, NMC), Dr. Gregory Brophy (Executive Medical Director of Physician Services, NMC), and Christopher Hickey (Senior Vice President and Chief Financial Officer, NMC) testified on behalf of NMC. Kaili Kuiper, Esq. and Julia Shaw of the Office of the Health Care Advocate participated in the hearing. Members of the public, including individuals affiliated with the applicant or with the interested parties, attended the hearing and provided public comment.

On April 17, 2017, in response to motions filed by the applicant and NMC, the Board continued the hearing to April 19, 2017, to allow for continued witness testimony and additional time for public comment.⁴ Following the hearing, the applicant, NMC, VAHHS, and the HCA each filed post-hearing submissions for the Board's consideration.

On May 12, 2017, Board members Hogan, Holmes and Lunge advised the applicant and interested parties that they were unable to reach a consensus decision, and that the proceeding

(Resp.) to Q001 (response filed approximately four months following request); Resp. to Q006 (filed approximately five months following request).

³ Dr. Elizabeth Wennar Rosenburg testified for the applicant on the second day of hearing.

⁴ Both days of hearing were recorded, transcribed and videotaped. Written transcripts of the hearing are available on the Board's website.

would be continued pending the Governor's appointment of additional Board members. Notice of Continuation of Proceeding (May 12, 2017). On May 24, 2017, Governor Scott appointed Kevin Mullin to replace Chair Gobeille and Maureen Usifer to replace Member Rambur. Both Chair Mullin and Member Usifer have now reviewed the entirety of the record, participated in Board deliberations and join in this decision.

Jurisdiction

The Board has jurisdiction over the certificate of need process pursuant to 18 V.S.A. § 9375(b)(8). The project as proposed by the applicant is subject to certificate of need review under 18 V.S.A. § 9434(a)(6).

Findings of Fact

1. The applicant proposes to open a for-profit multi-specialty ambulatory surgery center (ASC), to be known as the Green Mountain Surgery Center, at 535 Hercules Drive in Colchester. Application (App.) at 16. The location is about a ten-minute drive from Burlington, less than five miles from UVMHC, and approximately 24 miles from NMC. App. at 16; NMC Submission of Information in Opposition to Application (NMC Opp. Mem.) (March 6, 2017) at 1. The applicant has identified Chittenden County as its primary service area and Franklin County as its secondary service area. Response (Resp.) to Q001 (12/23/15) at 5-6.

2. The applicant was formed as a limited liability corporation in 2014, and has nine investors with ownership interests.⁵ Seven of the nine owners are physicians who plan to perform surgeries at the facility. Resp. to Q006 (1/25/17), Ownership Table (corrected) (2/27/17).

3. ASCs have become commonplace in other states and since 1982, Medicare has provided reimbursement for procedures performed at ASCs. Vermont has only one Medicare-certified ASC, The Eye Surgery Center, which began operations in 2008 after receiving a certificate of need. App. at 2-5, 60, 82.

4. The applicant hired Avanza Healthcare Strategies, a national health care consulting firm that has assisted more than 125 ASCs with planning, development, operational oversight and troubleshooting, to assist with plans for GMSC. App. at 14. In addition, the applicant engaged AMB Development Group, a health care architectural firm that specializes in ASC design, and Wiemann Lamphere Architects, a local firm with a reputation for sustainable construction, to design the facility. *Id.* at 15, 45-46.

5. The proposed facility is 12,879 square feet with two operating rooms, four procedure rooms, and 14 pre- and post-operation beds. App. at 17; Resp. to Q001 (12/23/15) at 4. Its design complies with the Facility Guidelines Institute (FGI) 2014 Guidelines for Design and Construction of Health Care Facilities. App. at 49, Exhibit 4. The applicant, with the assistance

⁵ Dr. Thomas Dowhan, who along with Amy Cooper was a primary planner and a founding investor in the ASC, has since sold his ownership shares to other investors. Letter from applicant correcting Resp. to Q006 (2/27/17).

of a local realtor, had considered leasing and renovating existing space, but found the cost excessive and that available buildings had operational drawbacks. *Id.* at 47.

6. The total cost of the project is \$11,623,283.46 and includes \$5,610,445.46 in total capitalized lease payments over ten years. Resp. to Q001 (12/23/15) at 26-28, Table 1 (Revised). The applicant intends to fund the approximately \$1.8 million start-up cost of the project through a \$680,000 loan at 7% interest and a \$1,132,838 equity contribution from the investing physicians. App. at 58, Table 2. As of the date of hearing, the applicant advised the Board that it was “on track to raise [its] targeted debt and equity by the fall of 2017” and had raised \$291,000 in equity from investors, and received preapproval for the loan. Transcript (TR) (4/13/17) at 19.

7. Vermont does not currently license or directly regulate ASCs. The Board will not have oversight of the ASC’s budget as it does for hospitals or for Accountable Care Organizations (ACOs). See 18 V.S.A. §§ 9451- 9457 (Hospital Budget Review); 18 V.S.A. § 9382 (*eff.* Jan. 1, 2018) (Oversight of Accountable Care Organizations).

8. The applicant intends to apply for the ASC to be certified as a Medicare-approved freestanding ASC and will comply with Medicare conditions of participation. As a Medicare-certified facility, the ASC will collect and annually report health care quality and outcome data to the Centers for Medicare & Medicaid Services (CMS). App. at 15, 40.

9. The Department of Disabilities, Aging and Independent Living (DAIL) is designated by CMS to provide some regulatory oversight over ASCs through its survey and certification program. App. at 7-8; see DAIL 2015 Annual Report (Jan. 2016) at 53, available at http://dail.vermont.gov/sites/dail/files/documents/SFY15_DAIL_Annual_Report.pdf. DAIL does not require ASCs to provide periodic, *e.g.* quarterly or annual, reporting. See Letter from Suzanne Leavitt, DAIL Director State Survey Agency (Feb. 24, 2017) (clarifying that DAIL does not require or review ASC quarterly reports).

10. Unlike Vermont’s hospitals, the applicant is not required to pay provider taxes, which are deposited into the State Health Care Resource Fund. See 33 V.S.A. §§ 1953, 1956. The applicant will pay property taxes on the facility, and taxes on its income. TR (4/13/17) at 41-42.

11. The applicant intends to seek accreditation from the Accreditation Association for Ambulatory Health Care, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or both. App. at 15; Resp. to Q001 (12/23/15) at 15-16. Although the two types of accreditation are generally comparable, accreditation from JCAHO is more rigorous. See Health Resources & Services Administration, Accreditation Resources: Comparison Chart (updated 02/19/2015), at <https://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/accreditationresources.pdf>.

12. The applicant confirmed at hearing that it will “participate in the ACOs [Accountable Care Organizations] as an affiliated provider and partner” and will “play an active role collaborating with ACOs, sharing data and adopting best practice evidence coordination protocols.” TR (4/13/17) at 23; see also TR 62 (applicant states it will “join” an ACO). The applicant has already reviewed and intends to sign affiliate partner agreements with Community

Health Accountable Care (CHAC) and OneCare Vermont. The applicant contends that its participation in the ACOs will help Vermont meet its expenditure and performance targets in the All-Payer ACO Model Agreement.⁶ TR (4/13/17) at 23-24.

13. The applicant expects to employ a staff of 22 full-time equivalents (FTEs) including 15 registered nurses, four surgical technologists, three administrative and clerical staff, an administrator and a Medical Director appointed by the ASC's Board of Managers. App. at 19.

14. Pursuant to federal law, physicians using the facility may only perform surgeries and procedures that are not expected to pose a significant safety risk to a patient when performed in an ASC, and for which standard medical practice dictates that the patient would not typically be expected to require active medical monitoring and care at midnight following the procedure. App. at 12, 20 (*citing* 42 C.F.R. § 416.166). Patients who are clinically high-risk due to the presence of co-morbidities, very advanced age or other factors will be ineligible to have their procedures at the ASC, and would have the procedure at a local hospital. *Id.*

15. The applicant initially claimed that there was an “identifiable need for expanded outpatient surgery capacity in Chittenden County.” It premised its claim on data from 2000 that projected a steady and significant rise in the county’s population—a 69% increase from 2000 to 2035. According to the applicant, the rise in population coupled with an older population would “increase pressure on existing outpatient surgery programs.” App. at 11; Resp. to Q001 at 7, Exhibit 1.

16. VAHHS provided credible, more recent data from the U.S. Census that projects a much slower Vermont growth rate over the same period—less than 0.5% annually for the overall population, and 4.12% for residents over age 65. VAHHS Opp. Mem. (3/6/17) at 11; Ex. 1 (KaufmanHall, *The Green Mountain Surgery Center Need Assessment*, March 1, 2017) at 10, 12-13.

17. Additionally, the applicant maintains that there is an unmet need in the region for “lower cost, greater efficiency, enhanced patient experience, increased price transparency, and physician demand associated with an ASC,” and that the project will address that unmet need. Resp. to Q006 (1/25/17) at 4; App. at 36 (applicant states ASCs provide “a lower cost, more convenient and less imposing environment for local residents to access routine surgical care.”).

18. The majority of procedures performed at the ASC would be gastrointestinal (GI)—the highest volume of which will be screening and diagnostic colonoscopies. The ASC will also offer pain management, obstetrics and gynecology (OB/GYN), orthopedic and general surgery. App. at 20, 28, 50. The applicant provided the following table of projected cases by specialty, based on actual historical outpatient cases (2014 average monthly volumes) performed by the physician investors:

⁶ The Vermont All-Payer ACO Model Agreement was signed in October 2016 by the Governor, Secretary of Human Services, Chair of the Green Mountain Care Board, and the Centers for Medicare & Medicaid Services. The Agreement allows Vermont to explore new ways of financing health care with Medicare’s participation, through an ACO delivery model. Information about the Agreement can be found at <https://www.gmcboard.vermont.gov/payment-reform/APM>.

**GREEN MOUNTAIN SURGERY CENTER
PROJECTED CASES BY SPECIALTY**

Specialty	Year 1	Year 2	Year 3	Year 4
GI	3,150	3,636	3,672	3,709
OB/GYN	579	668	675	681
ORTHO	284	327	330	334
PAIN MGT	847	978	988	998
GENERAL SURGERY	273	315	318	321
TOTAL BY SPECIALTY	5,132	5,924	5,983	6,043

Notes: Projected case volumes have been adjusted for acuity as only a certain percentage of physician cases will be performed at the proposed surgery center. Case volumes were projected assuming there would be a ramp up period during the first year of operation.

