	3
State of Vermont Green Mountain Care Board	1 CHAIR MULLIN: Good afternoon everyone.
	2 Welcome to the Green Mountain Surgery Center meeting.
	3 First item on the agenda is the Executive Director's
	4 report. Susan Barrett.
IN RE: APPLICATION OF ACTD. LLC FOR GREEN MOUNTAIN SURGERY CENTER } GMCB-010-15CON	5 MS. BARRETT: Thank you, Mr. Chair. I
-	6 have some scheduling amouncements. First, this
	7 Friday, April 19 we will have a meeting here in this
	8 auditorium at 9 a.m. and we will be potentially
Hearing held before the Green Mountain Care Board at the Pavilion Auditorium, 109 State Street, Montpelier, Vermont on April 1/, 2019, beginning at 1 p.m.	9 voting on hospital budget enforcement hearings.
Montpelier, Vermont on April 17,"2019, beginning at 1 p.m.	10 Thank you. I think everyone can hear me. I'm pretty
	11 loud.
	51
	13 Wednesday, April 24 we'll be hearing from Springfield
	14 Medical Center. we'll be hearing on a rate
BOARD MEMBERS:	15 adjustment to their budget as well as their
Kevin Mullin, Chair Maureen Usifer	16 enforcement hearing. we had had springfield
Kevin Mullin, Chair Maureen Usifer Jessica A. Holmes, Ph.D. Robin Linge, JD, M-CDS Tom Pelham	17 scheduled for today and due to Representative's
Ton Pelhan	18 passing and a funeral we've rescheduled that to April
<u>STAFF MEMBERS</u>	19 24, again in this auditorium, starting at 1 p.m., and
Susan Barnett, Esg., Executive Director Michael Barber, General Counsel	20 then we have finalized the date for our traveling
	21 board meeting will occur at the end of this month —
	22 next month May 29. It will be at Gifford Hospital,
CAPITOL COLRT REPORTERS, INC.	and there will be more details on our web site, and,
BURLINGTON, VERNON, 05402-0829	24 lastly, if folks have not signed in, I would ask that
E-mail: info(capito)courtreporters.com	25 you sign in at the back table and that is all I have
2	4
HEALTH CARE ADVOCATES	1 to amonce.
Fric Shouldice	2 MR. MULLIN: Representative Jickling is
INDEX	3 here. Do you want to recognize him?
	4 MS. BARRETT: Chyes. I want to
Page	5 recognize Representative Ben Jickling who is on the
Executive Director's Report & Approval of 3	6 House Health Care Committee. Thank you. Thank you
GNSC ON Presentation 7 Board Ouesticities 90 Health Care Advocate Questions 98 Interested Parties 90	7 for coming.
GASC CON Presentation 7 Board Questions/Comments 40 Health Care Advocate Questions 98	8 CHAIR MULLIN: with that we have two
Jill Berry Bowen 99,	9 minutes to approve. The first is wednesday, April 10
Interster ry Boven     99       Board Overtions/Connents     104       Health Care Advocate Questions     107	10 and the second is Friday, April 12. Is there a
	11 motion?
Internet to the second contracts     99       Board Oustions Comments     104       Health Care Advocate Questions     107       Public Comment     107       Public Comment     108       Kathy Okei Lly     109       Kathy Okei Lly     101       Dr. Julie Larsen     112	12 MS. USIFER: So moved.
Dr. Julie Larsen 112	13 MR. PELHAM: Second.
	14 CHAIR MULLIN: Been moved and seconded
	15 to approve both sets of minutes without any
	16 additions, deletions, or corrections. Is there any
	17 discussion? Hearing none all those in favor signify
	17 discussion: meaning rule arr duse in favor signing 18 by saying aye. (Board members respond aye) Any
	19 opposed? (No verbal response.)
	20 Thank you. So at this point we would
	21 like to turn to the CON hearing on Green Mountain
	22 Surgery Center and I an going to appoint Michael
	23 Barber to be the Hearing Officer and Michael will be
	55 11

