STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: The Collaborative Surgery Center	)))	GMCB-008-21con

ORDER ON APPLICANT'S REQUEST FOR RELIEF FROM CONDITIONS OF APPROVAL

On March 16, 2022, the Green Mountain Care Board issued a Certificate of Need (CON) that allows Collaborative Surgery Center, LLC (CSC or Applicant) to develop an ambulatory surgery center in Colchester, Vermont. The CON issued to CSC contains a number of conditions. On April 13, 2022, CSC asked the Board to amend or clarify certain conditions and to grant relief from other conditions (Request for Relief). Each of CSC's requests is addressed below.

Tolling of Timelines

In its first request, CSC asks the Board to toll and stay all timelines in the CON that are not specifically addressed in the Request for Relief until after the Board has adjudicated the Request for Relief. We deny this request without prejudice because it is unclear what "timelines" CSC seeks to have tolled and why tolling is appropriate. If CSC wishes to refile this request with more specificity, it may do so.

Condition #2

CSC's second request relates to Condition #2, which provides:

> *If the applicant develops a plan to offer specialties other than those approved in the Statement of Decision, it must petition the Board for approval.*

CSC requests clarification regarding the process by which the Board will consider approving additional specialties, including "details on the specific steps and information required, as well as the thresholds and/or criteria for approval or disapproval of new specialties." We provide the following clarification and explanation.

If CSC develops a plan to offer additional specialties and if the plan does not constitute a "material change" to the project (i.e., it does not constitute a new health care project as defined by statute or rule and it does not change project costs by more than 10% of the total approved cost), the Board will consider it to be a nonmaterial change. Before proceeding with any such plan, the Board expects CSC to

1. identify each new specialty sought to be added and the five most common procedures or surgeries within each new specialty that will be performed at CSC;
2. describe and provide data supporting the need(s) that will be met by adding each new specialty, which may include, for example, reports or descriptions of backlogs for surgeries or procedures within a specialty that will be mitigated by allowing the surgeries or procedures to be performed at CSC;
3. provide projected surgical volumes within each new specialty for the first three years;
4. explain whether, given the projected surgical volumes, additional staffing will be required and, if additional staffing will not be required, explain why existing staffing levels will be adequate to support the new specialties; and
5. provide revised payer mix, utilization, and staffing tables/spreadsheets demonstrating how the project will be impacted by the addition of the new specialties.

As specified in GMCB Rule 4.000, § 4.600(3), within twenty (20) days of receiving the information described above, the Board will inform CSC whether it will review the change. If the Board elects not to review the change, the CON will be deemed to be amended to incorporate the change. If the Board elects to review the change, it may require additional information relating to the statutory criteria. The information requested may depend on the specifics of the proposal. For example, if CSC wishes to add ophthalmology as a surgical specialty, the Board will likely want information that will enable it to understand how the Vermont Eye Surgery and Laser Center might be impacted before approving the change.

Condition #3

CSC's third request relates to Condition #3, which provides:

> *Within 30 days of receiving this Certificate of Need, CSC shall submit a finalized and fully executed copy of its lease, which shall include provisions to address the calculation of the rent in the event of either cost overruns or cost savings.*

CSC asserts that conditions in the construction industry and the broader economy have changed dramatically since it submitted its application and, as a result, it needs more time to finalize lease provisions that address the calculation of rent in the event of cost overruns or cost savings. CSC requests that Condition #3 be amended to require CSC to submit a finalized and fully executed copy of its lease with provisions addressing potential cost overruns before construction begins, but not sooner.

It is reasonable that CSC needs additional time to finalize the lease. However, we would like to see the lease prior to construction. Accordingly, we amend Condition #3 to require submission of the finalized and fully executed lease no less than 30 days before construction begins. The amended language is provided below:

> *No less than ~~Within~~ 30 days ~~of receiving this Certificate of Need~~ before construction begins, CSC shall submit a finalized and fully executed copy of its lease, which shall include provisions to address the calculation of the rent in the event of either cost overruns or cost savings.*

Condition #8.d.

CSC's fourth request relates to Condition #8.d., which provides

> *The applicant shall develop and implement a policy, which it will post to CSC's consumer website, requiring each physician who performs procedures or surgeries at CSC to use a patient decision aid such as shared decision-making that: . . . d) advises the patient of the pros and cons, including the comparative costs, of having the procedure performed in an ASC, rather than a hospital. The policy shall include a provision requiring certification by the provider of his or her compliance with such policy.*

CSC does not request relief from this condition.

