

**STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD**

In re: University of Vermont Medical Center)
Development of an Outpatient)
Surgery Center)
_____)

GMCB-004-23con

STATEMENT OF DECISION AND ORDER

Introduction

In this Statement of Decision and Order, we review the application of the University of Vermont Medical Center (UVMMC or applicant) for a Certificate of Need (CON) to replace the operating rooms at its Fanny Allen campus and to develop a multi-specialty Outpatient Surgery Center (OSC) at 119 Tilley Drive in South Burlington. The total cost of the proposed project is approximately \$129.6 million.

For the reasons set forth below, we approve the application and issue a CON to UVMMC, subject to the conditions set forth therein.

Procedural Background

On July 16, 2021, UVMMC applied for a Conceptual CON for planning and design of the project, which was granted on September 20, 2021. *In re: Application of the University of Vermont Medical Center for a Conceptual CON for Planning and Design of an Outpatient Surgery Center*, Docket No. GMCB-015-21con (Sept. 20, 2021).¹

On February 10, 2023, UVMMC applied for a CON for the project. Notice of the application was posted on the Green Mountain Care Board’s website on February 14, 2023, in accordance with 18 V.S.A. § 9440(c)(5)(A).

On February 15, 2023, the Vermont Office of the Health Care Advocate (HCA), representing the interests of Vermont health care consumers, intervened in the proceeding as an Interested Party (IP). *See* 18 V.S.A. § 9440(c)(9); GMCB Rule 4.000, § 4.406. On March 3, 2023, AFT-VT, Inc. (AFT-VT) requested IP status. AFT-VT’s request was granted over UVMMC’s objection on April 17, 2023. On April 17, 2023, Northwestern Medical Center (NMC) requested IP status. NMC’s request was granted on May 1, 2023. On May 12, 2023, Copley Hospital, Inc. (Copley) requested IP status. Copley’s request was granted on May 24, 2023.

¹ For projects anticipated to be over \$30 million, a Conceptual CON must be obtained that permits the applicant to make expenditures for planning. 18 V.S.A. § 9434(c).

Beginning February 23, 2023, the Board requested, through a series of interrogatories, that the applicant provide additional or clarifying information to assist the Board with its review. The application was closed pursuant to 18 V.S.A. § 9440(c)(4) on February 28, 2024. The Board retained the services of consultants to assist in its review of the application. These consultants issued reports on March 20, 2024, summarizing their analyses and findings. On April 1, 2024, the applicant submitted questions for the consultants, who responded on April 12, 2024. The applicant then submitted comments regarding the consultants' reports on April 25, 2024. One of the Board's consultants responded to the applicant's comments on May 3, 2024. Although the schedule provided an opportunity for the IPs to respond to the consultants' reports and provide a statement of position prior to the hearing, no such filings were received.

A hearing was held on May 20, 2024, at which UVMMC presented a PowerPoint (UVMMC ppt.) and provided witnesses to respond to questions from the Board and IPs. AFT-VT and the HCA submitted post-hearing statements on May 21 and May 24, 2024, respectively. The Board sent a final set of questions to the applicant on May 23, 2024. The applicant responded to the Board's questions on June 11, 2024. On June 7, 2024, all parties waived the procedural step of a proposal for decision set forth in 18 V.S.A. § 9440(d)(5). On June 21, 2024, the Board extended the review period an additional 30 days pursuant to 18 V.S.A. § 9440(c)(4). On June 24, 2024, the applicant requested authorization to incur a \$20,000 liability to order certain necessary electrical equipment before a CON decision was issued. The Board granted this request on July 3, 2024.

Jurisdiction

The Board has jurisdiction over the certificate of need process pursuant to 18 V.S.A. § 9433 and 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(b)(1).

Findings of Fact

1. The applicant currently has 25 operating rooms (ORs) divided between its main campus in Burlington, which has 20 inpatient (IP) and outpatient (OP) ORs, and its Fanny Allen campus in Colchester, which has five OP-only ORs. The applicant proposes to develop a multi-specialty OSC at 119 Tilley Drive, South Burlington, VT. Application (App.), 1. The proposed facility would house eight ORs, 12 prep rooms, and 36 recovery spaces (including eight 23-hour extended stay recovery rooms), plus shelled space for four additional ORs and 14 pre-and post-operative spaces that will be fit-up and utilized at a later date. App., 2, 19-23. The applicant also proposes to close Fanny Allen's five ORs and move its surgical staff to the new OSC. App., 3. Thus, five of the OSC's ORs would replace the Fanny Allen ORs; the other ORs would be new. *See* Mathematica Report (Mar. 20, 2024), v. The Fanny Allen ORs have been closed for extended periods in recent years due to air quality issues. *See* Response (Resp.) (Feb. 27, 2024), 7-8.

2. UVMMC is the state's largest community hospital, tertiary care facility, and sole academic medical center. App., 2. In FY 2019, UVMMC performed approximately 13,000 OP surgical cases at either the main campus or Fanny Allen and 5,900 IP cases at the main campus. Approximately 51% of the OP patients came from the Burlington Health Service Area (HSA),

while 8.8% came from the St. Albans HSA; 7.7% came from the Berlin HSA; 7.6% came from the Plattsburgh HSA; 5.6% came from the Middlebury HSA; and 18.8% came from elsewhere. App., 8 - 9.

3. The OSC would be located on UVMMC's South Burlington campus, 3.3 miles from the main campus and close to UVMMC's outpatient clinics, including Orthopedics, Cardiology, Ophthalmology, Dermatology, and Rehabilitation, which are also located on Tilley Drive. App., 6. The proposed OSC's location provides benefits that include accommodating a potential long-term need for additional space and providing easy access for providers, staff, learners, and patients to the full scope of hospital services on the main campus. App., 2, 6. The site is also served by newly enhanced public transportation and will have ample patient, employee, and ADA parking. See App., 6, 17. While planning the facility, the applicant considered whether it would be possible to purchase and renovate an existing building for use as an OSC. No available property was identified that could be repurposed at a reasonable cost and satisfied other indispensable criteria, including public transportation access and proximity to the hospital's main campus. App., 7.

4. UVMMC has an option agreement to purchase the 13.5-acre site at 119 Tilley Drive, from Pizzagalli Properties, LLC, contingent on successful permitting, site due diligence and CON approval. App., 17. Phase I and II archaeology surveys have indicated no need for further study or action. Resp. (Nov. 16, 2023), 12. Zoning, site plan, and water and wastewater allocation permits were approved in 2022. In early 2023, the applicant received an Act 250 permit. App., 18. The Department of Fish and Wildlife issued a Threatened and Endangered Species Takings permit that required UVMMC to remove and relocate the species *prunus americana* (wild plum) and monitor for five years. Resp. (Nov. 16, 2023), 9. The City of South Burlington required a multi-use path made of porous asphalt; a pocket park with seating, landscape plantings, and a gravel area; and landscaping and berms to screen the project and its mechanical equipment. *Id.* at 10. The Department of Environmental Conservation Stormwater Permit required four gravel stormwater wetlands to address runoff and utility easement grading restrictions. *Id.* at 10-11. Two water lines for water service and hydrant connection were required. *Id.* at 10.

5. The site design includes 270 onsite parking spaces for staff, patients, and visitors. A small exterior patio with outside seating will be located adjacent to the family waiting area, which will be accessible through an exterior entrance door. A staff outdoor area is planned on the northern side of the building. A future landscaped overlook with a connection to a city multi-use path to the east will be on the northern end of the site. App., 17 - 18.

6. The proposed building is 93,577 gross square feet (GSF), with one Main Grade Level (ground floor) and a partial Lower Level (basement). The ground floor level houses a covered drop off area with separate ingress and egress paths. A registration area with an adjoining waiting room will be located immediately inside the building entrance. The ground floor is designed to include eight identical ORs and adjacent instrument set-up rooms, eight Extended Recovery Beds, 12 Prep Bedrooms, 13 Phase 1 Recovery Cubicles and one Isolation Patient Room, and 14 Phase 2 Recovery Cubicles, encompassing a total of 83,602 gross square feet. The shell space, encompassing 9,975 gross square feet, includes four additional ORs and 14 additional pre- and post-operative spaces, namely four Extended Recovery Beds, five Prep Bedrooms, and five Phase

2 Recovery Cubicles. App., 18 - 21. The support services in the partial basement level include a Central Sterilization and Reprocessing area for the onsite sterilization of instruments, as well as space for sterile storage and a material handling area with loading dock for the delivery of clean linen and surgery supplies and the pickup of solid waste and recycled materials. The basement level will also include a separate entrance for employees, an employee changing area, locker and shower rooms, lactation room, bicycle storage, and a conference room. App., 20, 22.

7. The building is designed and would be constructed in accordance with applicable codes, including National Fire Protection Association (NFPA) standards, the International Building Code (IBC) 2015, the Vermont Energy Code, and the Guidelines for Design and Construction of Outpatient Facilities issued by the Facility Guidelines Institute (FGI). *See* App., 24, 42, Ex. 2; Resp. (Apr. 17, 2023), 1-2; NEMD Report (Mar. 20, 2024), 4. Efficiency Vermont was consulted on the project and provided feedback to ensure that it meets or exceeds energy-efficiency standards. The applicant will seek LEED certification for the facility, which will be designed to meet or exceed EnergyStar standards. App., 24, 31, Ex. 6.

8. UVMHC worked with the Special Services Transportation Agency (SSTA), which offers free, direct shuttle service from the Green Mountain Transit's Downtown Transit Center on Cherry Street in Burlington to Tilley Drive. App., 48. Public transportation does not always provide sufficient access to UVMHC's facilities and UVMHC routinely asks about and addresses patients' transportation needs as part of its surgical scheduling process. If alignment with the public transportation schedule is not possible for a patient with no other transportation options, UVMHC arranges and pays for transportation, often by taxi or Uber. Resp. (Nov. 16, 2023), 18.

9. The OSC incorporates Diversity, Equity, and Inclusion (DEI) principles in its design, such as gender-neutral bathrooms throughout the facility and lactation rooms for both patients and visitors. App., 18. Patients who have communication access needs or may have additional needs will be identified in the pre-assessment screening process and there are direct interpreted call-in lines in thirty-languages and on-call ASL interpreters through a third-party vendor. Testimony of Dr. Marissa Coleman, Tr., 45:4 – 25.

10. UVMHC officials testified that while some patients go out-of-state to get surgeries due to wait times, many Vermonters cannot afford to do this, and this burden falls disproportionately on Vermont's low income and least advantaged communities, including members of the refugee, immigrant, and BIPOC communities, as well as those living with a disability or older Vermonters. *See* Testimony of Dr. Marissa Coleman, Tr., 45:7 – 47:5.

11. The OSC would be open for first patient arrival on weekday mornings at 5:30 AM and would start preparing patients for surgery at 6:00 AM. The first surgical case would begin at 7:00 AM. The normal capacity surgical day is scheduled from 7:00 AM -5:00 PM (10-hour operating day). App., 26. The OSC would be limited to outpatient care; all patients will be expected to be discharged in less than 24 hours. When clinically necessary, 23-hour stays can be accommodated. The scheduled closing time would be 8:00 PM for the PACU/Stage 2 Recovery Unit. All 23-hour cases will be scheduled Mondays through Thursdays, allowing the OSC to close for the week by 8:00 PM on Fridays. App., 27.

12. Each of the planned ORs at the OSC is 630 sq. ft. The current FGI Guidelines provide for a minimum of 400 sq. ft. but recommend that ORs requiring additional personnel and large equipment have a clear floor area of at least 600 sq. ft. The industry standard for ORs designed for specialized surgery and advanced orthopedic procedures is 600 - 650 sq. ft. App., 21, Ex. 5. The configuration and uniformity of the ORs and pre- and post-operative areas will support higher patient throughput and greater provider efficiency. App., 5, 8, 20, 48.

13. UVMHC is exploring options to use the Fanny Allen OR space for other non-surgical services and to address other important patient care access needs. Once the new OSC is constructed, Fanny Allen will no longer serve as UVMHC's outpatient surgery facility. *See* App., 4 n.5; Testimony of Dr. Stephen Leffler, Tr., 18:16 – 20.

14. The total project cost is \$129,640,703. App., 32, 37. Within direct construction costs of approximately \$91 million, new construction is \$67.2 million; site work is \$4.5 million; fixed equipment is \$4.7 million; and construction contingency is \$14.6 million. Within related project costs of approximately \$38.6 million, furnishings, fixtures, and other equipment (FF&E) is \$19 million; architectural and engineering fees (A/E) are \$4.5 million; land acquisition is \$5.2 million; administrative expenses and permits are \$3.5 million; and other costs, including debt financing, are \$6.6 million. *See* Resp. (June 19, 2023), 25 (Table 1 – Project Costs). The project will be funded with a bond of \$100 million at an estimated rate of 5.0% from Oct. 2025 to Sept. 2049 and approximately \$29.6 million in equity. Resp. (June 19, 2023), 26 (Table 2 – Debt Financing Arrangement, Sources & Uses of Funds). UVMHC anticipates setting a fundraising goal of \$13 million to offset operating cash expenditures and reduce the impact on days cash on hand. *See id.*; Testimony of Dr. Stephen Leffler and Rick Vincent, Tr., 169:18 – 170:21.

15. UVMHC has engaged a Construction Manager (CM) to deliver the project with a Guaranteed Maximum Price (GMP). UVMHC has also retained an independent third-party construction cost consultant and put in place an estimating process to evaluate and monitor costs. UVMHC will endeavor to limit changes in scope and potential cost increases with a value management process and through reliance on certain subcontractors and key trade partners to suggest options to make the project less costly. *See* App., 41.

16. According to the GMCB's architectural consultant, the preliminary construction cost estimate of \$990/sq. ft., which includes both construction costs and required soft costs such as FF&E, A/E, and other associated costs, meets current industry standards in the northeast, as does the project cost estimate of approximately \$1,400/sq. ft. In addition, based on a cursory review of the civil and site plan, the architectural consultant reports that while the scope of the plan is extensive due to issues such as ledge on site and the installation of two gravel wetland areas, overall, it meets industry standard. NEMD Report (Mar. 20, 2024), 2.

17. UVMHC prepared construction level drawings for all aspects of the project. Resp. (May 22, 2023). GMCB's architectural consultant advised that the ORs are adequately sized for any type of surgery and meet the current industry standard, that there are sufficient Prep, Phase 1, and Phase 2 recovery areas for the number of ORs, and that the preliminary drawings represent a

well-thought-out plan. NEMD Report (Mar. 20, 2024), 3. GMCB also engaged a consultant to review the OSC equipment, which was found to be appropriate for the anticipated services, with pricing as expected. ECRI Report (Mar. 20, 2024), 6.

18. UVMMC's proposed shell spaces, spread across three areas, would accommodate another four ORs and 14 pre- and post-op spaces. App., 22, 32. The unfinished spaces will be built during the initial construction phase to avoid the disruption to the OSC's operations that would arise if constructed later. This will also avoid somewhere between \$5.7 million and \$7 million in future construction costs. App., 19 - 20. The cost to construct the shell space within the current project is \$3.5 million for 9,975 sq. ft., or \$354.26/sq. ft. Resp. (Nov. 16, 2023), 12. The annual operating cost for all shell spaces is \$6,220. Resp. (Jan. 17, 2024), 3-4.

19. UVMMC recognizes the uncertainty involved with its projections (described below) and believes part of the benefit of including shell space is to allow UVMMC to easily add additional ORs if they are needed or delay the expansion if they are not, allowing for some flexibility for the future. Testimony of Dr. Stephen Leffler, Tr., 248:25 – 249:7. UVMMC did not explore options for an OSC with fewer than 8-12 ORs. Resp. (Nov. 16, 2023), 19.