App. at 28.

19. All procedures that will be offered at the ASC are currently offered at UVMMC and NMC, as well as other hospitals in Vermont. Resp. to Q003 (7/26/16) at 8.

20. The applicant expects that once the ASC is fully operational, there will be a strong demand for other specialties which may include oral surgery, podiatry, and plastic surgery. App. at 20; Resp. to Q006 (1/25/17) at 2 (applicant states that “other providers such as dentists, oral surgeons, or podiatrists” may be interested in performing procedures at the ASC).

21. Physicians performing surgeries at the ASC will not be employed by the applicant, and will not lease the operating or procedure rooms. The physicians will bill for their professional services at the same rate as billed for the same services when performed in a hospital setting. App. at 23.

22. The ASC will bill amounts separately from the physicians’ fees, unless the physician and facility enter into an arrangement for global pricing. The ASC will bill one charge that is inclusive of room time, medications and recovery. App. at 23.

23. The applicant assumes that a minimum of 16 physicians will move 67% of their historical outpatient volume to the ASC; the remaining 33% will be performed at local hospitals. A physician’s determination of where the procedure will be performed will be driven by patient acuity, the type of procedure, and patient preference. App at 26; Resp. to Q001 (12/23/15) at 5; Resp. to Q003 (7/15/17) at 9.

24. The applicant does not anticipate that development of the ASC will result in “any material net increase in [the volume of] surgeries performed in the State” because it expects each of the physicians practicing at the ASC will perform the same number of surgeries as before the project was in operation. The applicant concedes, however, that there may be increased volumes “due to the reduction of wait times at UVMMC and NMC and the unquantifiable, but still very

real in-migration of elective surgeries that Vermonters are currently scheduling at ASCs in Florida, New York and Massachusetts.” Resp. to Q003 (7/15/17) at 9; App. at 38.

25. Even assuming an increase in utilization once the ASC is operational, the applicant does not expect there will be a parallel increase in aggregate costs to the health care system. Rather, the applicant contends that “the cost savings of an ASC as compared to hospital-based services will more than offset any modest increase in utilization.” App. at 32 (citing presentation to the N.C. legislature by N.C. Orthopaedic Association and its consultants in support of removing CON restrictions on ASCs).

26. The applicant projects operating room utilization will range from 44.2% to 60.7% in the ASC’s first year of operation, and from 52.1% to 71.5% in Year 4. For procedure room utilization the applicant projects a range of 52% to 77.5% in Year 1, and from 61.6% to 91.3% in Year 4. The projections are based on the historical volumes for the physicians who will be performing surgeries at the ASC, adjusted from the low to high end by increasing the average length of procedure. In other words, the medium utilization projection assumes a longer average length of procedure than the low projection, and the high projection assumes a longer length of procedure than the medium. Resp. to Q003 (7/26/16) at 1-4.

27. The ASC building was intentionally sized larger than is needed to allow for future growth and to ensure that “physicians have surgical room availability to allow for unexpected or last minute cases.” See Resp. to Q003 (7/26/16) at 1-2; Resp. to Q006 (1/25/17) at 2 (“other doctors or providers . . . who have not yet expressed interest in [the ASC] may do so.”). The applicant also believes that the utilization projections it presented in its application are likely understated because they are based on national benchmarks for established ASCs that have achieved efficiencies—and therefore shorter turnaround times—than the ASC will meet in its first years of operation. Resp. to Q003 at 11; TR (4/13/17) at 51-52 (Amy Cooper testifies that “it might be a stretch . . . meeting those sorts of turnover times without having nursing staff here, support staff here that is trained in the ASC environment, without having physicians for the most part that have adapted to a more efficient surgery time.”). Accounting for the expected longer turnaround times, the applicant opined at hearing that the ASC’s utilization rates would likely range from 65% to 90%. *Id.* at 52.

28. Data from the five hospitals geographically closest to the proposed facility (UVMMC, Central Vermont Medical Center, NMC, Copley Hospital and Porter Medical Center) indicate that the hospitals’ operating and procedure rooms are not currently nor projected to be overutilized through 2019, and can accommodate the demand for urgent, emergent and elective procedures. VAHHS Response to GMCB Request for Data from Member Hospitals (VAHHS Resp.) (May 6, 2016) at 6, 16, 26, 29.⁷ An analysis by VAHHS’ consultant, Kaufman, Hall & Associates (KaufmanHall), concludes that hospital operating and procedure room supply is sufficient to meet demand until at least 2030. VAHHS Hearing Presentation at 9; VAHHS Opp. Mem. (March 6, 2017), Exhibit 1 at 10, 17.

29. UVMMC has 22 operating rooms, seven procedure rooms, and eight endoscopy rooms that host approximately 20,000 surgeries and 13,000 endoscopies annually. VAHHS

⁷ These page numbers refer to the unmarked, sequential pagination in the VAHHS document.

Resp. (May 6, 2016) at 5; VAHHS Hearing Presentation at 13. Its main campus has the highest operating room utilization rate among the five hospitals surveyed at 74% for 2016, and is projected to rise to 76% from 2017 through 2019. VAHHS Resp. (May 6, 2016) at 10-12; VAHHS Hearing Presentation at 14. On UVMMC's Fanny Allen campus, the 2015 utilization rate is 41% for procedure rooms, 63% for operating rooms, and is 71% for the endoscopy rooms hospital-wide. *Id.*

30. UVMMC's Vice President of Clinical Services, Christina Oliver, testified that the hospital has ample capacity to accommodate increasing numbers of surgeries. TR (4/13/17) at 76 ("If our volumes were to increase, we have substantial capacity and we would simply increase our hours of operation."). Oliver described high patient satisfaction, no requests for physicians waiting to use endoscopy or procedure rooms, daily availability of the surgery rooms, and closely managed scheduling "in order to run most effectively." *Id.* at 76-79.

31. The applicant disputes VAHHS' claim that the data conclusively demonstrates that the hospitals have ample surgical capacity. The applicant maintains that the data does not reflect the hospitals' ability to use their operating and procedure rooms more efficiently and that some of the capacity may be "permanently unusable capacity due to OR/PR intake room ratios and staffing constraints." Resp. to Q006 (1/25/17) at 4.

32. The applicant further contends that the data does not reflect providers' ability to schedule surgeries at their or their patients' convenience, resulting in "wait times," an issue raised by several public commenters, and reported on by local media. Resp. to Q006 (1/25/17) at 4 (referring to a Burlington Free Press article). One commenter, a Chittenden County ophthalmologist, stated his belief that the hospital's claims of ample room availability and no complaints from physicians is "not true," and told the Board that he has personally complained to the hospital about scheduling difficulties. TR (4/13/17) at 119.

33. The applicant projects that about 4,000 procedures and surgeries will be performed at the ASC in 2018 that would otherwise have been performed at UVMMC. Resp. to Q003 (7/15/16) at 6. VAHHS estimates that UVMMC will host more than 30,000 procedures and surgeries in 2018. VAHHS Resp. (May 6, 2016) at 10-12. Assuming these projections are accurate and UVMMC does not replace the transferred procedures and surgeries, UVMMC would see an approximate 13% decrease in surgical volume.⁸

34. NMC has excess operating room and procedure room capacity. Operating room use is currently at 50% of capacity and procedure room use at 13% of capacity. NMC Opp. Mem. (March 8, 2017) at 2; *see also* NMC Motion to Intervene as an Interested Party (July 15, 2015) at ¶ 3.c.; TR (4/13/17) at 111(hospital CEO testifies that there is "excess capacity in our ORs, in our infrastructure").

35. The applicant estimates that 170 procedures and surgeries will be performed at the ASC in 2018 that would otherwise have been performed at NMC, representing 2.7% of its total

⁸ The applicant projects a slightly lower impact (12.1%), based on its projection that UVMMC will host 33,188 procedures and surgeries in 2018. Resp. to Q003 (7/15/16) at 6. In 2019, the applicant projects volume will increase to 13.8% of UVMMC's total estimated volume. *Id.* at 7.

volume. Resp. to Q003 (7/15/16) at 7-8. The applicant estimates this will increase to 3.1% in 2019. *Id.* at 8.

36. Peer-reviewed literature cited by the applicant indicates that there is typically a 2-5% reduction in outpatient surgeries performed at local hospitals when an ASC is introduced into the market. App. at 38, 60-61.

37. NMC receives high quality ratings and reports a high level of patient satisfaction. NMC recently engaged a consultant to assess its surgical processes and protocols, and has implemented some changes to eliminate inefficiencies and further enhance the patient experience. According to NMC's Chief Operations Officer, Jane Catton, the hospital has not received complaints from patients or from providers regarding use of the procedure rooms or operating rooms; Catton described the appellant's anecdotal claims of long wait times "an issue downstream" from the hospital itself, because providers determine their own practice schedules. TR (4/13/17) at 107-111.

38. Based on the current payer mix of all surgeons intending to perform surgeries at the ASC, the applicant expects that approximately 40% of surgeries performed will be reimbursed by Medicare, 12% by Medicaid, 35% by commercial payers, 8% self-pay, and 5% charity care and bad debt. App. at 28.

39. Based on its anticipated payer mix, the applicant projects 38% of its net patient revenues will come from Medicare, 9.7% from Medicaid, and 52.3% from commercial and self-pay. App. at 29. This compares to UVMMC's hospital service net revenues for fiscal year 2015 of 31.6% for Medicare, 11.4% for Medicaid, and 57.0% for commercial, self-pay and workers compensation. *Id.*

40. The applicant provided the following revenue projections, by payor category:

GREEN MOUNTAIN SURGERY CENTER
REVENUE (BEFORE DEDUCTIONS) BY PAYOR CATEGORY

	Year 1	Year 2	Year 3	Year 4
Medicare	\$2,221,818	\$2,604,440	\$2,668,195	\$2,736,866
Medicaid	\$566,720	\$664,074	\$681,023	\$697,878
Commercial	\$2,435,229	\$2,852,448	\$2,925,109	\$2,998,647
Self Pay	\$624,939	\$731,382	\$750,354	\$767,960
Total	\$5,848,706	\$6,852,344	\$7,024,680	\$7,201,351

App. at 28.