aftermon. This is a hearing in the case of in res         your right-hard so the court reporter can seer you           2         ACRD, ULC dring business as green Numtain Surgey         in.           2         Center. The dodet turber is GOC-00051 SON. As         in.           4         the drain said ay name is Midnel Barter. TTH be         in.           5         saving as the board's designated Haring office         for.           6         the drain said ay name is Midnel Barter. TTH be         saving as the board's designated Haring office           7         under Thile Bi depter 221 of the vertort statutes         for.           8         and the board's off-the depth of thes growerings.         The first one year in the rest of parties and haring office of the GN, is           11         ACT or ACD, the holder of the GN, is         for action, the holder of the GN, is           12         representing wornt. Account apply to these growers.         for action confliance that they with is a the trans.           13         ACT or ACD, the holder of the GN, is         surger of ACD, LLC and the Green Nutrain Surgery center.           14         Hailth System and Nerthestam Hedical Center who         Surgery of ACD, LLC and the Green Nutrain Surgery center.           14         Hailth System and Nerthestam Hedical Center who         Surgery of ACD, LLC and the Green Nutrain Surgery center.           15         headed on ur p			, 2010	
2       ACD, LLC dring basiness as Green Nutrain argery Genter. The docket nutber is OKD-00-15 GOL As the Chain saiding rame is Midteal Barber. TTI be serving as the bard's designed Hearing Officer for today. This is - this hearing will be conducted or under TriCle 18 depare 721 of the vemont statutes and the bard's designed Hearing Officer for example and the bard's designed Hearing Officer for serving as the bard's designed Hearing Officer for the bard's detriftione of Need regulation OGB and the soard's detriftione of Need regulation OGB and the soard's detriftione of Need regulation and the regolation of the Administrative processenting them CAD, LLC and the Green Nutratin surgery Center. In Need Need Y and Y, are attorneys Julia Stew and Interested parties is attorney Ann Oramer, and regresenting the office of the Health Care Adocate, and interested parties is attorney Ann Oramer, and regresenting the office of the Health Care Adocate, and interested parties is attorney Ann Oramer, and and interested parties is attorney Ann Des Administor es z. I would head of interupting the their agestions and their stated of interupting the their agestions and potentially opeating and their agestions and approximative for Health Care Adocate, att ther dwire drigs to head spatific and the netwire drigs to head appatific and the stated of interupting the their agestions and approximative for Health Care Adocate, att the dwire parties the the bard agestions, the approximative for Health Care Adocate, att the dwire parties thead and theagestions and the rest as a signe solubal by bard ages		5		7
3       Generative indicate number is softed 00-15 cont, fixed       3       (Potential witnesses were sorm.)         4       the drain said my mane is Midnel Barber. 11'II be       5       M. BWBER: M. Tyler, turn it over to         5       serving as the board's designated Hearing Officer for       6       M. BWBER: M. Tyler, turn it over to         6       table, A. The provisions of the Administrative       6       M. BWBER: M. Tyler, turn it over to         7       Raile 4. The provisions of the Administrative       7       M. BWBER: M. Tyler, turn it over to         13       Representing two risks at the table       7       Thank you very much for the time table, Wel'II start         14       Health Systems and Arrithesism Medial Carter Wo       13       M. SOURE: The You, Karen. The Mark         15       arrithmest my the office of the Haalth Care Advocate,       13       M. ROURE: The You, Karen. The Mark         16       magnetic the office of the Haalth Care Advocate,       16       M. ROURE: The You, Karen. The Mark         17       ard intersteping the Agreta for this Afternon's       16       M. ROURE: The You, Karen. The Mark         16       magnetic the start Mark Sort for the Care.       17       M. Bootter, The You, Karen. The Mark         17       ard intersteping the Mark Sort for the Sort for the Mark Sort for the Care.       18       M. ROUE: The Xou Kare.		-		
4       the drain said by mane is Middle Barber. If The serving as the board's disignated Haming Officer for tody. This is - this hearing will be conducted under Tricle B dapter 221 of the venous statutes and the bard's dartificate of the enalthed conducted to the dard's dartificate of the enalthed conducted to the dard's dartificate of the enalthed conducted to the dard's dartification of the follows are the conducted to the dard's dartification of the follows are the dard's dartification of the difficult compliance that they will be are introduction of the follows are the dard's dartification of the difficult compliance that they will be are introduction of the follows are the dard's dartification of the difficult compliance that they will be are introduction of the follows are introduction of the difficult compliance that they will be are indicated to an interestical parties is attorney. Julia Share and here in July of last years to partial and their operation is comply conter. Following years are their operation to be difficult participation. The test is a strained of interupting it. I think that will make things go snother. Following years are shall be and they are diverse and their operations and the are dord interupting it. I think the first surgery conter. We as a single speciality pain with sixt are allowed area dord interupting it. I think the first surgery conter was a gestoreare log with four procedure rooms in lower withers appring and before we now on and I turn it coer to work with so are allowed in the area with the board's abort and the to bard surgery on the were and they be attributed the dow. I the area work in the first surgery conter were a afforduble cost with so the area wore minil the potential withesees at the difference. I ho				
5     serving as the bard's designated learning officer for today. This is - this hearing will be conducted or der Tible 18 depends 20 of the vennot statutes and the bard's certificate of Neal regulation QGB     5     you.       8     and the bard's certificate of Neal regulation QGB     6     He. TUBR: Surve. I'm Rem Tyle with the film of Durkiel Surders representing ACD, LLC.       9     with the the add the today. Ne'll start the film of Durkiel Surders representing ACD, LLC.     Thank you very much for the time today. Ne'll start the today. Ne'll start the today. Ne'll start the today. Ne'll start the today.       10     Procedures Act do not apply to these proceedings.     10       11     ACT or ACD, the holds of the CM, is     11       12     representing twomt Association of Regritals and are interested parties is attorney Am Graer, and and Eric Strudifice.     13     Ne. ROCE: The John Reni. The the and Eric Strudifice.       13     and Eric Strudifice.     14     Ne. ROCE: The John Reni. The the and Eric Strudifice.     14       14     Hearing is as follow. First we're going to hear 12     14     Ne. ROCE: The John Reni. The the and Eric Strudifice.     14       15     Hearing is as follow. First we're going to hear 12     14     14     14     14       16     presentation there will be bard questions of 15     14     16     16       17     the add the Bard Mathers to hold their questions 16     14     16     16       18     <	3		-	
6       Ms. TMER: Sur-E. In Karen tyler with international statuses and the part's drug the definition of Durkiel Sanders representing ACD, LLC.         7       and the bard's drug the definitional statuses and the provisions of the definitional statuses.       fmark you very much for the time tody, we'll start the table interset part to the provisions of the definitional statuses.         8       and the bard's drug to the work statuses.       fmark you very much for the time tody, we'll start table interset part to the provisions of the definition to the finance and the we'll mode directly into the finance and the we'll me directly into the finance and the we'll the action the finance and the we'll and the finance and the we'll and the state and the finance and the we'll and the we'll and the finance and the we'll and the we'll and the finance and the we'll and the we'll and the finance and the we'll and the we'll and the finance and the we'll and the finance and the we'll and t	-	-		MR. BARBER: Ms. Tyler, turn it over to
7       urder Tritle 13 dropter 221 of the Vermont statutes       7       the film of Ourkiel Sunders representing ACD, ULC         8       and the locar's Cartificate of Neal regulation OVB       7       the film of Ourkiel Sunders representing ACD, ULC         9       Rile 4. The provisions of the Administrative       9       with just an introduction of the folks at the table         10       Procedures Act do not apply to these proceedings.       10       the and the well 11 me directly into the         11       Percentry to the loader of the ON, is       11       mer and then well 11 me directly into the         12       representing the office of the Hailth Care Advocate,       11       Ms. GODER: The Ayou, Karen. Th Any         16       representing the office of the Hailth Care Advocate,       11       Ms. GODER: The Ayou, Karen. Th Any         16       representing the office of the Hailth Care Advocate,       11       Ms. GODER: The Ayou, Karen. Th Any         17       also an interested parties is attomay. An Onese, and       15       Ms. GODER: The Ayou, Karen. Th Any         18       and the Sorten Markatin Sattermon's       14       Satter Markatin. Surgery Carter.       18         18       and the Sorten Markatin Sattermon's       14       Satter Markatin. Surgery Carter.       18         19       text and the Sate Advocate Sate Markatin. Surgery Carter. <t< td=""><td>5</td><td></td><th></th><td>-</td></t<>	5			-
8       and the Board's Certificate of Need regulation OCB       8       Thark you very much for the time today. We'll start         9       Rule 4. The provisions of the Administrative       9       with just an introduction of the folks at the table         10       Proceedings Act on ACD, the holder of the ON, is       10       Presentation regarding control the folks at the table         11       Act or ACD, the holder of the ON, is       11       Proceeding Admonstration regarding control the folks at the table         12       representing version of hospitals and       11       Proceeding Admonstration regarding control the CPN. Nutratin Surgery Center.         13       are interested party, are attorness Julia Stave       16       Proceeding The OFIC of AdDia.         14       Health systems and Northwestem Medical Center who       17       Addin Kee table and Means to hold their questors.         15       are interested party, are attorness Julia Stave       16       Ministrative of the Geen Muntatin Surgery Center.         16       representing the off interryclip it. I think       17       Addia Keen table and Means to hold their questors.         17       from ADD. Based on ur preharing or fore rei       10       Muntain Surgery Center.       18         18       addin the ord instave of interryclip it. I think       20       brink targery center was a       10         17	6			-
9       Rule 4. The provisions of the Athinistrative Procedures Act do not apply to these proceedings.       9       with just an introduction of the folks at the table here and then will not deterably into the presentation againing outfitton compliance that they will be presentation.         10       Proceedings and hordwestern Netical Center vito are interested parties is attorney Am Granes, and representing the office of the Health Care Advocate.       10       No. COFFE: Thank you, Karen. I'm Amy Association of Hear Gran Muntain Surgey Center.         11       representing the office of the instit for an Advocate and Eric Studice.       10       No. COFFE: Thank you, Karen. I'm Amy Administrator of the Gran Muntain Surgey Center.         10       and Eric Studice.       11       No. Coffee: The Advocate on presentation tables of interrupting it. I think that will nake things go smoother. Following your       11       No. Coffee: The Advocate on presentation there will be board questions and clarifying questions, and than we're going to hear of clarifying questions and potentially questions from the Health Care Advocate to ack some clarifying questions from the Health Care Advocate.       10       Ores. The second surgey center was it's a fairly new compt for Vemont, but it's a really unique medical facility. We create a very term is no leaded and with size a single speciality pain with size grand up it was a single speciality pain with size grand up it was a single speciality pain with size grand up it was a single speciality pain with size grand up it was a single speciality pain with size grand up it was a single speciality pain with size grand up it was a single speciality and with size grand up it was a single speciality pain with size grand up it was a s	7	•		• •
10       Procedures Act do not apply to these proceedings.       10       here and then we'll moe directly into the         11       Act or ACD, the holder of the CON, is       representation regarding condition compliance that they         13       Representing Vemort Association of Hospitals and       13       NS. CORR: Therk you, Karen. I'm Any         14       Health Systems and Northwestem Medical Genter with       13       NS. CORR: Therk you, Karen. I'm Any         16       representing the office of the Health Care Advocate,       16       NR. PONI: I'm Join Raoni. I'm the         17       also an interested party, are attorneys Julia Staw       16       NR. PONI: I'm Join Raoni. I'm the         18       and Eric Shuildice.       19       So the agenda for this afternom's       19         10       here add the deen Nutrain Surgey Carter.       18       I would Nike to therk you for the quorturity since         12       from ACD. Based on our prehearing conference I       19       build the caren Nutrain Surgey Carter.       18         14       until the end instead of interrupting it. I thrik       23       build the caren Nutrain Surgey Carter.       18         15       seed the tearth we'ler going to hear       6       10       06       10         15       thead instead of interrupting it. I thrik       23       build the caren Nutrain S		•		
11       ACT or ACID, the holder of the CDN, is represented tudy by attorney karen Tyler.       11       presentation regarding cordition compliance that they will be presenting.         12       represented tudy by attorney karen Tyler.       13       presentation treascitation of hespitals and the action table is attorney Arm Caner, and are interested partly, are attorneys Julia Staw and Bric Studice.       13       MS. COUPR: Thank you, karen. The May Cooper, manager of ACID, LLC and the Green Muntatin Surgery Carter.         16       representing tworth section to the Ast intervor's and Bric Studice.       16       MR. PONC: The John Raoni. The the administrator of the Green Muntain Surgery Carter.         12       from ACID. Based on an prehearing conference I       19       bial dub Green Muntain Surgery Carter.       11         12       expect your presentation to be 46 minutes or so. I       12       Muntain Care Band. I care from Utica, New York. I       11         13       heak add the Board Members to hold their questions and potentially upscitors, and then we're going to hear       12       12       Muntain Care Band. I care Advacet to aks some       20         14       that withing guestions, and then we're going to hear       12       12       12       13       More that the dub care Advacet to aks some       20       13       14       14       14       14       14       14       14       14       14       14       14       1		Rule 4. The provisions of the Administrative		-
12       represented today by attorney karen Tyler.       12       will be presenting.         13       Representing Vernor Association of Hopitals and       14         14       Health Systems and Northestern Medical Center who are interested parties is attorney Am Carer, and and interpreted party, are attorneys Julia Shw and Eric Shuldice.       16       Mc. COPR: Therk you, Karen. The Amy Care, anger of ACD, LLC and the Green Muntain Surgery Center.         16       representing the office of the Health Care Advocate, and Eric Shuldice.       16       Mc. ROME: I'm John Romi. I'm the administrator of the Green Muntain Surgery Center.         19       So the agenda for this afbernon's the fore for the Green Muntain Surgery Center.       18       Muntain Care Bard. I core from Utica, New York. I model here in July of last year to operate and help the denies of Manbers to hold their questions.         21       have asked the Bard Marbers to hold their questions.       12       Invold Here in July of Last year to operate and help the denies of Muntain Surgery Center.         22       expect your presentation there will be bard questions.       12       12       Invold Here in July of Last year to operate and help the denies of Muntain Surgery Center.       18         23       representation there will be bard questions. and for the Medical Center.       10       Muntain Care Bard.       10         24       trans Medical Center.       11       11       11       11       11       12	10	Procedures Act do not apply to these proceedings.	10	here and then we'll move directly into the
13       Representing Venior Association of Hospitals and Hailth Systems and Northwestem Medical Center who are interested party, are attorneys Julia Stave also an interested party, are attorneys Julia Stave also an interested party, are attorneys Julia Stave and Bric Studice.       13       NS. CODER: Therk you, Karen. I'm Any Cooper, marager of ACID, LLC and the Green Munitain Surgey Center.         16       representing the office of the Health Care Adocate, also an interested party, are attorneys Julia Stave and Bric Studice.       13       NS. CODER: Therk you, Karen. I'm Any Cooper, marager of ACID, LLC and the Green Munitain Surgey Center.         17       abso an interested party, are attorneys Julia Stave and Bric Studice.       16       MR. MONE: I'm Join Rami. I'm the attinistrator of the Green Munitain Surgey Center.         18       model here in July of last year to operate and help expect your presentation to be 45 minutes or so. I from Northwestem Medical Center, we'll here advocate to akk some scillarity questions; and then we're going to hear from Northwestem Medical Center, we'll here ore witness agin followed by board questions and scillatory surgey center as it's a fairly new corcept for Venmort, but it's a really urique medical facility. We create a very team structured environment, but it's a really urique medical facility. We create a very team structured environment, but it's a signey beet cutside the cont in word kak that you please put your rare down. The board will not be making any decisions tody, sori attific to those omments that the bard receives rare prober is no wetary and the parties is the board will accept ubblic comments that the bard receives rare prober is no wetary and the processing, and before we move and a ther proceset real sof the matery reporter to sever in all the pote		ACT or ACTD, the holder of the CON, is		presentation regarding condition compliance that they
14       Haith Systems and Northwestem Medical Genter who are interested parties is attorney Am Oraner, and regresenting the office of the Haith Care Advacta and Eric Studide.       14       Cooper, marager of ACID, LLC and the Green Monitatin Surgey Center.         16       representing the office of the Haith Care Advacta the aring is as follows. First we're going to hear from ACID. Eased on our prehenring conference I expect your presentation to be 45 minutes or so. I that will make things go smoother. Rollowing your       14       Cooper, marager of ACID, LLC and the Green Monitatin Surgey Center.         14       addition State and Mathers to hold their questions that will make things go smoother. Rollowing your       14       Surgery Center.         16       mode here in July of Hait heard Mathers to hold their questions, the typerturity for Haith Care Advacta to ack sme clarifying questions, and then we're going to hear from Northeestern Medical Center. We'll hear or witness again followed by board questions and to potentially questions from the Haith Care Advacta.       6         10       would ack that you please put you mare down.       16       16       Gres. The second surgery center wes a gastroarterology with four producer crosms in lover         14       addition to the comments fort the having any decisions today. So in addition to the comments fort the having any decisions today. So in addition to the comments fort the having so. So through foundal fue to mark and so. So through staff and iter producting and before we move on and I turn it over togay and before we mowe on and I turn it over to you, Ne, Tyler,	12	represented today by attorney Karen Tyler.	12	will be presenting.
15       are interested parties is attorney Am Oraner, and representing the office of the Hailth Care Adocate, and Eric Shouldice.       15       Surgery Genter.         16       and are interested party, are attorneys Julia shaw and Eric Shouldice.       16       NR. PROID: Thir John Reoni. Thir the administrator of the Green Muntain Surgery Center.         19       So the agends for this afternor's hearing is as follows. First verife oging to hear from ACID. Based on our prehearing conference I       17       18       Huntain Care Exard. I come from Utcla, NW orkk. I moved here in July of last year to operate and help         21       hearing is as follows. First very meretation to be 45 minutes or so. I       18       Huntain Care Exard. I come from Utcla, NW orkk. I moved here in July of last year to operate and help         22       that will make things go smother. Rollowing your       10       First surgery center was a       8         3       operation there will be board questions, the ground up it wes a single specialty pain with six       8         4       operation there will be board questions, the ground there brain of lowed by board questions and gestomaterology with four procedure rooms in lower       8         7       At the end were going to hear witness again followed by board questions tody. at the droing ny decisions tody. So through       6         10       would akk that you please put you rame down. the you whill out be making any decisions tody. at the droin the comments that the band receives orally at the exaring the othere withour at dad	13	Representing Vermont Association of Hospitals and	13	MS. COOPER: Thank you, Karen. I'm Amy
16       representing the office of the Health Care Adocate, also an interested party, are attorneys Julia Staw       16       MR. PRONI: I'm John Paorii. I'm the administrator of the Green Muntain Surgery Center.         19       So the agenda for this afternoon's hearing is as follows. First we're gring to hear       10       Muntain Care Adocate, it is is the first time I'w been at the Green Muntain Care Adocate. I come from Utica, New York. I model here in July of last year to operate and help build the Green Muntain Surgery Center. This is the ground up it was a single specialty pain with six         20       hearing is a follows. First we're gring to hear that will mee things go smother. Following your       20         21       presentation there will be board questions, the qoportunity for Health Care Adocate to ask some clarifying questions, and potentially questions form the Health Care Adocate.       6         2       presentation there will be board questions and potentially questions form the Health Care Adocate.       7         3       witness again followed by board questions and potentially questions from the Health Care Adocate.       7         3       witness again followed by board questions and potentially questions from the Health Care Adocate.       7         4       form Northwestern Medical Genter. We'll have or witness again followed by board questions and potentially questions from the Adocate.       7         7       At the end we're gring to have a public a commet period. If you would like to make comments it to addition to the onements that the board indues.       7	14	Health Systems and Northwestern Medical Center who	14	Cooper, manager of ACID, LLC and the Green Mountain
17also an interested party, are attorneys Julia Shaw and Eric Stouldice.17administrator of the Green Munitain Surgery Center. I would like to thark you for the opportunity since this is the first time I've been at the Green Munitain Care Board. I core from Utica, New York. I exercise a second surgery center that I have had the opportunity to mode here in July of last year to operate and help build the Green Munitain Surgery Center. This is the this is the first time I've been at the Green Munitain Care Board. I core from Utica, New York. I mode here in July of last year to operate and help build the Green Munitain Surgery Center. This is the this is the first surgery center that I have had the opportunity to work in. The first surgery center built from the 25 ground up it was a single specialty pain with six7678000910101091010109101010101010101110101012101010131110101415101015101010161110101711101811101910101010101110101211101311101415161516171617181718191819<	15	• •	15	Surgery Center.
18       and Eric Shuldice.         19       So the agenda for this afternon's         19       So the agenda for this afternon's         19       So the agenda for this afternon's         10       Paring is as follows. First we're going to hear         11       epect your presentation to be 45 minutes or so. I         12       epect your presentation to be 45 minutes or so. I         13       have asked the board Members to hold their questions.         14       this is the first surgery center that I have had the dyportunity.         15       this the due in stread of interrupting it. I think         16       presentation there will be board questions, the         17       presentation there will be board questions, and then we're going to have or         18       I would a the we're going to have a public.         19       witness agin followed by board questions and         10       potentially questions from the Health Care Adocate.         10       would ask that your name dow. The         11       today, there is a sign-p frace dustide the doord.         12       addition to the comments that the board receives         13       comment period.       If you would like to make comments         14       accert public comments for the day. So through         15       mathua	16	representing the office of the Health Care Advocate,	16	MR. PAONII: I'm John Paoni. I'm the
19So the agenda for this afternon's hearing is as follows. First we're going to hear from ACID. Based on our prehearing conference I expect your presentation to be 45 minutes or so. I have asked the board waters to hold their questions until the erd instead of interrupting it. I think that will make things go smother. Following your19this is the first time I've been at the Green Muntain Care Beard. I come from Utica, New York. I moved here in July of last year to operate and help to work in. The first surgery center that I have had the opportunity to work in. The first surgery center built from the ground up it was a single specialty pain with six61987110810810009101010109101010101010101010101110101010101012101010101010131410101010101415101010101015161717101010161718191010101819101010101019101010101010101010101010101110101010101012131414141	17	also an interested party, are attorneys Julia Shaw	17	administrator of the Green Mountain Surgery Center.
20       hearing is as follows. First we're going to hear       20       Muntain Care Board. I cone from Utica, New York. I         21       from ACD. Based on or prehearing conference I       21       model here in JUy of last year to gerate and help         22       expect your presentation to be 45 minutes or so. I       21       model here in JUy of last year to gerate and help         23       have asked the bard Wathers to hold their questions       11       model here in JUy of last year to gerate and help         24       until the end instead of interrupting it. I think       12       think surgery center that I have had the coprorunity         25       that will meke things go smother. Following your       6       1       ORs. The second surgery center was a         26       gestroanterology with four procedure rooms in lower       8         3       charing puestions and then we're going to hear       3         4       from Northwestern Medical Center. We'll have ore       So I'll tell you a little bit about an         5       witness again followed by board questions and       5       antulatory surgery center as it's a fairly new         6       potentially questions from the Health Care Advocate to ask some       3       erroanter period. If you would like to make coments         10       wolday, there is a sign-up sheet outside the door. I       would ask that you please put your rame down. The<	18	and Eric Shouldice.	18	I would like to thank you for the opportunity since
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14accept public comments for ten days. So through Monday, April 29. Those comments can be submitted via the board's web site, by telephone, or by U.S. mail.14they leave our facility. The Green Mountain Surgery Center will offer great service at an affordable cost to all the citizens of Vermont. We do not have any overnight stay for any patient. Our patients have the right to choose the facility that they will have the right to choose the facility that they will have their procedure performed. The Green Mountain Surgery Center will offer an alternative to those to you, Ms. Tyler, I would like to ask the court reporter to swear in all the potential witnesses at cone time. So if you were listed on the parties' witness list as a potential witness and you expect to1414accept public comments for ten days. So through they leave our facility. The Green Mountain Surgery Center will offer great service at an affordable cost to all the citizens of Vermont. We do not have any overnight stay for any patient. Our patients have the right to choose the facility that they will have their procedure performed. The Green Mountain Surgery Center will offer an alternative to those the you. Ms. Tyler, I would like to ask the court reporter to swear in all the potential witnesses at cone time. So if you were listed on the parties' witness list as a potential witness and you expect to1414accept public comments for ten days. So through to demonstrate how we are14				
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16via the board's web site, by telephone, or by U.S. mail.16to all the citizens of Vermont. We do not have any overnight stay for any patient. Our patients have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have their procedure performed. The Green Mountain Surgery Center will offer an alternative to those to you, Ms. Tyler, I would like to ask the court reporter to swear in all the potential witnesses at one time. So if you were listed on the parties' witness list as a potential witness and you expect to16to all the citizens of Vermont. We do not have any overnight stay for any patient. Our patients have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have the right to choose the facility that they will have they will have<			14	they leave our facility. The Green Mountain Surgery
17mail.17overnight stay for any patient. Our patients have18we have a court reporter here with us18the right to choose the facility that they will have19today and she's making a transcript of the18the right to choose the facility that they will have20proceeding, and before we move on and I turn it over20Surgery Center will offer an alternative to those21to you, Ms. Tyler, I would like to ask the court20Surgery Center will offer an alternative to those22reporter to swear in all the potential witnesses at22MS. COOPER: Now I was going to start at23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	15		15	Center will offer great service at an affordable cost
18we have a court reporter here with us18the right to choose the facility that they will have19today and she's making a transcript of the19their procedure performed. The Green Mountain20proceeding, and before we move on and I turn it over20Surgery Center will offer an alternative to those21to you, Ms. Tyler, I would like to ask the court21Vermonters. Thank you.22reporter to swear in all the potential witnesses at22MS. COOPER: Now I was going to start at23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	16	via the board's web site, by telephone, or by U.S.		to all the citizens of Vermont. We do not have any
19today and she's making a transcript of the19their procedure performed. The Green Mountain20proceeding, and before we move on and I turn it over20Surgery Center will offer an alternative to those21to you, Ms. Tyler, I would like to ask the court20Surgery Center will offer an alternative to those22reporter to swear in all the potential witnesses at22MS. COOPER: Now I was going to start at23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	17	mecil.	17	overnight stay for any patient. Our patients have
20proceeding, and before we move on and I turn it over to you, Ms. Tyler, I would like to ask the court20Surgery Center will offer an alternative to those21to you, Ms. Tyler, I would like to ask the court21Vermonters. Thank you.22reporter to swear in all the potential witnesses at22MS. COOPER: Now I was going to start at23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	18	we have a court reporter here with us	18	the right to choose the facility that they will have
21to you, Ms. Tyler, I would like to ask the court21Vermonters. Thank you.22reporter to swear in all the potential witnesses at22MS. COOPER: Now I was going to start at23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	19	today and she's making a transcript of the	19	their procedure performed. The Green Mountain
22reporter to swear in all the potential witnesses at one time. So if you were listed on the parties'22MS. COOPER: Now I was going to start at the top with condition number one and go through the 2424witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	20	proceeding, and before we move on and I turn it over	20	Surgery Center will offer an alternative to those
23one time. So if you were listed on the parties'23the top with condition number one and go through the24witness list as a potential witness and you expect to24conditions sequentially to demonstrate how we are	21	to you, Ms. Tyler, I would like to ask the court	21	Vermonters. Thank you.
24 witness list as a potential witness and you expect to 24 conditions sequentially to demonstrate how we are	22	reporter to swear in all the potential witnesses at	22	
	23	one time. So if you were listed on the parties'	23	the top with condition number one and go through the
25 testify today, if you would please stand up and raise 25 complying with those conditions of the CON.		· · · · · · · · · · · · · · · · · · ·		
			24	conditions sequentially to demonstrate how we are