20. UVMMC asserts that it is not feasible to expand outpatient surgical capacity on the main campus because many of the multi-purpose ORs there are small and cannot accommodate specialized equipment and technology that some outpatient procedures require and because there is no space available for additional post-operative and recovery spaces. App., 4.

21. The Fanny Allen ORs have not been significantly renovated in 30 years and UVMMC's Facilities Master Plan has included replacing them since 2017. App., 3 – 4. UVMMC has identified the project in its GMCB capital budget submissions since FY 2020. App., 2, 43. UVMMC's lease of the Fanny Allen campus was set to expire in 2026. *See* App., 1. However, UVMMC recently received a CON to purchase the Fanny Allen campus. *See In re Application of UVMMC for the Purchase of the Fanny Allen Campus in Colchester*, GMCB-002-24con, Statement of Decision and Order (July 5, 2024). Even with the purchase, expanding or renovating the Fanny Allen ORs is not a viable alternative to the OSC. Resp. (Jan. 17, 2024), 8. At 378-450 sq. ft., the Fanny Allen ORs are undersized by current standards and cannot accommodate the installation of advanced air handling systems or contemporary surgical and interoperative imaging equipment. The pre- and post-operative areas are small and not conducive to staff and visitor access or patient privacy. App., 4; *see also* Testimony of Dr. Mark Plante, Tr., 301:14 – 25 (describing inadequacy of the Fanny Allen space for specialized equipment such as fluoroscopy machines that are used in orthopedic surgeries); Testimony of Dr. Patrick Bender, Tr., 302:18 – 23 (describing the inability of Fanny Allen ORs to accommodate certain procedures such as total joint replacements). There is also no capacity for a 23-hour stay at Fanny Allen and a very small percentage of patients may need to stay twenty-three hours. Testimony of Dr. Claude Nichols, Tr., 67:11 – 68:1.

22. UVMMC asserts that the ongoing use of the Fanny Allen ORs is precarious, given recurring air quality issues and their limited size and uses. The rooms have twice been closed unexpectedly, creating backlogs that UVMMC attempted to relieve with measures such as

extending OR hours on the main campus. UVMMC states that the main campus ORs cannot absorb the loss of Fanny Allen given its projections for growth in surgical demand. App., 48.

23. UVMMC says that building an OSC at the Fanny Allen campus would be more expensive and very disruptive to UVMMC's operations; it would require either demolishing and expanding the building that currently houses the ORs – significantly disrupting patient care and likely costing more than the proposed OSC – or constructing an OSC in space now occupied by parking lots, requiring construction of a 400-space parking garage. Resp. (Jan. 16, 2024), 8-9.

24. UVMMC asserts that this project will improve the quality of health care by increasing the size of the ORs so that they can support modern technologies, surgical teams, and advanced air handling systems that minimize the risk of infection. The uniformity and interchangeability of the ORs will allow for more efficient scheduling; patients will not have to wait for one specific OR in which their surgeries can be performed to become available. App., 48. Additionally, it is sometimes beneficial for two surgical teams to collaborate in the OR on “dual” procedures (e.g., ENT and Plastics), enabling patients to receive two procedures in one appointment, which streamlines care delivery and enhances both patient satisfaction and access. These dual procedures are not possible at Fanny Allen today. App., 5.

25. Moving outpatient surgeries presently performed on the main campus to the OSC would increase capacity on the main campus for inpatient surgeries that are more complex such as cardiac, neurosurgery, complicated ENT, urology, cancer, and orthopedic surgeries. *See* App., 6 UVMMC officials testified that other surgeries, such as total joint replacement, rotator cuff, and some spine surgeries, if uncomplicated, can now be performed safely in an outpatient setting. This allows patients to be shifted from the inpatient setting to outpatient setting, which opens up resources on the main campus for patients who are critically ill, have cancer, or have comorbidities that require inpatient surgeries. Testimony of Dr. Claude Nichols, Tr., 65:17 – 67:10.

26. UVMMC asserts that it is currently operating at over 80% capacity across the main campus and the Fanny Allen campus. *See* Testimony of Chris Dillon, Tr., 223:20 – 224:2. This calculation is made using 250 days at 9.5 or 10 hours a day, or more. Operation start time is 7:30 AM and each OR at the two locations is in operation to either 5:00 PM or 7:00 PM. Some ORs are blocked to be in operation later. It can be variable day-to-day, with block time running at least until 5:00 PM and a couple of ORs blocked to operate a little bit later. *See* Testimony of Dr. Mark Plante, Tr., 307:5 – 308:22.

27. Surgeons, physicians, nurses, scientists, and students consider the quality of medical facilities when deciding where they will practice, research, and study. *See* App., 6. The OSC will provide a high-quality environment to attract learners and clinicians to study and practice in Vermont. App., 2, 6. UVMMC believes that many of its residents stay in the state after residency to provide care to Vermonters and that without a state-of-the-art OSC, UVMMC will no longer be able to attract quality residents. Testimony of Dr. Claude Nichols, Tr., 68:4 – 69:21. The OSC will also improve the patient experience and provide a more convenient setting than the main campus. *See* App., 5, 40, 48; Testimony of Dr. Stephen Leffler, Tr., 15:23 – 16:5.

28. UVMMC asserts that the University of Vermont Health Network (UVMHN) seeks to maximize access across its network and aims to use available capacity at affiliate hospitals primarily to meet projected increased demands for surgeries from patients in these hospitals' home communities. Resp. (Feb. 27, 2024), 12-13.

29. UVMMC transfers appropriate surgical cases to Central Vermont Medical Center (CVMC) and occasionally to Porter Medical Center (PMC), both of which are part of UVMHN. UVMMC will send more than 100 surgical cases this year to CVMC. *See* Testimony of Dr. Stephen Leffler, Tr., 18:24 – 19:4, 218:20 – 219:2. UVMMC plans to expand on opportunities to increase surgical access for patients able to travel to PMC. Resp. (Feb. 27, 2024), 12-13.

30. UVMMC asserts that while fractional capacity is available at CVMC, PMC, and certain network hospitals in New York, it is logistically difficult to utilize fractional capacity; ORs are not freely interchangeable – some are too small or otherwise inadequate to host some surgeries, and much of available OR time is in aged and small rooms which cannot accommodate contemporary surgery performed by larger teams using larger equipment. These space constraints limit UVMHN's operational flexibility. Resp. (Feb. 27, 2024), 11-13. To the extent possible, UVMMC seeks to schedule procedures with block time – predictable recurring pieces of OR time allocated to specific services or providers. Testimony of Chris Dillon, Tr., 48:20 – 24. In addition, when surgeons drive between facilities, it negatively impacts the number of cases they can perform in a day. Testimony of Dr. Stephen Leffler, Tr., 219:3 – 12. UVMMC asserts that while use of available fractional capacity at other UVMHN hospitals is not a substitute for the proposed OSC, UVMHN is engaged in multiple initiatives to coordinate and integrate OR operations in order to expand surgical access for patients as much as possible. Resp. (Feb. 27, 2024), 12-13.

31. UVMMC asserts that seeking OR time at non-UVMHN-affiliated hospitals is more complicated and challenging because of differences in electronic medical record systems and equipment and scheduling. *See* Testimony of Dr. Stephen Leffler, Tr., 219:15 – 25.

32. UVMMC interprets the demand model supporting its CON application as projecting a significant growth in demand for OP surgeries in Franklin County that NMC will need to direct any currently available capacity to meet. Resp. (Feb. 27, 2024), 10. UVMMC states that its consultant analysts projected NMC would be at capacity by 2030. UVMMC says it is aware that Copley is currently at capacity. Testimony of Dr. Stephen Leffler, Tr., 218:15 – 20.

33. UVMMC asserts that it collaborates with neighboring health care facilities by accepting referrals and transfers for procedures that cannot be performed elsewhere in the State. UVMMC believes other hospitals' top request of UVMMC is to take patient referrals. UVMMC asserts that it can accept those referrals only if it has adequate surgical capacity. *See* App., 39; Testimony of Dr. Stephen Leffler, Tr., 92:23 – 93:5; Testimony of Dr. Sunil Eappen, Tr., 96:19 – 23. UVMMC says it will continue to engage collaboratively with other providers with respect to their patients' care and avoid access constraints that make collaboration more difficult. App., 39. UVMMC leadership believes it would not be appropriate for hospitals to allocate surgical capacity and staff among themselves. Testimony of Dr. Sunil Eappen, Tr., 97:22 – 99:1.

34. To justify the need for the OSC, UVMMC provided estimates of both surgical demand and capacity. *See* Mathematica Report (Mar. 20, 2024), 1; App., 10-14. To estimate surgical demand, UVMMC started with a baseline demand and projected it forward over 10 years based on population and non-population factors. Mathematica Report (Mar. 20, 2024), 3-5. UVMMC used adjusted volumes from FY 2019 as its baseline demand because 2019 was the most recent year for which data were available that was not impacted by the COVID-19 pandemic, the October 2020 cyber-attack, or the closure of the Fanny Allen ORs. Mathematica Report (Mar. 20, 2024), 4.

35. The factors UVMMC used to project demand seek to account for 1) changes in the size and composition of the population in UVMMC's service area; 2) the average number of surgeries per demographic subgroup (for example, women ages 65 and older); and 3) changes in the number of surgeries due to epidemiological, technology, and policy factors (e.g., development of new surgical procedures or an increase in the proportion of the population with health insurance). UVMMC's approach to developing the demand projections implicitly assumes that the total demand served by the hospital (regardless of the location of the patient) will increase proportionally to the growth of the population of Chittenden County. UVMMC also assumes that it will not experience any shifts in market share. *See* Mathematica Report (Mar. 20, 2024), 3-4.

36. UVMMC presented three projections of surgical demand through 2030: 1) Scenario 1, from the Sg2 Model, 2) Scenario 2, from the Public Opinion Strategies (POS) model, and 3) Scenario 3, from a "Hybrid Model." In all three scenarios, surgical demand in each service line grows as a function of the population growth rate for the over-65 and under-65 populations, weighted by how many procedures are done for each of these population subgroups. Mathematica Report (Mar. 20, 2024), 4. The over-65 projection is important because that population subgroup is typically a higher utilizer of care. Testimony of Eve Hoar, Tr., 26:8 – 19.

37. Sg2 is a market analytics firm that develops forecasts of health care demand. The Sg2 Model projects baseline procedure volume for each service line through 2030 using growth rates from a proprietary model. This model reflects changes in population that are based on population growth estimates for the over-65 and under-65 populations from Claritas data available at the time (Claritas 2021). Claritas is a consumer analytics company. The Sg2 Model also includes adjustments for five non-population, demand-side factors related to economy and consumerism, health care policy, epidemiological changes, innovation and technology, and systems of care. Mathematica Report (Mar. 20, 2024), 5; Resp. (June 15, 2023), 23. The POS Model projects demand through 2030 based solely on growth rates for the over-65 and under-65 populations using POS forecasts that were commissioned by UVMMC. POS is a public opinion research firm that specializes in political opinion research. Mathematica Report (Mar. 20, 2024), 5; Testimony of Eve Hoar, Tr., 25:5 – 23. The POS population forecast compares U.S. Census data from 2019 with a state projection to 2030, instead of deriving both 2019 and 2030 estimates from the same source. Mathematica Report (Mar. 20, 2024), 9; Resp. (June 15, 2023), 17. The Hybrid Model combines Sg2's growth rate for the under-65 population, Sg2's non-population demand-side growth factors, and POS's higher over-65 population growth rates. *See* App., 11; Mathematica Report (Mar. 20, 2024), 4. The differences between the three models are reflected in the following table:

Population growth rates and other non-population growth factors in UVMMC’s demand projection models: 2020–2030

Factors	Sg2 model	POS model	Hybrid model
Population growth rate, 65 years of age and older	30%	62%	62%
Population growth rate, overall	4%	6%	6%
Other non-population growth factors ^a	Yes	No	Yes

Source: UVMMC OSC CON application, Pages 10-11, February 10, 2023.

Note: UVMMC did not provide a population growth rate for the population less than 65 years for the POS model.

^aNon-population growth factors in the Sg2 model include economy and consumerism, health care policy, epidemiological changes, innovation and technology, and systems of care. In addition to population, the Sg2 model produces a separate percent adjustment for each of these five factors.

Mathematica Report (Mar. 20, 2024), 4.

38. UVMMC’s three scenarios project that overall demand for surgeries will grow by between 14% and 22% by 2030, as reflected in the following table:

	10 year OR Volume Projections Based On:								
	Scenario 1: Sg2 Growth Rates			Scenario 2: Utilization for Updated Demographic Growth			Scenario 3: Sg2 Growth Rates Adjusted for Updated Demographic Growth		
	2030		2030	2030		2030	2030		2030
	IP	OP	IP + OP	IP	OP	IP + OP	IP	OP	IP + OP
Total Cases	6,231	15,938	22,169	7,226	15,980	23,206	6,717	17,050	23,767
Growth from 2019	2%	20%	14%	18%	20%	19%	10%	28%	22%

Figure 1.6. Ten-year surgical volume demand projections based on three growth scenarios.

App., 11.

39. Once UVMMC estimated the number of surgical cases that would be demanded, its consultant, Halsa Advisors, calculated the number of surgical minutes those cases would reflect in five and ten years from the baseline and how many ORs UVMMC would need. Testimony of Scott Walters, Tr., 30:4 – 34:25. This calculation depends on several inputs: 1) the number of ORs available; 2) the days and hours of operation for those rooms; 3) the average length of surgeries; 4) the average time to turn over ORs between surgeries; and 5) the utilization threshold imposed on the ORs (i.e., the percentage of overall OR capacity the hospital plans to deliberately leave unused). Mathematica Report (Mar. 20, 2024), 3. Halsa started with existing IP and OP case lengths and multiplied the projected cases by the historical case length by service line. Halsa relied on historical data rather than performance benchmarks to reflect UVMMC’s unique case mix. Halsa then added a turnaround allocation (based on actual performance) to calculate the total minutes for each type of case and service line. To calculate the number of ORs needed to meet total demand, Halsa used a utilization target of 75% and assumed OR availability ten hours per day, 250 days per year. Halsa recommends a 75% utilization target because Halsa believes that it allows some flexibility for add-ons, emergency cases, acute care surgery, and trauma patients needing to be added to the schedule and allows for unexpected cancellations. See Testimony of

Scott Walters, Tr., 30:4 - 35:12. The results of this analysis and UVMMC’s projections of total and additional ORs needed by 2030 are reflected in the following table:

Component of projected demand	Sg2 model	POS model	hybrid model
Estimated number of procedures demanded	22,169	23,206	23,767
Estimated number of ORs needed to meet demand	28.5	29.9	30.6
Number of ORs currently available	25	25	25
Estimated number of additional ORs needed to accommodate procedures that exceed current capacity	3.5	4.9	5.6

Source: Page 13, UVMMC’s OSC CON application, February 10, 2023.

Notes: The number of ORs needed to meet demand is calculated by assuming a 75 percent operating room utilization threshold. We calculate the number of additional ORs that will need to be constructed assuming that the 25 rooms currently available at UVMMC will remain available.

OR = operating rooms.

Mathematica Report (Mar. 20, 2024), 8.

40. Mathematica expressed concern with six components of UVMMC’s estimates, including lack of evidence of operating room shortages, use of a proprietary growth model that does not allow for external evaluation, use of POS’s population growth rates as opposed to US Census-based sources, relatively high turnover time, assumed growth in demand for inpatient surgeries, and the use of a 75% benchmark for OR use. Mathematica Report (Mar. 20, 2024), 9.

