**STATE OF VERMONT**
**GREEN MOUNTAIN CARE BOARD**

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| In re: Application of Attuned Living and Eating Centers, LLC | ) | GMCB-013-14con |

# STATEMENT OF DECISION

## Introduction

In this Certificate of Need (CON) application, Attuned Living and Eating Centers, LLC (the applicant) proposes to provide clinical services to patients suffering from Binge Eating Disorder (BED), a relatively new diagnosis that was for the first time included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[1] in May 2013. Although the applicant has operated a successful non-medical weight management retreat in Vermont for over forty years, the proposed project is intended to provide a unique clinical treatment model for patients suffering from this particular type of eating disorder.

For the reasons outlined in this Decision, we deny the application pursuant to 18 V.S.A. § 9440(d)(5).

## Procedural Background

On August 14, 2014, the applicant filed a CON application with the Board to develop an outpatient eating disorder treatment program in Ludlow, Vermont, accompanied by a request for expedited review and request that specific personal financial information be treated as confidential. On August 25, 2014 the Board granted the applicant's confidentiality request to the extent allowable by Vermont law; on August 29, 2014, the Board denied expedited review.

Following public notice in eleven Vermont newspapers, the Office of the Health Care Advocate (HCA) petitioned the Board for interested party status on September 17, 2014, which was granted on September 18, 2014. The Board has received no competing applications or additional requests for interested party or amicus curiae status.

The Board requested additional information from the applicant on September 10, 2014, October 10, 2014, December 12, 2014, February 16, 2015 and March 10, 2015. The applicant provided responses to each of the requests. The application was closed on January 16, 2015.

A hearing was held on February 26 and March 26, 2015. Randall Autry, Chief Executive Officer of Green Mountain at Fox Run, LLC, and Kari Anderson, President and Chief Clinical Director of Attuned Living and Eating Centers, LLC, appeared on the applicant's behalf. Alan Wayler and Marsha Hudnall, owners of Green Mountain at Fox Run, LLC, also attended the

[1] Published by the American Psychiatric Association, the DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The DSM-5 was published in 2013 after a 14-year revision process.

hearings. The HCA was represented by Kaili Kuiper, Esq. and Lila Richardson, Esq., who submitted oral and written comment to the Board stating that the applicant had failed to meet the CON criteria. Judith Henkin served as hearing officer by designation of Chair Al Gobeille.

A Proposed Statement of Decision was issued on April 15, 2015 denying the application. Pursuant to Section 9440(d)(5) of Title 18, the Board notified the applicant that it must file any exceptions, briefs, or request for oral argument or to present additional information no later than April 30, 2015. The applicant filed no materials or requests by that date; the Board now issues a final decision in this matter.

## Findings of Fact

1. Weight Control Communities, Inc., d/b/a Green Mountain at Fox Run (Fox Run), located in Ludlow, is a 40-bed short-term weight management and healthy lifestyle retreat center offering a program for women seeking a lasting lifestyle change and alternative to diet-based approaches to weight management.

2. Fox Run has been a family-owned business for over 41 years. Started in 1973 by Thelma Wayler, Fox Run is now owned by Alan Wayler and Marsha Hudnall, the founder's son and daughter-in-law.

3. Fox Run offers three integrated non-clinical programmatic components: educational opportunities for behavior related to eating, nutritional education, and fitness and movement education and training.

4. Fox Run does not offer medical services and does not track outcomes of its participants. To date, only one study of the Fox Run non-clinical program has been published, appearing in the International Journal of Eating Disorders in 1985. The study was not a controlled clinical trial, the sample size was small and results were self-reported by participants. Response (3/23/15) Attachment 1; Transcript (TR) (2/26/15) at 32-34.

5. Fox Run is licensed in Vermont as a hotel. Ninety-nine percent of its clientele is from out-of-state, with an average of only four Vermont participants annually. Response (11/18/14) at 5.

6. Currently, Fox Run refers women with clinical needs to individual therapists and occasionally to traditional outpatient and residential eating disorder programs. The owners of Fox Run believe that many of its participants would benefit from a clinical program and has formed the entity Attuned Living and Eating Centers, LLC to develop the proposed outpatient treatment center for women with Binge Eating Disorder (BED).