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1	Condition number one is that the	1	in response to condition 1B where we will list the
2	applicant shall develop a consumer friendly web site	2	types of procedure/surgery that this physician will
3	which shall provide information about each physician	3	perform and explain the evidence basis for
4	planning to offer surgeries at the Green Mountain	4	recommending the procedure and how the procedure
5	Surgery Center. So this is the consumer friendly web	5	improves health.
6	site that we have developed. This is currently on a	6	So, for example, at the top are the
7	development server. It is not live to the public	7	procedures commonly performed by this
8	yet. Per the CON we will launch our live to the	8	gastroenterologist; colonoscopy, diagnostic
9	public web site two weeks before we become	9	colonoscopy, screening colonoscopy, and upper
10	operational, but we have developed the site on the	10	gastrointestinal endoscopies, and then we have some
11	development server so that is what I plan to show you	11	text regarding how colorectal screenings improve
12	today.	12	health by detecting cancers in people with no prior
13	This is the home page here. The menu	13	history of cancer. The object of these procedures is
14	includes physicians, tour, a section for patients	14	to reduce colorectal cancer. Coloroscopies are an
15	where we have frequently asked questions, careers,	15	effective way to screen for colon cancer because they
16	and contact information at the right. On the bottom	16	have high sensitivity for early detection, require
17	of the web site we have a link to our pricing and	17	only a single session diagnosis and treatment, and
18	quality measures, a link to our policies, and a link	18	have long intervals between examinations in patients
19	here that connects to the Medicare's ASC quality	19	who are over the age of 50.
20	reporting program page where Medicare shows quality	20	For patients with symptoms of positive
21	results for ASCs nationally across the country. The	21	screening tests, diagnostic colonoscopies is
22	Green Mountain Surgery Center would be included there	22	generally the best choice for examination, and then
23	and patients can see the comparative quality results	23	endoscopy below is primarily used as a diagnostic
24	compared to other anbuilatory surgery centers across	24	tool to permit visual inspection of the esophagus,
25	the country.	25	stomach, and small intestine which can be viewed by a
	10		12

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1	To start with condition one I have	1	continuous flexible tube inserted through the mouth.
2	pictures here now. That's Dr. Laub who is here with	2	Upper endoscopy also includes certain therapeutic
3	us today. I also have — we don't have pictures of	3	procedures such as the removal of polyps which can be
4	all the physicians yet or the physicians fully	4	cancerous. We have the same information there for
5	loaded. I also have Dr. Young who you will be	5	Dr. Laub and Dr. Young with descriptions of their
6	hearing from today. All of the physician profiles	6	procedures and how they improve health.
7	will follow the exact same format so I will go	7	The next condition is that we shall
8	through and show you one of those profiles now. This	8	develop and implement a policy which we will post to
9	is an example doctor in the field of	9	the web site requiring each physician use a patient
10	gastroenterology. Up here is the introductory bit	10	decision aid such as shared decision making that
11	showing where this doctor practices, his years of	11	fully informs the patient to the benefits and risks
12	experience, and whether the physician is one of the	12	of all care alternatives, incorporates the best
13	owners of the Green Mountain Surgery Center which is	13	available scientific evidence, takes into account the
14	one of the conditions as part of condition one.	14	patient's values, goals, and preferences, and advises
15	Condition one also requires that the	15	the patients of the pros and cons, including the
16	credentials of the physician be listed so we've done	16	comparative costs, of having the procedure. The
17	that here underneath. Condition one also requires	17	policy shall include a provision requiring
18	that the physician's contact information for patients	18	certification by the provider of his or her
19	24/7 be available on the web site. That's down here	19	compliance with such a policy.
20	at the bottom. These here are tabs that you would	20	This policy was submitted initially last
21	tab through, but the contact information always	21	year and is here on our web site shared decision
22	remains down at the bottom.	22	making policy. I should also note that our web site
23	The hospital for this physician there is	23	that's live right now and open to the public, which
24	listed University of Vermont Medical Center and then	24	is mostly a splash page, but also has all of our
25	common procedures that this physician does. This is	25	policies already up there. So this is on the dead
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1	site but also on the live site, and there is our	1	desires to transfer patients requiring energency
2	shared decision making policy there. This button	2	services to UMMC and UMMC desires to accept such
3	opens into a PDF of the policy.	3	patients; and, whereas, the patients also desire to
4	The certification page that each	4	facilitate the continuity of care and to specify the
5	physician signs as part of the policy which was	5	rights and duties of each party as well as the
6	submitted when we submitted these policies last year	6	procedure for ensuring appropriate timely transfer of
7	to the board is signed and kept on file at the	7	patients and records between the parties, now,
8	surgery center in each physician's credentialing	8	therefore, for mutual consideration sufficiency of
9	file.	9	which is hereby acknowledged, the parties agree as
10	The next condition is condition 3. We	10	follows, and then the document reads with
11	shall develop and implement a policy which we shall	11	explanations of how we will effectively transfer
12	post to the consumer web site certifying that each	12	patients and medical information from the Green
13	physician will accept patients without regard to	13	Mountain Surgery Center to the UMM Medical Center.
14	payer type, insurance status, or their ability to pay	14	The next condition is condition 5, the
15	for services. The physician shall further certify	15	applicant shall enter into a transfer agreement with
16	that he shall not consider the source of payment or a	16	EMS service for emergency patient transportation. We
17	patient's ability to pay when determining whether to	17	have entered into an agreement with the Colchester
18	perform patient surgery at the ASC. We have our	18	Rescue Squad. That agreement was entered into on
19	payment status non-discrimination policy listed right	19	March 7 and the copy of that agreement was also
20	here. This was also submitted in full to the board	20	submitted to the board.
21	last year, and this policy here also contains a	21	The next condition is that the applicant
22	certification page after the policy which each	22	shall enter into a participation agreement with one
23	physician signs and we keep on file in their	23	or more risk bearing ACOs to receive fixed payment
24	credentialing file at the surgery center.	24	reinbursement in lieu of fee for service payments for
25	The next condition is condition 4, the	25	patients attributed to the ACO or obtain a binding
	14		16
1	applicant shall enter into a transfer agreement with	1	memorandum of agreement from the ACO confirming that
2	at least one local hospital or obtain a binding	2	it will enter into such a participation agreement
3	memorandum of agreement from such hospital confirming	3	once the ASC becomes operational. We entered into a
4	that it will enter into a transfer agreement once the	4	Memorandum of Understanding with OneCare in March of
5	ASC becomes operational. We have completed an	5	2018 and a copy of that agreement was submitted to

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5	ASC becomes operational. We have completed an
6	emergency transfer agreement with the University of
7	Vermont Medical Center. That was also submitted to
8	the board.

9 The transfer agreement reads, whereas, 10 Green Mountain Surgery Center seeks to operate an anbuilatory surgery center and is required to have an 11 effective procedure for the immediate transfer to a 12 13 hospital of patients requiring emergency medical care 14 beyond the capabilities of the Green Mountain Surgery 15 Center; and, whereas, the hospital to which Green 16 Mountain Surgery Center transfers patients requiring 17 such emergency care must be a local Medicare 18 participating hospital or a local non-participating hospital that meets the requirements for payment for 19 20 emergency services by Medicar; e, whereas, UM is a 21 tertiary acute care hospital located in Burlington, 22 vemont and is the only hospital that is local to 23 Green Mountain Surgery Center and meets the 24 requirements for payment of emergency services by

Medicare; whereas, Green Mountain Surgery Center

once the ASC becomes operational. We entered into a Memorandum of Understanding with OneCare in March of 2018 and a copy of that agreement was submitted to the board last year. We have also submitted a letter of interest to participate in the OneCare ACO program for the next calendar year which starts January 1, 2020. A copy of that letter of interest was also

submitted to the board. I also gave an update on our conversations with OneCare which had been pretty consistent and evolving over the last few months in the letter I wrote to the board on March 26th. The next condition is condition 7, the applicant shall obtain approval to enter into an

applicant shall obtain approval to enter into an agreement with QVS to operate as a Medicare certified antuilatory surgery center, and there are two ways to obtain certification from QVS. One is to go through a state agency that QVS has annointed and given responsibility for certifying different health care facilities, and the Department in Vermont that is responsible for that is DHL. The other way to get certified by Medicare is to go through one of the national accrediting organizations that has dean

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1	status with Medicare which means Medicare will accept	1	we are on track and plan to do that and would plan to
2	their recommendation on certification. One of those	2	notify the board when our web site is launched to the
3	national bodies is the Joint Commission. We have as	3	pblic.
4	a later condition of our CON that we have to obtain	4	Number 10 — condition number 10 is the
5	Joint Commission certification. So we can accomplish	5	applicant shall not offer services, procedures, or
6	both goals by getting, before we become operational,	6	surgeries without first demonstrating to the board
7	accreditation from the Joint Commission which also	7	that such services, procedures, or surgeries are
8	brings us dean status for Medicare. So that is the	8	evidence based and fall within the scope of those
9	route that we are pursuing to meet the condition of	9	approved in the Certificate of Need. I submitted on
10	obtaining CMS approval before we open.	10	March 18 studies showing the evidence basis of
11	Condition 8 is that the applicant shall	11	procedures to be performed across our initial plan
12	establish and post to the ASC's web site the	12	specialty list. The study submitted also showed the
13	commercial self pay and Medicare prices for the 25	13	efficacy and safety of performing these procedures in
14	most frequently performed procedures and surgeries or	14	an outpatient anbuilatory surgery center environment.
15	the commercial self pay and Medicare prices that	15	The scope within the context of this
16	comprise at least 75 percent of the ASC's overall	16	condition seems to mean specifically those procedures
17	volume. The applicant shall regularly update and	17	that can be performed safely and reliably in an
18	post this information no less than quarterly whether	18	ambulatory surgery center. This way of defining the
19	or not the prices or procedures have changed. So	19	scope was articulated in the statement of decision of
20	where we have allowed for that on our web site is at	20	our CON findings of fact number 14 which says that
21	the pricing and quality measure page here. We have	21	pursuant to federal law physicians using the facility
22	the Medicare prices and payment rates listed first.	22	may only perform surgeries and procedures that are
23	we also have provided a link here in the explanation	23	not expected to cause a significant safety risk to a
24	to the Madicare procedure price look-up tool in the	24	patient when performed in an ASC and for which the
25	event that a patient is coming in for a procedure	25	standard medical practice dictates that the patient
25		25	
	18		20
1	that is not on our list of the 25 most common and	1	would not typically be expected to require active
2	have directed them they can go to that web site to	2	medical monitoring and care after midnight following
3	type in that procedure and get an estimate of the	3	procedure.
4	cost in the ASC. We do have a FDF here which lists	4	Condition 11 is that the applicant shall
5	what we anticipate will be our 25 most common	5	require that each physician that performs procedures
6	procedures and then the Green Mountain Surgery Center	6	or surgeries at the ASC have admitting privileges at
7	Medicare payment from Medicare's published outpatient	7	one or more local hospitals. This requirement is
8	ASC procedure fee schedule that they published in	8	stipulated in our medical staff bylaws in section 4
9	January of 2019.	9	where we say under 4.2, membership qualifications,
	we plan to use the same format for the	10	
TO 1		TO	that membership on the medical staff of the center
10 11	-		that membership on the medical staff of the center shall be a privilege extended only to those
10 11 12	commercial self pay standard charges. It would have	10 11 12	shall be a privilege extended only to those
11 12	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of	11 12	shall be a privilege extended only to those professionally competent practitioners within the
11 12 13	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have	11 12 13	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active
11 12 13 14	commercial self pay standard charges. It would have again the same 25 most common procedures and a FDF of similar format that would open. We do not have information on this finalized yet so this does not	11 12 13 14	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved
11 12 13 14 15	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working	11 12 13 14 15	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures
11 12 13 14 15 16	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months.	11 12 13 14 15 16	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center.
11 12 13 14 15 16 17	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand	11 12 13 14 15 16 17	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file
11 12 13 14 15 16 17 18	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we	11 12 13 14 15 16 17 18	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence
11 12 13 14 15 16 17 18 19	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member	11 12 13 14 15 16 17 18 19	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals,
11 12 13 14 15 16 17 18 19 20	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member sites on the insurance carriers to get an estimate as	11 12 13 14 15 16 17 18 19 20	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals, copy of the bylaws. The pertinent section was
11 12 13 14 15 16 17 18 19 20 21	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member sites on the insurance carriers to get an estimate as well from their insurers of what the out-of-pocket	11 12 13 14 15 16 17 18 19 20 21	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals, copy of the bylaws. The pertinent section was submitted to the board on March 18.
11 12 13 14 15 16 17 18 19 20 21 22	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member sites on the insurance carriers to get an estimate as well from their insurers of what the out-of-pocket cost will be for their procedures.	11 12 13 14 15 16 17 18 19 20 21 22	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals, copy of the bylaws. The pertinent section was submitted to the board on March 18. Condition 12 is that the applicant must
11 12 13 14 15 16 17 18 19 20 21 22 23	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member sites on the insurance carriers to get an estimate as well from their insurers of what the out-of-pocket cost will be for their procedures. Condition 9 is that we shall make the	11 12 13 14 15 16 17 18 19 20 21 22 23	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals, copy of the bylaws. The pertinent section was submitted to the board on March 18. Condition 12 is that the applicant must successfully negotiate with Blue Cross/Blue Shield of
11 12 13 14 15 16 17 18 19 20 21 22	commercial self pay standard charges. It would have again the same 25 most common procedures and a PDF of similar format that would open. We do not have information on this finalized yet so this does not have prices in it yet, but that's what we are working towards over the next couple of months. We also have provided on the left-hand side links to the insurance carrier web sites that we contract with so that patients can use the member sites on the insurance carriers to get an estimate as well from their insurers of what the out-of-pocket cost will be for their procedures.	11 12 13 14 15 16 17 18 19 20 21 22	shall be a privilege extended only to those professionally competent practitioners within the center's primary service area who maintain active privileges at a local hospital with credit approved by the governing board if they perform procedures surgeries at the center. We also have in the credentialing file for each physician at the center a copy of evidence of their admitting privileges at local hospitals, copy of the bylaws. The pertinent section was submitted to the board on March 18. Condition 12 is that the applicant must