41. Mathematica notes that UVMMC’s projection model is the main source of evidence that the hospital is facing a shortage of ORs. However, all projection models require assumptions (and uncertainty) about the population’s growth, changes in market share, and other shifts that might affect demand for surgeries over time. Concrete evidence that UVMMC has been facing a long-term and growing shortage of ORs, either through longer wait times or more delayed care, would have strengthened UVMMC’s case, but was not provided. While UVMMC noted that of November 2023, it had 375 patients waiting 60 – 90 days for surgery, and 341 patients waiting more than 90 days, without more detailed wait time data over a longer period, Mathematica could not assess whether these counts are evidence of an OR shortage. *See* Mathematica Report (Mar. 20, 2024), 9. After Mathematica issued its report, UVMMC provided wait times data from May 2024, which showed it had reduced its wait list totals compared to November 2023, with 220 patients waiting 60-90 days and 304 patients waiting more than 90 days. Resp. (Jun. 11, 2024), 2.

42. Wait times can result from factors other than lack of capacity (e.g., prior authorization and patient decisions). *See* Testimony of Dr. Bender, Tr., 310:18 - 311:19; *In re ACTD LLC, d/b/a The Green Mountain Surgery Center*, Statement of Decision (July 10, 2017), 18 n.12 (“wait times” most often result from factors other than hospital room availability). A 2019 GMCB presentation that included an analysis of wait times found long wait times in certain specialties, including neurology, urology, and ENT, and summarized that workforce issues contributed substantially to wait times. GMCB, *FY2020 Hospital Budgets Non-Financial Reporting* (June 12, 2019), 27, <http://gmcboard.vermont.gov/sites/gmcb/files/FY%202020%20Hospital%20Budgets%20Non-Financial%20Report.pdf>.

43. UVMMC provided Mathematica with a detailed description of the individual non-population growth factors in the Sg2 model, including the numerical values for each growth factor and the data sources used to derive those estimates. Resp. (Feb. 27, 2024), 3. However, in the absence of more detailed information on how Sg2 uses the data to derive the estimates for these factors, Mathematica could not assess whether the model provides a reasonable source for UVMMC's demand projections. Mathematica Report (Mar. 20, 2024), 9.

44. The POS growth estimates for the over-65 population that UVMMC used in the Hybrid Model (62%) are high relative to other sources. Based on the U.S. Census's forecast, growth for the Burlington HSA from 2020-2030 is projected to be 36%, while the State's own projections range from 31% to 39%. *See* Mathematica Report (Mar. 20, 2024), 9. UVMMC did not offer specific validation of the POS forecast. *See* Testimony of Eve Hoar, Tr., 262:15 – 22 (describing strong reputation of Claritas forecast, not POS). A more recent Claritas forecast (Claritas 2024) that was not available when UVMMC developed its demand projections estimates 41% growth in the over-65 population. *See* Testimony of Even Hoar, Tr., 25:24 – 26:19; Resp. (Feb. 27, 2024), 4-5. In response to a question about whether the population projections included information on Vermont's housing shortage, UVMMC provided information showing that housing was a data item in the Claritas forecast but did not provide specific information on the manner in which the projections reflect Vermont's specific housing challenges. *See* Resp. (Jun. 11, 2024), 6.

45. Mathematica's review of the literature revealed that there is no single, ideal measure of OR utilization. If utilization is measured as including turnover time, it would be reasonable to provide estimates for a higher utilization benchmark. A simulation-based 2003 study suggests peak efficiency in the OR results when utilization (surgery plus turnover time) is between 85% and 95%. UVMMC argued that this simulation incorporated unrealistic assumptions and disputed its applicability to real-world utilization. Resp. to Consultant Reports (Apr. 25, 2024), 3-4.

46. Given Mathematica's concerns, GMCB requested adjustments to UVMMC's models. GMCB also asked UVMMC to provide its updated results in an Excel workbook so it could replicate the calculations. In response, UVMMC made several updates to its model by 1) using separate turnover times for inpatient and outpatient surgeries and creating a weighted average of the two based on their respective volumes, 2) subtracting a surgical room turnover to each OR at the end of each day, 3) replacing the Hybrid Model with the Sg2 Model (Scenario 1 instead of Scenario 3), and 4) using Claritas's latest population growth estimates (Claritas 2024). Mathematica Report (Mar. 20, 2024), 12; Resp. to Consultant Reports (Apr. 25, 2024), 5. Mathematica believes that this "March 12, 2024 Model" provides a more reasonable forecast of OR need than the version UVMMC used, although both models assume a 75% OR utilization rate and incorporate Sg2's proprietary non-population growth factors. The March 12, 2024, Model projects a need for 30.7 ORs by 2029. Mathematica Report (Mar. 20, 2024), 12-13.

47. To evaluate the sensitivity of using a higher utilization threshold, Mathematica simulated how the March 12, 2024 Model's results would change if UVMMC used an 80%, 85%, or 90% utilization threshold. The results are reflected in the following table:

Impact of Utilization levels on OR need in Mathematica-modified model

Year	75% utilization	80% utilization	85% utilization	90% utilization
2019	26.4	24.8	23.3	22.0
2020	23.1	21.6	20.4	19.2
2021	27.9	26.1	24.6	23.2
2022	25.1	23.5	22.1	20.9
2023	27.2	25.5	24.0	22.7
2024	28.6	26.8	25.2	23.8
2025	29.2	27.4	25.8	24.4
2026	29.6	27.8	26.1	24.7
2027	30.0	28.1	26.4	25.0
2028	30.3	28.4	26.8	25.3
2029	30.7	28.8	27.1	25.6

Mathematica Report (Mar. 20, 2024), 14.

48. Separate from this proceeding, Mathematica built a statewide model using information reported in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) and the Vermont Uniform Hospital Discharge Data System (VUHDDS) to forecast outpatient surgical demand by the hospital service area (HSA) in which the patient lives, as well as the type of surgery. Mathematica’s model estimated that the number of outpatient surgeries demanded in the Burlington HSA, as determined by patients’ residence, would increase by 2.4% annually, and 27% cumulatively, from 2019 to 2029. This estimate grew to 3.5% per year when factoring non-demographic trends from the baseline period. Mathematica’s projections exceeded the March 12, 2024 Model’s estimate of 2.1% annual growth and 24% cumulative growth over the same period. However, several features of Mathematica’s model limit its value for assessing the reasonableness of the projections in UVMMC’s CON application. Mathematica Report (Mar. 20, 2024), 14-16.

49. UVMMC maintains it is not trying to take other hospitals’ market share. Testimony of Dr. Stephen Leffler, Tr., 257:13 – 17. In planning the OSC, UVMMC assumed its market share of outpatient surgeries would remain the same and its modeling does not anticipate capturing volume from other facilities. Resp. (Dec. 8, 2023), 2; Resp. (Feb. 27, 2024), 10-11; *see* Testimony of Eve Hoar, Tr., 29:2 – 18. In the baseline year of UVMMC’s demand model, approximately 9% of UVMMC’s outpatient surgery patients resided in Franklin County. App., 9. UVMMC states that it is unable to determine whether NMC has the facilities or staff necessary to provide the outpatient surgery services that UVMMC provided to this patient population. Resp. (Feb. 27, 2024), 10.

50. The applicant’s original Integrated Communications and Engagement Strategy included a plan for social media, paid content placements, newspaper ads, and a “paid search ‘capture campaign’ relative to competitors.” App., Ex 4., 34. Search campaigns are text ads on search results that allow advertisers to reach people while they are searching online for the products and services that the advertiser offers. *See, e.g.,* Google Ads Help, *Choose the right campaign type*, <https://support.google.com/google-ads/answer/2567043?sjid=3283102867545572055-NA>.

UVMMC officials stated at the hearing that while “awareness is important, . . . we should not market to try to attract more patients. It is not what we need to do.” Testimony of Dr. Stephen Leffler, Tr., 259:1 – 5. UVMMC officials also agreed that the hospital should not spend \$130,000 on marketing to try to attract more patients. *See* Testimony of Dr. Sunil Eappen, Tr., 260:4 – 6.

51. The Board’s consultant, Ascendient, reviewed the financial materials and assumptions in the application. Despite a decline in historical performance, UVMMC’s operating margin in the past three years aligns with the S&P median operating margin for US non-profit health care systems. Medians were 1.1% in 2022, 1.9% in 2021, 0.1% in 2020, placing UVMMC slightly above the median in 2021 and slightly below the median in 2020 and 2022. UVMMC experienced a dramatic turnaround in FY 2023, with actual FY 2023 operating income exceeding projections by approximately \$9 million. UVMMC achieved these positive FY 2023 results despite a \$17.1 million operating loss in the first quarter of the year; its operating margin in the third and fourth quarters of FY 2023 averaged 6.0%. Ascendient Report (Mar. 20, 2024), 8-10.

52. UVMMC has reserved capital to be able to afford this project. Testimony of Dr. Stephen Leffler, Tr., 17:15 – 18. In 2023, UVMHN experienced a bond rating downgrade by Fitch from an “A-plus” to an “A” rating. UVMMC represents that in the annual rating review process that all three rating agencies, S&P Global, Moody’s and Fitch, performed a full review of UVMHN’s multi-year financial framework, which included all assumptions and the anticipated \$100 million debt issuance included in the OSC CON application. S&P Global assessed an “A” rating, Stable Outlook; Moody’s an “A3” rating, Stable Outlook; and Fitch an “A” Rating, Stable Outlook. Because all the ratings remain in the A category, UVMMC does not expect any impact on the cost of borrowing from Fitch adjusting its rating from A+ to A. Resp. (Aug. 15, 2023), 7.

53. The Network continues to pay off its existing debt at a rate of approximately \$20 million per year. However, its debt-to capitalization ratio will soon fall below the range UVMMC believes is healthy for an A-rated organization, reaching approximately 27% within three years without additional borrowing. App., 44. UVMMC asserts that it and UVMHN already have the capacity to borrow more money to make necessary capital investments and that the project will produce a positive incremental EBIDA operating margin of \$83,196,439 and an incremental operating margin of \$28,185,531 over the first 4.5 years of operation (with incremental expenses of \$251.7 million and incremental revenue of \$279.9 million). App., 44-45; Response to Consultant Reports (Apr. 25, 2024), 10; Testimony of Eve Hoar, Tr., 57:2 – 9.

54. The tax-exempt bond that UVMMC would use for this project is for a total of \$150 million, \$100 million of which will be used to finance the OSC project; the rest will be used to finance the fit-up of the already approved Dermatology/Ophthalmology project and UVMMC’s purchase of the Fanny Allen campus. Resp. (Jan. 16, 2024), 7-8.

55. UVMMC’s days cash on hand declined from 185 days in FY 2021 to 112 in FY 2022, well below rating agencies’ A-rated medians of 175 – 225. This decline was the result of UVMMC’s operating loss, its large increase in operating expenses, and significant investment losses (\$234 million). UVMMC’s average age of plant has slowly but consistently risen over the past three years and by the end of 2023 will be 13.37, slightly higher than the rating agencies’ A-

rated median of 11-13 years. UVMMC's debt-to-capitalization ratio is 43%, slightly above what UVMMC states is a healthy range for an A-rated health care organization, generally between 30% and 40%, meaning it has more debt than its peers. UVMMC expects this ratio to fall below 30% by 2027 without the OSC project as UVMMC continues to pay off its long-term debts without significant issuing of new debt. Ascendient Report (Mar. 20, 2024), 11-13.

56. Based on UVMMC's projections, the project would positively impact UVMMC's key financial metrics of average age of plant, debt-to-capitalization ratio, and operating EBIDA margin, but would reduce its days cash on hand by two, from 157 days in 2027 without the project to 155 days with the project (at projected daily operating expenses of \$6,171,000). Ascendient described this as slightly concerning given that UVMMC is trying to increase its days cash on hand. Ascendient Report (March 20, 2024), vi, 11-13. However, after Ascendient issued its report, it was revealed in testimony that UVMMC anticipates fundraising \$13 million, which could offset operating cash expenditures and reduce the impact on days cash on hand. *See Findings*, ¶ 14, *supra*.

57. UVMMC's financial projections assume that reimbursement rate increases will continue to keep pace with cost inflation and that UVMMC will apply future rate increases to fund cost inflation to all payers equally. Ascendient Report (Mar. 20, 2024), 10. Ascendient observes that, in FY 2024, faced with expected "cost inflation" of 5.2%, a projected Medicare rate increase of 2.9%, and a projected Medicaid rate increase of 0.7%, UVMMC requested a commercial rate increase from the Board of 13.45%. If future years continue the recent trend of Medicare and Medicaid rate increases not covering total cost inflation, commercial insurance rates would have to increase at a higher rate than projected overall cost inflation to realize the revenue growth assumed by UVMMC in its application. Ascendient Report (Mar. 20, 2024), 10. If UVMMC does not receive the rate increases it requests from the Board and does not achieve its projected margin, UVMMC would first reduce capital spending to preserve days cash on hand. UVMMC states that if revenues consistently fail to cover operating expenses and fail to produce a positive operating margin, UVMMC would have to cut other operating expenses. Resp. (Aug. 15, 2023), 10

58. In the incremental pro forma, inpatient cases significantly drive net patient revenue and operating margin. Without the inclusion of inpatient cases, the OSC would operate with an incremental loss each year and its incremental cash flow would also be negative. Resp. (Feb. 27, 2024), 9; Ascendient Report (Mar. 20, 2024), 4-5. UVMMC notes that in the incremental pro forma, there is no margin for moving surgeries from Fanny Allen and the main campus to the OSC. *See Testimony of Eve Hoar, Tr.*, 235:12 – 236:13.

59. A revised pro forma submitted on April 25, 2024, in response to concerns raised by Ascendient, includes \$14.4 million in additional expenses for surgeon compensation that was not included in the initial pro forma. *See Resp. to Consultant Reports* (April 25, 2024), 10. Originally, the OSC was expected to contribute \$42.6 million in additional operating margin and \$41.9 million in additional cashflow, cumulatively over its first 4.5 years. Ascendient Report (Mar. 20, 2024), 2. Including the additional surgeon compensation reduces the additional operating margin to \$28.2 million and additional cash flow to \$27.5 million. Resp. to Consultant Reports (April 25, 2024), 9-10; Ascendient Reply (May 1, 2024), 1. The annual incremental operating margin is expected to

be positive in each of these years, increasing from \$266,254 in FY 2025 (half-year) to just under \$11.5 million in FY 2029. Resp. to Consultant Reports (April 25, 2024), 10.

60. UVMMC's incremental pro forma does not include costs and revenues for pre- and post-surgery services such as imaging, labs, and office visits, whose margins would increase the profitability of the project. App., Ex. 4, 28; Testimony of Eve Hoar, Tr., 197:17 – 199:11. Also excluded from the pro forma are future estimates of revenue opportunities or expense savings from vacated OR space at the Fanny Allen campus that would be created by the project. App., Ex. 4, 28. UVMMC also believes there are opportunities for efficiencies that are not reflected in the pro forma. Testimony of Eve Hoar, Tr., 178:15 – 25. Not all efficiencies are modeled, and throughput may be higher and cost per unit and cost per case may be lower because of the OSC's increased efficiency. Testimony of Dr. Sunil Eappen and Dr. Mark Plante, Tr., 180:2 – 16.

61. Although UVMMC states sending patients out of state for procedures is often more expensive, witnesses were unable to provide data to support that assertion during the hearing or in response to post-hearing questions, where comparisons were not provided for outpatient procedures. See Testimony of Eve Hoar, Tr., 171:22 – 24; Resp. (Jun. 11, 2024), 3 (data for total knee replacement was not specified to be outpatient and comparison to Dartmouth Health was provided only per inpatient encounter).