7. As a new diagnosis – BED was listed as a disorder for the first time in the DSM-5 in May 2013 – treating women with BED remains an emerging area for research and treatment.

8. The applicant is currently developing a treatment model and proposes to offer three programs, each of which is designed to address medical and psychological comorbidities,

help women improve their body image, and re-establish healthy eating patterns based on a mindful eating philosophy.

9. The Outpatient Therapy Program (OTP) offers a single session per day, one or more times per week as required, consisting of:
    a) Individual psychiatric assessment and pharmacological treatment by a psychiatrist;
    b) Individual BED assessment conducted by a doctoral or master's level psychotherapist;
    c) Individual and group therapy provided by a doctoral or master's level psychotherapist; and
    d) Nutritional therapy conducted by a registered dietician.

10. The Intensive Outpatient Program (IOP) offers three to four hours per day, three to five days per week, for a period of four to six weeks. The IOP is designed to stabilize dysfunctional eating behavior related to BED with the goal of returning the patient to normal activities. The program includes the following services:
    a) Individual psychiatric assessment and pharmacological treatment by a psychiatrist;
    b) Individual BED assessment conducted by a doctoral or master's level psychotherapist; and
    c) Individual and group therapy provided by a master's or doctoral level psychotherapist.

    Specific focus of therapy will depend on the individual's treatment plan, but may include:
    - Cognitive behavioral therapy;
    - Dialectical behavioral therapy;
    - Mindfulness-based therapy;
    - Interpersonal group therapy;
    - Meal support therapy;
    - Body image therapy;
    - Expressive therapies;
    - Art and music therapies;
    - Supported exposure therapy with one supervised meal per day;
    - Family therapy conducted by a master's level or doctoral level psychotherapist;
    - Nutritional therapy conducted by a registered dietitian; and
    - Primary care intervention for identified medical complications.

11. The Partial Hospitalization Program (PHP) is intended for patients that require a higher degree of monitoring and support, and will provide participants with approximately six hours of intensive therapy per day, five days a week, for six to eight weeks. The services will be similar to those offered by the IOP program, but the intensity of therapy will be greater and more frequent. In addition to the therapies and activities offered to IOP patients, PHP participants may be offered additional supervised meals, grocery shopping, cooking classes, and restaurant outings.

12. Criteria for admission to the IOP and PHP programs are based on clinical guidelines set by the program's clinical leadership team.[2] Patients will be screened to determine that they are psychologically and medically stable prior to their admission. A multidisciplinary clinical team will evaluate each patient and develop an individualized treatment plan.

13. The applicant also intends to offer an optional Transitional Living Program component to provide IOP and PHP participants with additional non-clinical support in the off-hours. For an additional cost, the program includes overnight accommodations and activities for those who do not wish to secure their own accommodations during treatment. The Transitional Living Program will be housed a little over a mile from the proposed outpatient treatment center at the existing Fox Run facility. Program participants that do not choose the Transitional Living Program may secure their own accommodations at area hotels or rentals.

14. The applicant estimates annual operating costs for the project of $1,727,191 in Year 1, $1,768,860 in Year 2, and $1,827,968 in Year 3. The applicant projects an additional cost of $59,268 to renovate existing space. The project will be financed with an equity contribution of $392,068 from Fox Run's owners.

15. The applicant has developed admission guidelines for its IOP and PHP programs, and is in the process of developing policies, forms and tools for data collection to use once its operations commence.

16. For the IOP and PHP programs, the applicant is currently developing a treatment model which will integrate proposed new clinical service components with existing non-clinical services offered at Fox Run. According to the applicant, the treatment model will be the first of its kind in the United States to offer evidence-based treatment specifically for BED in conjunction with a behavioral approach to address dysfunctional eating in a non-clinical setting for weight management, based on mindful eating principles. Application at 8-9.

17. In support of its application, the applicant submitted copies of published journal articles describing the clinical treatment modalities it plans to incorporate into its proposed IOP and PHP treatment program. Application, Appendix A.