Condition #10

CSC's fifth request relates to Condition #10, which provides:

> *The applicant shall post to its website the commercial, self-pay, and Medicare prices for each of the twenty-five (25) most frequently performed procedures and surgeries, or, if it will result in disclosure of a greater number of prices, the commercial, self-pay, and Medicare prices of each of the procedures and surgeries that comprise at least 75 percent of CSC's overall volume. The applicant shall regularly update this information, no less than quarterly, whether or not prices or procedures have changed.*

CSC requests that the Board amend this condition to require only annual reporting, which it asserts is in alignment with federal price transparency requirements for hospitals and will help decrease administrative costs associated with more frequent reporting.

CSC emphasized during the application review process that it would provide transparent pricing. *See* Application (App.), 20 ("CSC will post prices on the Center's website . . . ."); Response to Questions (Resp.) (Dec. 2, 2021), 5 ("We intend to be fully transparent with CSC's fees. A section of our website will be dedicated to pricing information . . . ."); *see also* App., 72 ("[U]nlike a hospital, the ASC will offer transparent pricing, removing the element of price uncertainty that may prevent some from seeking care who need it."). To reduce administrative burden, we are willing to grant CSC relief with respect to how often it determines which procedures and surgeries to include on its website (i.e., which 25 procedures and surgeries are performed most frequently or comprise at least 75% of the facility's overall volume). However, we are concerned that granting

CSC's request in full would allow it to post stale and inaccurate pricing information, which is not helpful to patients and may even be harmful. We therefore amend the condition as follows:

> *The applicant shall post to its website the commercial, self-pay, and Medicare prices for each of the twenty-five (25) most frequently performed procedures and surgeries, or, if it will result in disclosure of a greater number of prices, the commercial, self-pay, and Medicare prices of each of the procedures and surgeries that comprise at least 75 percent of CSC's overall volume. The applicant shall ~~regularly~~ update the list of procedures and surgeries ~~this information,~~ no less than ~~quarterly~~ annually~~, whether or not prices or procedures have changed~~ and shall update the prices for procedures and surgeries when they change.*

Condition #16

CSC's sixth request relates to Condition #16, which provides:

> *The applicant must successfully negotiate prices with commercial insurers that are lower than any hospital in Vermont. Within 30 days of executing an initial contract and annually thereafter, the applicant must submit letters from Cigna, Blue Cross and Blue Shield of Vermont, and MVP confirming CSC's compliance with this condition. The price of a procedure or surgery that is billed to patients that self-pay may not exceed the lowest price billed to patients covered by commercial insurance.*

CSC claims that Condition #16 "imposes an unacceptable, and unreasonable, financial risk to the CSC that renders the project untenable." Specifically, CSC claims that Condition #16 "creates massive annual uncertainty regarding facility payment levels for independent providers who wish to invest in and operate at the CSC" and "will negatively impact the CSC's ability to recruit independent physicians to the state, especially given that no such limitations are placed on physicians working at ASCs in other states." However, CSC provides no evidence to support these claims, which are at odds with the evidence in the record.

CSC will be physically connected to another ASC, the Green Mountain Surgery Center (GMSC). The CON issued to GMSC includes a condition very similar to Condition #16 of CSC's CON. *See In re: ACTD LLC, d/b/a The Green Mountain Surgery Center*, GMCB-010-15con, Statement of Decision (June 4, 2019), 22-23. Notwithstanding this condition, GMSC has successfully recruited six physicians from outside the state, a fact that CSC emphasized during the application review process. *See, e.g.,* Resp. (Sept. 21, 2021), 15 (stating that six of the approximately 30 surgeons on GMSC's medical staff "have been attracted from out of state").

It is unclear whether CSC has approached commercial insurers yet to discuss reimbursement rates, let alone how the reimbursements CSC might negotiate in compliance with Condition #16 compare to the reimbursement levels CSC assumed in developing its financial projections. *See* App., 35 (assuming a blended reimbursement rate of 135% of Medicare for non-Medicare payers.). On this record, we cannot find that Condition #16 renders the project "untenable" or introduces "unacceptable . . . financial risk."

We also note that Condition #16 will not impact CSC's commercial reimbursement negotiations indefinitely. Once a CON expires, the holder of the CON is under no further obligation regarding the conditions set forth in the CON. GMCB Rule 4.000, § 4.500(4). CONs expire when the Board accepts the final implementation report for the project. *See* 18 V.S.A. § 9443(c).