62. UVMMC states that the margin for all its services comes from commercial payers who make up for the losses it incurs on Medicaid cases. It is undisputed that commercial payers pay more than Medicaid and Medicare in every line of the hospital's business and UVMMC expects that to be the case at the OSC as well. See Testimony of Dr. Sunil Eappen, Tr., 283:3 – 15. At hearing, UVMMC witnesses confirmed that Medicare payments provide for a small margin on outpatient surgeries. Testimony of Rick Vincent, Tr., 282:17 – 19 (“It's pretty close to break even [on these services], small, small margin on the care.”); see also Testimony of Rick Vincent and Dr. Sunil Eappen, Tr., 282:24 – 283:15 (stating that UVMMC loses money on Medicaid cases). However, following the hearing, UVMMC said that it anticipates the relative cost coverage by payer at the OSC will be close to the cost coverage by payer across UVMMC overall, with Medicare covering an average of 67% of costs, Medicaid covering an average of 58% of costs, and commercial payers covering an average of 185% of costs. See Resp. (Jun. 11, 2024), 7. Reimbursement rates paid by Medicare Advantage (MA) plans are generally lower than the rates paid by other commercial plans and are closer to traditional Medicare reimbursement rates. See Trish, Erin et. al., *Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance*, JAMA Internal Medicine (2017) 177(9), 1287-1295, available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>; Pelech, Daria, *An Analysis of Private Sector Prices for Physicians' Services*, Congressional Budget Office, Working Paper 2018-01, available at <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf>. This means that non-MA commercial payers likely pay more than 185% of costs across UVMMC overall.

63. Nationally, Medicare prices are designed to provide modest profit margins for efficient hospitals. See Christopher Waley, Rose Kerber, Daniel Wang, Aaron Kofner, Brian Briscoombe, *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led*

Transparency Initiative (RAND Report), vi (citing Medicare Payment Advisory Commission, 2022), available at https://www.rand.org/pubs/research_reports/RRA1144-2.html. The average commercial reimbursement at ASCs nationally is 170% of Medicare. RAND Report, 18 (stating that “ASC facility prices were stable, approximately 171 percent of Medicare between 2020 and 2022”); Sage Transparency 2.0, ASC (showing the national average total facility plus physician price as a percentage of Medicare from 2020 – 2022 as 170%).

64. Approximately 75% of the reimbursement for outpatient cases is projected to come from commercial payers, with only 11% coming from Medicare. Resp. to Consultant Reports (Apr. 25, 2024), 8; Resp. (Feb. 27, 2024), Q.10 Resp. Medicare Advantage is grouped with commercial in this split. Testimony of Marc Stanislas, Tr., 167:10 – 21.

65. UVMHC acknowledged that the Board could “figure out ways to reimburse [it] less for the care [it] deliver[s] at the OSC and [it] will have less or no margin.” Without that margin, it asserts that it will have less money to invest in other services that do not generate a margin, such as dialysis, mental health, and pediatric surgery care. UVMHC maintains that it is still important for it to open the OSC, even if the project gets squeezed down to where it is not making a margin. Testimony of Dr. Stephen Leffler, Tr., 280:18 – 281:11.

66. The OSC will receive two types of cases: shifted cases – outpatient cases expected to come from patients shifting from the main campus and Fanny Allen to the OSC facility – and incremental cases – new outpatient cases that would not have otherwise received surgical care at UVMHC. The main campus and Fanny Allen use hospital-based (HOPD) billing, whereas the new OSC will be reimbursed as a free-standing ASC, which means an HOPD-to-ASC reimbursement adjustment is necessary to reflect the difference in facility fee schedules for the shifted cases. Ascendant Report (Mar. 20, 2024), 5-6.

67. UVMHC calculated an outpatient reimbursement adjustment to reflect the anticipated reduction in reimbursement rates for shifted outpatient cases. *See* Resp. (June 11, 2024), 8.

[REDACTED]

In other words, UVMHC’s FY 2019 average facility reimbursements/case for specialties that will move cases to the OSC (in FY22 dollars) were compared to the Intellimarker² 90th percentile. UVMHC states that the 90th percentile was used because the Intellimarker data reflects many stand-alone and limited-specialty ambulatory surgery centers. *See* Resp. (June 11, 2024), 8.

[REDACTED] ut, in the absence of benchmarks for “like” facilities, its consultant attempted to make the best use that it

² Intellimarker is a financial benchmarking study on ambulatory surgery centers. UVMHC had access to the Intellimarker data through its consultant, Stroudwater Associates. *See* Resp. (June 11, 2024), 8.

could of a benchmark that is of limited applicability to this project. Resp. (Aug. 15, 2023), 2-3; Resp. (June 11, 2024), 8. Following the hearing, UVMMC provided the Intellimarker medians and 90th percentiles for the specialties that will move cases to the OSC, which reflected [REDACTED] Resp. (June 11, 2024), 9.

68. UVMMC anticipates a [REDACTED] reduction in the facility reimbursements it will receive from Medicare on outpatient surgeries performed at the OSC. *See* Resp. (June 15, 2023), 9; Ascendent Report (Mar. 20, 2024), 6. UVMMC assumes the average commercial facility reimbursement will decrease by 7-10% for all outpatient cases. Resp. (Feb. 27, 2024), 9; Resp. to Consultant Reports (Apr. 25, 2024), 9. UVMMC's anticipated reduction for shifted commercial cases is just over 2%. Testimony of Rick Vincent, Tr., 215:14 – 24; *see also* Resp. to Consultant Reports (Apr. 25, 2024), 8-9. The difference in the commercial adjustment for shifted cases is due to a different payer mix and case mix. Resp. to Consultant Reports (Apr. 25, 2024), 9.

69. For cases moving from the inpatient setting to the outpatient setting, commercial and Medicare decrease by 50% while Medicaid rates decrease by 25%. Testimony of Rick Vincent, Tr., 216:1 – 7. UVMMC did not directly discuss a shift of inpatient cases to an outpatient setting prior to the hearing, but rather focused on how moving certain procedures into the OSC will free up main campus ORs for inpatient surgeries. *See, e.g., App.*, 38.

70. UVMMC is beginning to try to use publicly available price transparency data to help it understand its relative commercial prices. To date, however, it has relied on the same national reports the Board uses, such the RAND Hospital Price Transparency Study, which it combs through to make valid comparisons. *See* Testimony of Rick Vincent, Tr., 270:2 – 271:16. The recently released fifth round of the RAND study shows UVMMC in the top decile ranking (i.e., most expensive) for outpatient services, with a relative private outpatient facility plus physician price equal to 427% of Medicare. RAND Report, Supplemental Material Annex, Table 1 (Hospitals), Row 3686. Meanwhile, Copley was at 152% of Medicare (1st decile) and NMC was at 244% of Medicare (5th decile). *Id.* at Rows 3690 & 3696. According to the RAND study, the standardized price per outpatient service was \$566.73 at UVMMC, \$314.51 at Copley, and \$242.50 at NMC. *Id.* at Rows 3686, 3690, & 3696. UVMMC suggests that the RAND data needs to factor in the average age of Vermont's commercially insured patients. *See* Testimony of Rick Vincent, Tr., 271:25 – 273:3. However, RAND's relative prices incorporate Medicare's adjustments for case mix (e.g., procedural and patient complexity) and thus the analysis addresses differentials in the types of services that patients in different age groups experience. *See* RAND Report, vi. UVMMC is not aware of how expensive its proposed OSC would be compared to other outpatient options in Vermont, including Green Mountain Surgery Center, NMC, or Copley. Testimony of Rick Vincent, Tr., 273:3 – 10. UVMMC posited at hearing that its outpatient services may be priced relatively high because they are offered in an inpatient setting. Testimony of Dr. Sunil Eappen, Tr., 292:19 – 293:7.

71. The direct staffing model for the OSC was developed using the American Society of Paranesthesia Nurses benchmark for Paranesthesia staffing and the American Association of Perioperative Registered Nurses benchmark for OR staffing. Required administrative support staff and Central Sterile Reprocessing staff are also included in the direct staffing model. Before

opening the OSC, UVMMC will work with relevant union bargaining units regarding staffing plans and models. App., 24. Testimony of Mary Broadworth, Tr., 49:8 – 17. UVMMC states it is tracking its ability to recruit and retain employees and is seeing better than industry and regional averages regarding retention. Testimony of Mary Broadworth, Tr., 263:15 – 265:25.

72. Based on key assumptions used in the model, the OSC is projected to require 107.1 FTEs in direct staff, 57.5 of which will be incremental additions to the organization. Approximately 50 current or already budgeted FTEs will shift to the new OSC from either Fanny Allen ORs or the main campus. An increase from eight to 10 ORs would require 18 FTEs. UVMMC employs 107 (81.4 FTEs) physicians who perform surgeries and invasive procedures (Proceduralists). After the OSC opens, 77 Proceduralists will operate at both the OSC and the main campus and 30 Proceduralists will operate exclusively on the main campus. No Proceduralists will operate exclusively at the OSC. App., 24-26; Resp. (Nov. 16, 2023), 15-16; Testimony of Mary Broadworth, Tr., 49:18 – 50:11, 263:8 – 264:10.

73. UVMMC might rely on nurses from the main campus at the OSC; any increased cost for replacement staff is included in the pro forma. Testimony of Eve Hoar, Tr., 236:14 – 25.

74. Current surgeons and community physicians are expected to fill the incremental capacity for the three ORs without the need to hire additional surgeons. The services currently projected to operate at the OSC are collectively 14% behind median productivity per Sullivan Cotter benchmarks, suggesting that several of these services have the capacity to expand into the first phase of the OSC ORs. These benchmarks were used to estimate surgeons' incremental work relative value unit (wRVU) compensation in the revised pro forma. Resp. (June 11, 2024), 4.

75. There will be a need for additional Anesthesia staff beyond those relocating from Fanny Allen. One additional Anesthesiologist and four Anesthesia Advanced Practice (APP) providers will be required to support the eight-OR facility. The cost of these positions is included in UVMMC's financial assessment. The need grows by one additional Anesthesiologist MD and one APP for 10 ORs. The plan assumes that one Pathologist and one Pathology Physician Assistant (PA) will relocate to the OSC and support the OSC in-person and Network remotely. App., 25.

76. The indirect/ancillary staffing model necessary to support the new OSC was created in collaboration with supporting departments. Approximately 15 additional FTEs will be needed to maintain facility operations, primarily in the Environmental Services, Security, Facility, Radiology, IT, and Pharmacy departments. If ORs are increased from eight to 10, two additional FTEs would be needed to support those two additional ORs. App., 25.

77. In total, the new OSC, with eight ORs in operation, will require 78 incremental FTEs. Most of them, 57.5 FTEs, are needed for direct Anesthesia, OR, and Central Sterile Reprocessing (CSR) staffing. If two more ORs were to open at the OSC, increasing its total ORs from eight to ten, an additional 22 incremental FTEs would be needed. App., 25-26.

78. Given known staffing shortages in several roles, both nationally and at UVMMC, the staffing numbers reflect assumptions that 25% of OR RNs, 10% of Surgical Tech FTEs, and 10%

of Paranesthesia RN FTEs will be Travelers. These assumptions, along with the associated cost for those contracted FTEs by role are included in the operating cost on UVMMC's pro forma. App., 26; Testimony of Mary Broadworth, Tr., 50:1 – 6. The 25% assumption is very conservative. Testimony of Mary Broadworth, Tr., 192:25 – 193:2; Testimony of Dr. Stephen Leffler, Tr., 194:15 – 17; *see also* Resp. (Aug. 15, 2023), 3.

79. Clinical staff salary expense makes up approximately 40% of the OSC total operating expenses and is the single largest direct expense for the OSC. UVMMC represents that several factors impact clinical staff salary inflation, including the need for high-cost Travelers to provide temporary staffing. Resp. (Nov. 16, 2023), 15-16. Because Traveler costs have come down recently, UVMMC probably overstated some of the wages for Travelers in its projections. *See* Testimony of Dr. Stephen Leffler, Tr., 108:2 – 12. Due to the overestimated expenses, the margin in the incremental pro forma is likely underestimated.

80. UVMMC asserts that the project goals and facility plan will be positive assets in attracting potential candidates for available positions and a strong plan executed well in advance of First Patient Day will be essential to the project's success. UVMMC asserts that the Network recently strengthened its affiliation with the UVM College of Nursing and Health Sciences with the goal of expanding an already established training program for hiring new graduates. App., 26; Resp. (Nov. 16, 2023), 17. UVMMC expects to hire 120 new RN graduates from its partnerships with universities by the middle of the summer. Testimony of Mary Broadworth, Tr., 269:3 – 23. UVMMC asserts it will also continue its ongoing efforts to increase housing and childcare opportunities for both existing and new employees. App., 26. In addition, UVMMC represents that it has invested in an enhanced talent acquisition program that includes increased marketing; implementation of an expedited application process; and hiring incentives for most positions such as sign-on bonus, payment of relocation cost and enhanced employee referral bonus. Resp. (Nov. 16, 2023), 13-15; Testimony of Mary Broadworth, Tr., 50:7 – 24.

81. The project is not expected to impact UVMMC's ongoing data collection and monitoring efforts. App., 39. UVMMC will continue to collect, report, and monitor key quality measures to ensure the OSC meets or exceeds industry standards and benchmarks. App. 39-40. The resources for benchmarking and identifying national industry standards include the Centers for Medicare & Medicaid Services (CMS) Ambulatory Surgical Quality Reporting (ASCQR) Program, the National Healthcare Safety Network (NHSN) Same Day Outcome Measures (SDOM); the Association of Perioperative Registered Nurses (AORN) and the Association for the Advancement of Medical Instrumentation® (AAMI); American Hospital Association (AHA) Health Equity, Diversity & Inclusion Measures for Hospitals and Health System (HHS) Dashboards; and Agency for Healthcare Research and Quality (AHRQ). App., 29-30. UVMMC will collect and report outpatient surgical quality measures categorized by the Institute of Medicine's six aims of health framework (STEEEP model), Safe, Timely, Efficient, Effective, Equitable, Patient/Family-Centered. App., 31.

82. The applicant has explained that the project will not impact established protocols and adherence to evidence-based practices; consistent with its current assessment process at Fanny Allen, only patients with an ASA (American Society of Anesthesiology) score of 3 or below with

low risk for complications and infection will be appropriate for surgical care at the OSC. App., 40-41. UVMMC reports that it complies with the Joint Commission requirements on Infection Prevention and Surveillance; its Infection Prevention Team was established in 1984, is led by the Hospital Epidemiologist and includes members certified in infection prevention. UVMMC also continues its efforts to prevent the spread of COVID-19 and adopts visitation policies that have been updated in accordance with the latest science and best practices. App., 40-41.

83. UVMMC represents that the Information Technology (IT) capital costs and design elements related to the overall construction of the facility have been included in the project budget's estimates. Additional impacts related to IT applications, new hardware technology, project implementation, internal IT review processes, employee training and cyber security have also been evaluated. App., 31.

84. UVMMC asserts that if a patient seeking services at the OSC expresses a need for mental health care services and is not in acute crisis, the patient would be referred to their primary care physician who, working with their mental health care provider colleagues, would be in the best position to assess the patient's needs. For patients in acute crisis, staff would follow UVMMC's suicide risk assessment protocol, which may include contacting 911 or the UVMMC internal Medical Emergency Team at the main campus. App., 49.

85. The HCA submitted Post-Hearing Comments on May 24, 2024 (HCA Comments). It expressed the opinion that UVMMC presented sufficient evidence that the OSC would help improve access to surgical services and would serve the public good. HCA Comments, 1. However, it also voiced concerns related to affordability, noting that the RAND data reflects that UVMMC's total facility and outpatient facility plus physician prices as a percent of Medicare are high compared to its peer group (*see Findings, ¶ 70, supra*), and recommended that the Board impose certain conditions on the project. First, it urged the Board to set a price cap for all medical services offered at the OSC by limiting price to approximately 5% above commercial breakeven for Medicare because this level "strikes an appropriate balance between allowing the hospital to earn a small margin in alignment with both the mission of a nonprofit hospital and the need to reduce undue impacts on affordability." Second, the HCA recommends prohibiting charging facility fees for services at the OSC. HCA Comments, 1-2. Third, the HCA recommends that all revenue in excess of 2.5% margin from the OSC be earmarked to support future inpatient mental health and substance use disorder related investments. HCA Comments, 2. Fourth, the HCA recommends a condition prohibiting UVMMC from conducting a marketing and advertising campaign and removing any amount budgeted for such activities. HCA Comments, 2. Fifth, the HCA recommends that reporting is required to determine the OSC's impact on wait times, such as requiring UVMMC to provide quarterly or biannual updates on the OSC's impact on wait times. HCA Comments, 2.