18. According to the applicant, only two entities in Vermont specifically offer eating disorder treatment. The Vermont Center for Integrative Therapy in Burlington offers treatment with affiliated independent specialists in areas of anxiety, depression, eating disorders, chronic pain, trauma and obsessive-compulsive disorders. The Creative Clinical Associates in Stowe and Berlin provide counseling and therapy services for clients with a range of issues including eating disorders, low self-esteem, substance abuse, and codependency. Both entities provide outpatient services only, and do not offer formal day treatment programs. Application at 20-21.

[2] The clinical leadership team consists of two staff, the clinical director, and the program psychiatrist, who also serves as medical director.

19. In addition, there are individual therapists practicing in Vermont who treat eating disorders but are not affiliated with any programs that provide an organized and comprehensive approach to treating BED. *Id*. at 21.

20. The applicant has reached out to therapists and health care facilities in Vermont that treat eating disorders to identify potential interest in collaboration, but the discussions have not generated any commitments for collaboration. The applicant has discussed collaboration with the leadership of the Brattleboro Retreat, particularly for coverage for the program's 0.25 FTE psychiatry position (ten hours per week). *Id.* The Retreat advised the Board that it is "prepared to enter into a discussion of the provision of mental health services" with the applicant. Letter from Brattleboro Retreat, March 20, 2015. The applicant has also reached out to Springfield Medical Care Systems, which has stated that its community health facility "has an interest in collaborating" with the applicant, *see* Response (3/23/15), Attachment 3, and to Rutland Regional Medical Center. TR (3/26/15) at 18.

21. Once in operation, there is currently no regulatory entity which would provide oversight of the proposed treatment program. At hearing, the applicant testified that unlike Vermont, most states require licensure or other oversight of similar types of behavioral health programs. Transcript (TR) (2/26/14) at 70-71. The applicant indicated that it will seek Joint Commission Behavioral Health accreditation[3] after it begins operation; accreditation requires successful completion of a ten-step process that generally takes from four to six months. The applicant testified that the accreditation serves as a "stamp of approval." *Id*.

22. The average total cost for a six-week IOP program including lodging is $13,656; for the PHP program the cost is $28,410. Response (1/9/15) at 10-11. These amounts include average estimated costs for meals and lodging, but do not include any after hour participation in the non-clinical program at Fox Run.

23. The applicant intends to market its program to "population centers across the country." The applicant will offer "outreach to professionals," including educational presentations in the community and at conferences related to eating disorders. According to the applicant, its approach to marketing is "mainly a relationship marketing process that's employed by most eating disorder treatment centers." TR (2/26/15) at 53-55.

24. The applicant maintains that approximately 75% of program participants will self-pay for services and approximately 25% will be reimbursed for services by commercial payers. Response (9/19/14), Attachment 2, Table 6B. The applicant will not participate in Medicaid but will consider working with Medicaid on single-case agreements. TR (2/26/15) at 22, 72. In addition, the applicant intends to provide up to $50,000 in Year 1 for scholarships for low-income Vermont residents that meet clinical eligibility for the programs. Response (9/19/14) at 1-2.

25. The applicant has had preliminary conversations with Blue Cross and Blue Shield of Vermont regarding insurance coverage for its clinical programs. TR (2/26/15) at 54. As of

[3] The Joint Commission is an independent, not-for-profit organization that certifies and accredits more than 20,500 health care organizations and programs.

hearing date, the applicant has received no determination of coverage nor entered into any contracts with Vermont insurers. TR (3/26/15) at 11-12.

26. The applicant projects that in Year 1 of the IOP program, nine of 81 participants will be from Vermont, in Year 2 twelve of 101, and in Year 3 fifteen of 121. For the PHP program, the applicant projects that in Year 1 ten of 109 participants will be from Vermont, in Year 2, 14 of 127, and in Year 3, 18 of 146. The applicant bases the projections on an incidence rate of 3.0% for Vermont women between the ages of 18 and 65, and treatment rates of 5% for the IOP program and 6% for the PHP program. Responses (11/18/14) at 3-4.