41. The applicant expects that it will generate significant savings to Medicare—which it projects will be approximately 40% of its revenues—because Medicare reimburses ASCs at a lower rate than it does hospitals for the same procedures. App. at 24, Table 3; *see also* Resp. to Q003 (7/15/16) at 14.

42. The applicant also expects savings from commercial payers. Based on a 2014 study of 18 metropolitan areas that did not include Vermont, the applicant assumes that commercial payers will reimburse the ASC at 50% of hospital reimbursements. App. at 22, 24; TR (4/13/17) at 17-18; 56-57.

43. The three major commercial health insurers in Vermont—MVP, Blue Cross and Blue Shield of Vermont (BCBSVT) and Cigna—have each expressed support for the project. *See* Letters of Support from MVP Healthcare (1/17/17); BCBSVT (3/16/17); CIGNA (dated 3/6/17 and received 3/23/17).

44. Medicaid reimbursements for procedures performed at an ASC are governed by state and federal law. Prices for procedures performed at the ASC are not likely to exceed Medicaid prices for the same procedures performed at a hospital, given the state legislative prohibition on the use of facility fees for outpatient medical services. *See* 33 V.S.A. § 1905a (prohibits provider-based billing at off-campus hospital outpatient facilities).

45. The ASC's determination on whether to accept a patient will be made based on the patient's medical needs and condition, and not on his or her ability to pay. App. at 21. The ASC will accept all forms of insurance including governmental (Medicare and Medicaid) and private pay, and will provide free and discounted care to needy self-pay patients. App. at 54, 70, 73. All but one physician planning to perform surgeries at the ASC currently accepts Medicaid. Resp. to Q001 (12/23/15) at 13. The applicant testified at hearing that the ASC would not adopt a policy requiring physicians using the facility to accept patients from all payors. TR (4/13/17) at 41.

46. The applicant has adopted a charity care policy that is consistent with the policies at UVMMC and NMC, and "is committed to providing free and discounted care to needy patients at a level on par with Vermont nonprofit hospitals." Resp. to Q003 at 13; Exhibit Q15 (Free and Discount Care Policy); TR (4/19/17) at 13:13; *see also* App. at 54, Exhibit 2.a.; Resp. to Q001 at 23-26.

47. NMC forecasts that its payor mix will be negatively impacted if the Board issues the applicant a CON; specifically, it expects to see an increase in the proportion of its reimbursements attributable to Medicaid. NMC points to the example of Dr. Thomas Dowhan, a surgeon affiliated with the hospital who also performs surgeries at The Eye Surgery Center. In 2016, of the 56 eye surgeries Dr. Dowhan performed at NMC, only three were covered by commercial insurance. In contrast, the percentage of commercial insurance-reimbursed surgeries performed by other surgeons at NMC is five times greater than Dr. Dowhan's. NMC Submission of Information in Opposition to Application (NMC Opp. Memo.) (March 3, 2017) at 12-13.⁹

48. UVMMC saw an estimated decrease of approximately 1,500 eye surgeries following the opening of The Eye Surgery Center, and a continual decline for the following four years. The

⁹ At hearing, NMC's witness described a physician who performs eye surgeries at both The Eye Surgery Center and NMC; at NMC, 95% of the surgeries he performs are reimbursed by government payers. TR (4/19/17) at 7. Given the information in NMC's opposition memo, it appears that the witness was referring to Dr. Dowhan.

hospital has begun to recoup some of the surgeries, but has not seen a restoration to its previous volumes. TR (4/13/17) at 84.

49. The applicant maintains that the ASC's billing method—charging the patient a single facility fee—is a “step toward bundled payments.” TR (4/13/17) at 43-44; *see also* App. at 10 (“ASCs are paid . . . based upon a global fee for each surgical procedure that is similar to approaches such as bundled payments”). The applicant has begun discussions with several of the large, self-insured employers that provided letters of support for the project about the possibility of offering bundled payments for some procedures. TR (4/13/17) at 42-44.

50. The applicant will dedicate a staff member to provide potential patients with price estimates for their surgeries on request. In advance of surgery, all patients will receive written disclosures that outline the total price of their surgical procedure and the portion of the price for which the patient is responsible. The applicant will offer price transparency tools on its website to communicate price information to the public. App. at 9; Resp. to Q001 at 20-21. When asked by the Board whether the applicant would “guarantee as a center policy to ensure that your prices will always be lower than hospitals . . . and making sure that stays true” the applicant responded “yes” and confirmed that its written policy will be displayed on its website and communicated to commercial insurers in the course of rate negotiations. TR (4/13/17) at 34-35.

51. The applicant will require that all physicians practicing at the ASC sign a “Collaborative Care Agreement.” The agreement is based on Vermont’s Blueprint for Health and national Patient Center Medical Home guidelines. The agreement includes the following principles: (i) timely access to care, (ii) communication, (iii) adherence to widely accepted evidence-based principles of care, and (iv) support of the primary care practice (PCP) as the Medical Home for most patients. Under the terms of the agreement, after a physician performs a procedure at the ASC, he or she will provide the patient’s PCP with guidelines and instructions for follow-up care, including parameters for additional consultation. App. at 71.

52. All ASC surgical patients will receive written instructions for after-hour care, and will be instructed in writing that if their condition warrants, to call 911 and go to the nearest emergency room. The ASC’s phone line will have the same emergency information on a recording for after-hour callers. The applicant will require that physicians performing surgeries at the ASC maintain after-hours on-call policies and 24-hour call coverage to answer patient inquiries. App. at 53.

53. The applicant has consulted with Vermont Information Technology Leaders (VITL) concerning implementing an electronic health record (EHR). Resp. to Q001 at 21-22. The applicant has chosen AMPI Solutions as its EHR vendor. AMPI’s parent company is a member of the CommonWell Health Alliance which holds a large portion of the acute care EHR market. TR (4/13/17) at 21-22; Applicant’s Hearing Presentation at 19.

54. The applicant contacted UVMMC in November 2015 to obtain a Transfer Agreement with the hospital. Dr. Stephen Leffler, Chief Medical Officer for UVMMC, advised the applicant that it would “engage in discussions . . . about the feasibility and parameters of a potential Transfer Agreement” if the CON application is approved. Resp. to Q001 (12/23/16), Exhibit 6.

55. The applicant has entered into a Memorandum of Agreement with the Colchester EMS Department to provide emergency ambulance service from the ASC location to UVMMC. Resp. to Q001 at Exhibit 7.

56. The ASC would be located off Interstate 89 and will have ample free parking, including handicapped spaces. The Chittenden County Transportation Authority's (CCTA) Milton commuter bus stops at Mountain View Drive, several blocks and a half-mile from the proposed location. The applicant will ask CCTA whether the bus route can be modified if the CON is approved. App. at 73-74; Resp. to Q006 at 12. Additionally, eligible patients may request transportation from Special Services Transportation Agency (SSTA), a not-for-profit agency that provides transportation for the elderly and disabled, to reach the facility. App. at 73-74.

57. The Board has received more than 70 written public comments on this application. Submissions include comments from individual Vermonters, medical practitioners, organizations such as AARP Vermont, the Vermont Troopers' Association, the Boys and Girls Club of Burlington and the Vermont State Employees Association, Vermont-based businesses such as Burton Snowboards, Seventh Generation, Rhino Foods and Lake Champlain Chocolates, and from the Town of Colchester and its legislative representative. In addition to the written comments, many persons signed up to comment at the close of the April 13, 2017 public hearing. The vast majority of commenters favor the proposal, citing a need for consumer choice, lower costs of care, and concerns about wait times at UVMMC. The HCA supports approval of the application, with conditions. The minority of commenters that oppose the ASC claim that it would undermine integration of Vermont's health care system, drawing the healthiest and highest-paying patients from hospitals.

Conclusions of Law

Vermont's health care landscape is in transition. Our success at bending the cost curve will depend on taking an integrated, statewide approach to payment and delivery reforms, using tools such as the All-Payer ACO Model Agreement to set our course. The applicant thus bears the burden to demonstrate that it will not operate outside the bounds of our reform endeavor, and that it meets each of the eight criteria set forth in statute before the project can proceed. *See* GMCB Rule 4.000, § 4.302.3 (applicant bears burden of proof). Having determined that the applicant has met its burden, we address each criterion below.

I.

To satisfy the first criterion, the applicant must show that the application is consistent with the Health Resource Allocation Plan (HRAP). The HRAP, last updated in 2009, identifies needs in Vermont's health care system, resources to address those needs, and priorities for addressing them on a statewide basis. 18 V.S.A. § 9437(1).¹⁰ We use the standards contained in

¹⁰ The Health Resource Allocation Plan is posted to the Board's website at <http://gmcbboard.vermont.gov/sites/gmcb/files/documents/vermonthhealthresourceallocationplan2009.pdf>.

the HRAP, where and to the extent applicable, as guidance in assessing whether the applicant has met this criterion.

Two of the HRAP standards relevant to this application address the health benefit and value of the services that the applicant proposes to offer. *See* Standard 1.2 (additional services must be proven to improve health); Standard 1.7 (project must be consistent with evidence-based practice). The most common procedure that will be offered at the ASC is colonoscopy, *see* Finding of Fact (Finding) ¶ 18, which is a widely accepted method to screen for colon cancer. In 2016, the U.S. Preventive Services Task Force, an independent panel of national experts in prevention and evidence-based medicine, issued a statement recommending colorectal cancer screening beginning at age 50. U.S. Preventive Services Task Force Recommendation Statement, *Screening for Colorectal Cancer* (June 21, 2016), available at <http://jamanetwork.com/journals/jama/fullarticle/2529486> (provides summary of organizations, including the American Cancer Society and National Comprehensive Care Network, that recommend colonoscopies every ten years). UVMMC and other hospitals in the region already provide colonoscopies, as well as other services the applicant will offer—in some cases by physicians who will perform surgeries at the ASC—and these procedures are currently considered standard medical practices. *See* Finding ¶ 19. We conclude that the applicant has satisfied these standards, and impose conditions today that limit the expansion of services, require transparency for the consumer, and require physicians to employ shared decision-making tools when recommending a procedure or surgery to a patient, as assurance that they continue to be met into the future.