Finally, we note that CSC committed to transfer half of its distributable profits to support primary care, mental health, and other community services. While we would certainly like to see CSC make good on this commitment, we do not consider it to be part of the project and we imposed no conditions requiring that these transfers be made. *See* Statement of Decision, 19 (noting that the Board was evaluating the application on its own merits and was not taking the charitable foundation into account in its review). CSC is therefore under no obligation to make these transfers and the flexibility it has to reduce the allocation of distributable profits also undercuts its assertions that the project "simply cannot move forward" with Condition #16 as written.

CSC also argues that Condition #16 is "seemingly outside the Board's jurisdiction in issuing conditions of approval" because it "requires that the CSC ensure a certain outcome with third-party health insurers who are not a party to the CON and not subject to CON conditions." This argument is not adequately developed or supported by CSC.

It is not apparent how the Board's authority to impose Condition #16 is undermined by the fact that it operates only on CSC. *See In re Vermont Health Serv. Corp.,* 144 Vt. 617 (1984) (upholding the authority of the Commissioner of Insurance to issue supplemental orders in connection with a health insurance rate decision that required the insurer to incorporate certain modifications into its hospital contracts); *In re UPC Vermont Wind, LLC,* 185 Vt. 296 (2009) (considering the Public Service Board's imposition of a condition in a Certificate of Public Good that required the applicant to make all reasonable efforts to enter into stably priced contracts with Vermont utilities); *Appeal of Clipper Home*, 133 N.H. 593 (1990) (finding that, in denying a facility's request for relief from a CON condition that capped its Medicaid reimbursements for the first five years of operation, the Health Services Planning and Review Board was not seeking to involve itself in setting Medicaid rates but was merely exercising its authority to include conditions in a CON and to enforce them).

Pursuant to 18 V.S.A. § 9440(d)(4), the Board has the authority to impose conditions in furtherance of the purposes of the CON statutes, provided the conditions are directly within the scope of the proposed project and the criteria used in reviewing the application. Condition #16 fits squarely within this authority; in short, Condition #16, in combination with other conditions in the CON, helps ensure that the project will provide the low-cost, high-quality alternative for outpatient surgery described in the application.

In its application, CSC asserted that, because of their greater efficiency, ASCs can accept lower reimbursement than hospitals. App., 9 ("Lower reimbursement for services at ASCs is feasible due to lower overhead, efficient staffing, and optimal utilization of space and operating hours as ASCs are only able to hold patients for 23 hours and often do not have the capacity to allow for overnight stays."), 20 ("CSC's efficient structure and lower reimbursement rates will help reduce health care costs."), 63 ("ASCs characteristically have lower building, staffing and overhead costs than

hospitals. These and other operational efficiencies enable ASCs to offer lower charge structures and enter into lower-cost contracts with insurers than hospitals, resulting in reduced costs to patients and payers."); *see also* Munnich, Elizabeth L; Parente, Stephen T. Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up, 33(5) Health Affairs. 764-769 (May 2014) (cited at App. 9, n.20) (concluding that, on average, patients treated in ASCs spent 31.8 fewer minutes undergoing procedures than patients treated in hospitals, a 25 percent difference relative to the mean procedure time, and estimating that ASCs could generate savings of $363 - $1,000 per outpatient case in connection with these efficiencies, even excluding time savings outside of the operating room).

Unless payment methodologies change significantly, we know that CSC will offer a lower cost setting of care for the Medicaid and Medicare programs and their beneficiaries. *See* App. 10 (noting that the 2020 relative weight factor for ASCs was 41% lower than the Outpatient Prospective Payment System factor used to determine what is paid to hospitals); *see also* Vermont Medicaid State Plan, Attachment 4.19-B, page 2a (1a) (establishing a peer group base rate for ASCs of 82% of the Medicare 2022 OPPS national APC payment rate without local adjustment, lower than the base rate for in-state critical access hospitals, 110%, the in-state academic medical center, 85.5%, and other in-state hospitals, 87%). However, as we noted in the Statement of Decision, CSC plans to generate over 58% of its revenues from commercial and self-pay patients. *See* Statement of Decision, 15. Moreover, cost savings are particularly needed in the commercial market. *See id.*

CSC claimed that it would provide significant cost savings to privately insured patients. *See, e.g.,* App., 71 ("[B]y offering a lower-cost health care alternative to hospital outpatient departments, outpatient surgery services will become more affordable to low- and middle-income Vermonters. Our best estimate is that for privately insured patients, the cost of a procedure at a free-standing ambulatory surgery center is on average 50 percent less than in a hospital setting."). CSC calculated that GMSC had saved commercial payers an estimated $5.3 million in fiscal year 2020 and asserted "[i]t is reasonable to expect that CSC would produce similar savings, and possibly more, depending on the mix of procedures being performed." App., 33. As noted above and in the Statement of Decision, GMSC was required to comply with a condition very similar to Condition #16. It was reasonable for the Board to impose the same condition on CSC to ensure meaningful cost savings of the magnitude cited by CSC in its application.