27. The applicant estimates that approximately 60% of its patients will be taking psychotropic medications, TR (2/26/15) at 42, each of which has significant side effects. Response (2/25/15), Appendix 1. In addition, individuals with BED report greater general and specific psychopathology than those without eating disorders, and program participants are likely to have a variety of co-morbid chronic conditions including diabetes, heart disease, high cholesterol, high blood pressure, depression, anxiety, and obesity. *See* Application at 7; *Id*. Appendix A, National Institute of Health Public Access Author Manuscript (Iacovino *et al.*,) *Psychological Treatments for Binge Eating Disorder* (Aug. 2012).

28. The applicant plans to employ a 0.25 FTE (ten hours per week) program psychiatrist who will serve as both the program's medical director and psychiatrist. In the role of psychiatrist, this employee is expected to ensure that clients meet admission criteria, complete the initial psychiatric evaluation, write orders for the client's participation in the IOP or PHP program, see clients once they enter the program, and communicate with interdisciplinary staff in formal and informal settings. If the psychiatrist prescribes psychotropic medications, he or she will schedule weekly meetings with the client for medical management. In the role of Medical Director, this same employee will be expected to guide activities associated with the program accreditation, quality assurance, provider credentialing and will perform other responsibilities typically falling under an outpatient treatment center medical director. Responses (11/18/14) at 12.

29. For other staffing needs, the applicant proposes to fill the majority of its FTEs (9.6) with administrative positions, including executive director, finance/HR Director, marketing director, marketing outreach coordinator, office manager, and intake. Most clinical positions are not full time, and total 4.6 FTEs. Similarly, the majority of the amount budgeted for staffing is attributed to administrative positions. Response (11/18/14) at 16.

30. The applicant does not intend to utilize electronic medical records initially, but will instead rely on paper records until the volume and revenues justify the acquisition of an electronic medical record. Protected health information will be transmitted in a HIPAA compliant format, patient demographic and financial information will be stored on a HIPAA compliant server, and the treatment center will contract with a third party vendor for secure electronic claims transmission. Application at 32.

31. The applicant submitted three letters of support for the project which state, in near-identical language, that their authors work with people with eating disorders, that they currently send

high need clients to destination programs in other parts of the country, that they are confident the program will be of high quality, and that they would refer clients to the program. Response (11/18/14), Attachment 4.

Standard of Review

Vermont's Certificate of Need process is governed by 18 V.S.A. §§ 9431-9446 and Green Mountain Care Board Rule 4.000: *Certificate of Need*. The applicant bears the burden to demonstrate that each of the criteria set forth in 18 V.S.A. § 9437(1)-(7) is met.[4] Rule 4.000, §4.302(3).

Conclusions of Law

Section 9437 of Title 18 contains criteria that must be satisfied before the Board may grant an applicant a Certificate of Need. Because we conclude that the applicant has failed to meet statutory criteria 1, 3, 4 and 6, we find it unnecessary to discuss the remaining criteria.

**1. The applicant has not shown that its application is consistent with the health resource allocation plan (HRAP). 18 V.S.A. § 9437(1).**

Based on our review, we find that the applicant has failed to meet several of the applicable HRAP standards.

(A) HRAP Standard 1.2 states:

> Applicants seeking to expand or introduce a specific health care services [sic] shall show that such services have been shown to improve health. To the extent such services have been the subject of comparative effectiveness research, an applicant shall show that the results of this research support the proposed project.

As outlined throughout the application and as explained at hearing, the applicant is proposing a new health care service that will integrate clinical services with existing non-clinical services. According to the applicant, the treatment model, still in the development stage, will be the first of its kind in the United States to offer evidence-based treatment for BED in conjunction with a non-clinical behavioral approach to address dysfunctional eating patterns. Application at 8-9. In support of its proposal, the applicant provided the Board several published articles discussing the clinical treatment modalities it plans to incorporate into its proposed IOP and PHP treatment programs. Application, Appendix A.