Under Standard 1.3, an applicant must show that a collaborative approach to delivering services that are also provided by a neighboring facility is not feasible or appropriate. At this juncture, and absent any current agreement or affiliation with the hospitals (UVMMC and NMC), we do not believe it is feasible that they collaborate to deliver services. Moreover, in light of their divergent positions regarding the need for this project, we find that the applicant has demonstrated that collaboration with the hospitals, at this point in time, is not appropriate. The applicant has thus met this standard. As this project moves ahead, however, we expect—based on the applicant’s representations and as reflected in this decision and conditions of our approval—that the applicant will participate in Vermont’s efforts for system-wide payment and delivery reform, which will inevitably require its cooperation with the hospitals (and the converse) if patients are to receive integrated care across settings. Consequently, we condition our approval on the applicant entering into a patient transfer agreement with one or more local hospitals to safeguard patients in the event of an emergency, *see* Finding ¶ 54; CON Condition (Condition) A.4, and a participation agreement with one or more risk-bearing ACOs to ensure that it becomes integrated into a state-wide system of care. *See* Finding ¶ 12; Condition A.6.

Standard 1.4 requires that an applicant proposing services for which a higher volume is positively correlated to better quality must show that it can maintain appropriate volume, while not eroding volume at other facilities such that quality could be compromised. We find the applicant has met this standard, and that a shift in volume from the hospitals to the ASC will not adversely erode volumes so as to impact quality. Although we agree with the premise that experienced, practiced care will produce better outcomes, the types of surgeries that can be performed at an ASC are not novel, are low risk, and any correlation of volume and quality does

not raise the same issues as if, for example, the applicant was offering uncommon, complex, or risky, life-saving surgeries. *See* Finding ¶ 14. Although projections indicate a potential loss to UVMHC of approximately 13% of its surgical volume to the ASC, UVMHC performs more than 20,000 surgeries and 13,000 endoscopies annually, *see* Finding ¶ 29, rendering the ASC's impact on its volumes insubstantial in terms of maintaining or improving quality of care. NMC will potentially lose approximately 3% of its volume, consistent with the average reduction in hospital surgical volume when an ASC is introduced to the market. Findings ¶¶ 35, 36. Importantly, we are not convinced that surgical volumes will remain stagnant once the ASC begins operations; to the contrary, we reasonably expect the overall number of surgeries will rise, even if marginally, due to benign factors such as pent-up demand, the availability of lower cost care for some patients, and the in-migration of patients that may otherwise obtain their care out-of-state. Finding ¶ 24. In addition, absent the hospitals' plans to, for example, limit hours or repurpose current operating room space, some of the volume moved out of the hospital setting will likely be replaced, minimizing reductions in the provider tax and State Health Care Resource Fund. *See* Findings ¶¶ 48 (UVMHC regained some of the 1,500 eye surgeries it lost when the Eye Surgery Center opened), 10. As a final point on this standard, we note the physicians that transfer surgeries to the ASC will not decrease the number of surgeries they perform, and should therefore see no decline in their quality of care. Finding ¶ 24. Based on these reasons, we find the applicant has met this standard.

We next address the HRAP standards pertaining to construction projects, which we also find have been satisfied. In general, these standards were adequately addressed in the course of our review, are uncontested, and do not require copious explanation. *See, e.g.*, Standard 1.10 (construction must be energy-efficient); Standard 1.12 (construction must comply with FGI Guidelines).

We briefly address Standards 1.9 (applicant must show costs and methods of proposed construction necessary and reasonable, and that project is cost-effective) and 1.11 (applicant must show that new construction is more appropriate than renovation)—both of which overlap with the requirements in the second CON criterion—in light of the dissent's view that the applicant failed to consider less expensive alternatives such as building a smaller facility or renovating an existing space. As gleaned from the record and reflected in our findings, the applicant engaged two architectural firms to design the facility, one that specializes in ASC construction, the other a local firm that has garnered a reputation for high performance, sustainable construction. Finding ¶ 4. With the assistance of a local realtor, the applicant considered existing structures as options for the ASC, and detailed the cost and operational issues with the buildings under consideration. Finding ¶ 5. We find the applicant has demonstrated sufficient diligence in its review of alternatives and concern for cost, and has thus satisfied these standards.

The remaining relevant HRAP standards are met either through the requirement that the ASC be Medicare-certified, *see* Standard 1.6 (applicant must collect and monitor data relating to quality and outcomes); Standard 3.13 (procedures offered cannot require an overnight stay and can be performed safely in an ASC); through evidence in the record and enforced by Board-imposed conditions, *see* Standard 3.15 (ASC must provide patients with access to information and services for surgical complications on a 24-hour basis); Standard 3.16 (applicant must provide access to all residents within its service area without regard to payer type, insurance

status, or ability to pay); Standard 3.17 (ASC will secure Medicare certification, transport agreement with EMS, ensure staff are qualified and that clinical professionals have or are eligible for operating privileges at a local hospital, institute a policy review system, cooperate with review organizations and institute best practices protocol), or through uncontested evidence in the record. *See* Standard 1.8 (applicant must have comprehensive evidence-based system for disease control); Standard 3.14 (ASC location must be within appropriate travel time to hospitals with three or more operating rooms).

Based on the above, we conclude that the applicant has met the first criterion.

II.

Next, the applicant must demonstrate that the cost of the project is reasonable. 18 V.S.A. § 9437(2). Within this inquiry, the applicant must show that it can sustain any financial burden likely to result from completion of the project, that the project will not result in “an undue increase” in the cost of care, and “that less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.” 18 V.S.A. § 9437(2).

Our review of the record weighs in favor of a finding that the applicant can sustain the project’s costs. *See* 18 V.S.A. § 9437(2)(A). The applicant’s planning process was careful, focused and comprehensive. The applicant retained consultants with proven expertise in developing ASCs to help define the project’s scope and identify possible regulatory and operational hurdles which could cause a rise in costs, and similarly chose an architectural firm experienced in ASC design. Findings ¶ 4. The applicant apportioned funding for the project between equity from investors—nearly all of whom will perform surgeries at the facility—and a bank loan for which it has obtained pre-approval. Finding ¶ 6. The applicant has raised \$291,000 as of April 2017, and reports that its financing is “on track to raise [its] targeted debt and equity by the fall of 2017.” *Id.* We therefore conclude that the applicant has met this portion of the criterion.

We further conclude that less expensive alternatives are not available, would be unsatisfactory, or are not feasible or appropriate. *See* 18 V.S.A. § 9437(2)(C). As discussed in our review of the HRAP standards above, the record shows that the applicant considered renovating existing space and determined, based on cost and operational functionality, that new construction was more feasible and appropriate. Finding ¶ 5. While we acknowledge the dissent’s concern, and the applicant’s admission, that utilization projections indicate that the facility is designed larger than is needed during its first several years of operation, we do not conclude that constructing a slightly smaller building than the planned two-operating room, four-procedure room facility, would be either feasible or appropriate. We find credible the applicant’s explanation that its actual utilization for Years 1 to 4 will most likely be higher than in its projections as submitted to the Board, which are based on turn-around times for established ASCs. Finding ¶ 27 (applicant testifies that it will not initially achieve turnaround times that established ASCs can achieve).

The more difficult question is whether the project will result in an undue increase in the costs of care. 18 V.S.A. § 9437(2)(B). In making this determination, the Board must weigh the

financial implications of the project on hospitals and other clinical settings, and decide whether that impact is outweighed by the public benefit of the project, if any. 18 V.S.A. § 9437(2)(B)(i), (ii).

We first address the financial implications on hospitals and other settings. The applicant's projections indicate that UVMMC and NMC will each experience a decline in surgical volume as a result of the project. *See* Findings ¶¶ 33, 35 (UVMMC would see an approximate 13% decrease, while NMC would see a 2.7% decrease). In addition, we expect that they will see a shift in payer mix, with more commercially insured, higher reimbursed care provided at the ASC, and more governmental, lower reimbursed care provided at the hospitals. Although we condition today's decision on the ASC implementing a policy requiring its physicians to accept all payers, *see* Condition A.3, we also acknowledge that some payer shifting may nonetheless occur because individuals whose care is reimbursed by the government—the poor, elderly and disabled—may present risk factors that will prevent those individuals from receiving their care at the ASC. *See* Finding ¶ 14 (federal law prohibits ASC to accept high risk patients).

Notwithstanding the hospitals' projections of declining volumes and reimbursements, we initially acknowledge that there may be some rise in system-wide utilization due to benign factors such as pent-up demand, availability of lower cost care for some patients, the in-migration of patients who may otherwise have obtained their care out-of-state, and a potential shift from inpatient to outpatient settings for some surgeries. *See* Finding ¶ 24. Two further observations are noteworthy; first, at hearing, Board Member Holmes asked whether the hospitals would consider “repurposing” space or reducing costs so “care that used to be provided in a high-cost setting would no longer be.” TR (4/13/17) at 95. We believe these approaches have merit, and as Vermont's health care landscape is changing, encourage the hospitals to take them into consideration.

We further note that this Board regulates the hospitals' budgets, and we do not foresee calamitous and irreversible financial implications resulting from decreased surgical volumes. Both hospitals have in recent years exceeded their revenue projections; for fiscal year (FY) 2015 and FY 2016, UVMMC's actual net patient revenue exceeded budgeted revenue by 2.5% and 2.2%, respectively, while NMC exceeded budgeted revenue for the same two fiscal years by 7.7% and 1.9%. GMCB, *Vermont Hospital Enforcement Analysis (System Summary FY 2015 Actuals)*, http://gmcboard.vermont.gov/sites/gmcb/files/documents/A15-Hospital-System-Enforcement-Summary_FINAL-MAY16.pdf; GMCB, *Vermont Hospital Budgets (FY 2016 Budget to Actual Reviews)*, <http://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/Actual%202016%20Final%20Summary.pdf>.

The preceding considerations must next be weighed against the public benefit of the project. The first benefit we consider is increased savings to the health care system. It is undisputed that the ASC will generate savings to the Medicare program, which reimburses ASCs at a lower rate than it does hospitals. The applicant projects that Medicare will account for 40% of its revenues. Finding ¶ 41. This only holds true, however, if Medicare volumes do not significantly increase. The same caveat applies to Medicaid savings, which would be slimmer than Medicare savings. Because Vermont law prohibits provider-based billing, the ASC's

Medicaid reimbursements should not exceed prices at off-campus hospital outpatient facilities, and should also be lower than those that are billed from the hospital's campus. Finding ¶ 44.