Next, CSC asserts that Condition #16 places it in a disadvantageous position relative to hospitals and suggests that the large local health network could decrease the prices of any procedures at one of its network hospitals to a level that would be financially unsustainable for the CSC and then recover the difference through unreasonably high ancillary charges and/or increase the cost of the procedure at the other network hospitals. CSC asserts that it has no protection from this potential scenario.

GMSC made a similar argument and we rejected it, reasoning that this kind of conduct on the part of hospitals would implicate "predatory pricing" prohibitions in state and federal law. *In re: ACTD LLC, d/b/a The Green Mountain Surgery Center*, GMCB-010-15con, Statement of Decision (June 4, 2019), 23 (citing 9 V.S.A. § 2461c(a), which prohibits a person, with the intent to harm

competition, from pricing goods or services in a manner that tends to create or maintain a monopoly or otherwise harms competition). We explained that we would not modify this important condition based on a fear that hospitals will at some point in the future engage in what we viewed as legally questionable conduct. *See id.* The same considerations that led us to deny GMSC's arguments apply to CSC's current request. We will, however, amend Condition #16 so that it does not require CSC to accept commercial reimbursement for a procedure or surgery that is less than the reimbursement Medicare or Medicaid would pay to CSC. Creating a "floor" to this condition should help alleviate the concerns expressed by CSC.

Lastly, CSC argues that it "is in no position to confidently determine what the actual 'price charged' at any hospital is" because "[r]eal price transparency in hospital-provided care is lacking." Again, we rejected a similar argument made by GMSC in connection with the similar condition in its CON. *See In re: ACTD LLC, d/b/a The Green Mountain Surgery Center*, GMCB-010-15con, Statement of Decision (June 4, 2019), 22 ("We do not see why [the negotiation] process could not accommodate the requirements of Condition 12 if the expectation is clear that GMSC's rates must be below the rates of Vermont hospitals.").

We do not understand why hospital price transparency is required for CSC to comply with Condition #16. Even if hospital price transparency is required, and even if CSC is correct that hospital disclosures to date are inadequate and do not provide sufficient transparency, we note that, beginning July 1, 2022, the Transparency in Coverage Final Rules will require non-grandfathered group health plans and health insurers offering non-grandfathered coverage in the group and individual markets to disclose, on a public website, information regarding in-network rates for covered items and services. *See* U.S. Dept. of Labor, FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

The language of Condition #16, as amended, is set forth below:

> *The applicant must successfully negotiate prices with commercial insurers that are lower than any hospital in Vermont, except where such prices are below the amount paid to CSC under the Medicare or Medicaid programs. Within 30 days of executing an initial contract and annually thereafter, the applicant must submit letters from Cigna, Blue Cross and Blue Shield of Vermont, and MVP confirming CSC's compliance with this condition. The price of a procedure or surgery that is billed to patients that self-pay may not exceed the lowest price billed to patients covered by commercial insurance.*

Condition #18

CSC's seventh request relates to Condition #18, which provides:

> *The applicant shall quarterly compile for inclusion in its next-due implementation report, and post to its website within forty-five (45) days of the close of each quarter, CSC's payer mix by revenue. In the event that the applicant's payer mix is not in line with its projections in the application, CSC shall include in its implementation report a justification for the*

deviations and proposed remedies to ensure inclusion of all Vermonters, regardless of payer type.

CSC asks that it be permitted to provide this information annually, not quarterly, in order to reduce the administrative burden of reporting.