22         23         24         25         24         25         26           2         applicant shall negatizer reintursements that it can dimension setting applicant shall negatizer reintursements that it can dimension setting and angresie when performed in a heapting as we submitted on Nerth 26. We are planning, as we submitted on Nerth 26. We are planning and 20. We are planning as well as the submit show that there of the submit show that the submit show the				
2       applicant shall reprise the interments for the same       2       They are also offered to bac that information sent to the enther via post null in writing or via to the enther via post null in writing or via to the enther via post null in writing or via to the enther via post null in writing or via the sector on the or discounted on the there will be enther via post null in writing or via the sector of the or discounted on the there will be enther via post null in writing or via the sector of the or discounted on the there will be enther via post null in writing or via the sector of the or discounted on the there will be enther via post null in writing or via the sector of the or policies. Or after or local care of the or discourte on the or well be policies or or the sector problem to patients on the sector of the sector policies. Or after or burs care policy to write in the instruction of the physician of the the process for are will be process for are wi	_	21		23
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18       Condition 13 is that the price of a procedure or surgery that is billed to patients that self pay may not exceed the lowest price billed to patients covered by commercial insurance. This is covered under our self pay policy, policy runters 3.14, which 23       18       MS. COOFR: Therk you. Condition 17 is that the applicant shall begin the process for correct and by the Joint Commission, and Tike I         24       policy states that a patient can be considered self pay if they are having a medically necessary       20       correctification and plan to earn accreditation from the Joint Commission before we become operational.         25       procedure and maintain no health benefits to the best of the center's knowledge. Health benefits corn to be a verified if a patient maintains health benefits corn to a the board on March 18.       24         1       procedure and maintain no health benefits corn to a the board on March 18.       24         3       verified if a patient maintains health benefits corn to a the board on March 18.       24         4       an insurer with which the facility is not contracted.       3       require that physicians sign a collaborative care agreement. We have that agreement, shmitted it to the board on March 18.         5       The following discount policy applies and that first 6       18       address the one other element that we were plarning to address at the hearing is our request to modify 8         10       commercial insurance for the same procedures.       19       that.         11       R. MBBR: Miss Cooper, I'm a little 6	17	-	17	
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25 explanation to them is given to what their 25 So the information with this condition	12 13 14 15 16 17 18 19 20 21 22 23	cognizant of time here. If it's a policy you're going over, and I don't mean to break your — but if it's a policy, the board has it and has read it and I don't think you need to summarize it. MS. COOPER: Okay. Thank you. The next three conditions relate to policies so I was going to ask John to give a brief overview of what those policies are without reading them please, John. MR. PAONI: So the first one is the benefits verification policy and as part of our work flow that we would verify insurance benefits for all patients coming to the surgery center. Every patient	12 13 14 15 16 17 18 19 20 21 22 23	surgery center to submit on a quarterly basis information to the board and also publicly post it on its web site concerning each provider's productivity and payer mix. Specifically they are asked to submit for each individual provider a breakdown of the procedures and surgeries that person performed at the surgery center, a breakdown of the procedures and surgeries that person performed by payer mix at the surgery center, a breakdown of the procedures and surgeries that person performed at local hospitals by payer mix, and finally the number of patients that provider found inappropriate for care at the surgery center and the reason for that determination in each
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	25		27
1	and the reason that we've asked to modify it is that	1	percent of patients needing cataract surgeries access
2	the providers consider all of the information that's	2	surgeries within four weeks.
3	requested private information. It's information that	3	we also submitted, and which I have
4	they keep confidential, that they consider sensitive	4	here, information about the cost savings of
5	and competitively sensitive. So, for example, it's	5	ophthalmology services. The information we included
6	not information that would typically be available to	6	comes from Medicare's procedure price look up and I'm
7	a prospective employer of a physician unless the	7	just going to see how I can enlarge this view. Maybe
8	employer asked for it specifically and the provider	8	it's big enough. I'm not sure. In any case the tool
9	chose to disclose it. So, you know, for these	9	shows on the left if you were to type in at the top a
10	reasons as we've explained in the letter that we	10	procedure code — thank you — the procedure code
11	submitted in early January we believe this	11	here is 68700, plastic repair of tear, Medicare will
12	information qualifies for — to be withheld from	12	provide you with the rate paid on average nationally
13	public inspection under the Public Records Act, and	13	to an arbulatory surgical center and the rate paid on
14	we've cited the appropriate provisions which would be	14	nationally — on average to hospital outpatient
15	Section 317 C7 and C9.	15	departments. This tool is also very useful and
16	So what the surgery center is asking for	16	consumer patient friendly in that it shows on the
17	instead is to disclose all of the information that	17	blue bars what the patient responsibility is per
18	the board has requested but to disclose it on an	18	Medicare plan design, and the total cost there is on
19	aggregated basis by speciality rather than, you know,	19	the bottom. The average total cost of this procedure
20	by individual provider. The board, of course, is	20	in an ASC is 805 dollars. The average total cost in
20	charged with regulatory oversight of the surgery	20	a hospital is 1812 dollars.
21		22	•
22	center as an entity and not with the conduct of each	22	And this is another ophthalmology procedure. All procedures included in this
23	individual physician. So we believe that providing	23	
24	the information on the aggregated basis as we've	24	presentation are for ophthalmology. I won't go
25	requested will serve the purpose of the condition,	25	through every one. I think we included about 15
	26		
	20		28
1	give the board the information that it needs to	1	28 ophthalmology procedures that we would plan to do.
1 2		1 2	
	give the board the information that it needs to		ophthalmology procedures that we would plan to do.
2	give the board the information that it needs to oversee operations of the surgery center while not	2	ophthalmology procedures that we would plan to do. Every one, of course, has a much lower total cost and
2 3	give the board the information that it needs to oversee operations of the surgery center while not requiring the disclosure of again, you know, personal private, confidential, and competitively sensitive	2 3	ophthalmology procedures that we would plan to do. Every one, of course, has a much lower total cost and patient responsibility in the ambulatory surgery
2 3 4	give the board the information that it needs to oversee operations of the surgery center while not requiring the disclosure of again, you know, personal private, confidential, and competitively sensitive information on the public web site on the part of	2 3 4	ophthalmology procedures that we would plan to do. Every one, of course, has a much lower total cost and patient responsibility in the ambulatory surgery center versus the hospital outpatient department. Okay, and at this point I would turn it
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	1	center in Vermont. At the time we explained that	1	practice and our patients.
	2	retinal surgeries are routinely performed in both	2	UMMC is not fully meeting the needs of
	3	single specialty and multi-specialty ambulatory	3	my practice at this time. UMMC recently announced a
	4	surgical centers throughout the country and that we	4	problematic policy change with respect to how
	5	would like to offer our patients the convenience and	5	operating room time is scheduled. We were informed
	6	affordability of having their procedures performed in	6	recently that starting on April 29 of this year, this
	7	a small outpatient surgical setting rather than	7	month, most surgeons, vitreoretinal services
	8	exclusively at the academic medical center. While	8	included, will be required to release to other
	9	conversations were cordial and exploratory we were	9	surgeons operating room block time that is not fully
	10	ultimately told that staffing constraints and	10	scheduled with cases seven days in advance of the
	11	scheduling complications would prohibit us from	11	proposed date of surgery. This new hospital-wide
	12	bringing our services to the existing anbulatory	12	rude does not work for Retina Center of Vennont and
	13	surgical center.	13	its patients as many vitreoretinal surgeries are
	14	Discouraged but still determined we then	14	urgently needed ones that cannot be schedulled more
	15	approached smaller regional hospitals and began to	15	than a week in advance. Last year approximately 50
	16	explore with them the possibility of treating our	16	percent of our procedures were scheduled fewer than
	17	patients there instead. These conversations	17	seven days in advance.
	18	conducted over the phone, via e-mail, and sometimes	18	While I will be able to schedule
	19	in person ultimately did not bear fruit either as the	19	separate operating room time outside of my normal
	20	hospitals shied away from further conversations after	20	block time for urgent and emergent procedures under
	21	citing a need to spend more time investigating how	21	the new policy, that would come at great expense to
	22	hosting retinal surgeries would fit in with	22	my other patients who have appointments for office
	23	participation in new payment models.	23	based care whose appointments I would then have to
	24	Then in 2017 we went back to the only	24	cancel and reschedule in order to go to the hospital
	25	existing anbuilatory surgical center in the state and	25	to meet UMMC's scheduiling demands for my operating
[				
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	1	reengaged that group in conversations, however, once	1	room bound surgical patients. I see office based
	2	again it was decided that offering retinal services	2	patients during all times outside of my operating
	3	would not be possible due to reasons related to	3	room block time every work week, and very many of
	4	reporting scheduling — reported scheduling conflicts	4	those patients' needs are no less pressing nor vision
	5	and lack of general anesthesia capabilities. We also	5	threatening than are those of the operating room
	6	began conversations with the Green Mountain Surgery	6	bound patients. One can permanently lose vision just
	7	Center about the possibility of bringing our cases	7	as quickly from age related macular degeneration that

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Center about the possibility of bringing our cases 1 8 there in 2015, but not early enough in the process to 9 be counted as part of the original set of projections 10 they prepared for the project which was submitted in 10 July of that year. No promises were made at that 11 11 12 time when we began conversations with the Green 12 13 Mountain Surgery Center as they still had to 13 determine whether they would get a Certificate of 14 14 15 Need and what sort of restrictions might accompany 15 16 16 it. 17 They also had to understand - excuse me 17 18 - whether costs for the retinal equipment would fit 18 into their budget. We also continued pursuing other 19 19 potential options to bring patients to the existing 20 20 21 antulatory surgical center or a smaller hospital 21 22 through to the end of 2017. Now four years after we 22 23 began searching for a more suitable option for our 23 24 patients we finally have the opportunity to operate 24 25 in a setting that will better meet the needs of our 25

as quickly from age related macular degeneration that needs office based care, for example, medication injection into the eye, as from a retinal detachment that needs operating room based surgery. I care for far, far more urgently in need office based patients than I do urgently in need operating room based patients every single week.

UMMC has thrown many OR scheduling barriers such as this one in front of us over the years. That is a major reason why we've been searching so urgently for a different option for our patients. Most of the UMMC OR policy changes we have simply swallowed as protest is rarely successful and we have managed to adjust. This one, which has been repeatedly threatened and which I have every reason to believe will continue to be repeatedly threatened even if it is put aside in 2019 which we have been told will not happen, is a hazardous step too far and is completely out of step with the