The applicant also claims that the ASC will also generate meaningful savings from commercial reimbursements, citing a study that shows that ASCs are reimbursed approximately 50% of hospitals' reimbursements. Finding ¶ 42. The study, and the applicant's conclusion drawn from the study, are not directly applicable to our analysis. The study was conducted across 18 major metropolitan markets that bear little resemblance to our rural state. *Id.* Moreover, Vermont's largest commercial payer, BCBSVT, does not peg reimbursements to Medicare as do many commercial insurers (for example, commercial reimbursement might be set at 110% of Medicare), but instead uses a community fee schedule for independent physicians and community hospitals, and an academic medical center reimbursement schedule for UVMHC. *See* Green Mountain Care Board Report to the Vermont Legislature, *The Advisability and Feasibility of Expanding to Commercial Health Insurers the Prohibition on Any Increased Reimbursement Rates or Provider-Based Billing for Health Care Providers Newly Transferred to or Acquired by a Hospital, (In accordance with Act 143 of 2016, Section 4)*, (Feb. 1, 2017)¹¹ at 7. MVP, however, the smaller of Vermont's two major insurers, uses Medicare as a reference point for setting its commercial reimbursement to providers. *Id.* Accordingly, to ensure that commercial savings are realized, we condition our approval on 1) the applicant successfully negotiating with BCBSVT to accept reimbursements below the community fee schedule; and 2) for MVP and other insurers, the reimbursement must be lower than if the procedure/surgery were performed in a hospital setting. *See* Condition B.12. We additionally require the applicant to post its policy on its consumer website, and post the current price of each of the most frequently performed procedures and surgeries. *See* Condition B.9.

Again, the savings projected by the applicant can only be fully realized if utilization remains level or increases only marginally. The applicant's supposition that cost savings of an ASC "more than offset any modest increase in utilization" is optimistic, and based on the limited information presented to the North Carolina legislature by an advocacy group (state orthopedic association) requesting removal of CON restrictions on ASCs. Finding ¶ 25. Further, any savings based on lower reimbursements for services must be balanced against the fixed costs that remain in the hospital system, which could become a driver of higher hospital rates. On balance, however, we conclude that the ASC should reduce the rate of growth in the overall cost of care, particularly with the series of conditions we impose on the applicant that include the requirement that it become integrated into the state-wide system of care by entering into a participation agreement with one or more risk-bearing ACO(s). We further conclude that these savings and the public benefit that flows from reducing the cost of care outweighs the impact on UVMHC, NMC, and the larger hospital system.

Last, we are not deaf to the voices of many Vermonters who provided comment urging the Board to approve this application. Many spoke of the need for a lower cost alternative for care. With the conditions that we impose today, we anticipate that individuals with high-deductible health plans, as well as those who self-pay, should see lower out-of-pocket costs and that over time, the rate of growth of Vermonters' health care premiums will be tempered.

¹¹ The report notes that BCBSVT also uses some unique arrangements for certain providers.

Based on the above discussion, and in light of the conditions imposed in this CON, we conclude that the applicant has satisfied the second criterion.

III.

The third criterion requires that the applicant demonstrate that there is an “identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide.” 18 V.S.A. § 9437(3). According to the applicant, there is an unmet need in the northwestern region of the state for “lower cost, greater efficiency, enhanced patient experience, increased price transparency, and physician demand associated with an ASC.” Finding ¶ 17. The applicant submits that ASCs are commonplace in other states, and that for many patients they provide lower cost quality care outside of the hospital setting. *Id.* In addition, Medicare-certified ASCs are subject to federal oversight for quality, *see* Findings ¶¶ 8, 9, and typically have high levels of patient satisfaction.

VAHHS responds that the services offered at the ASC are duplicative of those already available, that there is ample operating and procedure room capacity for the next twenty years, and were surgical demand in the region to increase, the hospitals could extend their staffed hours. Findings ¶¶ 28, 30; VAHHS Opp. Memo (March 6, 2017) at 10-11. VAHHS also dismisses the notion that “wait times” are a useful measure of need. *Id.*

“Need” is not defined in our CON law or in our rule. The statute, however, articulates important principles that are foundational to our analysis. In its introductory section, the statute sets forth the “policy and purpose” underlying Vermont’s CON law, stating that new health care projects must be developed in a manner that avoids unnecessary duplication, limits health care cost growth, maintains and improves the quality and access to health care services, and promotes rational allocation of health care resources. 18 V.S.A. § 9431(a). In addition, the Board’s analysis is guided by the principles that comprise the framework for health care reform that include working to build an integrated health care system that fosters universal access for Vermonters to affordable, appropriate quality care. *See* 18 V.S.A § 9371 (Principles for Health Care Reform).

Addressing whether this project avoids unnecessary duplication, we note that there are inherent differences between a hospital and ASC setting, and we thus frame the issue more broadly than a simple comparison of services to be offered. For example, if we were to focus only on the procedures and surgeries that will be offered at the ASC, we might well conclude that because those procedures are also performed at the local hospitals, the project would unnecessarily duplicate those services. Our inquiry and focus must be wider, taking into consideration the state’s elemental health care reform principles and goals.

The issue of “capacity” is the core of VAHHS’ and NMC’s opposition to the project. The hospitals have provided projections showing that they have ample surgical capacity now, and can meet projected surgical demand until at least 2030. Findings ¶¶ 19, 20. Although we are not swayed by anecdotal reports that “wait times”¹² are primarily caused by hospital space

¹² We find credible the hospitals’ claim that “wait times” most often result from factors other than hospital room or staff availability. *See* VAHHS Opp. Mem. (March 3, 2017) at 12; Finding ¶ 37.

inavailability and find the hospitals' projections are credible, the "need" that the project will address is one for more affordable care for individual Vermonters. *See* 18 V.S.A. § 9371 (1) ("All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting"); § 9371 (2) ("Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care."). As may be surmised from our discussion of the second statutory criterion above, and as was echoed by many Vermonters who voiced their support for this project, *see* Finding ¶ 57, we find that there is an identifiable need and demand for more affordable health care services and for controlling the escalating costs of health care statewide.

Having demonstrated a need for the project, the applicant must also show that the need "is appropriate for the applicant to provide." 18 V.S.A. § 9437(3). Though addressed only tangentially in the record by the applicant and interested parties, it merits our discussion here.

To demonstrate its ability to integrate into our state's system of care, the applicant has expressed its willingness to participate in an ACO and asserts that it will assist Vermont in meeting its quality and performance targets. We therefore condition our approval on the applicant's participation in an ACO, as well as on additional conditions intended to foster affordability, transparency and quality care. With these guardrails in place, the applicant can follow through on its pledge of more affordable, accessible care for Vermonters. We encourage the legislature, however, to examine whether these entities—new to our state but prevalent in others—should be subject to more stringent regulatory oversight to ensure that they in fact reduce health care costs, provide high quality care, and to prevent any increase in unchecked utilization.

Based on the above, we conclude that the applicant has met the third criterion.

IV.

To satisfy the fourth criterion, the applicant must demonstrate that the project improves the quality of health care or provides greater access for Vermonters, or both. 18 V.S.A. § 9437(4). Because we find that the quality of care at the hospitals is already high—both NMC and UVMHC report high quality measures and level of patient satisfaction—we focus our attention on the issue of access.

The applicant claims that the project will increase access for Vermonters by providing "a lower cost, more convenient and less imposing environment for local residents to access routine surgical care." Finding ¶ 17. In addition, the applicant suggests that access will increase because the project will help address "wait times," and that the ASC will accept patients regardless of their ability to pay. Findings ¶¶ 32, 45. In contrast, VAHHS asserts that the project will not increase access for Vermonters because adding capacity to a well-served region of the state will drive up health care costs; the project relies on a fee-for-service model that will be detrimental to the state's health care reform efforts; and the applicant will not require physicians performing surgeries at the ASC to accept all payers. *See* VAHHS Opp. Memo. (March 6, 2017) at 2-3, 19; VAHHS Post-hearing Memo. (May 2, 2017) at 7.

We initially set aside some of the applicant's and VAHHS' claims that are not determinative of our conclusion. While we agree that some Vermonters may prefer to schedule their care at an ASC, rather than at a local hospital, we are not convinced that a substantial number of these same Vermonters, based solely on preference of venue and convenience, will postpone or forgo care entirely if the ASC were not developed. Further, as we already noted, we decline to infer from anecdotal stories of "wait times" that any delays in scheduling or obtaining care are predominantly attributable to a lack of surgical room availability. *See* p. 19, fn. 12. We also have addressed the cost issue under the second criterion and have concluded that the project will not unduly impact the cost of care in Vermont. Consistent with the overriding theme we heard in much of the public comment, we agree that reducing the cost of health care services will increase Vermonters' ability to pay for those services, and correspondingly increase access to care.

We have two areas of concern, however, and impose conditions on our approval as guardrails to better ensure that the applicant will retain an ongoing commitment to lowering system-wide costs. First, the ASC's business model is primarily based on a fee-for-service reimbursement model that runs counter to the course the state has chosen for its reform efforts, as reflected in the All-Payer ACO Model Agreement. For that reason, we reiterate that our approval is conditioned on the ASC becoming part of the statewide system of care through an ACO participation agreement, as it has asserted that it already plans to do. Finding ¶ 12; *see* Condition A.6. We formalize the applicant's representation as a condition of operation to ensure that the ASC becomes a partner, rather than an impediment, to reaching our health care goals.

We are also concerned that the applicant's policy to accept all patients regardless of ability to pay does not require individual physicians to adhere to its provisions. At hearing, the applicant confirmed that one of the physicians planning to perform surgeries at the ASC does not take Medicaid patients. Finding ¶ 45. In response to Board questioning, the applicant declined to commit to a policy that would prohibit the physician from doing so. *Id.* We find that the applicant's refusal to effectively implement its non-discrimination policy troublesome because it renders the policy toothless, and erects a barrier to care for some, particularly the poorest, Vermonters. We therefore impose as a condition of operation that the applicant require that all physicians planning to perform procedures or surgeries at the facility agree to accept all payers, and to base their determination of venue for any particular surgery—whether hospital or ASC—on factors other than type or amount of reimbursement. *See* Findings ¶¶ 14, 45; Condition A.3.

We conclude the applicant has met this criterion, and impose conditions as discussed above.

V.

The fifth criterion requires an applicant to show that the project "will not have an undue adverse impact on any other existing services provided by the applicant." 18 V.S.A. § 9437(5) Because the applicant offers no services at this time, to the extent this criterion is applicable, we conclude that it is satisfied.

VI.