86. The public comment period ended on May 30, 2024. The Board received 20 written public comments on this application and three letters from legislative delegations. The public comments in favor of the project expressed a belief in the need for the additional capacity. The public comments opposed to the project expressed concern about the project's staffing challenges, increased expense to the health care system, increased market power, and negative impact on

independent providers. The letters from the Franklin County Delegation and a joint letter from representatives for Orleans, Lamoille, Washington, and Caledonia Counties expressed concern about the impact on smaller hospitals, staffing costs, and capacity. The letter from the Chittenden County delegation expressed support for the project.

Standard of Review

Vermont's CON process is governed by 18 V.S.A. §§ 9431-9446 and GMCB Rule 4.000. An applicant bears the burden to establish that a CON should be granted because the project meets each of the CON criteria set forth in 18 V.S.A. § 9437. *See* Rule 4.000. § 4.302(3).

Introduction

UVMMC seeks to construct a large multi-specialty OSC with eight ORs, 12 prep rooms, and 36 recovery spaces, plus shelled space for four additional ORs and 14 pre-and post-operative spaces that would be fit up later. Findings, ¶ 1. The total cost of the project is approximately \$130 million. *See* Findings, ¶ 14. For reasons outlined below, we approve UVMMC's application, subject to the conditions set forth therein, including conditions that cap commercial reimbursement for surgeries performed at the OSC at 170% of Medicare levels and limit UVMMC's ability to fit up and use more than six ORs without Board approval.

As evidenced by the Board's split decision and the conditions we place on our approval of the application, the path to reaching a decision in this case was not easy. UVMMC's proposal has the potential to significantly impact health care in Vermont for decades and these potential impacts implicate core concerns of the CON program. Furthermore, the application comes at a pivotal time for the future of health care in the state.³ While we respect the dissenting opinions of our colleagues, we believe that, with the conditions we impose on the project through the CON, it satisfies the statutory criteria and should be approved.

Conclusions of Law

I.

The first statutory criterion requires an applicant to demonstrate that the project aligns with statewide health care reform goals and principles because it takes into consideration health care

³ Following years of negative operating margins at Vermont hospitals, particularly rural hospitals, and large increases in hospital prices and insurance rates, Vermont is currently engaged in a hospital system transformation effort to ensure local access to essential services in a way that is affordable and sustainable. *See* Act 167 (2022), Sec. 2 (requiring "a data-informed, patient-focused, community-inclusive engagement process for Vermont's hospitals to reduce inefficiencies, lower costs, improve population health outcomes, reduce health inequities, and increase access to essential services . . ."); *see also* Green Mountain Care Board Presentation, Act 167 (2022): A Brief History & Why Hospital System Transformation is Necessary to Preserve Vermonters' Access to Essential Services (June 19, 2024), available at <https://gmcboard.vermont.gov/2024-meetings>. Furthermore, as the Vermont All-Payer Accountable Care Organization Model nears an end, Vermont is evaluating whether to participate in another statewide reform initiative known as the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, which would begin as early as 2026 and which may significantly change how hospitals are paid.

payment and delivery system reform initiatives; addresses current and future community needs in a manner that balances statewide needs; and is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the Health Resource Allocation Plan (HRAP). 18 V.S.A. § 9437(1).

A. Payment and Delivery System Reform Initiatives

Payment and delivery system reform initiatives advance principles that the Legislature adopted to serve “as a framework for reforming health care in Vermont.” 18 V.S.A. § 9371. Five of these health care reform principles are particularly relevant to this project:

- (1) The State of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.
- (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.
- (3) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. The health care system must ensure that Vermonters have access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care. Other aspects of Vermont’s health care infrastructure, including the educational and research missions of the State’s academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.
- (4) Every Vermonter should be able to choose his or her health care providers.
- (5) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.

The project supports patients’ ability to receive appropriate care at the appropriate time in the appropriate setting (principal #1) and it also promotes patients’ ability to choose their health care providers (principal #4). Fanny Allen does not meet current standards for outpatient surgical care and, for many patients, outpatient procedures at the main campus are logistically more difficult than they would be at the OSC. *See Findings, ¶¶ 21, 27.* Furthermore, despite uncertainty in the demand projections, which we describe in section III, it is reasonably likely that UVMHC will see increased demand for outpatient surgeries over time and the project will allow the hospital to meet that demand, providing patients with the option of receiving care close to home.

The project’s implications for health care financing (principal #5), as well as its support of cost containment and its impact on cost as a barrier to access (principals #1 and #2), are described further in section II. We note here, however, that Vermont has some of the lowest Medicare

expenditures in the country and some of the highest private health insurance expenditures in the country. *See* Green Mountain Care Board 2023 Annual Report (Jan. 16, 2024), 43 (noting that, in 2020 and the two years prior, Medicare spending per-enrollee for Vermont residents ranked lowest in the nation), 45 (noting that, in 2020, prior to large rate increases in 2021-2023, Vermont ranked 8th for private health insurance per-enrollee healthcare expenditure), *available at* <https://gmcboard.vermont.gov/document/2023-annual-report>. Making care more affordable for the commercially insured population will be an urgent focus of the State in implementing any future health care reform initiative.

The project's support of equal access to appropriate mental health care (principal #3) is described in section IX.

By creating a modern outpatient surgical facility that will be attractive to learners, the project will support the educational and research mission of UVMMC (principal #3), the state's only academic medical center. *See* Findings, ¶ 27. The project could also harm the nonprofit missions of neighboring hospitals (principal #3) by reducing their surgical volumes and negatively impacting their revenues and quality (see the discussion in section II and the discussion later in this section regarding CON Standard 1.4). However, with the conditions we place on the CON, particularly the condition limiting UVMMC to the use of six ORs initially and the condition prohibiting UVMMC from marketing, we do not believe this is a likely result.

B. Addressing Current and Future Needs in a Manner That Balances Statewide Needs

We discuss the issue of need in section III.

C. Consistency with Health Resources Allocation Plan

The Health Resource Allocation Plan (HRAP) identifies needs in Vermont's health care system, resources to address those needs, and priorities for addressing them on a statewide basis.⁴ In light of the factual findings in this decision and the conditions in the CON, we conclude that the project is consistent with the HRAP. We note the following:

- **CON Standard 1.3** (to the extent neighboring facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering services has been taken or is not feasible or appropriate).

UVMMC asserts that its most significant form of collaboration is its ability to accept referrals and transfers from unaffiliated providers and hospitals, which it can only do if it has adequate surgical capacity. UVMMC says it will continue to engage collaboratively with other providers with respect to their patients' care and avoid access constraints that make collaboration more difficult. *See* Findings, ¶ 33.

⁴ While the HRAP is in the process of being updated we consider the current HRAP standards, available at <https://gmcboard.vermont.gov/sites/gmcb/files/documents/Vermont%20Health%20Resource%20Allocation%20Plan%202009%207.1.09.pdf>.

UVMMC described how UVMHN hospitals collaborate to deliver surgical services. Where appropriate, UVMMC transfers surgical cases to CVMC and PMC. Findings, ¶ 29. Sending large volumes of patients to other UVMHN hospitals, however, is challenging given the limited available time slots. It is logistically difficult to utilize fractional capacity; ORs are not freely interchangeable – some are too small or otherwise inadequate to host some surgeries. These space constraints limit UVMHN’s operational flexibility. *See* Findings, ¶¶ 28-30.

While NMC has available surgical capacity, the record does not reflect that UVMMC collaborated with NMC to meet projected increases in surgical demand. UVMMC raised several obstacles to such collaboration. UVMMC officials testified that it would not be appropriate for hospitals to allocate surgical capacity and staff among themselves. Findings, ¶ 33. UVMMC suggested that NMC is projected to be at capacity by 2030 given demand growth in its region. *See* Findings, ¶ 32. UVMMC officials testified that seeking OR time at non-UVMHN-affiliated hospitals is challenging because of differences in electronic medical record (EMR) systems and equipment. Findings, ¶ 31. UVMMC officials also testified that requiring surgeons to drive between facilities is not efficient because it reduces the number of surgeries they can perform in a day. *See* Findings, ¶ 30. That inefficiency would likely be magnified if entire surgical teams were required to travel from UVMMC to NMC. The alternative, surgeons from UVMMC working with surgical teams from NMC, might risk negatively impacting safety and quality if the teams are not consistent over time.

- **CON Standard 1.4** (if an application proposes services for which a higher volume is positively correlated to better quality, the applicant shall show that it will be able to maintain appropriate volume for the service and that the addition of the service at the facility will not erode volume at any other Vermont facility in such a way that quality could be compromised).

This CON Standard overlaps with CON criterion 2 in that it is concerned with eroding volumes at other facilities (although it focuses on impacts to quality, not cost). As discussed further in section II, with the conditions included the CON, particularly the condition limiting UVMMC to the use of six ORs initially and the condition prohibiting UVMMC from marketing, it is unlikely that the OSC will materially erode surgical volumes at neighboring facilities.

- **CON STANDARD 1.11** (applicants proposing new health care projects requiring new construction shall demonstrate that new construction is the more appropriate alternative when compared to renovation).

This CON Standard overlaps with an aspect of the second CON criterion dealing with the availability of alternatives, which is analyzed in section II. As we explain there, renovating the Fanny Allen ORs is not a viable option, it is not feasible to expand outpatient surgical capacity on the main campus, and UVMMC was not able to identify an adequate existing property to purchase and renovate, making construction the appropriate alternative. *See* Findings, ¶¶ 3, 20-21.

II.

The second criterion requires an applicant to demonstrate that the cost of the project is reasonable because the applicant's financial condition will sustain any financial burden likely to result from the project; the project will not result in an undue increase in the cost of care or an undue impact on the affordability of medical care for consumers; less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate; and appropriate energy efficiency measures have been incorporated into the project. 18 V.S.A. § 9437(2).

A. Ability to Sustain Financial Burden

UVMMC has demonstrated that its financial condition can sustain any financial burden likely to result from the project.

UVMMC has reserved capital and debt capacity to support the project, which will be financed with \$100 million from a tax-exempt bond and approximately \$30 million in equity contributions. Findings, ¶¶ 52-54. UVMMC's financial condition experienced a dramatic turnaround in FY 2023 compared to FY 2022. UVMMC's FY 2023 operating income exceeded projections by roughly \$9 million. UVMMC achieved these positive FY 2023 results despite a \$17.1 million operating loss in the first quarter of the year; its operating margin in the third and fourth quarters of FY 2023 averaged 6.0%. Findings, ¶ 51.

Even after adjusting the incremental pro forma to include additional wRVU compensation for surgeons that would result from increased productivity, UVMMC expects the project will generate an incremental EBIDA operating margin of more than \$83 million and an incremental operating margin of more than \$28 million over the first 4.5 years of operation. Findings, ¶¶ 53, 59. These margins are likely understated because UVMMC used a conservative approach in developing its financial projections and erred on the side of underestimating revenues and overestimating costs. *See* Findings, ¶¶ 60, 78-79. The project would also improve UVMMC's debt-to-capitalization ratio and average age of plant. *See* Findings, ¶ 56.

While the Board's consultant found it "a bit concerning" that the project was anticipated to lower UVMMC's days cash on hand in 2027 by two days, it was subsequently disclosed at the hearing that UVMMC has an internal fundraising goal of \$13 million that was not reflected in the financials, which could reduce or even eliminate this modest decrease in days cash on hand. Findings, ¶ 56. We include a condition in the CON requiring UVMMC to cover at least this amount of the project's cost through fundraising to ensure that the project's impact on days cash on hand is not used to justify a future commercial rate increase.

B. Undue Increase in Cost or Impact on Affordability

UVMMC failed to demonstrate that the project will not result in an undue impact on the affordability of medical care for consumers. In analyzing this aspect of the second CON criterion, we must consider and weigh relevant factors, including the financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures, and

charges, and whether these impacts, if any, are outweighed by the benefit of the project to the public. 18 V.S.A. § 9437(2)(B).

Over time, the project should allow for some surgical cases to be shifted from an inpatient setting to an outpatient setting, where reimbursement rates are lower. The impact of this shift is unclear though and we do not expect it to be great. *See Findings*, ¶ 69. The project will also likely prevent some people from choosing to leave the state to get their surgery. While this is preferable for many reasons, the impact on cost and affordability is similarly unclear; for private payers, who are projected to contribute the majority of the OSC's revenues and who are currently struggling to afford steep increases in the cost of health care, UVMHC is an expensive setting for outpatient care; according to a recent report on hospital pricing nationally, UVMHC is among the most expensive hospitals in the country for outpatient services. *See Findings*, ¶¶ 64, 70.

For the over-65 population, whose projected growth is driving the need for this project, the OSC will be a materially lower cost setting. *See Findings*, ¶¶ 36, 44. This is because Medicare facility reimbursements for outpatient surgeries done at the OSC will be less than if the surgeries were done at the main campus or Fanny Allen. *Findings*, ¶ 68. However, UVMHC has not assumed a similar decline in commercial reimbursements, which are expected to decrease only 7-10%. *See Findings*, ¶ 68.

UVMHC did not adequately justify the commercial reimbursement adjustment it used in the project's financial modeling. [REDACTED]

[REDACTED] *See Findings*, ¶ 67. However, UVMHC did not adequately explain why the 90th percentile specifically is an appropriate upper bound. Moreover, information that UVMHC supplied after the hearing shows that two of the service lines that will move to the OSC [REDACTED]. *See Findings*, ¶ 67.

Several recent analyses show much greater differences between commercial HOPD and ASC prices than UVMHC assumed. For instance, a 2023 analysis by Mathematica compared the commercial prices of five ambulatory procedures commonly provided at both HOPDs and ASCs and found that the total median price (facility plus physician fee) was 35% to 46% lower at an ASC than an HOPD. Li E, *Commercial Insurance Prices for Common Outpatient Services Vary Significantly Across Settings and Providers*, Mathematica Blog (June 26, 2023) (discussed at Confidential Tr., 19:4 – 24), available at <https://www.mathematica.org/blogs/prices-for-common-outpatient-services-vary-significantly-across-settings-and-providers>. More recently, an article in the American Journal of Managed Care explained how, after adjusting for patient characteristics, risk, and geographic market location, commercial prices at HOPDs were 54.9% higher than those at ASCs for colonoscopies, 44.4% higher for arthroscopy, and 44% higher for cataract removal surgery. *See Robinson J, Waley CM, Prices and Complications in Hospital-Based and Freestanding Surgery Centers*, 30 Am J Manag Care 4, 179-184 (2024), available at <https://www.ajmc.com/view/prices-and-complications-in-hospital-based-and-freestanding-surgery-centers>. Even more recently still, a publication from RAND found that, for five common procedures, private insurer payments to HOPDs were 3.4 times larger than payments to ASCs,

while Medicare payments to HOPDs were 2.5 times larger than payments to ASCs (i.e., there was a slightly *larger* payment differential based on site of care among private insurers than Medicare). RAND Report at 19-20.