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1	reality of how retina practices across — access	1	afforded to those vermonters who might benefit from
2	operating rooms across the country. The one size	2	it. In addition, it makes no patient care related
3	fits all approach adopted by UMMC, doviously a large	3	sense whatsoever to prohibit cataract extractions by
4	institution with many stakeholders to manage at the	4	vitreoretinal surgeons in instances wherein the need
5	same time, does not meet the needs of my patients and	5	for those extractions only becomes evident right in
6	my practice. This is why I'm interested in	6	the middle of a vitreoretinal surgical procedure
7	performing vitreoretinal surgeries in the Green	7	and/or in instances where in simultaneous interocular
8	Mountain Surgery Center. It is commonplace for	8	lens prosthesis placement by second lens dedicated
9	vitreoretinal procedures to be performed in	9	surgeons is not needed and/or is contraindicated
10	anbuilatory surgery centers in other parts of the	10	medically.
11	country for reasons of cost savings, quality,	11	In conclusion, one size fits all does
12	efficiency, and patient preference for the ASC	12	not work for vitreoretinal surgical services for an
13	environment.	13	entire state. Vermont patients deserve options and
14	Based on discussions I have had with	14	cost competition. Having gone to great lengths to
15	Green Mountain Surgery Center management over the	15	explore all of the possible options, I have no doubt
16	past few months I expect that the Green Mountain	16	that the Green Mountain Surgery Center is the best
17	Surgery Center will be much better able to	17	suited to meet my patients and my practice's needs.
18	accommodate my scheduling needs than UVMMC, and I	18	Thank you.
19	understand that Green Mountain Surgery Center will be	19	DR. YOUNG: My name is Michelle Young
20	able to provide all equipment and staffing that I	20	and I am a vitreoretinal surgeon. I've been
21	need to care for nearly all of my operating room	21	practicing ophthalmology in Vermont since 2004 first
22	bound patients. Green Mountain Surgery Center's	22	at the UMM Medical Center and at Retina Center of
23	small size will enable mimbleness that will be a huge	23	Vermont since 2009. I perform surgeries at the UVM
24	improvement over Retina Center of Vermont's current	24	Medical Center which is currently the only facility
25	experience.	25	in Vermont with the necessary equipment and staff
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1	I've been asked to address as part of	1	trained to handle vitreoretinal surgeries.
2	this testimony whether it would be feasible for the	2	Like my partner Dr. Weissgold I am
3	Green Mountain Surgery Center to offer vitreoretinal	3	concerned about UMMC's recent policy change
4	but not cataract surgeries. It would not make sense	4	regarding CR block schedulting which requires surgeons
5	from a care centric standpoint to authorize the Green	5	to release unscheduled block time seven days in
6	Mountain Surgery Center to offer only some of the	6	advance. Most vitreoretinal surgeries need to be
7	surgical eye services that are appropriately	7	scheduled within one to seven days, and as a result
8	performed in an ambuilatory surgical center. Some	8	I'm now being offered OR time for emergent and urgent
9	patients needing vitreoretinal surgeries also need	9	procedures during weekdays when I have fully blocked
10	cataract surgeries. It is not rare for a patient	10	clinics and after I have released my block time which
11	undergoing vitreoretinal surgical repair of a complex	11	means I'll be forced into a situation that will
12	retinal detachment, for example, to also need a	12	necessitate rescheduling my clinic patients some with
13	cataract removed to enable the highest quality,	13	potential blinding diseases and whose care is just as
14	safest vitreoretinal repair. Sometimes the needs for	14	urgent as the patient needing surgery in the
15	those patients' cataract extractions is known in	15	operating room.
16	advance. For a variety of reasons it has been nearly	16	I would like to have the option to
17	impossible to schedule cataract surgeons to perform	17	perform vitreoretinal surgeries in the Green Mountain
18	those cataract extractions simultaneous with	18	Surgery Center. In states where ASCs are present
19	vitreoretinal surgical repairs at UMMC.	19	vitreoretinal procedures are often performed there at
20	I understand Green Mountain Surgery	20	lover cost for the patient. ASCs can provide
21	Center has already planned to meet this need with	21	equivalent or higher quality and greater efficiency
22	same session same day planned cataract extractions by	22	than regional medical centers. I expect that the
23	cataract surgeons and vitreoretinal procedures by	23	Green Mountain Surgery Center will provide a high
24	vitreoretinal surgeons. This offering is near	24	quality facility that meets my scheduling needs which
25	universal in all other states but has yet to be	25	is ultimately for the well being of my patients.

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1	I have been asked to consider whether it	1	than the recommended time to have the surgery.
2	would be possible for me to perform vitreoretinal	2	In order to continue to serve my
3	procedures at the Green Mountain Surgery Center but	3	patients I have supplemented the lack of surgery days
4	perform no cataract surgery at the same center. My	4	at UMMC by obtaining operating privileges at other
5	answer is this is just not possible. I do not	5	smaller regional hospitals in St. Albans and
6	perform routine cataract surgery, but I do perform	6	Middlebury. Although this is a benefit for patients
7	cataract surgeries in conjunction with complicated	7	needing plastic surgery in Franklin or Addison
8	vitreoretinal procedures as I need to. I also	8	County, most of my patients live in Chittenden County
9	perform cataract surgery in patients in whom previous	9	and they have additional driving time in order to
10	cataract surgeries have become complicated by loss of	10	have their surgery because of this. This is
11	lens material into the posterior segment. During any	11	unfortunate that this means more time off work for
12	vitreoretinal surgery it's possible that I will need	12	their families and caregivers.
13	to perform cataract surgery as part of the procedure	13	The high cost of surgery at the academic
14	and it's not always possible to know in advance	14	medical center in Burlington is also a barrier to
15	whether or not a patient will need a lens procedure	15	care for me and my patients. One of my patients
16	done in addition to their scheduled vitreoretinal	16	desired to have surgery that was not covered by his
17	surgery.	17	insurance and was quoted an almost — almost \$20,000
18	I've tried for years along with Dr.	18	institutional or hospital fee for his surgery at
19	Weissgold to find an operating environment that will	19	UMMC. This surgery is the same day outpatient
20	better meet the needs of my practice and my patients.	20	surgery that takes less than a few hours. If that
21	There is no question in my mind that having access to	21	were his only option, the patient would need to
22	an ASC environment at the Green Mountain Surgery	22	forego having the surgery altogether. However, thank
23	Center will improve the efficiency and effectiveness	23	goochess for him he is now schedulled to have his
24	of both my clinical and my surgical practices for the	24	surgery at the Green Mountain Surgery Center for an
25	benefit of my patients. Thank you.	25	institutional fee less than a tenth of that figure
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1	DR. LAUB: Thank you for the opportunity	1	quoted by UMMC.
2	to make some comments here today. My name is Donald	2	In conclusion, I would like to say, I
3	Laub. I've been a practicing plastic surgeon in	3	can't emphasize this enough, there's a great benefit
4	Vermont since I was hired by the old Fletcher Allen	4	for the people of Vermont that they now have the
5	in August of 1997. I'm currently in private practice	5	option for timely and affordable surgical care in the
6	at Four Seasons Dermatology in Colchester. Since I	6	form of the anbuilatory surgery center like the Green
7	started with Fletcher Allen in 1997 I have had a busy	7	Mountain Surgery Center. Thank you.
8	reconstructive surgery practice including working	8	MR. BARBER: Thank you. Is that the

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MR. BARBER: Thank you. Is that the conclusion of your presentation?

MS. TMLER: So that concludes the presentation. Perhaps it would make sense for the witnesses who are already seated to take any questions from the board and then to bring Ms. Cooper and Mr. Paoni back.

MR. BARBER: Yeah that makes sense. Okay. So I guess we'll open it up to the board members for questions for these witnesses.

MS. LUNCE: Shall I go first? MR. BARBER: Sure.

MS. LUNCE: Thank you for coming. I know you all have very busy schedules and we appreciate you taking the time to come speak with us today about this application CON. So I just want to confirm for the two of you who do the aphthalmology surgery that you initially approached the applicant

8 reconstructive surgery practice including working 9 with the orthopedic department at UMMC and serving 10 as the medical director of the craniofacial center 10 11 providing a wide variety of other necessary medical 11 12 treatment for Vermont residents. 12 13 I separated from UMMC in October of 13 2017 after 20 years there. At that time I thought 14 14 15 about leaving the state entirely, but decided to stay 15 16 partly because of the possibility of operating at the 16 17 Green Mountain Surgery Center. When I worked at 17 18 UMMC I operated five days a month consistently. 18 After I separated from UMMC I was given less than 19 19 20 one full day of scheduled operating room time per 20 21 month after over five months of neoptiation. 21 22 Needless to say the severely reduced operating room 22

- 23 time has led to many of my patients to have delays of 24 months before having surgery. For example, one baby
- 25 with a cleft palate had to wait three months later

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1	in 2015?	1	CHAIR MULLIN: Just an expansion on
2	DR. WEISSCOLD: Yes.	2	Robin's question. Can you go into more detail on why
3	MG. LLINGE: You have to verbalize it for	3	you weren't successful in the 2015 discussion and
4	our court reporter.	4	when you ultimately came back to that discussion?
5	DR. WEISSCOLD: SOTTY.	5	DR. WEISSCOLD: Which discussion are you
6	MG. LUNCE: Thank you, and currently are	6	referring to?
7	either of you obing stand alone cataract surgeries?	7	CHAIR MULLIN: The discussion with the
8	DR. WEISSCOLD: No.	8	ambulatory surgical center to be able to conduct your
9	DR. YOUNG: Well except in the context	9	operations there.
10	— no except when it's a lens that's in the posterior	10	DR. WEISSCOLD: The then existing one?
11	segment. So we may be — it depends how you define	11	CHAIR MULLIN: NO.
12	stand alone cataract surgery, but yes there are times	12	DR. WEISSGOLD: The Green Mountain
13	the only reason we're going to the operating room is	13	Surgery Center — oh we were not successful. It was
14	to remove lens material from the eye, but when it's	14	just very preliminary discussions and we were still
15	caught up in the back of the eye we also must perform	15	in discussion with other entities about whether we
16	a vitrectory.	16	could go there.
17	MS. LLNGE: Got it. Thank you.	17	CHAIR MULLIN: So it was one long
18	DR. WEISSCOLD: When I do that surgery I	18	continuing discussion?
19	will sometimes also put in a lens implant.	19	DR. WEISSGOLD: No. I would say it was
20	MS. LUNGE: Great. Thank you for	20	punctuated every several months or so.
21	explaining that. As you know we're not clinicians	21	CHAIR MULLIN: Okay. Thank you.
22	here so it's helpful to have the layperson	22	MR. BARBER: While these three witnesses
23	explanation, and in terms of plastic surgery my	23	are up Eric Shouldice, Julia Shaw, do you have
24	questions there were could you give us a sense of the	24	questions for these witnesses?
25	percentage perhaps, or you can tell me what the best	25	MS. SHAW: I don't believe we have any
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			••
1	way to explain it is, but the percentage of your	1	questions for these witnesses. Thank you.
1 2	way to explain it is, but the percentage of your practice that's medically necessary procedures versus	1 2	
			questions for these witnesses. Thank you.
2	practice that's medically necessary procedures versus	2	questions for these witnesses. Thank you. MR. BARBER: I think so, Ms. Cooper and
2 3	practice that's medically necessary procedures versus what I would call cosmetic? There might be a better	2 3	questions for these witnesses. Thank you. MR. BARBER: I think so, Ms. Cooper and Mr. Paoni, if you could go back up on the stand, I
2 3 4	practice that's medically necessary procedures versus what I would call cosmetic? There might be a better word for it than that.	2 3 4	questions for these witnesses. Thank you. MR. BARBER: I think so, Ms. Cooper and Mr. Paoni, if you could go back up on the stand, I think the board does have questions for you guys.
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	45		47
1	equivalent reinbursement paid to hospitals for	1	making sure that stays true, and you said the answer
2	providing the same services. Can you tell me how	2	to that is yes.
3	that actually satisfies the condition 12?	3	So there's a difference between ensuring
4	MS. COOPER: Sure. I think I tried to	4	that your prices are below the average and ensuring
5	also in my letter explain that connercial payments,	5	that your prices are below the minimum. Let me just
6	facility payments to hospitals for outpatient	6	finnish, and so — and in particular if you look at
7	surgeries vary arrong different hospitals. There is	7	the average reimbursement, if the average were the
8	no uniform community fee schedule for facility	8	same as the median, then 50 percent of the hospitals
9	payments to hospitals for outpatient surgery in the	9	would be cheaper than the ambulatory surgical center
10	connercial market like there is in the Medicare	10	if you're pitching at the average, and so $-$ and
11	market. That makes it impossible for us as the Green	11	frankly the average is going to be higher than the
12	Mountain Surgery Center to know what the hospital	12	median because you're going to have an outlier with
13	outpatient payment is from a different — from a	13	the academic medical center pulling up the average.
14	connercial insurer for a particular surgery.	14	So the median is actually going to be lower than the
15	I submitted a list of our initial	15	average here.
16	planned procedures by CPT code which had between	16	So my concern is that in your testimony
17	three or four hundred codes on it. I don't know what	17	when you first put forth the idea of a low cost
18	hospitals receive from commercial insurers in	18	alternative to Vennonters in the ambulatory surgical
19	equivalent facility payments for those three hundred	19	center, you know, you advocated this was going to be
20	codes. It's very hard information to get. I don't	20	a lover cost than all hospitals, in fact there were
21	think it's even possible to get. So I need to	21	numbers out there that the prices would be 50 percent
22	negotiate with commercial insurers and say here's	22	less, there was lots of testimony that the prices
23	what I think my costs are for providing this, here's	23	would be about 50 percent less, the rates would be 50
24	what I would like in reimbursement, and they need to	24	percent less than hospitals, and even in your
25	come back to me and say we think that one is too	25	response to some of the board's questions January of
	46		48
1	high, this one is fine, okay, and that's how we'll	1	2019, so just this past January you confirmed, this
2	have an agreement.	2	is a quote, 'We confirm that surgeries and procedures
3	I did attempt to ask Blue Cross Blue	3	offered at the Green Mountain Surgery Center will be
4	Shield for information about their payments to	4	offered at lover cost than the same surgeries and
5	hospitals for the equivalent outpatient surgeries and	5	procedures in hospital outpatient settings, including
6	they declined to provide me with any of that	6	surgeries and procedures offered in specialties of
7	information. So the only way that I can think to	7	plastic surgery and ophthalmology." So that's
8	achieve this, meeting this condition while also	8	suggesting it's lover than the minimum. It's cheaper
9	dealing with the realities of the commercial	9	than the hospitals. It's not cheaper than the
10	insurance contracting market in the state, is to	10	average.
11	agree to prices for payment with the commercial	11	MS. COOPER: So understanding again that
12	insurers and then have them attest to me, because	12	the payments paid by commercial insurers to hospital
13	they won't share their payment rates to hospitals	13	cutpatient departments for individual procedures are
14	what they are, that what they are paying us is lower	14	extremely varied and different from each other on the
15	than what they are paying hospitals.	15	order of thousands of dollars sometimes, had the
16	MS. HOLMES: Okay, but let me clarify.	16	question been asked would you state as a policy that
17	There's a difference between lower than what they are	17	you will be lower than the minimum price paid to any
18	paying hospitals and lower than the average	18	hospital, I may not have answered in the affirmative.
19	reinbursement. So let me remind you of $-I$ asked	19	The question was asked will you be lower than the
20	you at the first hearing the testimony — I asked you	20	hospitals undefined whether that's the minimum price,
21	a question would you be willing to guarantee as a	21	the median price, or the average price, and I said
22	center policy to ensure that your prices will always	22	yes I can confirm I'll be lower than the hospitals,
23	be lower than hospitals and put that policy on your	23	and then I'm defining that now more specifically as
24	web site and in your negotiations with commercial	24	the average of the hospital prices. It was never
25	payers effectively state that that's your policy and	25	specifically defined prior to that.
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1	There also is no doubt that the	1	reinbursed prices for the anbulatory surgical center
2	hospitals see us as a major threat and are — have	2	are always lower than the other hospital prices in
3	been opposed to our opening this whole time, and	3	the state?
4	could, because we offer a very limited set of	4	MS. COOPER: So what I have done in
5	procedures, artificially lover their prices on	5	terms of looking at price comparisons we often quote
6	certain procedures that we offer and then we would	6	Medicare and Medicare prices to payment rates to
7	have to match that minimum price had we agreed to	7	anbulatory surgery centers are 44 percent lower than
8	contract at lover than the minimum hospital price,	8	payment rates to hospitals on average, but if you
9	and that would be a threat to the existence of our	9	look at a whole list of 350 CPT codes and you compare
10	business if our conpetitors, because they offer a	10	an ambulatory surgery center rate to a hospital rate,
11	much wider array of services that they get other	11	there are some payments in there where the hospital
12	reinbursements for and wouldn't threaten our	12	gets paid hundreds of dollars for a code that an
13	business, to have artificially lowered their prices	13	antuilatory surgery center gets paid \$20 for, and so
14	on certain procedures that we do, that is a scenario	14	that level of variation exists and may exist for all
15	that I could quickly see playing itself out had we	15	I know in the commercial market. There may be a
16	agreed to have prices that are only always below the	16	hospital for all I know, where anyone knows, that is
17	minimum price of any hospital.	17	taking some ridiculously low payment on a procedure
18	MS. HOLMES: Well I just want to remind	18	that we would do and that I could not accept and
19	you, you said the answer to the question was yes your	19	still have a business. So I can't make a promise
20	prices will always be lover than hospitals. That was	20	that in the commercial market without knowing what
21	the question I asked you and you've answered yes, and	21	all the prices are that we would be below any minimum
22	so I'm just going to remind you of that. So it is	22	price that an insurer — a connercial insurer
23	possible in your current negotiations that there	23	contracted for with a hospital.
24	could be hospitals that will be cheaper than your	24	MS. HOLMES: Another condition that we
25	center for some of these procedures?	25	had is that the ASC implement a policy that requires
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	50		<u> </u>
1	50 MS. CCOPER: I suppose there could be.	1	<u> </u>
1 2			52 all providers to accept all patients regardless of
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	MS. COOPER: I suppose there could be. Our hospital in our primary service area is the academic medical center. So when we consider what our charges will be we look at our own cost, and if we have any knowledge of what the local hospital in our primary service area is, we certainly ensure that our standard charges will be below that and in a lot of cases half of the price that we know of at the local hospital in our primary service area if we know what that charge is. There was at the beginning of 2019 a rule passed by Medicare that hospitals have to list charges on their web site for patients to see. The hospitals here in Vermont do have price lists posted on their web site, but there are holes all over it in terms of different OPT codes have no prices next to them or are not on the list. Some codes are on the list and have prices. So where we can find data on what the local hospital price is we are ensuring that our standard charges that we are planning to offer	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	52 all providers to accept all patients regardless of ability to pay. They must base their determination of venue on factors other than type or a reimbursement. So a question I have for you is how will you enforce such a policy? What data will you be using to ensure all patients are served and there isn't cream skimming going on, and what consequences would exist if there was evidence of that within the providers in your group? How are you going to enforce this policy? I see you have it on your web site. How are you going to enforce it? How are you going to check that is not happening? MS. COOPER: So we have — we are going to be compiling our payer mix data quarterly, also to post to our web site. So we will be reviewing all of the cases that come to the center and which — whether they were covered by Medicare or commercial or other insurance, and that way we will have insight into certain physicians if they are bringing us only commercial cases or only self pay cases. We also have a peer review policy where surgeons review other
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	MS. COOPER: I suppose there could be. Our hospital in our primary service area is the academic medical center. So when we consider what our charges will be we look at our own cost, and if we have any knowledge of what the local hospital in our primary service area is, we certainly ensure that our standard charges will be below that and in a lot of cases half of the price that we know of at the local hospital in our primary service area if we know what that charge is. There was at the beginning of 2019 a rule passed by Medicare that hospitals have to list charges on their web site for patients to see. The hospitals here in Vemont do have price lists posted on their web site, but there are holes all over it in terms of different OPT codes have no prices next to them or are not on the list. Some codes are on the list and have prices. So where we can find data on what the local hospital price is we are ensuring that our standard charges that we are planning to offer are well below that and in a lot of cases 50 percent	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	52 all providers to accept all patients regardless of ability to pay. They must base their determination of venue on factors other than type or a reimbursement. So a question I have for you is how will you enforce such a policy? What data will you be using to ensure all patients are served and there isn't cream skimming going on, and what consequences would exist if there was evidence of that within the providers in your group? How are you going to enforce this policy? I see you have it on your web site. How are you going to enforce it? How are you going to check that is not happening? MS. COOPER: So we have — we are going to be compiling our payer mix data quarterly, also to post to our web site. So we will be reviewing all of the cases that come to the center and which — whether they were covered by Medicare or commercial or other insurance, and that way we will have insight into certain physicians if they are bringing us only commercial cases or only self pay cases. We also