The applicant has not met its burden to show that combining clinical services with the type of non-clinical services already offered at Fox Run is efficacious or has been shown to improve health. Although Fox Run has operated a weight management program for women for over four decades, the program is non-clinical and does not track patient outcomes. Transcript (2/26/15) at 31 ("We have no outcomes associated with Green Mountain at Fox Run."). To date, only one

[4] Although subsection 18 V.S.A. § 9437(8) is also a requirement for the grant of a CON, that criterion concerns the purchase or lease of new health care information technology, and is plainly inapplicable here.

study of the Fox Run non-clinical program has been published, appearing in the International Journal of Eating Disorders in 1985. Notably, the study was not a controlled clinical trial, the sample size was small, results were self-reported by participants, and the study failed to evaluate the efficacy of the program components. Rather than identifying a behavioral profile that discriminates between successful and unsuccessful respondents, the study found that continued success at weight maintenance is related to increased regular exercise and later age of onset of obesity. Response (3/23/15), Attachment 1.

Further, the articles and reference materials provided by the applicant do not sufficiently demonstrate that the efficacy of its proposed treatment model has been adequately supported by research. Rather, the studies discussed in the articles are limited by small sample sizes, non-randomized designs, relatively short follow-up periods, and findings that are admittedly preliminary.[5] While we recognize that BED is a new diagnosis, we are not persuaded that the applicant's proposed treatment model, which at this time is conceptual, will produce health benefits for participants above and beyond those obtained at the existing non-clinical program at Fox Run.

Accordingly, the applicant has failed to meet its burden to prove Standard 1.2.

(B) Next, HRAP Standard 1.3 states:

> To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.

As evinced by many of the questions we posed at hearing and through written interrogatories, *see, e.g.* Response (3/23/15), ¶¶ 7, 8, the applicant has failed to prove that it will be able to foster collaborations with other area health care providers to assist in delivering clinical services to program participants. Despite serving a population with a high percentage (60%) of psychotropic medication usage and likelihood of co-morbid conditions, the proposed programs are thinly staffed – for example, the psychiatrist/medical director position is planned as a 0.25% FTE. Patients who choose not to participate in the Transitional Living Program (at an additional cost) may experience from eighteen to twenty or more hours per day of unstructured time in the Ludlow community, away from home and without familiar support mechanisms. *See* Findings of Fact ¶¶ 10, 11, 13, 27, 28, 29. Given this set of facts, we are not convinced that the applicant has adequately shown that it has cultivated the type of collaborative approach with local providers that will likely be needed to care for this patient population.

Rather, we find that at this point in time, the applicant's plans regarding collaboration and integration into the medical community are preliminary and speculative. *See* TR (3/26/15) at 36

[5] For example, *An Exploratory Study of a Meditation-Based Intervention for Binge Eating Disorder*, (Kristeller and Hallett), involved only 18 participants and was limited to a discussion of a non-clinical aspect of BED treatment. Journal of Health Psychology (1999). Vol 4(3), 357-363. Similarly, an Australian study discussed in *Adding Mindfulness to CBT Programs for Binge Eating: A Mixed-Methods Evaluation*, (Woolhouse *et al*.) was limited to thirty participants and did not include a control group. Application, Appendix A.

(applicant testifies that "the plan is to work with those people, with those organizations that are currently a part of the Blueprint and were committed to developing contracts and being a part of the integrated health system"). Indeed, the applicant only recently initiated discussions with several local providers, many months after filing its application, and only after the Board expressed its concerns on the first day of hearing. *See, e.g.*, Responses (3/23/15) at 4, 9, 10. Although the applicant has since provided letters from the Brattleboro Retreat and Springfield Medical Care Systems which indicate a possible interest in collaboration, no entity has entered into a firm agreement with the applicant via a memorandum of understanding or contract. Given the scant evidence that it will be able to work collaboratively with other providers and facilities, the applicant has failed to meet Standard 1.3.

(C) HRAP Standard 1.6 states:

> Applicants seeking to develop a new health care project shall explain how the applicant will collect and monitor data relating to health care quality and outcomes related to the proposed new health care project. To the extent practicable, such data collection and monitoring shall be aligned with related data collection and monitoring efforts, whether within the applicant's organization, other organizations or the government.

The Board requested that the applicant provide documentation relative to data collection, quality improvement and consumer satisfaction. The applicant provided admission guidelines for both the IOP and PHP programs, as well as draft versions of data collection documents and forms, noting that policies, forms, tools and related items are currently under development. *See* Responses (9/19/14), Attachments 6, 7, 8.