The record also suggests that UVMMC need not charge Vermont's commercially insured population as much as proposed for outpatient surgeries performed at the OSC. First, as explained above, the project is expected to generate an incremental EBIDA operating margin of over \$83 million and an incremental operating margin of over \$28 million in the first 4.5 years of operation alone. *See Findings*, ¶ 53. Second, these projected margins are likely understated because UVMMC used a conservative approach to developing its financial projections and erred on the side of underestimating revenues and overestimating costs, using conservative staffing expense estimates; excluding net revenues for pre- and post-surgery services (e.g., imaging, labs, and office visits) and net revenues that could be realized from repurposing the vacated space at Fanny Allen; and not factoring in increases in efficiency that are expected to come with the new facility. *See Findings*, ¶¶ 60, 78-79. UVMMC also has a fundraising goal of 10% of the project's total cost, or \$13 million, which was not included in the financial projections. *Findings*, ¶ 56. Third, hospital officials testified that UVMMC believes so strongly in this project, it is willing to move forward with the project even if it does not attain a margin. *Findings*, ¶ 65.

In sum, commercial ratepayers will see a meager cost benefit from this profitable project, substantially less benefit than Medicare, resulting in an unjustified and undue impact on the affordability of care for commercial ratepayers (i.e., individuals, businesses, and other employers). We seek to address this, and to further the purposes of the CON statutes, by conditioning our approval of the project on a commercial price ceiling under which UVMMC's commercial reimbursements for cases done at the OSC may not exceed 170% of Medicare, which is the average commercial reimbursement at ASCs nationally. *Findings*, ¶ 63.

Medicare prices are designed to provide modest profit margins for efficient hospitals. *Findings*, ¶ 63. At the hearing, hospital officials testified that Medicare payments provide for a small margin on outpatient surgeries. *Findings*, ¶ 62.⁵ Medicare also provides a useful benchmark; Medicare rates are adjusted for several key sources of legitimate variation in costs (e.g., geographic adjustments based on local variation in wages and the cost of doing business) and Medicare pricing logic is transparent, making it possible to monitor compliance with a condition tied to Medicare prices. *See RAND Report*, *Findings*, ¶ 63, *supra*, at 28 – 29.

As we have done in similar cases in the past, we also include a condition in the CON stating that the price of surgeries billed to patients that self-pay may not exceed the lowest price billed to patients covered by commercial insurance. *See In re ACTD LLC, d/b/a The Green Mountain Surgery Center*, Docket No. GMCB-010-15con, Certificate of Need (July 10, 2017), Condition 13; *In re The Collaborative Surgery Center*, Docket No. GMCB-008-21con, Certificate of Need (Mar. 16, 2022), Condition 16. It is unfair for self-pay patients to pay more than commercially insured patients just because they do not have insurers to bargain the price for them.

⁵ While UVMMC later stated that it expects cost coverage ratios at the OSC to be similar to cost coverage ratios for the hospital overall, this doesn't seem plausible given that cost coverage is generally higher for outpatient care and the cost coverage ratios for the institution as a whole would reflect inpatient care.

Finally, in evaluating whether an applicant has demonstrated that its project will not result in an undue increase in cost or an undue impact on affordability, the Board must consider the impact of the project on other clinical settings. Our concern here is that the project could draw patients from other facilities (e.g., nearby hospitals such as NMC and Copley) to UVMMC, where costs are likely higher. *See Findings*, ¶ 70. Additionally, the loss of patients could negatively impact the finances of these other facilities, leading them to increase their prices.

UVMMC has not explicitly modeled any increase in market share. *See Findings*, ¶ 49. However, the OSC is more likely to draw patients away from neighboring facilities if it is larger than it needs to be to care for the future demand of UVMMC's current patient population. UVMMC's demand projections are analyzed in section III.

The OSC might also draw patients away from neighboring facilities due to marketing. While UVMMC asserts that it has no strategic intention to attract additional outpatient surgery patients from other hospitals, its Business Plan for the OSC described a plan for social media, paid content placements, newspaper ads, and a "paid search 'capture campaign' relative to competitors." *Findings*, ¶¶ 49-50. UVMMC acknowledged at the hearing that the hospital does not need to spend money on marketing to try to attract more patients. *See Findings*, ¶ 50.

In light of the above, we include a condition in the CON that prohibits UVMMC from undertaking any paid search campaign relative to competitors or from spending money on marketing or advertising to attract patients to the OSC. This condition is consistent with UVMMC's stated intentions, would prevent wasteful spending, and will also help protect against any undue impacts on the cost of care or affordability that could result from UVMMC increasing its market share and reducing other facilities' outpatient surgical volumes. With this condition and the other conditions in the CON, we do not believe that the OSC will draw material numbers of patients from neighboring facilities and that any negative impact on their services, expenditures, and charges, are outweighed by the benefit of the project to the public.

C. Less Expensive Alternatives and Energy Efficiency

UVMMC has demonstrated that less expensive alternatives are not available, would be unsatisfactory, or are not feasible or appropriate, and that appropriate energy efficiency measures have been incorporated into the project.

Renovating the existing Fanny Allen ORs is not feasible or appropriate. The Fanny Allen ORs are undersized and cannot be enlarged or retrofitted to meet contemporary standards, including installation of advanced air handling systems or contemporary surgical and interoperative imaging equipment. *Findings*, ¶ 21. Building an OSC at the Fanny Allen campus is also not a viable alternative because it would be more expensive and very disruptive to UVMMC's operations. *See Findings*, ¶ 23. Expanding OR capacity at the main campus is not feasible or appropriate. *See Findings*, ¶ 20. Finally, while planning for the facility, UVMMC was not able to identify an adequate existing property to purchase and renovate. *See Findings*, ¶ 3.

Finally, the project incorporates appropriate energy efficiency measures. Efficiency Vermont was consulted on the project and provided feedback to ensure that it meets or exceeds energy-efficiency standards. UVMMC will also seek LEED certification for the facility, which will be designed to meet or exceed EnergyStar standards. Findings, ¶ 7.

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

III.

The third criterion requires an 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).

Because we recognize the need for UVMMC to update its outpatient surgical facilities⁶ and because there is a reasonable likelihood that demand for outpatient surgeries will increase over time, even if not at the rate assumed by UVMMC, we allow UVMMC to proceed with the project on the condition that it only fit up and use six of the eight ORs initially and that it obtain the Board's approval to fit up or use the remaining two ORs or any of the shell space (i.e., the four shelled ORs and 14 shelled pre- and post-operative spaces). This approach allows UVMMC to replace its five Fanny Allen ORs with larger and more modern ORs that can accommodate more types of surgeries and be used more efficiently, allowing for greater throughput. *See Findings, ¶¶ 20 - 22, 24, 60.* It also allows UVMMC to add one additional OR to accommodate growth in demand. It is a cautious approach that recognizes that projections rely on assumptions, which may or may not hold true, and allows for expansion if necessary.

Illustrating the challenges of projecting demand, our consultant expressed several concerns with UVMMC's projections, including 1) a lack of supporting evidence of OR shortages, 2) aggressive population growth assumptions, and 3) the use of a 75% utilization threshold. *See Findings, ¶ 40.*

Regarding the first concern, a lack of supporting evidence of OR shortages, our consultant noted that UVMMC was unable to provide concrete evidence of a long-term and growing shortage of operating rooms, either through longer wait times or more delayed care. Findings, ¶ 41. Although the wait times data suggest surgical *access* challenges, it should be noted that wait times can result from factors other than lack of *capacity* (e.g., administrative factors, such as prior authorization, or lack of adequate staffing) and without more detailed data over a longer period, our consultant had difficulty assessing whether the wait counts provided were evidence of an operating room shortage. *See Findings, ¶¶ 41-42.* Moreover, wait times data from May 2024, after our consultant issued its report, showed a reduction in the number of people waiting compared to November 2023, reflecting UVMMC's efforts to address wait times. Findings, ¶ 41.

⁶ The Board previously recognized this need when it granted UVMMC a Conceptual CON to plan for the replacement of the Fanny Allen ORs. *See In re Application of the University of Vermont Medical Center for a Conceptual CON For Planning and Design of an Outpatient Surgery Center*, GMCB-015-21con, Statement of Decision (Sept. 20, 2021).

Regarding the second concern, aggressive population growth assumptions, the 62% growth rate used by UVMMC for the over-65 population is high relative to other sources. Recent projections from Claritas (Claritas 2024) show a 41% growth rate for this group. Meanwhile, the U.S. Census's forecasted growth for the Burlington HSA is 36% and the State's own projections range from 31% to 39%. Findings, ¶ 44. The accuracy of this projection is significant to the outcome of the demand models because the over-65 population is a higher utilizer of health care. Findings, ¶ 36.

Regarding the third concern, use of a 75% utilization threshold, UVMMC assumed its ORs would be used 75% of the time, meaning the ORs would not be used 25% of the time. Findings, ¶ 39. However, UVMMC stated that it is currently operating at 80% capacity despite the suboptimal conditions it has described in this proceeding of small ORs on multiple campuses where not all rooms can accommodate all procedures. *See* Findings, ¶ 26. Mathematica's review of the literature also suggested a benchmark of 85% or higher may be reasonable. *See* Findings, ¶ 45. Finally, while UVMMC asserted that it is prudent to schedule ORs at 75% capacity so there is room to fit in unexpected cases, advance scheduling is not the same as total facility usage and the later should reflect both the scheduled and urgent procedures. *See* Findings, ¶ 39.

Under the March 12, 2024 Model, which utilizes the Claritas 2024 projections and the Sg2 non-population factors, 85% utilization would require six ORs until 2025 and only 0.1 more than that in 2026. Findings, ¶ 47. During that time, UVMMC will have built the project and commenced operations and may have more concrete data to support fitting up the seventh and eight ORs. Given the uncertainty inherent in the models, it is prudent to take a flexible approach and allow UVMMC to construct the physical space it designed, but only fit up and use a smaller portion of that space initially. UVMMC took a similar approach in designing the shell space, which it stated would allow it to easily add ORs if they are needed or delay expansion if they are not. *See* Findings, ¶ 19.

We would at least want to see the following in any request from UVMMC to fit up and use more than the six ORs: data showing existing ORs are being fully utilized, data showing productivity (wRVUs/clinical FTE) is at or above appropriate benchmarks, and consistently tracked wait times data. We do not envision a request would require a full-blown CON process or take an exceedingly long time, so long as we are provided with adequate data.

With UVMMC limited to the use of six ORs initially, the project will meet a need that is appropriate for UVMMC to provide, namely future demand of the hospital's current patient population for outpatient surgeries.

Based on the above, and in light of the conditions we place on the CON today, we conclude that the third criterion is satisfied.

IV.

The fourth criterion requires an applicant to demonstrate that the project improves the quality of health care or provides greater access for Vermonters, or both. 18 V.S.A. § 9437(4).

The project will improve the quality of health care and improve access by replacing the outdated Fanny Allen ORs with modern ORs that meet current facility guidelines and allow for contemporary surgical and imaging equipment. Findings, ¶¶ 12, 21. The facility will provide a high-quality environment to attract learners and clinicians to study and practice in Vermont. Findings, ¶ 27. The project will move outpatient surgical procedures from the main campus and Fanny Allen to a more convenient and comfortable outpatient facility close to UVMMC's outpatient clinics, including Orthopedics, Cardiology, Ophthalmology, Dermatology, and Rehabilitation. *See* Findings, ¶ 3. This will create more space at the main campus for patients in need of inpatient surgery, helping UVMMC meet the acute care needs of patients from referring hospitals. *See* Findings, ¶¶ 25, 33. The facility incorporates Diversity, Equity and Inclusion principles in its design and UVMMC will provide interpretation services to enhance access for individuals who require these services. Findings, ¶ 9.

For the reasons discussed above, and with the conditions imposed today, we find this fourth criterion satisfied.

V.

The fifth criterion requires an applicant to demonstrate 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).

We have concerns about UVMMC's ability to staff the project and concerns that other services at UVMMC could be adversely impacted if a significant number of employees currently supporting these other services end up staffing the OSC. *See* Findings, ¶¶ 72 - 78. UVMMC has engaged in extensive recruitment efforts, including strengthening its relationships with area universities, expanding childcare and housing opportunities, and implementing hiring incentives. Findings, ¶ 80. However, certain staffing shortages exist nationally and locally for OR RNs, Surgical Techs, and Paranesthesia RNs. Findings, ¶ 78.

A condition limiting UVMMC initially to six ORs will reduce the project's staffing demands and thereby reduce the likelihood of adverse impacts on other services. UVMMC provided staffing projections for an eight OR facility and described the incremental FTEs need for 10 ORs. While it is unlikely that going from eight ORs to six would *reduce* staffing needs by the same amount that going from eight ORs to 10 would *increase* staffing needs, it would nevertheless likely reduce staffing needs. *See* Findings, ¶¶ 75-77.

With the conditions imposed today, we find this fifth criterion satisfied.

VI.

What was previously the sixth criterion is now an overarching consideration, namely that the project serves the public good. *See* Act 167 (2018), § 6 (repealing 18 V.S.A. § 9437(6) and moving the “public good” language to the lead-in sentence). Our administrative rule identifies

factors that we may consider in determining whether a project will serve the public good. GMCB Rule 4.000, § 4.402(3). While several of these factors are relevant to this project, they have largely been addressed above. We note the following:

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

Medically underserved patients with less income/transportation are disproportionately affected by wait times because traveling to seek care out of their geographic area is less feasible and they will not have an alternative to waiting. *See Findings, ¶ 10.* In addition, the medically underserved deserve higher quality care that replacing Fanny Allen's ORs will provide.

Patients who have communication access needs or may have additional needs will be identified in the pre-assessment screening process and there are direct interpreted call-in lines in thirty-languages and on-call ASL interpreters through a third-party vendor. *Findings, ¶ 9.*

As discussed in section VII, the OSC is served by newly enhanced public transportation. If alignment with the public transportation schedule is not possible for a patient with no other transportation options, UVMMC arranges and pays for transportation. *Findings, ¶ 8.* The site also has ample ADA parking. *Findings, ¶ 3.*

(b) Whether the applicant has demonstrated that it has analyzed the impact of the project on the Vermont health care system.

See Conclusions of Law, §§ I - III, supra.

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

See Conclusions of Law, § I, supra.

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

See Conclusions of Law, § II, supra.

Based on the above, we find this criterion has been satisfied.

VII.

The seventh criterion requires an applicant to demonstrate that it has adequately considered the availability of affordable, accessible patient transportation services to the facility. 18 V.S.A. § 9437(7).

We find this condition has been satisfied. The OSC is served by newly enhanced public transportation. If alignment with the public transportation schedule is not possible for a patient with no other transportation options, UVMMC arranges and pays for transportation. Findings, ¶ 8. The site also has ample patient, employee, and ADA parking. Findings, ¶ 3.

VIII.

The eighth criterion, pertaining to information technology projects, has been satisfied as well. 18 V.S.A. § 9437(8). UVMMC has included IT capital costs and design elements in the project budget's estimates and has evaluated additional impacts related to IT applications, new hardware technology, project implementation, internal IT review processes, employee training, and cyber security. Findings, ¶ 83.

IX.

The ninth and final criterion requires an applicant to demonstrate that the project supports equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate. 18 V.S.A. § 9437(9).

We find this criterion satisfied, to the extent it is applicable. If a patient seeking services at the OSC expresses a need for mental health services and is not in acute crisis, they will be referred to their primary care physician. If a patient is in acute crisis, staff will follow UVMMC's suicide risk assessment protocol. Findings, ¶ 84.

Conclusion

For the reasons outlined in this decision, the Board conditionally approves UVMMC's application and issues a Certificate of Need, subject to the conditions described therein, which are imposed pursuant to 18 V.S.A. § 9440(d)(4) in furtherance of the purposes of Title 18, chapter 221, subchapter 005 of the Vermont Statutes Annotated.

SO ORDERED.