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urwilling to ask the connercial insurers to attest to

a letter saying that your prices - the negotiated

review policy that that also include reviewing case

mix and payer mix from other surgeons so that could

1       be included.       1       procedure eactly mean, and according to Tike Mris         2       MS. HUMES: So that whole process if       Highins the definition of elective surgary is not         3       somedow was only bringing in say connercial, there       Highins the definition of elective surgary is not         4       would be sme action that would be taken, say hey ou       Signal canter is doing.         5       got to relatione your payer mix here at the       Signal canter is doing.         7       MS. CODER: Yes.       Signal canter is doing.         8       MS. HUMES: Gay, and also similar to       Signal canter is doing.         9       that you have — we have confittored aproval on the approval on the procedures that the pay mix here at the casts marking policy.       No         10       addition of fared decision making policy.       No         11       how lift you effore that policy.       No         12       patients with all the infomation they need and they are ranging patients in that decision making policy.       No         13       are regging patients in that decision making policy.       No         14       do to more that policy.       No         15       MS. CODER: So you have on that policy.       No         16       depth doct how we're going to enfore that policy.       No         17
2MS. HDMES: So that whole process if sondody use only bringing in say connercial, there a wold be sone action that wold be taken, say hey you got to relatince your paper mix here at the atuilatory surgical center?1Hubbles that wold be taken, say hey you got to relatince your paper mix here at the atuilatory surgical center?2Hubbles that wold be taken, say hey you got to relatince your paper mix here at the atuilatory surgical center?2Hubbles that wold at the atuilatory surgical center is doing.7MS. COPR: MS.MS. HOMES: day, and also similar to adoption of shared decision making policy. So again a doption of shared decision making policy. So again are engaging patients in that decision making? Hub d you enforce that policy?7MS. COPR: So I mark they need at they are engaging patients in that decision making? Hub Hub do you enforce that policy here's what it to you that but all to all the physicians at all hospitals and surgery centers. We — this is the normal part of on we taik with our patients to that. Thate ort complated needing an audit review process on that policy.1Hubble here they to you have the alternation advector the free and decides that they were thore they here's what it says unhase to do, the response to they and any of now etaik with our patients to they atter satisfaction - you says that they alter advect and surgery centers. We — this to they and they you here's what it to an other ways whick, the office, the find duct straingly to that they alter advect advect advect and advect we have advect advect and advect ad
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4would be some action that would be taken, say hey you got to relatince your payer mix hare at the athotory surgical center?4probably most of the procedures that the arbilatory surgical center is dring.5and black you payer mix hare at the athotic your payer mix hare at the that you have — we have contributed approal on the athotic of abrend decision making policy. So again the will you enforce that providers are providing pay patients in that decision making? How do you enforce that policy?6So 10 yeas 1 waret due were the patient that you have — we have conditioned approal on the are orgging patients in that decision making? How do you enforce that policy?8MS. GODER: So Wat we meant by the that you have — we have conditioned approal to you enforce that policy?11how will you enforce that policy?11MS. GODER: So Wat we meant by the decides that they went to pay for. We cartainly would anticipate that the great majority of all procedures at the carter would one under the free and discounted care policy.12max spectra for any taken to do, the response that in an informal correr procedure with harpen at at all hospitals and surgery centers. We — this is the normal part of our practice given that need bad1from all the surgens who I sat with and discussed that.1424at all hospitals and surgery one size strift do patient satisfaction surveys. That might be a arother way, whick, to find out attally if they services. So I'm acrise what is soluded from tard?24the policy with, I have not companiate needing an audit review proces on that policy.36att review proces on that policy.37moreal pay policy, which is 
5       got to rebalance your payer mix hare at the antibilatory surgical center?       5       surgical center is dring.         6       antibilatory surgical center?       6       So I guess I wanted some Clarification         7       MS. CODFR: Yes.       7       on what you meant, and I'm sure that wen't what you meant by the charity care policy rut incluing elective or committic         9       that you have — we have conditioned approval on the payer payer mix have and they want to have and decides that they want the mark and insome they match and insome they concelle that wanter and insome they concelle that wanter and insome they concelle that wanter and insome they wanter and insome they concelle that wantere and they wanter and inso
6       antulatory surgical center?       6       So I guess I wanted some clarification         7       MS. GOPR: Yes.       7       or with you meant, and I'm sure that wean't what you meant by the durity         9       that you have — we have conditioned approval on the adoption of shared decision making policy. So again       7       or with you meant by the durity on meant by the durity or are policy not including elective or cosmetic.         10       arbit and that durits are provided approval on the durity are engaging patients in that ducision making? How du you enforce that policy?       8       So I guess I wanted some clarification or write you meant by the durity or aneant by the durity or are policy not including elective or cosmetic.         11       how will you enforce that policy?       How will you enforce that policy?       10         12       patients with all the information they need and they are engaging to enforce that policy.       11       No. GOPR: So I haven't thought in the dusision making policy here's what it as you have to do, the resporse is pothably directly from UMM or patients about shared decision making policy here's what it as a you have to do, the resporse is about shared decision making policy here's what it is an informed corsent procedures, we do this in the effice, we is a three and iscoursed it would are induced that.         10       that I have gattern for our practice given that needback       No. GOPR: we have not defined it it.         22       that I have gattern statisfaction surveys. The might be in durity the addiscused it we that would be commend and they were
7       Ms. COPR: Yes.       7       or what you meart, and I'm sure that wen't what you         8       Ms. HDMES: Glay, and also similar to       8         10       adaption of shared decision making policy. So again       8         11       how will you enforce that provides are providing       11         12       patients with all the information twey need and they need an
8       NS. HUMES: Gay, and also similar to 9       8       meant, but what is it that you meant by the derify care policy not including elective or connetic procedure?         9       that you have — we have conditioned approval on the patients with all the information they need and they are ergoging patients in that decision meking? How do you enforce that policy?       NS. COPER: So what we meant by that we again cometic procedures that the patient decides that they want to have and decides that they want to pay for. We certainly would articipate that do you enforce that policy?         11       NS. COPER: So y have no decides that they want to pay for. We certainly would articipate that decides that they want to have and decides that they want to pay for. We certainly would articipate that decides that they want to pay for. We certainly would articipate that use again cometic yor all procedures at the center would come under the free and discounted care policy. The believe actually that largage is probably directly want to pay for. We certainly would articipate that use again cometic yould articipate that the great majority of all procedures at the center would come under the free and discounted care policy. The believe actually that largage is probably directly the that we procedure with harpers about their procedures, whe that pays at all hospitals and surgery centers. We – this is the nomal part of our practice given that need back the policy with, I have not contemplated needing an audit review process on that policy.       NS. HOLMES: I did it.         74       NS. HOLMES: Ratient satisfaction — you so that we informed of all the alternatives and all of that.       Ye         75       NS. HOLMES: Ratient satisfaction = you so nyour self pay policy, which is or ownetic. So I was que
9that you have — we have conditioned approval on the adption of shared decision making policy. So again 119care policy not including elective or cosmetic. 1011how will you enforce that providers are providing 12 patients with all the information they need and they 13 are engaging patients in that decision making? How 14 the dot an enforce that policy?9care policy not including elective or cosmetic. 10 models that they were and they were again cosmetic procedures that the patient the great majority of all procedures at the enter the great majority of all procedures at the enter the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all procedures at the enter to pay for. We certainly would anticipate that the great majority of all the attematives and all the surgeons who I sat with and prices that might be a other way, vehicle, to find out actually if they were informed of all the alternatives and all of that.9Mo. HOMES: Therestific form it is or cosmetic the pay of they only applies to medically necessary54 13for all the surgeons who I sat with and discussed audit review process on that policy.54 the pay of hyperis to medically necessary54 14from all the surgeons who I sat with and discussed audit review process on that policy.54 the policy wit
10       adption of shared decision making policy. So again how will you enforce that providers are providing patients with all the infomation they nead and they are regging patients in that decision making? How do you enforce that policy?       10       procedure?         11       how will you enforce that providers are providing patients with all the infomation they nead and they are again gratients in that decision making? How do you enforce that policy?       11       MS. COPRE: So what we mant by that we again cosmetic procedures that the patient decides that they want to have and decides that they want to pay for. We cartainly would anticipate that the great majority of all procedures at the carter would care policy.         15       MS. COPRE: So I haven't thought in the distance that it is asy ou have to b, the reporce that policy.       11       MS. COPRE: We cartainly would anticipate that the great majority of all procedures at the carter would care policy.         16       depth abut how we're going to enforce that policy.       17       It believe achally that langage is probably directly from UMC or Northest policies. It durit the says ou have to b, the reporce that policy.       17       It believe achally that langage is probably directly from UMC or Northest policies. It durit it.         20       that I have gotten from nearly everyne is yes this is the online docare policy.       18       MS. HOMES: I did it.         21       here shat the great mode and discussed the policy with the authore shat the great mode and socures are policy.       18       MS. HOMES: I did it.         22       from all the surgeons who I sat with
11how will you enforce that providers are providing patients with all the information they need and they are engaging patients in that decision making? How do you enforce that policy?11MS. COOFR: So what we meant by that we again comentic procedures that the patient decides that they want to have and decides that they were and decides that they want to pay for. we certainly wolld anticipate that the great majority of all procedures at the center would come under the free and discurted care policy. It is something when I talk to all the physicians about shared decision making policy here's what it is, here's what it says you have to do, the response that I have gotten from nearly everyone is yes this is the normal part of how we talk with our patients about their procedures, we do this in the office, we do it in an informed corsent procedure wind happens the policy with, I have not contemplated needing an audit review process on that policy.11MS. COOFR: we informed of all the alternatives and all of the policy with, I have not contemplated needing an audit review process on that policy.11MS. COOFR: we can define it more specific definitions to match.561from all the surgeons who I sat with and discussed the policy with, I have not contemplated needing an audit review process on that policy.561from all the surgeons who I sat with and discussed the policy with, I have not contemplated needing an audit review process on that policy.561from all the surgeons who I sat with and discussed the policy with, I have not contemplated needing an audit review process on that policy.561from all the surgeons who I sat with and discussed the policy with, I have not contemplated needing an audi
12       patients with all the information they need and they       12       was again cosnetic procedures that the patient         13       are ergging patients in that decision making? How       13       decides that they want to have and decides that they want to pay for. We cartainly would anticipate that         14       do you enforce that policy?       13       decides that they want to bave and decides that they want to pay for. We cartainly would anticipate that         15       MS. COPR: So I haven't thrught in       14       decides that they want to bave and decides that they want to pay for. We cartainly would anticipate that         16       depth about how we're going to enforce that policy.       15       the to pay for. We cartainly would anticipate that         18       about shared decision making policy here's what it       16       would one under the free and disconted care policy.         20       that I have gotten from nearly everyone is yes this       is the normal part of how we talk with our patients       20         21       their procedures, we do this in the office, we       MS. HOMES: Interestingly UMMC they       21         22       do it in an informed corsent procedure witch the policy with, I have not cortemplated meeting an       autil review process on that policy.       MS. HOMES: Relieft at the yeart they exclude. Yours we elective         24       the policy with, I have not cortemplated meeting an       autit review process on that policy. <td< th=""></td<>
13       are engaging patients in that decision making? How       13       decides that they want to have and decides that they         14       MS. COUPR: So I haven't thought in       13       decides that they want to have and decides that they         15       MS. COUPR: So I haven't thought in       14       the great majority of all procedures at the center         16       depth about how we're going to enforce that policy.       16       want to pay for. We certainly would anticipate that         17       It is something when I talk to all the physicians       about show we're going to enforce that policy.       17         18       about show we're going to enforce that policy.       18       the great majority of all procedures at the center         19       is, here's what it says you have to do, the response       19       usdid come under the free and discusted care policy.         10       thit in an informed consent procedure which happers       20       NS. HUMES: I did it.         21       is the normal part of our practice given that need back       14       MS. COPR: we just tried to match it.         25       the policy with, I have not contemplated needing an audit review process on that policy.       MS. COPR: we have not defined it       Secifically what they exclude. Yours wes elective or cometic. So I wes questioning what is in the elective catagory.         26       arother wap, vehicle, to find out actally if they were informe
14db you enforce that policy?14went to pay for. we certainly would anticipate that15M6. COTR: so I haven't thought in14went to pay for. we certainly would anticipate that16depth about how we're going to enforce that policy.14the great majority of all procedures at the center16depth about how we're going to enforce that policy.14the great majority of all procedures at the center18about shared decision making policy here's what it15the great majority of all procedures at the center20that I have gotten from mearly everyore is yes this16the lieve actually that language is probably directly21is the normal part of how we talk with our patients20MS. HAMES: I did it.22bit in an informed consent procedure which happers21MS. HAMES: Interestingly UMMC they23do it in an informed consent procedure which happers23lay out what they exclude; sterilization, reversal24at all hospitals and surgery centers. we — this is24MF. and cosmetic. testh extraction, sterilization,25the policy with, I have not contemplated needing anaudit review process on that policy.43audit review process on that policy.4MS. COURE: we have not defined it4batient satisfaction surveys. That might be550 i wea questions dout the5or pare informed of all the alternatives and all of574mother aspect of some of our contitions, your self10MS. HOMES: Okay. That would be7mother asp
15MS. COPER: So I haven't thought in depth about how we're going to enforce that policy. It is something when I talk to all the physicians about shared decision making policy here's what it system about their procedures, we do this in the office, we 20 that I have gotten from nearly everyore is yes this is the romal part of how we talk with our patients 22 about their procedures, we do this in the office, we 23 do it in an informed corsent procedure which heapens 24 at all hospitals and surgery centers. We — this is 25 the normal part of our practice given that need back15 the great majority of all procedures at the center would cone under the free and disconted care policy. I believe actually that language is probably directly from UMMC or Northwest policies. I don't know if you checked that. 20 MS. HOMES: I did it. 21 a dout their procedures, we do this in the office, we 23 do it in an informed corsent procedure which heapens 24 the policy with, I have not contemplated needing an audit review process on that policy.15 the policy with, I have not contemplated needing an audit review process on that policy.16 the policy with, I have not contemplated needing an audit review process on that policy.17 the subsection surveys. That might be arother way, vehicle, to find out actually if they services. So I'm curicus what is excluded from that?15 to a nother sepact of some of our conditions, your self pay policy only applies to medically necessary services. So I'm curicus what is excluded from that?15 to a nother sepact of some of our conditions, your self pay policy only applies to medically necessary services. So I'm curicus what is excluded from that?15 to a nother sepact of some of our conditions, your self pay policy only applies to medically necessary <b< th=""></b<>
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$\perp 1$ particulation for monitor or the modules of $\parallel \perp 1$ at the first of $\mu$ is possible of $\mu$ in the model of $\mu$ is a specified discutile.
18 elective cosmetic procedures. 18 off charges for various income levels, but I was not
19 MS. HOLMES: Okay, and actually that 19 sure the discount off of what charge would that be.
20 brings up a second question because the charity care 20 MS. COOPER: So that would be the
21 policy, which there was a condition that must be on 21 standard charges that we have which will be listed on
22 par with UM and Northwestern's, in that policy you 22 our web site.
23 state that services connected with elective or 23 MS. HOLMES: Discount off the commercial
24 cosmetic procedures are not included, and so I was 24 charges?
25 actually curious and looked up what's elective 25 MS. COOPER: Yes. Yes.