Although the applicant states that it will collect and track structural, process and outcome measures, its plans to do so are preliminary. Adding to our discomfort with the applicant's generalized explanation as to how it will track quality and outcomes, we are concerned with the absence of regulatory oversight over the applicant's project once in operation; similar behavioral health projects in most states, unlike Vermont, require licensure or other oversight. TR (2/26/14) at 70-71. Even if the applicant were to obtain Joint Commission Behavioral Health accreditation, it would be unable to do so until after it commences operations, and completes a multi-step accreditation process. *See* Finding of Fact ¶21.

Absent a developed plan to monitor data relating to quality and outcomes, or regulatory mechanism for oversight and tracking once the project is operating, we conclude the applicant has not met its burden to prove this standard.

(D) HRAP Standard 1.7 states:

> Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. Such explanation may include a description of how practitioners will be made aware of evidence based practice guidelines and how such guidelines will be incorporated into ongoing decision making.

The applicant has provided only a general overview of mindfulness-based eating awareness methods, cognitive behavioral therapy, dialectical behavior therapy, interpersonal therapy, mindfulness-based cognitive therapy, and self-determination theory that it states it will incorporate into its program model. It has not explained with specificity to what extent each of these modalities will be incorporated into its programs, or how and why its programs are consistent with evidence-based practice. Further, and as discussed previously, the literature provided by the applicant discussing BED treatment is preliminary, marginally supportive of its proposed treatment model, or is otherwise inconclusive.

Accordingly, CON Standard 1.7 has not been met.

**2. The applicant did not "demonstrate an identifiable, existing or reasonably anticipated need for the project." 18 V.S.A. § 9437(3).**

According to data provided by the applicant, the National Institute of Health and Substance Abuse and Mental Health Services Administration estimates the BED incidence rate for women nationally is from 2% to 5%. Response (11/18/14) at 3. Based on a 3% incidence, the applicant anticipates that in its first year, an estimated 81 women will participate in the IOP program, and 109 in the PHP program. Of these, nine IOP participants will be from Vermont, while ten PHP participants will be Vermonters.

Although the applicant's projections suggest a Vermont population that needs and would utilize its services, we find that the applicant's projections of utilization are optimistic. For comparison, only 1.0% of Fox Run participants are Vermont residents. While the applicant projects that 25% of participants will receive reimbursement from commercial insurers, the applicant has only begun to explore coverage with BlueCross and BlueShield of Vermont,[6] the state's largest insurer, and the finding of medical necessity and attendant access to insurance coverage is uncertain. The costs of the programs are not insubstantial; a patient in the PHP program may spend on average over $28,000, and the charges that are ancillary to the cost of treatment – transportation, meals and lodging – are not reimbursable by commercial insurance. Even with the promise of contribution to a scholarship fund for Vermonters, we find that under these circumstances, it is less than certain that 19 Vermonters who may in fact need treatment for this eating disorder will choose to participate in the program during its first year, as projected by the applicant.

We also question, in light of the newness of the BED diagnosis and the preliminary and inconclusive nature of the research submitted by the applicant, whether its treatment model – again, only in the development stage – fills any type of gap in treatment and that effective treatment could not be obtained elsewhere. The three letters of support from local practitioners averring that the program is needed in Vermont are not persuasive, particularly in light of the near-identical testimonials in each. Finding of Fact ¶ 31.

Based on the record, we conclude that the applicant has not met the need criterion.

[6] At hearing, Randall Autry testified that the applicant would seek to become an in-network provider with BlueCross and BlueShield of Vermont, based on an assumption that it could prove medical necessity. TR (2/26/14) at 23.

**3. The applicant has failed to "show that the project will provide improved quality of health care in this state, greater access to health care for Vermont residents, or satisfy both objectives." 18 V.S.A. § 9437(4).**

We initially reiterate our concern, discussed above, that few Vermonters will utilize the program due to prohibitive costs and the uncertainty of insurance reimbursement. We also note that the applicant's marketing strategy will chiefly target population centers located outside of the state. Finding of Fact ¶ 23. For this reason, we cannot conclude that the applicant has shown that the project will provide Vermonters greater access to health care.