Dated: July 29, 2024, at Montpelier, Vermont

<u>s/ Owen Foster, Chair</u>)	GREEN MOUNTAIN
)	CARE BOARD
<u>s/ Jessica Holmes</u>)	OF VERMONT
)	
<u>s/ Robin Lunge</u>)	

Chair Foster, concurring.

I concur in issuing the CON subject to the conditions set forth therein. The applicant fails to meet several of the CON criteria, which GMCB seeks to rectify by imposing CON conditions. While UVMMC seemingly claims that GMCB may not address the project’s shortcomings through CON conditions, for the reasons set forth herein and in the dissents of Members Murman and Walsh, the application must be denied absent such conditions.

I. UVMMC’s Application Is Inconsistent with Statewide Healthcare Reform Goals.

UVMMC fails to demonstrate that the OSC is consistent with several principles of health care reform, including (1) “systemic barriers, such as cost must not prevent people from accessing necessary health care” and “[a]ll Vermonters must receive affordable and appropriate health care . . .,” (2) “[o]verall 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,” and (3) “the financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.” 18 V.S.A. § 9371(1), (2), (11).

First, UVMMC does not satisfy its burden to establish that its proposal is consistent with Vermonters receiving affordable health care. The applicant’s commercial prices are extraordinarily—and unnecessarily—high. *See* Findings, ¶¶ 67, 70. UVMMC’s proposed commercial prices would yield an operating margin of tens of millions of dollars, which UVMMC concedes would come from commercially insured Vermonters. Findings, ¶¶ 53 (UVMMC estimating OSC would generate over \$83m in incremental EBIDA operating margin and over \$28.2m of incremental operating margin in the first 4.5 years); 62 (conceding all positive operating margin would be borne by commercially insured Vermonters). Thus, UVMMC proposes Vermont’s commercially insured population pay significantly *more* than what is necessary to provide the subject services.

The applicant argues that charging the commercially insured far more than necessary is appropriate because, as a non-profit, it reinvests those dollars into other services. Testimony of Stephen Leffler, Tr., 280:15 - 281:11. This argument has no limits and UVMMC does not reconcile its position with the pressing need to contain health care costs and to ensure Vermonters have affordable health care—the absence of which is also a serious barrier to equity and access.

Not only are UVMMC’s proposed commercial prices unjustified, but the magnitude of the financial reallocation from Vermonters to UVMMC is likely understated. UVMMC’s projected commercially funded excess margin notably does not include adjacent services (such as imaging, labs, and office visits) expected to result from the project, and excludes revenue opportunities from Fanny Allen, purported efficiency gains created by the OSC, and increased throughput. Findings, ¶ 60. UVMMC’s overestimated expenses (including staffing expenses) likewise deflate the projected excess margin. Findings, ¶¶ 78-79. UVMMC also omitted its \$13m fundraising goal from its financial projections. Findings, ¶ 56.

The record is bereft of justification for what amounts to a transfer of an excess of tens of millions of dollars from Vermonters to UVMMC—a proposition that does not square with the immense strain health care costs are imposing on our state and the principle that “all Vermonters must receive affordable and appropriate health care.”

Second, UVMMC’s proposed commercial pricing is inconsistent with the principle that “[o]verall health care costs must be contained” and that spending “must balance the health care needs of the population with the ability to pay for such care.” As UVMMC concedes, the health care needs this project proposes to address could be financed with far less financial burden being placed on Vermont’s commercial population. Findings, ¶¶ 59, 62.

Third, UVMMC fails to demonstrate that its proposed financing of the OSC is “fair,” “sustainable,” or “shared equitably.” UVMMC provided inconsistent and conflicting evidence relating to federal payer reimbursements. UVMMC leadership testified that UVMMC makes a “small margin” from Medicare. UVMMC later recanted, claiming that Medicare cost coverage will be an average of only 67% of costs. *See* Findings, ¶ 62. Notably, Medicare prices are designed to provide reasonable margins for efficient hospitals. Findings, ¶ 63. To the extent UVMMC’s later assertion that Medicare covers only 67% of UVMMC’s costs is accurate, it is concerning and highlights the inequity of UVMMC’s proposal. Requiring struggling Vermont families and businesses to cover the applicant’s excessive costs (and resultant inadequate Medicare cost coverage) is not fair or equitable.

UVMMC proposes that the federal Medicare program receive a large discount off what it currently pays UVMMC for the subject services. Findings, ¶ 68. Charging Medicare *less* while simultaneously seeking to charge commercially insured Vermonters significantly *above* the costs of care is inconsistent with our health care reform goals. It is also not sustainable.

The project increases UVMMC’s operating expenses (Findings, ¶ 53), and Medicare and Medicaid rate increases have fallen short of UVMMC’s expense growth. Findings, ¶ 57 (in FY24 UVMMC projected a Medicare rate increase of 2.9%, a Medicaid increase of 0.7%, and requested 13.35% from commercial). Thus, the financial viability of this project relies on commercially insured Vermonters filling that funding gap by increasing *more* than projected overall cost inflation. Findings, ¶ 57. UVMMC’s proposed high commercial prices would impose unnecessary costs on Vermonters regardless of whether they use the OSC or reside in Chittenden County. Considering UVMMC’s remarkable commercial prices and the enormous premium increases Vermonters now annually bear—QHP rate jumps of 12.8% to 24% are presently before GMCB—it is not reasonable to expect Vermont’s dwindling commercial population to fund the applicant’s substantial initial and projected ongoing government payer shortfalls.

Moreover, the applicant did not satisfactorily establish its ability to staff the project. UVMMC has recently struggled to accurately forecast its reliance on expensive traveling nurses. In FY23 UVMMC anticipated utilizing 226.5 travelers but ultimately needed 370. UVMMC’s FY23 traveler estimates missed the mark by over 63%. *See* Letter from UVMHN re FY 2023 Actual-to-Budget Narrative (Jan. 31, 2024), Ex. B, 8 (identifying budgeted vs. actual travelers), <https://gmcboard.vermont.gov/sites/gmcb/files/documents/Exhibits.pdf>. Should UVMMC’s OSC

traveler projections vary as wildly as in its budget, the cost of the project would substantially increase, and as presently proposed by UVMMC Vermont's commercial market would cover those costs.

UVMMC seemingly attempts to prevent GMCB from protecting Vermonters from excessive costs for the subject services by arguing that “the Board is not authorized to fix prices for specific OSC services without first adopting rules to govern this complex undertaking . . .” and that setting a price cap “would be arbitrary and an abuse of the Board’s discretion.” UVMMC June 11, 2024 Ltr., 1-2. I disagree; GMCB has authority to approve an application “in whole or in part” and to impose conditions that further the purposes of the CON statute. 18 V.S.A. § 9440(d)(4). Without the conditions, the application would necessarily be denied due to the applicant’s failure to comply with the applicable statutory and regulatory requirements, and I would not join the majority.

II. UVMMC Fails To Demonstrate It Has Taken A Collaborative Approach To Delivering The Services Or That Doing So Is Not Feasible Or Appropriate As Required By CON Standard 1.3.

NMC has available surgical capacity, however UVMMC did not demonstrate that it collaborated with NMC to meet current and projected surgical demand. While UVMMC claims that seeking OR time at non-UVMHN hospitals is difficult for a host of reasons (such as different EMRs, physician travel time, and working with another hospital’s staff), UVMMC does not explain what attempts it made to overcome these perceived challenges. UVMMC does not explain how much surgical space is available at NMC, or what amount of the projected demand could be satisfied if it were utilized. While using NMC’s surgical capacity may be an inconvenience, UVMMC does not seem to have earnestly explored the option. Given the immense project expense, more was needed to comply with this required showing. *See Findings, ¶ 31.*

UVMMC insists that its most significant form of collaboration is its ability to accept patient referrals and transfers. This is a non sequitur; if UVMMC’s projected surgical demand could be addressed by using NMC’s available capacity, then UVMMC could accept referrals and transfers. Without evaluating the potential use of NMC’s existing capacity, UVMMC’s claims of appropriate cost, scale, and scope are made in a vacuum and it has not adequately demonstrated that it has taken a collaborative approach to delivering the subject services.

III. UVMMC Fails to Adequately Demonstrate That There Is an Identifiable, Existing, Or Reasonably Anticipated Need For The Proposed Project

As demonstrated by GMCB’s opinion and Members Murman’s and Walsh’s dissents, whether UVMMC has met its burden to demonstrate need is debatable. I share the concerns capably raised and analyzed in the majority and dissenting opinions. Additionally, UVMMC’s use of an inscrutable proprietary growth model, and the GMCB consultant’s inability to analyze the Sg2 non-population factors limit confidence in projections that result from models using those factors. *See Findings, ¶¶ 40, 43.* UVMMC did not show a long-term and growing shortage of operating rooms. UVMMC relies on its excessive wait times to demonstrate need. But UVMMC

has long had extensive wait times across numerous services, including many that do not require operating rooms. *See* UVMMC FY25 Budget Workbook, 2 (chart identifying service lines and corresponding “percentage of new patients scheduled to be seen within 30 days”), *available at* <https://gmcboard.vermont.gov/node/11552>. Wait times can result from myriad causes other than lack of operating rooms (including poor scheduling, staffing, slow room turnover, insufficient post-acute services, operational challenges, etc.). Findings, ¶ 41. It is overly simplistic and unpersuasive to equate surgical wait times to operating room need, particularly here, where UVMMC could modestly increase operating hours and utilization to satisfy its backlog. *See* Murman Dissent. UVMMC’s population forecasts also may not account for the critical and widely recognized housing shortage that Vermont faces. *See* Findings, ¶ 44. Lastly, each of the operating rooms UVMMC proposes is 630 sq. feet, yet UVMMC did not address whether a mix of 450 and 630 sq. ft. rooms would be adequate and/or reduce costs.

While UVMMC has failed to provide reliable projections, I am comfortable joining the majority in light of the conditions placed on the project that minimize the downside risks associated with the applicant’s unclear showing of demand.

IV. UVMMC’s Proposal Would Unduly Increase Costs And Impact Affordability Of Vermont Health Care.

As discussed *supra*, UVMMC’s proposal unduly increases costs and negatively impacts Vermonters’ ability to afford health care. *See* Concurrence, at I. UVMMC additionally falls short of satisfying this criterion because it does not adequately evaluate the project’s impact on other hospitals in the region. 18 V.S.A. § 9437(2)(B).

A new, large, expensive surgical center will naturally be attractive and desirable to patients in nearby HSAs. UVMMC thus was expected to satisfactorily address the potential impact on nearby (and more affordable) facilities, including Copley and NMC. *See* Findings, ¶ 70. Given the lack of reliability of UVMMC’s projected demand, this criterion was especially critical. UVMMC’s conclusory assertion that demand will be so great that it will not compete for patients from other HSAs is insufficient and it is also inconsistent with UVMMC’s business plan that revealed an intent to run social media campaigns, paid content placements, newspaper ads and a “paid search ‘capture campaign’ relative to competitors.” Findings, ¶ 50. While UVMMC executives were seemingly unaware of the planned marketing campaign—and indeed later disavowed it—the fact that UVMMC made such plans is troubling and casts doubt on UVMMC’s purported confidence in its demand projections. Were UVMMC to siphon patients from Copley or NMC it could negatively impact the finances of these other facilities, leading them to increase their prices to respond to the loss of patients. Notably, Copley faces serious financial challenges and NMC’s financial health has been deteriorating for the last several years.

V. CONCLUSION

The applicant requests GMCB approve a project with commercial prices that, at a minimum, would yield an excess of tens of millions of dollars from Vermont’s struggling commercial market. Considering the real pain Vermonters experience trying to afford health care

and the financial strain at our local nonprofit insurers, I cannot approve this project as proposed. Our health care system is at an inflection point, and projects that impose unwarranted costs on Vermonters and small businesses will only exacerbate the problem. Vermonters have no spare dollars to give to our health care system. UVMMC itself acknowledges it could provide the subject services while imposing significantly less financial burden—which GMCB’s order hereby mandates.

Dated: July 29, 2024, at Montpelier, Vermont.

s/ Owen Foster)

Board Member Walsh, dissenting.

I dissent from my colleagues’ approval of the University of Vermont Medical Center (UVMMC)’s proposed OSC. Four reasons show that UVMMC has not met its burden to establish that a CON should be granted.

First, UVMMC’s population growth and surgical demand projections are unreliable. The projections for surgical demand are based on population growth estimates that are twice as high as estimates made by the State of Vermont and fifty percent higher than estimates from the US Census Bureau. *See Findings*, ¶ 44. The overly optimistic growth estimates lead to inflated surgical demand forecasts and an inaccurate reflection of the true demand for surgical services.

Moreover, based on data presented by the applicant, it is possible to work through the inflated demand forecast without additional infrastructure. UVMMC could accomplish this by increasing the number of days its current operating rooms are open from 250 to 280 and increasing the number of hours per day the rooms are available from 10 to 12. *See Resp.* (Mar. 12, 2024), Workbook Version B (amended). Additional capacity is also available nearby. *See In re The Collaborative Surgery Center*, Docket No. GMCB-008-21con, Survey Responses of NMC and Copley (Oct. 2021); *Findings*, ¶¶ 30, 32. The use of available capacity at nearby facilities would be consistent with HRAP CON Standard 1.3, which states, “To the extent neighboring healthcare facilities provide the services proposed by a new project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.”

Second, the applicant failed to provide convincing evidence of a lack of current capacity. UVMMC’s written testimony was unclear and sometimes contradictory. Under direct questioning, UVMMC administrators did not answer questions regarding the percentage of operating and procedure rooms currently running during standard hours, nights, and weekends, nor did they answer questions regarding the proportion of operating and procedure rooms that are fully staffed. *See Testimony of Dr. Patrick Bender, Dr. Mark Plante, and Dr. Stephen Leffler, Tr.*, 224:14 – 228:1. Additionally, the applicant did not explain whether wait times resulted from difficulty getting an initial appointment with a specialist (referred to as a “bottleneck” in systems engineering) or lack of available operating rooms.

This is important information because building additional operating infrastructure will not fix an initial appointment bottleneck. Excess capacity in healthcare is a large problem because it induces demand. See Brownlee S, Colucci J, & Walsh T, *Productivity and the Healthcare Workforce*, New America Foundation White Paper (Oct. 2013), available at https://static.newamerica.org/attachments/4177-productivity-and-the-health-care-workforce-2/Brownlee_Colucci_Walsh_ProductivityNAF_10.2013_2.b8d2fac5c5a442b79d88bbcd11306e0a.pdf; Wennberg JE, *Supply-Sensitive Care: A Dartmouth Atlas Project Topic Brief*, The Dartmouth Institute for Health Policy and Clinical Practice (Jan. 2007), available at <https://www.ncbi.nlm.nih.gov/books/NBK586632/>. This is because in a healthcare system, care is used more readily if available, which increases cost and can exacerbate inefficiencies in the system. The applicant's clinical care witnesses describe numerous inefficiencies that could be addressed without additional infrastructure, such as specialized surgical teams. See Pasquer A, Ducarroz S, Lifante JC, Skinner S, Poncet G & Duclos A., *Operating room organization and surgical performance: a systematic review*, *Patient Safety in Surgery* (Jan. 2024). This is one example of numerous proven ways to address access challenges through optimizing care and maximizing current facilities without adding costly infrastructure. See Nolan T, Schall M, Berwick DM, et al., *Reducing Delays and Waiting Times Throughout the Healthcare System: Breakthrough Series Guide*, Boston: Institute for Healthcare Improvement (1996); Mihalj M, Corona A, Andereggen L, et al., *Managing bottlenecks in the perioperative setting: Optimizing patient care and reducing costs*, *Best Practice & Research Clinical Anesthesiology* 36 (2022), 299 – 310; Wang J, Vahid S, Eberg M, et al., *Clearing the surgical backlog caused by COVID-19 in Ontario: a time series modeling study*, *CMAJ* 2020 November 2;192:E1347-56.