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	57		59
1	MS. HOLMES: Okay.	1	you will have your public web site available? I know
2	MS. COOPER: And we do not plan to have	2	it's two weeks before opening. Is that currently
3	any asset checking as part of our free and discounted	3	June 1 for opening?
4	care policy so we can remove — when we resubmit the	4	MS. COOPER: So the way that the Joint
5	policy with a more clearly defined what procedures	5	Commission and CMS certification process works is
6	are excluded we'll also remove the reference to asset	6	that I have to give them my calendar of when we'll be
7	check.	7	available to be surveyed for two months and they come
8	MS. HOLMES: Fantastic. Thank you.	8	whenever they want. So they might come on week two,
9	MS. LUNGE: Hi, Amy, good to see you. I	9	they might come on week six, week eight. So I don't
10	just want to return first to the question of price.	10	know when we're going to get our Joint Commission
11	Do you recall when we were here during the hearing	11	accreditation 0/6 certification, but then everything
12	talking about charging one price for your procedures?	12	flows from that date afterwards. We would hope to
13	MS. COOPER: Yes.	13	open as soon as possible after that date.
14	MS. LUNCE: Regardless of payer type?	14	мъ.шмэ: Okay. Thank you. So you'll
15	MS. COOPER: Yes.	15	keep us posted on how that's going?
16	MS. LUNCE: Have you in your commercial	16	MS. COOPER: Yes.
17	negotiation suggested the Medicare price as the	17	MS. LUNCE: In terms of shared decision
18	discounted reinbursement level?	18	making and in condition 2 are you — will you have
19	MS. COOPER: No.	19	decision aides available for the services offered by
20	MS. LUNGE: Thank you, and are you in	20	the surgeons performing surgeries at your center?
21	negotiations with more than one commercial payer at	21	MS. COOPER: We still have work to do in
22	this point?	22	terms of working with the surgeons on what they
23	MS. COOPER: Just to clarify I believe	23	currently use and what are the right decision aides.
24	that I indicated that the price for the procedure	24	We at the center do not have that knowledge and would
25	ought to be the same no matter who the commercial	25	rely on our surgeons to provide guidance which I
		r	
	58		60
1	payers were because they are often different based on	1	believe is how the policy is written as well.
2	payers were because they are often different based on which commercial insurer you have. That was the	2	believe is how the policy is written as well. MS. LLNCE: Great, but I guess my
2 3	payers were because they are often different based on which commercial insurer you have. That was the intent. I have found through learning about the	2 3	believe is how the policy is written as well. MS. LLINGE: Great, but I guess my question was obviously the surgeons would be going
2 3 4	payers were because they are often different based on which commercial insurer you have. That was the intent. I have found through learning about the commercial insurance contracting market more, having	2 3 4	believe is how the policy is written as well. MS. LLINGE: Great, but I guess my question was obviously the surgeons would be going over the decision aides with their own patients, but
2 3 4 5	payers were because they are often different based on which commercial insurer you have. That was the intent. I have found through learning about the	2 3	believe is how the policy is written as well. MS. LLINGE: Great, but I guess my question was obviously the surgeons would be going
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conditions do you have an estimate of the date when

contract, and if the board wants to put a condition

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1	that we sign that contract, we are comfortable with	1	addressing that. So in terms of the Joint Commission
2	that as well.	2	review I think you had mentioned in some of your
3	MS. LLINGE: Thank you, and it's probably	3	materials that the Joint Commission review includes
4	prenature since you're still in your negotiations on	4	reviewing surgeries. So can you just explain a
5	the — with your payers, but have you — do you have	5	little bit more about how that process works?
e	any thoughts on alternative payment models that you	6	MS. COOPER: Yes absolutely, and I
7	would participate in should the ACO be amenable to	7	apologize to Representative Jickling who is here from
8	that?	8	House Health Care. I just went through this
9	MS. COOPER: Yeah we have discussed	9	yesterday. Susan, you were there as well, but the $-$
10	doing episode based bundled payments where we would	10	I have materials describing the accreditation process
11	get our surgeons, anesthesia, and the facility	11	of the Joint Commission. So a survey lasts two to
12	together. We work with the ACO on which procedures,	12	three days and surveyors will come and visit the
13	you know, are most — they would be most interested	13	ambulatory surgery center and interview staff and
14	in based on volumes I suppose of attributed patients,	14	patients to validate the meeting of the Joint
15	and that if we could work out a bundled rate between	15	Commission's and CMS requirement. They actually will
16	the facility and the surgeon and the	16	trace two patients throughout the facility from their
17	anesthesiologist, all of our providers and surgeons	17	check-in to their pre-op, into their procedures,
18	and anesthesiologists in the facility are very open	18	their post-op, their discharge conversation, and
19	to that. We have educated that that would be part of	19	instruction, and audit all that to make sure that the
20	our plan as we go forward, and that was the same	20	facility is meeting all of the requirements. They
21	ideas that Vicki Loaner and Kevin Stone reflected to	21	don't just rely on interviews with staff or
22	me in our recent conversation about what they were	22	management. It is actually a condition of being
23	thinking would be the first alternative payment model	23	eligible for a survey that a center has — even a new
24	that we might get into.	24	center has seen at least 10 patients before you can
25	MS. LUNCE: Thank you. In reference to	25	ask the Joint Commission or CMS to come in to do a
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1 the transfer agreement with UVM and the agreement. 1 2 with the antulance service, it's actually related 2 3 also to B11. I was curious to know if all of the 3 physicians practicing with you would have privileges 4 4 5 at UMMC. I just wanted to understand if there might 5 6 be a circumstance where there was a surgeon who 6 7 didn't have a relationship with UMMC but would have 7 8 a patient with you that would then get transferred to 8 9 UMMC so there could be a continuity of care issue. 9 10 MS. COOPER: Yes there may be a case 10 11 that the surgeon would not have privileges at UMMC, 11 12 but their patient would get transferred to UMMC. 12 13 That shouldn't be a problem, though, in terms of 13 continuity of care. The communication would still 14 14 work between the physician and the - and UMMC. 15 15 16 Often a lot of comunity physicians don't follow 16 17 their patients in the hospital. Patients often are 17 18 taken over their care by a hospitalist in the 18 19 hospital. The surgeon or other physician remains in 19 the community and communicates with the hospitalist 20 20 21 about the care of the patient. So that's - there is 21 22 a working system set up in the event that we were to 22 23 have a patient who is a patient of a non-UVMC 23 24 credentialed physician admitted to UMMC. 24 25 MS. LUNGE: Okay. Thank you for 25

MS. LUNCE: And so maybe I misunderstood, but I thought you said a few minutes ago that the web site would be up two weeks before you opened. You can't open until you do the Joint Commission, but somehow you're going to have patients before you open?

survey.

MG. COOPER: Yes. So we are just having preliminary patients only scheduled for the purpose of CMS certification. We are not charging anything or receiving any kind of reinbursement for services. These patients essentially get a free service from the facility. We are only doing it in order to meet CVG certification. There are no other patients scheduled for any reason and we are not charging anything for these patients.

MS. LUNCE: Thank you. That's helpful. So in terms of B9 about the 25 most frequent procedures and surgeries it sounds like what you'll be posting is the charges not the actual price.

MS. COOPER: So price is a term that gets defined a lot of different ways.

MS. LLNGE: Not the allowed amount. MS. COOPER: Right. The allowed amount from the commercial insurers. So the allowed amount

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1	from different connercial insurers will likely be	1	cosmetic procedures.
2	different. So we had thought about well should we	2	MS. LUNCE: And the — so in the second
3	show an average of the allowed amount or should —	3	piece of your procedure the self pay patient
4	what should we show here. The only consistent number	4	undergoes multiple procedures. Procedures subsequent
5	will be the standard charge and then the allowed	5	to the first shall be subject to a 50 percent
6	amount with commercial insurers will always be below	6	discount off of self pay rates. That's a little bit
7	that because the way the negotiations work is they	7	unclear in terms of ensuring that it is also equal to
8	want discounts off the standard charges. So we	8	or lover than the commercial rate. So I'm hoping
9	thought that the best way from a consumer perspective	9	that you will be willing to add a little more clarity
10	to present the information would be to say here's the	10	in your self pay policy because I think it's not
11	charge that's standard and the same throughout, but	11	clear exactly what people would be expected to pay
12	if you have commercial insurance, this is the	12	when.
13	absolute maximum it would be and it's most likely	13	
14	much, much lower than this charge. It also would be	14	MS. COOPER: Cleay, and just so this is just meant to mirror the way that it typically works
14		14	
	consistent with the way that other facilities are		on a commercial contract where the first procedure —
16	showing their prices now since the Medicare rule	16	multiple procedures are done. The first procedure is
17	passed where hospital outpatient departments must	17	paid at a hundred percent of the rate and then
18	show their charges.	18	subsequent procedures are paid at 50 percent of the
19	MS. LUNCE: You also indicated that you	19	rate. So I guess just the clarifying words that
20	will work with patients to make sure they understand	20	might need to be added would be that the second
21	the transparent cost of their procedure. Are you	21	procedure will be subject to a 50 percent discount
22	also doing that with people who are trying to shop	22	off the lowest allowed amount that the center gets
23	for services?	23	paid by contract for commercial insurers for the same
24	MS. COOPER: So our patients are the	24	procedure. Would that satisfy?
25	only people that we will have access to their	25	MS. LUNCE: Yes.
	e contraction of the second se		
1	66 insurance information about So who — if they are	1	68 MS_COOPER: We can undete that milio/
1	insurance information about. So who — if they are	1	MS. COOPER: We can update that policy
2	insurance information about. So who — if they are covered by Unitas or Aetna or CUGNA, and so we can	2	MS. COOPER: We can update that policy and resubmit it.
2 3	insurance information about. So who — if they are covered by Unitas or Aetna or CIGNA, and so we can look up what our arrangement is with those insurers	2 3	MS. COOPER: We can update that policy and resubmit it. MS. LUNGE: Thank you. How are you
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Pages 65 to 68

amendment request for B21 so you talked a little bit

about the information potentially being competitively

assumption?