Under the sixth criterion, the applicant must show that the project will serve the public good. 18 V.S.A. § 9437(6). Although the statutory language is spare, our administrative rule suggests factors we may consider in making this determination. *See* GMCB Rule 4.000, § 4.402.3. Several of the factors are relevant and we therefore address them below.

The first factor to consider is “[w]hether the project will help meet the needs of medically underserved groups and the goals of universal access to health services.” *Id.* at §4.402.3(a). As we discussed earlier in this decision, we find that the ASC will make care for some Vermonters—those with self-pay or high deductible health plans who may postpone recommended procedures, for example—more affordable. This, in tandem with conditions that the applicant institute a charity care policy as proposed and require that all physicians operating at the ASC accept all payers, leads us to a conclusion that the project will help meet the needs of underserved Vermonters.

The next factor requires us to determine “[w]hether the project will help facilitate implementation of the Blueprint [for Health].” *Id.* at §4.402.3(b). Here, the applicant will require all physicians practicing at the ASC to sign a “Collaborative Care Agreement,” based on Blueprint and national Patient Center Medical Home guidelines, *see* Finding ¶ 51, and we therefore conclude that it does.

The last three factors have each been fully addressed elsewhere in this decision, and we find they have been met. *See* GMCB Rule 4.000, § 4.402.3(c) (analyzes the project’s impact on the Vermont health care system and furthers integration and coordination of services); (d) (whether and to what extent project is consistent with current reform initiatives); (f) (whether and to what extent project will adversely impact ability of existing facilities to provide medically necessary services to all in need).

For these reasons, and based on our discussions in Sections I, II and III of this decision, we conclude that the applicant has met this criterion.

VII.

The seventh criterion requires that the applicant adequately consider the availability of affordable, accessible patient transportation services to the facility. The ASC will be located near an exit to a major highway, and has ample, free parking, including handicapped spaces. Finding ¶ 56. Public transportation is available, and the applicant represented that it would enter into talks with CCTA to modify an existing bus route to minimize the walking distance (currently a half-mile), to the facility. *Id.* In addition, eligible patients can arrange transportation from SSTA. *Id.*

We find that the applicant has met this criterion.

VIII.

The final criterion, to the extent it may be applicable, has been satisfied. *See* 18 V.S.A. §§ 9437(8) (applies to information technology projects). The applicant has conferred with VITL concerning implementation of an EHR at the facility, and has chosen a vendor with substantial experience in the acute care EHR market. Finding ¶ 53.

Conclusion

The Board issues a Certificate of Need to the applicant based on our conclusion that it has met its burden of proof. Our decision does not, however, and should not, be viewed as an open door for any similar health care entity that seeks to operate in this State. We issue this CON today because the applicant has affirmatively met each of the statutory criterion, and has demonstrated its commitment to join in our statewide health care reform efforts. With the conditions we impose today, we seek to hold the applicant to its pledge that it will lower health care costs, increase access to care, and maintain or improve the quality of health care in Vermont.

SO ORDERED.

Dated: July 10, 2017 at Montpelier, Vermont

s/ Jessica Holmes)
)
s/ Robin Lunge*)
)
s/ Kevin Mullin)
)
s/ Maureen Usifer)

GREEN MOUNTAIN
CARE BOARD
OF VERMONT

*Board member Robin Lunge has filed a separate concurrence. Board member Cornelius Hogan has filed a separate dissent.

Filed: July 10, 2017

Lunge, concurring.

With reservations, I join the majority in approving the applicant's request for a certificate of need to develop the Green Mountain Surgery Center. I write separately to discuss my concerns with the evidence presented with respect to the second (cost) and third (need) statutory criteria. The conditions required by the Board, if met and consistently followed by the applicant and the physicians using the facility, help to alleviate my most significant concerns.

I.

Under Vermont law, the applicant must demonstrate that the cost of the project is reasonable and sustainable by the applicant, that the project will not increase costs of care, and that less expensive alternatives are not available or appropriate. 18 V.S.A. § 9437(2). When determining the impact on the cost of care, the Board must weigh the financial implications of the project on hospitals and other clinical settings and whether that impact is outweighed by the public benefit of the project. 18 V.S.A. § 9437(2)(B). In my opinion, the evidence for this criterion is mixed for two reasons. First, the applicant's price projections are not based on Vermont law and factual circumstances. See Findings of Fact (Finding) ¶¶ 42, 44; Discussion in Majority Opinion (Maj. Op.) at 16-18. Second, cost and price are not synonymous. If increases in utilization outpace actual price reduction, total cost of care will increase. While the majority briefly acknowledged these issues, I want to expand upon the discussion. Maj. Op. at 16-18.

On the first point, the applicant has shown that the project would create a less expensive alternative for Medicare patients. Finding ¶ 41. This is inherent in Medicare's reimbursement methodology, which provides a facility fee based on the cost of operating the facility. Medicare pays more for hospital-based services than for ASC-based services because the cost of operating a hospital is greater than that of an ASC. The applicant assumes that Medicare will pay for approximately 40% of its cases. Finding ¶ 41.

Medicaid reimbursement is a different matter entirely. The applicant assumed that Vermont Medicaid would create a fee schedule resulting in lower reimbursement for this setting, using the Medicare cost ratio of 56%. *See* GMSC Overview Powerpoint at 13; TR (4/13/2017) at 56-57. However, Medicaid reimbursements for procedures performed at an ASC are governed by state law and vary from state to state. Prices for procedures performed at the ASC are not likely to exceed Medicaid prices for the same procedures performed at a hospital given the state legislative prohibition on the use of facility fees for outpatient medical services. *See* 33 V.S.A. § 1905a (prohibits provider-based billing at off-campus hospital outpatient facilities); Finding ¶ 44. Because of this, Medicaid prices are likely to be the same for the ASC as for hospitals. Accordingly, any increase in utilization simply results in greater pressures on the state Medicaid budget and, eventually, Vermont taxpayers. Medicaid cases, however, are only 12% of the total estimated cases to be done by the ASC, the lowest reimbursed by insurance.

With respect to commercial reimbursement, the evidence presented by the applicant was not relevant to rural markets. *See* App. at 22; Resp. to Q001 (12/23/15) at 11; Finding ¶ 42; Maj. Op. at 17. Moreover, the applicant failed to consider the issues raised by Vermont's unique commercial insurance market. Vermont's largest payer, Blue Cross Blue Shield of Vermont,

does not use Medicare as a reference price, but instead reimburses on two, primary fee schedules: an academic medical center schedule and a community fee schedule. While it is possible, it seems unlikely, that BCBSVT will create a third fee schedule for one entity with 1800-2100 total commercial cases. However, the community fee schedule typically reimburses a lower price than the academic medical center, which would result in lower prices than UVMMC. Because NMC is reimbursed on the community fee schedule as well, the ASC is unlikely to be cheaper than NMC.

The applicant estimates that commercial cases will make up 35% of the cases at the ASC. Most of these cases will likely be drawn from UVMMC, rather than the other hospitals in the region. Thus, taking into consideration Vermont-specific pricing factors, a majority of the commercial reimbursements at the ASC are likely to be cheaper.

I must emphasize that should the General Assembly, or the Board, equalize commercial fee-for-service reimbursement between the academic medical center and independent physicians for outpatient services in the future through a “pay parity” policy, the applicant’s assertion that it offers a lower cost setting would no longer be true and a primary rationale for approving the ASC would be eliminated.

While the ASC will not offer a cheaper price for all patients, it may offer a cheaper price for more than half of the patient population it serves given current reimbursement policy and law in Vermont. This will result in reduced cost-sharing for patients who have a coinsurance requirement for outpatient services.¹ Requiring that the commercial and self-pay rates be lower than outpatient services at a hospital and below the community fee schedule for BCBSVT ensures that the applicant’s claim that prices will be less for consumers becomes reality for most of the ASC’s patients. CON Condition (Condition) B.12. Further, requiring proactive consumer education on price is essential to ensure that patients know and understand the financial impact on their cost-sharing, if any. Conditions A.2 and B.14.

Conditioning the CON on all surgeons using the ASC accepting Medicaid and requiring that the charity care and bad debt policies be at least as generous as non-profit hospitals will provide standards for lower income patients wishing to use the facility. Condition B.15. These policies will also ensure that prices are at least as favorable for these populations. Finally, the price transparency conditions should allow patients traveling from other communities to determine whether the price is in fact cheaper than local hospitals, thus saving travel time for patients and minimizing impacts on the community hospitals. Condition B.9.

These conditions allow me to concur with the majority in granting a CON to the applicant.

On the second point, the applicant failed to present adequate evidence, in my view, to show that total cost for services (price multiplied by utilization) would not be increased overall. For this reason, conditions aimed toward controlling utilization are necessary to ensure that utilization remains flat or is modestly increased. Conditions A.2, A.6, B.10, and B.18.

¹ Patients with a co-payment will be unaffected by any reduction of price in their out-of-pocket costs.

The applicant does not expect there will be an increase in aggregate costs to the health care system, even with increased utilization. Finding ¶ 24. To the contrary, the applicant contends that “the cost savings of an ASC as compared to hospital-based services will more than offset any modest increase in utilization.” App. at 32 (citing presentation to the N.C. legislature by N.C. Orthopaedic Association and its consultants in support of removing CON restrictions on ASCs); Finding ¶¶ 24-25; Maj. Op. at 17-18.

I remain concerned that volume for the categories of services offered by the ASC² will increase across all settings in the region. This concern is based on the public comments and evidence presented that surgeons expect to be able to do more procedures and surgeries due to easier scheduling and faster turnaround times than other facilities, especially UVMHC. Findings ¶¶ 20, 24, 26, 27, and 28. Without more specific data or constraints on utilization, it’s unclear whether the price reduction for a subset of patients will offset increases in volume across the region. If utilization increases are not offset by price reductions, there could be an increase in insurance premiums resulting from adding this capacity to the system. I am also concerned that in a fee-for-service system, the incentive for a for-profit ASC and its investors is to increase the volume of surgeries performed in order to create profit.

The conditions imposed by the Board alleviate my concern that current financial incentives will drive up utilization. The requirement that the ASC participate in health care reform efforts with the goal of moving away from fee-for-service to value based payment methodologies could address this concern if the ACO models achieve scale. Condition A.6. Specifically, participation in a risk-based ACO model and acceptance of a fixed cost reimbursement amount address my concern that increased volumes will drive up aggregate costs while ensuring that the ASC remains financially viable because reimbursement would no longer be tied to volume. Condition A.6. Hospitals in the region are participating in this kind of payment arrangement, and requiring the ASC to adopt a similar payment methodology creates consistent financial incentives and common payment methodologies across settings within our health care system as well.