Third, the proposed OSC contradicts Vermont's current healthcare reform needs and goals. See 18 V.S.A. § 9437(1). These goals include improving statewide access to care, especially primary care, mental health care, and care for individuals struggling with substance use, improving statewide affordability, and reducing cost growth. See 18 V.S.A. § 9371. According to recently published data, UVMMC's prices have risen far faster than the US average, and its current commercial outpatient care prices are among the nation's highest. See Findings, ¶ 70.

The applicant predicted increased inpatient and outpatient surgeries when the OSC is completed. See Mathematica Report (Mar. 20, 2024), 6, Table 3. Moreover, the materials submitted by the applicant included a "capture campaign" detailing plans for marketing the new facility to attract patients from surrounding areas. Findings, ¶ 50. The additional volume at such a costly facility will increase costs to commercial payers, directly resulting in higher premiums for Vermonters, whether or not they receive care at the OSC. Higher premiums make healthcare less affordable to individuals and increase costs for businesses and communities. We also know that individuals delay or avoid care when it becomes unaffordable, especially for those struggling with high housing, food, and transportation prices. In this way, approving this OSC would concentrate care at the highest-priced facility in the state and in the wealthiest county, far from rural communities, increasing costs and decreasing affordability while doing nothing to address our rural communities' needs for primary care, mental health services, and access to substance use treatment.

Additionally, hospital leaders across the state have highlighted the issue of insufficient discharge options leading to a shortage of inpatient beds for patients needing further care, rehabilitation, and nursing home support. Although the OSC is designed for surgeries that typically don't require additional inpatient assistance, all surgeries carry inherent risks, and some patients may encounter difficulties and subsequently need these already overstressed services, leading to more bottlenecks for inpatient care.

This is important because our consultant indicated that increased inpatient case volumes drive the OSC's operating margin; without these additional inpatient cases, UVMMC would operate with an incremental loss each year. *See Findings, ¶ 58.* Furthermore, basing the OSC's financial viability on inpatient volume growth is questionable because inpatient surgery trends are declining in Vermont and nationally.

Fourth, this project risks destabilizing surrounding hospitals providing surgical care to their local communities. The proposed project would significantly increase UVMMC's operative capacity, equivalent to the size of NMC and Copley combined. There is a significant risk that this would draw services away from these hospitals, even without UVMMC heavily marketing their new site. This would further destabilize already struggling hospitals by the loss of surgical services. It would also lead to greater statewide dependence on UVMMC, a high-priced hospital that already has a monopolistic healthcare market position and demonstrates inefficient systems, stagnating quality, and long wait times for primary and secondary care. *See RAND Report; Green Mountain Care Board FY 2024 UVMMC Budget Deliberations (Sept. 13, 2023), available at <https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Hospital%20Budget%20Deliberations%20UVMMC%2009.13.23.pdf>; Agency of Human Services, Green Mountain Care Board, Department of Financial Regulation, Health Services Wait Times Report Findings (Feb. 16, 2022), available at <https://dfr.vermont.gov/about-us/councils-and-commissions/health-services-wait-times>.*

This directly contradicts our healthcare reform's current goals, which are to stabilize hospitals and local services and shift care away from high-cost settings like UVMMC to more cost-effective and accessible locations across the state. This proposal is an example of the type of consolidation that we are actively trying to move away from and will lead to UVMMC being in a position to further raise their prices. For this reason, the project is inconsistent with CON Statutory Criterion 2.b, which states: "The project will not result in an undue increase in costs of medical care or an undue impact on affordability for patients." 18 V.S.A. § 9437(2)(B).

My colleagues have opted to apply conditions to their approval to limit prices and limit attempts to gain market share. The Office of the Healthcare Advocate submitted a public comment with similar suggestions and a recommendation that OSC's revenue above 2.5% over costs be diverted to support primary care, mental healthcare, and treatments for people battling with substance use. *See Findings, ¶ 85.* These are all good ideas but would be difficult to operationalize in the short term. More importantly, however, conditions are only enforceable during the life of the CON, meaning they **expire when the Board accepts the final implementation report**. GMCB Rule 4.500(4). At that point, these concerns will renew without a clear, straightforward regulatory process to mitigate them. Overall, I believe the conditions, because they are short-lived,

will not sufficiently address my concerns with the proposal. Rather, the numerous conditions highlight precisely why there is a lack of alignment between this project and the current needs of Vermonters.

In summary, the information presented by UVMMC in support of its CON application demonstrates administrative and operational challenges in the system rather than long-term demand. We know that adding infrastructure does not address these types of challenges. In fact, it usually exacerbates them. *See* Rutherford PA, Anderson A, Kotagal UR, et al., *Achieving Hospital-wide Patient Flow (Second Edition): The Right Care, in the Right Place, at the Right Time*, Institute for Healthcare Improvement White Paper (2020), available at <https://www.ihl.org/sites/default/files/IHIAchievingHospitalWidePatientFlowWhitePaper.pdf>. Furthermore, creating new infrastructure without first optimizing existing capacity and correcting inefficiencies leads to long-term excess capacity, which will induce unnecessary demand and lead to higher costs, additional risks, and unnecessary and avoidable care. *See* Mahilj et al., *supra*.

Dated: July 29, 2024, at Montpelier, Vermont.

s/ Thom Walsh)

Board Member Murman, dissenting.

UVMMC's proposal to develop a large and expensive outpatient surgery center (OSC) raises concerns that are at the core of the CON program – concerns of unnecessary duplication, consolidation of care and reduction of access in rural and less affluent areas of the state, and undue increases in the costs of care for all Vermonters, even those that would not use the OSC. *See* 18 V.S.A. § 9431(a) (describing the policy and purpose of CON review). Having closely reviewed the application, I cannot conclude that UVMMC has met its burden to establish that a CON should be granted. I therefore disagree with the majority's decision to conditionally approve the project.

First, UVMMC has not demonstrated that there is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for UVMMC to provide. *See* 18 V.S.A. § 9437(3).

UVMMC's demand projections are not supported by experience. UVMMC projects that outpatient surgical case volumes will increase 28% between 2019 and 2030. Findings, ¶ 38. However, outpatient surgical volumes at UVMMC have changed little in almost a decade. *See* Resp. (Jan. 16, 2024), 9-13 (showing outpatient surgical volumes from 2015 - 2019); Resp. (June 11, 2024), 2 (showing outpatient surgical volumes from 2019 - 2024). Even though 2024 year-to-date surgical volumes may reflect continued pent-up demand associated with the COVID and Fanny Allen OR closures, annualized 2024 year-to-date surgical volumes are well below those predicted by UVMMC's model. *See* Resp. (June 11, 2024), 2; Mathematica Report (March 20, 2024), 10 (describing the surgical growth projected by UVMMC's model). UVMMC's model projects that inpatient surgeries will increase approximately 10% between 2019 and 2029, while

the data UVMMC has provided shows that inpatient case numbers have, in fact, been declining. *See Findings*, ¶ 38; *Resp.* (June 11, 2024), 2 (showing 5,948 IP in FY 2019 and 5,329 annualized for FY2024, a 10% reduction in IP volume).

In addition to being unsupported by actual experience, UVMMC's modeling is inconsistent with prior representations of the Vermont Association of Hospitals and Health Systems, based on a Kauffman Hall consulting report, regarding outpatient surgical capacity needs in the area. The report asserted that there was sufficient operating and procedure room capacity in northwestern Vermont to meet demand until 2050. *In re ACTD LLC, d/b/a The Green Mountain Surgery Center*, Docket No. GMCB-010-15con, Post-Hearing Memorandum in Opposition to the Green Mountain Surgery Center CON Application on Behalf of the Vermont Association of Hospitals and Health Systems (May 2, 2017), 2.

Although UVMMC points to wait times as evidence of a lack of capacity, it is unclear what is driving wait times. UVMMC failed to establish that wait times are the result of inadequate surgical capacity and not some other operational factor. *See Findings*, ¶ 42. Furthermore, based on data that UVMMC submitted, Fanny Allen has capacity for approximately 985 additional surgeries this year, which could eliminate the current backlog. *See Resp.* (June 11, 2024), 2 (projecting a total of 4,203 outpatient surgeries will be done at Fanny Allen in 2024 and showing 524 patients waiting 60 days or more as of May 16, 2024); *Resp.* (Jan. 16, 2024), 13 (showing total capacity of the five Fanny Allen ORs as being 6,918 in CY 2018, when there were no closures for air quality issues, which would be 5,188 at 75% utilization). In contradiction to testimony UVMMC provided in the hearing, it stated in a written response to GMCB questions that in 2024 the five Fanny Allen ORs are projecting a 61% utilization rate (taking the projected case count of 4,203 from UVMMC's June 11, 2024 Response at 2 and dividing it by CY capacity of 6,918 from UVMMC's Jan. 16, 2024 Response at 13), which is below the 25th percentile from a Vizient benchmark UVMMC submitted for staffed ORs. *See Resp.* (Nov. 16, 2023), 34.

Even if UVMMC's projected growth in outpatient surgical demand is realistic, it could be met with fewer ORs than have been proposed. UVMMC and Mathematica assumed 62,500 staffed hours per year (250 days at 10 hours per day for 50 weeks for 25 ORs). *See Mathematica Report* (Mar. 20, 2024), 6-7. If the OR capacity numbers from UVMMC's Jan. 16, 2024 Response (approximately 70,000 available hours per year) are used instead of the application's assumptions, at 75% utilization, UVMMC would need 28 ORs in 2029, not 31 ORs. *See Resp.* (Jan. 16, 2024), 11 (noting that the 18 main campus ORs are available 58.4 hours per week, not 50). This still assumes a 15.4% increase in demand from FY 2024 - 2029, a growth rate not seen in at least a decade. Alternatively, if growth rates of 1% for inpatient cases and 2% for outpatient cases (roughly the annual growth rates in the submission) were applied to FY 2024 projected caseloads, there would still be historically high growth in cases (5,600 inpatient cases, 15,683 outpatient cases, and 21,203 total cases, equating to 8.5% growth), but the OR need would be 26. *See Mathematica Report* (Mar. 20, 2024), vi (noting that UVMMC predicts demand for outpatient surgeries will increase at an average annual rate of 2.1% and cumulatively 24% from 2019 – 2029). Building capacity for 12 new ORs would be far beyond UVMMC's needs in the next 5 years.

Second, UVMMC did not establish that the project will not result in an undue increase in the costs of medical care. *See* 18 V.S.A. § 9437(2)(B).

According to the GMCB consultant, Ascendient, the entirety of the margin that UVMMC will make on this project is due to the incremental increase in inpatient surgery. *See* Findings, ¶ 58. As discussed above, there is no compelling evidence that this will occur. Additionally, as seen in the majority opinion, the GMCB is not willing to approve hospital budgets predicated on the high prices that UVMMC assumes it will charge for outpatient care. This would mean that UVMMC is likely to lose money on this project, which will in turn put more pressure on their other service lines to increase revenue. Given UVMMC's stated budgeting approach that when expense growth exceeds revenue there is a request to increase commercial rate, we would expect to see an increased request for commercial rate reimbursement. *See, e.g.*, Testimony of Dr. Sunil Eappen, Tr., 283:3 – 15; In re: FY 2024 Hospital Budget Hearing – The University of Vermont Health Network (Aug. 23, 2023), Testimony of Rick Vincent, Tr., 55:25 – 56:9.

One possible outcome of creating expensive and unnecessary outpatient surgical capacity is that the capacity will be underutilized. Building duplicative facilities places the expense of the facility on ratepayers, without giving them the benefits of this expense.

Alternatively, the facility could be fully utilized, but only because care is shifted to UVMMC from other areas of the state or because of induced demand. Each of these possible scenarios is likely to result in an undue increase in the cost of medical care. Shifting care from other lower cost sites can directly increase the cost of care. Given that UVMMC has higher outpatient prices than 12 of the 13 other hospitals in Vermont, *see* RAND Report, induced demand would lead to increased charges to insurers, and thus overall higher insurance rates. If revenue from surgical volume were to decrease at other hospitals, it can lead to financial destabilization of these hospitals, who may then need to rely more heavily on state subsidization or commercial rate increases to offset fixed costs.

Third, UVMMC did not establish that less expensive alternatives do not exist or would be unsatisfactory, not feasible, or not appropriate. *See* 18 V.S.A. § 9437(2)(C). UVMMC made no effort to use available OR space at NMC. While UVMMC officials testified regarding challenges with UVMMC doctors working at NMC (e.g., different electronic medical record systems and different equipment), there were apparently no efforts made to overcome those challenges. *See* Findings, ¶ 31.

UVMMC also never considered an OSC with fewer than 8-12 rooms. *See* Findings, ¶ 19. While the Fanny Allen ORs are smaller and older than ideal, significant investment has been made in improving those facilities. *See* Testimony of Dr. Stephen Leffler, Tr., 15:1 – 6. UVMMC could have investigated building a smaller facility, such as a four-bed OSC with modern ORs, while keeping the Fanny Allen ORs open for far lower cost than the proposed project. While such an arrangement would still potentially shift care from other regions to UVMMC, as I discuss elsewhere, at least it would be a lower cost alternative.

Finally, UVMMC did not establish that the project aligns with statewide health care reform goals and principles; it does not take into consideration Act 167 and GMCB goals of improving sustainability of the healthcare delivery system outside of UVMHN.

Health care reform efforts are likely to be aimed at strengthening facilities to provide care away from expensive tertiary care centers that can be performed with high quality in other settings. Currently over 48% of UVMMC’s outpatient surgical cases come from outside of the Burlington HSA. *See Findings, ¶ 2.* Moreover, UVMMC’s planning documents anticipated a “capture campaign” vis-à-vis competitors. *Findings, ¶ 50.* The proposed project adds significant procedural capacity in a younger, high-income region, risking potential shifts from more rural and less affluent areas and raising significant concerns regarding equitable access to healthcare. Not only does overbuilding surgical capacity at UVMMC risk increasing shifts of care to UVMMC, but also it reduces the likelihood that any of these volumes move back to local communities where appropriate, which could lead to further degradation of Vermont’s health care delivery system. Many other Vermont hospitals have sufficient local population to have minimum numbers of cases performed to meet optimal quality. However, if these cases get shifted to UVMMC this could erode these case numbers. If high margin cases leave local community hospitals, revenue shortfalls and increased travel times could occur, leading to reduced convenient access to care for much of Vermont’s rural communities.

All of this said, I am sympathetic to UVMMC’s concern that the Fanny Allen ORs do not accommodate outpatient total joints and other outpatient surgeries needing larger space. It is possible that this may be one of the factors leading to low utilization (~61%) at the Fanny Allen ORs this year. I would have been interested in reviewing a lower cost alternative that was designed to have eight or fewer ORs, including shell space. I would have wanted UVMMC to meet its burden to demonstrate that a lower cost alternative did not exist that was consistent with HRAP, CON statutes, and the state’s health care reform goals. I would like to have been provided conceptual figures as to the cost of building and the impact to revenue from adding additional ORs to UVMMC’s current outpatient surgical facility. Additionally, I would have wanted UVMMC to demonstrate that it had explored collaborative approaches with other hospitals to perform these surgeries in existing facilities in Vermont.

Because UVMMC did not demonstrate a need for this project; did not establish that the project will not result in an undue increase in the costs of medical care; did not establish that less expensive alternatives do not exist or would be unsatisfactory, infeasible, or inappropriate; and did not establish that the project aligns with statewide health care reform goals and principles, I must dissent from the Order granting this CON.

Dated: July 29, 2024, at Montpelier, Vermont.

s/ David Murman)

Filed: July 29, 2024

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

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Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed within ten days of the date of this Order.