Next, the applicant has not shown that this project will improve the quality of health care in this state. As discussed throughout this decision, the proposed treatment model is still in the development stage. Although the applicant maintains that each patient will be medically and psychologically screened prior to admission, we are nonetheless concerned about patient stability and safety, particularly in light of the estimated 60% of patients that will be taking psychotropic medications, all which may have serious side effects. In addition, individuals with BED report greater general and specific psychopathology than those without eating disorders, and are likely to have a variety of co-morbid chronic conditions including diabetes, heart disease, high cholesterol, high blood pressure, depression, anxiety, and obesity, which coupled with the use of psychotropic medications, introduce a significant level of medical complexity. The applicant does not intend to utilize electronic medical records initially, instead relying on paper record-keeping. And as discussed elsewhere in this decision, the applicant has been unsuccessful to date in securing firm agreements to collaborate with local providers and hospitals. *See* Finding of Fact ¶ 20. Given that the majority of participants will be from out-of-state – some residing in local hotels, with up to twenty hours a day of unscheduled time – the applicant has not provided sufficient assurances that participants will receive needed continuity of care, or that additional strain will not be placed on Vermont providers.

Adding to our concerns, we cannot conclude that the applicant's staffing plan is sufficient to meet the needs of its intended population. The applicant anticipates employing a 0.25 FTE (10 hours per week, over one or two days) program psychiatrist who will serve as both the program's medical director and psychiatrist. The dual role encompasses a wide array of responsibilities. *See* Findings of Fact, ¶ 29. It is difficult to assess whether all of these activities can be adequately completed by a single employee in ten hours per week. It is also notable that the majority of the FTEs (9.6) are for administrative positions, while the majority of clinical positions are less than full time and total only 4.6 FTEs.

In light of these concerns and lack of convincing evidence in the record, we cannot conclude that the project as proposed will result in improved health or access to health care for Vermonters.

**4. Last, the applicant has failed to "show the project will serve the public good." 18 V.S.A. § 9437(6).**

Throughout this decision, we have discussed what we conclude are shortfalls indicating that the proposed project will not serve the public good. Without extensive, repeated discussion, we thus provide a summation of the reasons why the applicant has not shown that this project meets this criterion.

First, as discussed pertaining to Criterion 3, we question the need for this project in Vermont at this time. The applicant has presented this project in what appears to be a planning, conceptual state, with scant, factually supported evidence that it appropriately addresses a medical need. Further, the applicant has not demonstrated that its intended population cannot obtain needed clinical services in a different venue, closer to home, and likely at a lesser expense due to the availability of commercial insurance reimbursement.

Next, the applicant has not demonstrated that it can adequately provide clinical services for its intended population – approximately 60% of whom will be taking psychotropic medications and many of whom will be suffering from other co-morbid chronic conditions – with the proposed, limited clinical staffing, without firm commitments of collaboration from other area providers, and without any ongoing state or federal regulatory monitoring and oversight.

Last, construing the "public" in public good to apply to the citizens of Vermont and consistent with this Board's jurisdictional confines, the evidence is unpersuasive that this project will add value to the Vermont health care landscape, and provide needed, accessible medical services to Vermonters. The applicant has not shown that its services will be integrated with those of other Vermont providers, nor has it addressed the potential strain on those providers from a population largely from out-of-state, who may need ancillary treatment or services while in Vermont.

## Conclusion

Based on the foregoing, we conclude that the project as proposed does not meet each of the applicable statutory criteria. Accordingly, the application for a Certificate of Need is denied.

## Order

Pursuant to 18 V.S.A. § 9440(d), the Green Mountain Care Board denies the application of Attuned Living and Eating Centers, LLC and a Certificate of Need shall not issue.

**SO ORDERED.**

Dated: May 4, 2015 at Montpelier, Vermont

s/ Alfred Gobeille )
)
s/ Cornelius Hogan ) GREEN MOUNTAIN
) CARE BOARD
s/ Jessica Holmes ) OF VERMONT
)
s/ Betty Rambur )
)
s/ Allan Ramsay )

Filed: May 4, 2015

Attest: s/ Janet Richard
Green Mountain Care Board, Administrative Services Coordinator