Because Vermont, through the All-Payer ACO Agreement, agreed to reduce the per capita cost trend in Medicare by 0.2% from the national trend, we must ensure that any increases in Medicare utilization do not also increase total cost of care. Indeed, several of the conditions imposed by the Board attempt to ensure utilization is appropriate and that reimbursement methods move away from fee-for-service toward a model that does not incent doing more services. Conditions A.2, A.6, B.10, and B.18

My concerns about utilization are also addressed by the condition requiring the applicant to ensure its surgeons use a shared-decision making approach and requiring that the applicant submit information about how this will be implemented prior to beginning construction on the facility. Condition A.2. The most common procedure that will be offered at the ASC is colonoscopy, which is a widely accepted method, but not the only method, to screen for colon cancer. *See* Finding ¶ 18; App. at 22. The U.S. Preventive Services Task Force, an independent panel of national experts in prevention and evidence-based medicine, last year issued a statement recommending colorectal cancer screening beginning at age 50. *See Screening for Colorectal*

² *See* Finding ¶ 18.

Cancer, U.S. Preventive Services Task Force Recommendation Statement (June 21, 2016), available at <http://jamanetwork.com/journals/jama/fullarticle/2529486> (provides summary of other organizations, including the American Cancer Society and National Comprehensive Care Network, that recommend colonoscopies every ten years). The Task Force recommendation, however, provides multiple options for patients who are not at high risk for colon cancer. See *Cancer Screening Guidelines for Providers*, Vermont Department of Health, available at <http://www.healthvermont.gov/sites/default/files/documents/2016/12/CancerScreeningGuidelines-Providers.pdf>). Patients should have the opportunity to understand these options and choose whether they would prefer the colonoscopy over other non-invasive options.

If the applicant can more clearly provide the evidence-basis, if available, for recommending the surgery or procedure type this will clarify appropriate utilization of this service. Condition B.10. In the absence of clinical evidence or protocols for when the surgery or procedure type is appropriately recommended, utilizing shared decision making with patients to promote patient preferences should have a positive impact on overall costs. Elective, or “preference-sensitive”, care includes “interventions for which there is more than one option and where outcomes will differ according to the option used. This category...includes elective surgery....[B]ecause patients delegate decision making to doctors, physician opinion rather than patient preference often determines which treatment patients receive...This can result in a serious but commonly overlooked medical error: operating on the wrong patients –on those who, were they fully informed, would not have wanted the operation they received.” Wennberg, John E., *Tracking Medicine* at 9 (2010). Promotion of shared decision making often results in patients choosing less invasion options and can reduce surgical utilization appropriately.

In general, there is insufficient specificity provided by the applicant about the services to be provided and the resulting impact of expanding capacity for these services on the total cost of care in the region from my perspective. I therefore do not find the applicant’s assertion that cost will not be increased by overall increases in utilization credible given the evidence. Requiring meaningful participation in a risk-bearing ACO combined with the conditions related to affordability and transparency, however, may place sufficient guardrails to ensure that costs do not increase. Conditions A.6, B.9, B.12, B.13, B.14, B.15.

II.

The third statutory criterion requires that the applicant demonstrate that there is an “identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide.” 18 V.S.A. § 9437(3). According to the applicant, there is an unmet need in the northwestern region of the state for “lower cost, greater efficiency, enhanced patient experience, increased price transparency, and physician demand associated with an ASC.” Finding ¶ 17.

I have great difficulty with the applicant’s definition of need. It is undisputed that the applicant would be providing services that are currently provided in local hospitals in the region. Indeed, the evidence indicates that there is capacity at UVMMC and NMC to meet the projected demand for procedures and surgeries until 2030. Finding ¶ 28. The applicant also included

excess capacity in the project's footprint in order to accommodate increased volumes over time. Finding ¶ 27.

18 V.S.A. § 9431 establishes as public policy that all new health care projects must be developed in a manner that avoids unnecessary duplication of services, and promotes rational allocation of health care resources in the state. In addition, Rule 4.102 indicates that the purpose of the CON process is to prevent unnecessary duplication of health care facilities and services and promote cost containment. Adding new fixed infrastructure costs into a region where there is sufficient supply is inconsistent with this policy. The Board, however, received multiple public comments from both providers and patients indicating a lack of efficiency in accessing procedure and operating rooms at UVMMC. Finding ¶57.

To address this issue, Board Member Hogan and I would, at minimum, impose a condition that the applicant redesign the facility so that it was not overbuilt for the projections provided given the existing capacity. I was not able to convince a majority of the Board to adopt this limitation, however, and remain concerned about adding new fixed costs into our health care system.

Nevertheless, with the conditions required of the applicant to begin operations, I have overcome my reservations and concur with the Board in the outcome.

Dated: July 10, 2017 at Montpelier, Vermont

s/ Robin Lunge
Member, Green Mountain Care Board

Hogan, dissenting.

I disagree with the Board’s decision today to grant a certificate of need to the applicant for the proposed ambulatory surgery center (the Surgery Center). Because the Surgery Center would contribute to the fragmentation of Vermont’s health care system and increase costs systemwide, I would deny the CON.

Below is a review of my findings regarding the Surgery Center. My approach involved reviewing the application, the subsequent questions and answers, the testimony, and public comment to determine whether it met the CON criteria set forth in Act 48, Title 18, and the Health Resource Allocation Plan (HRAP). My conclusions are primarily guided by Act 48, which is intended to have the Board work towards a systematic view of health care in Vermont. *See* 18 V.S.A. § 9371(1) (“The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters.”)

For almost six years now, we have been on that path. The creation of the All-Payer Model¹ and the Accountable Care Organizations (ACOs),² particularly OneCare Vermont, are examples of the Board’s influence and work towards creating a health care system that will ultimately reduce costs for Vermonters. That work must continue.

Act 48

Enacted in 2011, Act 48 promised major reform to health care in Vermont. In addition to creating the Green Mountain Care Board, it clearly required a *systems-based approach* to health care. *See* 18 V.S.A. § 9371(13) (“Vermont’s health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.”) Indeed, its very title refers to creation of a “universal and unified health system.” 2011 Vt. Acts & Resolves 239. Thus, any CON review must take this system requirement and our progress toward it into account.

We made a serious attempt to keep the promise of Act 48 by attempting to implement a single-payer health care system. It came close, but no cigar. Our next big step came in 2016, with negotiation of the All-Payer Model ACO Agreement between the State and the federal government. The ACO delivery model contemplated in the Agreement and starting January 1, 2018, is premised on a statewide system of care. We are getting there.

In fact, key indicators representing system development mark our progress. For instance, according to the State Health Access Data Assistance Center (SHADAC), the percentage of Vermonters with fair or poor health status has fallen from 13.7 percent in 2009 to 10 percent in

¹ The Vermont All-Payer Accountable Care Organization Model Agreement (“All-Payer Model”), signed by Vermont’s Governor, Secretary of Human Services, Chair of the Green Mountain Care Board, and the Centers for Medicare and Medicaid Services (CMS), aims to reduce health care cost growth by moving from the current fee-for-service provider reimbursement model to a model that incentivizes health care quality over volume, and improved patient outcomes.

² An Accountable Care Organization is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of patients assigned to it.

2015.³ See *Analysis of Current Pop. Survey's Ann. Social and Econ. Supp.*, State Health Compare, SHADAC, U. of Minn. As of 2015, Vermont had the second-lowest percentage of residents with fair or poor health status, behind only New Hampshire, and far ahead of the rest of the nation. *Id.* In addition, Vermont has among the lowest rates of potentially preventable hospitalizations per 100,000 adults in the United States, with preventable hospitalizations approximately 33 percent lower than the national average. *Id.* During the same period, 92.4 percent of adult Vermonters reported being able to access health care when needed. See *Analysis of Behavioral Risk Factor Surveillance System*, State Health Compare, SHADAC, U. of Minn. The State achieved this while reducing growth in personal health care spending from 5.9 percent in 2004-2009 to 2.4 percent in 2014, aligning it for the first time with growth in income. See David Lassman, et al., *Health Spending by State 1991-2014: Measuring per capita Spending by Payers and Programs*, 36 HEALTH AFFAIRS 1, 3, 5 (June 14, 2017).

These figures show Vermont's progress in the context of overall health care reform. The applicant has not demonstrated how it would build upon this progress, particularly with respect to population-level contributors to the cost of care and the quality of Vermonters' health. The Surgery Center would add additional capacity to an area of the State with abundant capacity, would provide services only to select low-risk patients, and would not commit to obligating its providers to accept Medicaid patients, which would change hospitals' payer mix for the worse over time. See TR (4/13/17) at 41. Instead of working within our system of care, the Surgery Center would fragment it, funneling healthier and higher-paying patients away from the hospitals. See Resp. to Q006 (1/25/17) at 8. Viewed in this context, the Surgery Center would not help Vermont reach its health reform goals under Act 48.

Title 18

Title 18 outlines eight criteria an applicant must meet before the Board may issue a CON. As noted above, the burden is on the applicant to meet *all* of the statutory criteria, not merely a predominance or majority. GMCB Rule 4.302. Based on my review of the full record in this matter, the applicant has failed to meet several of the statutory criteria.

A. Impact on the Costs of Medical Care

First, the applicant did not show that the Surgery Center will not result in an undue increase in the costs of medical care. See 18 V.S.A. § 9437(2)(B). The applicant claims that the Surgery Center will decrease the total cost of care through "operational efficiencies," but offered no evidence in support of its position. The applicant also failed to produce convincing evidence demonstrating "the financial implications of the project on hospitals and other clinical settings." 18 V.S.A. § 9437(2)(B)(i). Essentially, the applicant argues that the University of Vermont Medical Center's (UVMCMC) size and financial strength are so formidable that it would not be meaningfully impacted by the loss of revenue caused by a comparatively small number of procedures moving to the Surgery Center.