To reduce administrative burden and better align posting and reporting requirements, we modify Condition #18 as follows:

> *The applicant shall ~~quarterly compile for inclusion~~ include its payer mix by revenue in each ~~its next-due~~ implementation report that it submits to the Board, and shall post this information to its website within forty-five (45) days of ~~the close of each quarter, CSC's payer mix by revenue~~ each submission. In the event that the applicant's payer mix is not in line with its projections in the application, CSC shall include in its implementation report a justification for the deviations and proposed remedies to ensure inclusion of all Vermonters, regardless of payer type.*

Condition #21

CSC's eighth request relates to Condition #21, which provides:

> *The applicant shall quarterly update and compile for inclusion in its next-due implementation report, the following information:*
>
> *(a) The types of procedures and surgeries performed at CSC and the number of times each procedure and surgery was performed.*
> *(b) A breakdown, by payer mix, of the types of procedures and surgeries each physician performed at CSC and at local hospitals (specify the hospital).*
> *(c) The number of patients each physician determined were inappropriate for care at CSC and the reason for each determination.*
>
> *The information in (b) and (c) of this condition is to be submitted confidentially. Within 45 days of the close of each quarter, CSC shall post the information specified in (a)-(c) of this condition on its website. The information on providers may be reported by specialty on the website. In the event there is only one provider for any given specialty, the report posted on the website may note "small numbers prevent us from providing this information," or words to that effect.*

CSC asks that it be allowed to report on item (a) on an annual basis to reduce administrative costs. CSC also requests relief from reporting for items (b) and (c), asserting that physicians find this type of reporting intrusive and administratively cumbersome and that physicians performing procedures at ASCs in other states are not subject to such reporting, which puts CSC at a disadvantage when recruiting physicians from other states.

To reduce administrative burden and better align posting and reporting requirements, we modify Condition #21 as follows:

> *The applicant shall include ~~quarterly update and compile for inclusion in its next-due implementation report,~~ the following information in each implementation report:*
>
> *(a) The types of procedures and surgeries performed at CSC and the number of times each procedure and surgery was performed.*
> *(b) A breakdown, by payer mix, of the types of procedures and surgeries each physician performed at CSC and at local hospitals (specify the hospital).*
> *(c) The number of patients each physician determined were inappropriate for care at CSC and the reason for each determination.*
>
> *The information in (b) and (c) of this condition is to be submitted confidentially. Within 45 days of ~~the close of each quarter~~ submitting each implementation report, CSC shall post the information specified in (a)-(c) of this condition on its website. The information on providers may be reported by specialty on the website. In the event there is only one provider for any given specialty, the report posted on the website may note "small numbers prevent us from providing this information," or words to that effect.*

Condition #22.e.

CSC's ninth request relates to Condition #22.e, which requires CSC to annually submit a profit and loss statement and balance sheet. CSC asserts that this requirement is inconsistent with the Board's authority to oversee hospital budgets, is detrimental to physician recruitment, and is intrusive and administratively burdensome.

We deny CSC's request. It is not overly burdensome to submit a profit and loss statement and balance sheet on an annual basis. Furthermore, we are not relying on our authority to establish hospital budgets to support this condition; we imposed this condition so that we could better monitor the implementation of the project.

Condition #23

CSC's tenth and final request relates to Condition #23, which provides

> *The project as described in the application shall be fully implemented within two (2) years of the date of this certificate of need, or the certificate of need shall become invalid and deemed revoked.*

CSC requests "a minimum of four years" to implement the project, citing local and world events that have occurred since it submitted its application and the impact that these events have on its ability to complete the project in a timely, cost-effective manner.

CSC initially stated that, because it would be using existing infrastructure, it could bring its operating suites on-line within 12- to 18-months of the Board's approval of a CON. *See* Request for Expedited Review, 2 ("The building housing the CSC is already constructed and much of the necessary capital infrastructure is in place . . . As a result, the CSC can be fully functioning between a year and 18 months after its CON is approved."); *see also* App., 3 ("The CSC will be housed in an already constructed building that will allow the project to be completed within 12 to 18 months."). If this timeline became unrealistic at some point during the CON review process, that

fact should have been disclosed to us. Nevertheless, we grant CSC's request. Condition is amended as follows:

> *The project as described in the application shall be fully implemented within ~~two (2)~~ four (4) years of the date of this certificate of need, or the certificate of need shall become invalid and deemed revoked.*

For clarification, we note that 1) CSC must still submit implementation reports under Condition #21 for four years following the opening of the facility; and 2) the total project cost is unchanged by the amendment to Condition #23.

So ordered.

Dated: May 4, 2022
Montpelier, Vermont

s/ Kevin Mullin, Chair	)	
	)	GREEN MOUNTAIN
s/ Jessica Holmes	)	CARE BOARD
	)	OF VERMONT
s/ Robin Lunge	)	
	)	
s/ Tom Pelham	)	
	)	
s/ Thom Walsh	)	

Filed: May 4, 2022

Attest: s/ Jean Stetter
Green Mountain Care Board
Administrative Services Director

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