I am not persuaded. Hospitals are required by law to provide services at reduced cost or on a charity care basis, *see, e.g.*, 42 U.S.C. § 1395dd (requiring Medicare-participating hospitals

³ The data cited in this dissent can be accessed via the SHADAC website at <http://shadac.org/>.

to treat patients regardless of insurance status or ability to pay), unlike privately-owned surgery centers which overwhelmingly cater to healthier, higher-paying patients. Over time, as these patients get care at the Surgery Center, the hospitals will see higher-acuity patients while their patient mix will be increasingly dominated by government (lower) payers. Since hospitals have fixed costs regardless of the number of services performed, every dollar that goes to the Surgery Center will contribute to a rapid growth in health insurance premiums, as hospitals shift costs to remain financially viable. There is evidence that this has already happened in Vermont.

Representatives of Northwestern Medical Center credibly testified that its revenue and payor mix for eye surgeries was significantly affected by competition with the Vermont Eye Surgery Center in South Burlington, an ASC which opened in 2008. TR (4/19/17) at 7. Extrapolating that revenue and payor mix to all procedures offered at the Surgery Center, the hospital predicts that “it will be increasingly difficult...to provide critical service[s] to the community such as emergency room service, urgent care, our birthing center, comprehensive pain and addiction services, and population health services.” *Id.*

Moreover, because the State does not currently license or regulate ASCs, the Surgery Center would effectively be an unregulated spender, increasing the cost-risk to Vermont’s health care system over time. Indeed, the excess capacity introduced by the Surgery Center is likely to increase the volume of services provided in the region, and thus the total cost of care. Even if we were to believe the applicant’s chimerical claim that volume would not measurably increase with capacity, the applicant failed to show that the Surgery Center would not unnecessarily contribute to an increase in the total cost of care by introducing more fixed costs into Vermont’s health care system.

The Surgery Center could well deliver on its promise to provide a lower-cost alternative setting of care for certain procedures. But, reducing the costs of specific services is very different than addressing the overall cost of health care. For this reason, the applicant, in my view, failed to meet its burden of showing that the Surgery Center would not increase the total cost of care in the region.

B. Existence of Less Expensive Alternatives

Second, the applicant failed to show that “less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.” 18 V.S.A. § 9437(2)(C). The applicant said that it would bill a separate facility charge inclusive of room time, medications and recovery, but has not disclosed what those charges would be or whether they would in line with other facilities in New England. Because Medicare generally reimburses a higher facility fee for outpatient services performed in a hospital setting, *see* 79 Fed. Reg. 66770-01, 66910 (Nov. 10, 2014), the Surgery Center has the potential to achieve significant Medicare savings.

The applicant went even further, however, claiming that the Surgery Center could achieve comparable cost-savings across commercial and Medicaid payers with no testimony as to how this would be accomplished within a fee for service payment model. Incredibly, to estimate Medicaid savings, the applicant simply assumed that Medicaid would pay at the same rates as Medicare. *See* GMSC Overview Powerpoint at 13; TR (4/13/2017) at 56-57. And, to

estimate commercial savings, the applicant cited a 2014 study providing only a limited comparison of facility fees by three commercial payers for certain procedures, which did not consider rural markets like Vermont. *See* App. at 22; Resp. to Q001 (12/23/15) at 11.

The applicant likewise offered little evidence to show how its proposed 12,879 square feet facility would be less expensive than building or leasing a smaller space. By the applicant's own admission, the planned facility is oversized for the projected number of patients, especially in the context of population growth rates in Chittenden County. *See* Resp. to Q001 (12/23/15) at 1. This disparity is best represented by the applicant's projected volumes over a four-year period growing at a rate two to three times faster than the population growth rate Chittenden County as projected by the U.S. Census Bureau. *See* VAHHS Powerpoint at 8. Even with such a fantastical growth rate, the applicant's Year 4 projections show procedure rooms at 61 percent of capacity, and operating rooms at 53 percent of capacity. I thus fail to see how the Surgery Center represents the least-cost, most-appropriate setting for the delivery of care.

C. Identifiable, Existing, or Reasonably Anticipated Need

Title 18 requires the applicant to demonstrate that "there is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide." 18 V.S.A. § 9437(3). This need has not been established. In fact, the applicant readily concedes that services offered at the Surgery Center would be duplicative of those offered hospitals in the region, contrary to the State's public policy. *See* 18 V.S.A. § 9431 (requiring that that "new health care projects be offered or developed in a manner which avoids unnecessary duplication").

The applicant instead claims that there is an identifiable need for "lower-cost alternative settings of care" in Vermont. I disagree. Analysis of UVMHC's surgical rooms and procedure rooms shows excess capacity on its Main Campus, even discounting other opportunities to increase efficiency over time. *See* Resp. of VAHHS (5/6/2016) at 10-12; VAHHS Powerpoint at 14 (showing that UVMHC's capacity is at 71 percent for the procedure rooms, and 74 percent for operating rooms at the Main Campus). There is also much currently unused capacity at UVMHC's Fanny Allen Campus. *See id.* (showing capacity at UVMHC's Fanny Allen campus at 41 percent for procedure rooms and, 63 percent for operating rooms). There is no "need" to add new fixed costs into a part of the state with enough operating and procedure room supply to meet the region's needs until 2030. *See id.* at 9.

The applicant also points to anecdotal reports from providers, including physicians who would work at the Surgery Center, and patients showing long wait times to access operating and procedure rooms in the region, particularly at UVMHC. *See, e.g.,* Resp. to Q003 (7/26/2016) at 10. Need, however, is not determined at a specific point in time. It is constantly assessing and reacting to the facts. The fact is, UVMHC can and should make adjustments to shorten wait times, but the applicant has not persuasively shown how the Surgery Center would reduce wait times without more physicians providing care.

D. Greater Access to Health Care

The applicant is also required to show that the Surgery Center would improve the quality of health care in the state or provide greater access to care. *See* 18 V.S.A. § 9437(4). It has done neither. First, the applicant offered no concrete evidence that the Surgery Center would improve the quality of care. By every quality indicator, Vermont has one of the best health care systems in the country, and our regional hospitals already provide excellent care and report high levels of patient satisfaction. Second, constructing yet another surgical venue to increase capacity and volume of services is not the same as providing access to care; given the excess capacity shown in the combination of the two nearest hospitals, additional space is simply not needed. With the current movement in Vermont to the All-Payer Model and focus on preventative care, and on programs that take into account the social determinates of health, my view is that any growth in surgical capacity should be pegged to the growth rate of the population.

E. Serves the Public Good

Under Title 18, any new health project must “serve the public good.” 18 V.S.A. § 9437(6). The applicant’s definition of public good, however, is narrowly defined as competition and convenience for patients and providers, and entirely ignores the issue of excess capacity discussed above. It is apparent to me that the applicant is really looking for an “open door” with few meaningful limits. The Surgery Center would be neither deeply regulated nor part of the State’s ever-emerging health care system, at a time when Vermont has begun its collaboration with the federal government and other providers across the state to control costs, improve quality and the overall health of Vermonters. Unlike our hospitals and ACOs, the Surgery Center would be subject to little regulatory constraint, and unless legislative changes are forthcoming, the Board will not direct oversight of its budget, which is critical to bending the cost curve. *See* 18 V.S.A. §§ 9451- 9457 (Hospital Budget Review); 18 V.S.A. § 9382 (*eff.* Jan. 1, 2018) (Oversight of Accountable Care Organizations). The public good is not well served if overall health care costs are allowed to rise without regulatory restraints. *See* 18 V.S.A. § 9401(b)(2) (State policy is to “Utilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services”).

Not only would the Surgery Center operate without any financial oversight, but its profits would be returned to the individual physician-investors, raising the ethical concern of doctors referring patients to themselves as shareholders. And while the applicant states that it will work towards effective integration into Vermont’s health care system and coordination with other Vermont providers, the Surgery Center is not legally required to collaborate or partner with other entities working towards Vermont’s common health care goals, and I find its bare assertion unconvincing. Without crucial third-party relationships and interoperability with essential components of Vermont’s health care system, the Surgery Center will be an island unto itself.

Ultimately, we must ask ourselves – what is the limit of patient and provider choice? Vermont’s health care system is based on cooperation, not competition, *see* 18 V.S.A. § 9371(13), and allowing a new, virtually unregulated entity to infuse more dollars into the system—while diverting revenue from our system of regulated hospitals that serve *all* Vermonters—is contrary to the public good, irrespective of choice or convenience.

Conclusion

The law and rules governing CON applications are clear. The applicant must convince the Board with hard evidence that it has met the statutory criteria. The burden is not on the Board to prove that the positions taken by the applicant were right or wrong. For the reasons outlined above, I believe the applicant failed to produce facts supporting its positions as to Act 48, Title 18, and the HRAP.

The Board made a crucial decision today without considering the larger environment – for instance, the effect of any potential federal changes to Medicaid funding on hospitals. At the very least, any decision such as this, which fundamentally alters the landscape of health care in Vermont, should wait until there is less uncertainty at the federal level. Additionally, with this decision, it will be increasingly difficult for the Board to justify denying CONs to future applicants who want to open similar facilities in parts of Vermont where local hospitals are far more financially vulnerable than UVMMC.

In large part, the issue boils down to whether the Board creates a system of health care, as required by Act 48, or whether it backs away from system development and opens the door to unfettered competition between providers. Competition can be good, but it must happen within a regulated system. We are very close to some important payoffs with that system, including creating a true hospital network through our ACOs, global hospital budgets, the end of fee for service, and imposing overall cost control with the All-Payer Model. At this critical juncture, the Board should not be turning its back on its statutory mandate.

With the Board's decision today, we will lose the collaborative relationships we have had with most hospitals around the State for six years. They simply will not trust us. As a result, the hospital budget process will become increasingly hostile, especially as hospitals find themselves under mounting financial pressure. Ultimately, it will not be a battle the Board can win. We will also lose the relationship we have developed with the federal government, to which we assured progress towards developing an integrated health care system.

The Board will eventually lose control of the Surgery Center as well. The conditions imposed in the CON are a good start, but I believe those conditions will prove to be unenforceable. If the Surgery Center does not meet its conditions after opening, I find it unlikely that the Board would either revoke its CON or impose sanctions through the statutory enforcement process. In any event, absent new legislation, once the implementation period ends, the Surgery Center will largely be free from any State licensing or regulatory requirements.

At the end of the day, this case presented a major test for the survival of an integrated health care system in Vermont, and I fear the Board has not risen to the challenge. I respectfully dissent.

Dated: July 10, 2017 at Montpelier, Vermont

s/ Cornelius Hogan
Member, Green Mountain Care Board