MS. COOPER: Yes. It doesn't include

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1		1	
	sensitive for future employment. Are you — do you	1	did, and if you were to come to her and say, you
2	think that there are other issues where that	2	know, we see a strange trend in this data for this
3	disclosure of that information would be a problem?	3	practice area, then I think that would give Any an
4	MS. TYLER: I think — a couple things.	4	opportunity internally to think about well who are
5	we mentioned in the letter — we mentioned back in	5	those practitioners and address the issue on a
6	January the employment context and also basically the	6	provider-by-provider basis internally.
7	information that's to be disclosed reveals the	7	M5. CCOPER: Thank you. I would also
8	physician's productivity, the financial productivity	8	add that I did a meno that I submitted to the board
9	of the physician's practice for someone who chooses	9	to show our projected payer mix compared with the
10	you know to figure that out, and of course it also	10	local hospital in Chittenden County payer mix, and
11	shows how many of the physician's patients he or she	11	those two payer mixes were quite similar. I think
12	is referring to the surgery center as opposed to the	12	that there will always be that benchmark available,
13	local hospital.	13	and if the surgery center's payer mix were to become
14	So I think there was also concern about	14	out of line with the local hospital, that also speaks
15	that relationship because of course all the providers	15	to the same patient base that would be maybe a cause
16	who do surgery at the surgery center will continue to	16	for concern, and that is a way that we could monitor
17	do some procedures at the hospital and I think they	17	that.
18	are sensitive about displaying, you know, how that	18	There's also, Karen mentioned, the
19	breaks down because they do continue to depend on	19	physician's personal productivity data as being
20	access to hospital facilities to operate their	20	sensitive financially and competitively. When
21	practice overall. There has been tremendous	21	physicians become employed by a hospital or sell
22	opposition to the surgery center in general from the	22	their practice to the hospital there's often a long
23	hospitals. When we submitted the application there	23	negotiation around whether the practice will be paid
24	was concern about retaliation against physicians that	24	anything for the value of the practice and of their
25	chose to participate as owners, and I think that	25	patient base, and a lot of those discussions get into
	70		72
1	there continues to be a degree of sensitivity about	1	exactly this kind of data; what's the payment, what's
2	publicizing for each doctor how many of my patients	2	the payer mix, what's the patient base, how active is
3	an I referring to the surgery center as opposed to,	3	the surgeon, and so to have individual physicians who
4	you know, the local hospital.	4	may need to or want to in the future sell their
5	MS. LLNCE: well the purpose behind that	5	practice to the hospital have all that data publicly
6	condition was to ensure that there wasn't steering	6	
7	-		available would harm them immensely in those
1	min mesentially so how also would be able		available would harm them immensely in those
8	going on essentially. So how else would we be able	7	negotiations about potential sale of their practices.
8	to monitor that?	7 8	negotiations about potential sale of their practices. MS. LUNCE: Thank you. That was
9	to monitor that? MS. TYLER: Well I think what I said	7 8 9	negotiations about potential sale of their practices. MS. LUNCE: Thank you. That was helpful. Since you brought up payer mix let's turn
9 10	to monitor that? MS. TYLER: Well I think what I said earlier is you know the board is —	7 8 9 10	negotiations about potential sale of their practices. MS. LLNCE: Thank you. That was helpful. Since you brought up payer mix let's turn to payer mix. So in the mano that you provided on
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	73		75
1	you didn't include a deduction for bad debt or free	1	changed in year one. So just to say that the year
2	care then for UMMC.	2	one numbers the change is more pronounced than a
3	MS. COOPER: No because it wasn't	3	steady state change going forward which will be 4 to
4	included in others so we didn't include it in	4	8 percent less per year because we resurveyed the
5	their's. That's the most apples-to-apples	5	physicians and said what are your monthly volumes now
6	comparison.	6	and used those numbers for our updated projections as
7	MS. LLNGE: But you did include DSH?	7	opposed to the monthly volume numbers for 2014 that
8	MS. COOPER: Yes which we could have not	8	they put in the original projection. So it was just
9	included DSH as well. If we don't include DSH, it	9	a change in their monthly volume between those three
10	makes the payer mix shift more towards conmercial for	10	years and intervening time.
11	UMMC.	11	MS. LLINCE: Thank you, and the change in
12	MS. LLINGE: Did you look at the payer	12	OB/GrN is between 38 and 47 percent in cases in that
13	mix for Northwestern?	13	chart?
14	MS. COOPER: No.	14	MS. CCOPER: Yes.
15	MS. LLNGE: So let me get organized	15	MS. LUNCE: According to your narrative
16	here. So turning to scope, of the initial physicians	16	that's due to retirements?
17	provided in your application 10 remain the same; is	17	MS. CCOPER: Yes.
18	that correct?	18	MS. LUNCE: Orthopedics is an increase
19	MS. COOPER: Versus the initial	19	between 41 and 63 percent due to practice changes?
20	projections and the updated projections, yes.	20	MS. CCOPER: Yeeh. Busier. More
21	MS. LLNGE: And that was out of how many	21	volume.
22	original docs participating?	22	MS. LUNCE: And then 93 to 94 percent
23	MS. COOPER: 16.	23	reduction in pain management?
24	MS. LLNGE: And there are 14 new	24	MS. CCOPER: Yeah. We had two original
25	physicians included in the updated projections?	25	busy physicians in pain management who have changed

	74		76
1	MS. COOPER: Yes. Yes.	1	their practices to not do procedures that would work
2	MS. LUNGE: And in your updated	2	in an ASC any more.
3	projections you're currently showing a 17 percent —	3	MS. LUNGE: Thank you, and I noticed in
4	between 4 percent and 17 percent decrease in GI for	4	your narrative that you indicated that that was due
5	cases?	5	to change in patient demand, reimbursement levels,
6	MS. COOPER: I think that's correct. I	6	and practice patterns as you just explained. Can you
7	don't have it in front of me.	7	talk about the reimbursement level piece of that?
8	MS. LUNGE: It's page 2 of your November	8	MS. COOPER: The payment rates for
9	19 memo if that helps.	9	certain pain procedures sometimes conmercial insurers
10	MS. COOPER: Yes.	10	here in the state have decided to stop covering
11	MS. LUNGE: GI was originally 60	11	procedures that they used to cover. So when I
12	percent. You were projecting 60 percent of your	12	reached out to these physicians after they did not
13	volume to be related to GI originally?	13	have updated projections I said what's going on and
14	MS. COOPER: Yes.	14	they said well the connercial insurers decided to
15	MS. LUNGE: And the change there is why?	15	stop covering some of the stuff we were doing.
16	MS. CCOPER: So the changes — you can	16	MS. LLINGE: Got it. Thank you, and then
17	see the changes in year two and year three and year	17	a reduction in general surgery between 36 and 45
18	four are between 4 and 8 percent.	18	percent as well. This chart indicates that you
19	MS. LUNGE: Why is it changing?	19	didn't originally project cases for plastic surgery
20	MS. COOPER: The change in year one is	20	or ophthalmology, right?
21	more pronounced because in our updated projections we	21	MS. COOPER: Yes that's true.
22	think it's going to take us longer to ramp up than we	22	MS. LUNGE: Thank you.
23	did initially. So in our initial projections we had	23	MS. CCOPER: I just — also our actuals
24	a higher number of initial patients in year one.	24	when we are actually operating may look different
25	Here we have a lower number because our assumption	25	than the projections also just because these changes

77 1 that I mentioned in that submission that have been 1 physician M who was	79
	a pain management specialist in
2 occurring since 2015; physicians retiring, moving, et 2 the original project	tion is obviously a different
	and got a new specialty in
	ring if you could please update
	see apples-to-apples with
<b>5</b>	- it's a little hard to track
	ere there's actually people who
8 MS. LLNGE: And did you update these 8 left and people who	
	PER: I'll have to check with
	its who I mentioned who filled all
	the projections for me.
	GE: Great. Thank you. So just
	st finalizing questions around
	in your original submission
	used on the specialties GI,
	management, and general surgery
	tions also did not include plastic
	ogy, or any other specialty; is
19 surgeons are practicing in Chittenden County? 19 that right?	
	PER: That's correct.
	CE: In terms of payer mix I was
	evenue projections by payer mix
	gnificantly from your original
	new projections, which are on
25 of reaching out to individual physicians with 25 page 7 of that submi	ission, indicate that you're
	~
78 1 surveys. This was run by our consultants Avanza 1 expecting between 42	80 2 and 49 percent less revenue from
	ercent less revenue from
	rcent less revenue from
	B percent from self pay; is that
	percencindii seni pay; is that
	PER: Yes.
	KEE: So what's causing that shift to in Medicare and Medicaid?
A projections and undated tinancialis is not softemind 11. A particularly downwar	
9 that we're doing regularly at all. The ones that I 9 MS. COO	PER: well that's just a function
9that we're doing regularly at all. The ones that I9MS. 00010do have I have submitted to the board.10of the different phy	PER: well that's just a function sicians that we have in the mix
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9that we're doing regularly at all. The ones that I9MS. COO10do have I have submitted to the board.10of the different phy11MS. LUNCE: Thank you, and in terms of10now than the ones the12ophthalmology in your application you explained at12updated projections of13the time of the application those services were not13their current payer if14included because you did not have as many interested14manager or someone if15surgeons as you did now and had not completed due15Because our group of16diligence on cost and efficiency of moving16it would be a natura17vitreoretinal cases; is that right?17mix would change. F18MS. COOPER: Yes.18different specialtie19MS. LUNCE: So in terms of your19mixes. GI, for exam20projected cases by physician — this is on page 4 and20Force on Preventative215 of that same submission — I was noticing that in21that wrong — but re22your original — it looks like the physicians listed22covering colon cance23in your original projections compared to your — the23covering colon cance24new physician list are a little bit hard to track24which then makes the	PER: well that's just a function sicians that we have in the mix nat we had earlier. When we do we also ask the physicians for mix, and again their practice in their office gives it to us. <sup>5</sup> physicians has changed so much al result of that, that our payer for example, physicians in as often have very different payer ple, basically the American Task we Health Metrics — I'm saying scently updated their commercial insurers have started

	81		83
1	they have all these patients who are 45 who are	1	CHAIR MULLIN: So I'll be brief because
2	commercially insured that they didn't have before.	2	the two previous members have been very thorough, but
3	Also if you have OB/GAN doctors, they	3	I wanted to ask you what you envisioned could
4	generally don't have any Medicare patients because	4	possibly be in the future as far as the expansion of
5	Medicare is old. If you have eye doctors, they	5	scope. You could start with ophthalmology, we could
6	generally have mostly Medicare patients. Retina	6	talk about each one of the special ties, but I'm just
7	surgery is a low volume surgery — low volume	7	curicus what you think the bounds of what the
8	speciality in ophthalmology, very low volume compared	8	expansion of the scope would be.
9	to cataract or others. So while those are mostly	9	MS. COOPER: In terms of specialties
10	Medicare patients it's not a large part of our mix	10	that we would consider bringing on in the near term
11	compared to the high volume GI, for example.	11	the only other that I have had conversations about
12	MG. LINGE: Okay. It also looks in your	12	would be pediatric dentistry. There is a need for
13	cases by payer category that you're expecting a	13	children who have to get teeth pulled and need
14	significant decrease in Medicare cases overall,	14	general anesthesia for that to be done in procedure
15	between 30 and 40 percent, over the course of the	15	rooms or operating rooms, and I have heard from two
16	four years. That's on page 9.	16	dental providers and the Community Health Center in
17	MS. COOPER: Yes.	17	Burlington that there is a need for general
18	MS. LUNCE: And again that's related to	18	anesthesia services in procedure rooms to do that
19	the shift in how many cases are coming from which	19	sort of work. So that's the only one that I have had
20	specialty?	20	conversations about in the near term.
21	M5. COOPER: From which specialty. So,	21	CHAIR MULLIN: On the ortho looks like
22	for example, we also previously had pain management	22	primarily hand surgeries. What do you see as future
23	is a very high volume specialty. It's, you know,	23	possibilities being performed at your facility?
24	injectable things that are done quickly and a lot of	24	MS. COOPER: That is entirely dependent
25	them usually. Those two physicians in particular had	25	on whether there's any physician interest. There
[			
	82		84
1	a lot of Medicare patients and they are not part of	1	were three years ago two independent orthopedic
2	a lot of Medicare patients and they are not part of our projections any more. So that changed our mix.	2	were three years ago two independent orthopedic practices in the state, one in Chittenden County with
2 3	a lot of Medicare patients and they are not part of our projections any more. So that changed our mix. MS. LUNGE: Great. Thank you for	2 3	were three years ago two independent orthopedic practices in the state, one in Chittenden County with four physicians that did all kinds of general ortho
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	a lot of Medicare patients and they are not part of our projections any more. So that changed our mix. MS. LLNEE: Great. Thank you for explaining that. Going back to condition 10 so you indicated today that you — or I should say that you mentioned you submitted to us evidence basis for the specialities that you were intending to provide. When we reviewed that I guess my question for you is are you also relying on any articles that you provided in your initial application because quite frankly in, for example, the materials that you provided for GI, just to pick one out, I was surprised to see that you only provided evidence basically around colonoscopies, but I assure that you intend to do other procedures in the GI speciality other than colonoscopies. MS. COOPER: We are also relying on all of the evidence that's been presented since the original application as well. MS. LLNGE: Okay. That's helpful because I was trying to get a sense of what you	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	were three years ago two independent orthopedic practices in the state, one in Chittenden County with four physicians that did all kinds of general ortho cases, one in the central part of the state. Those physicians sold their practices and became employed in 2016. There's no other independent orthopedic surgeons that I know of right now that would want to use the center. OHAIR MILLIN: Would you agree that a central focus of the initial CON was a focus on the Vermont patient, the consumer, basically a focus on really access, quality, and cost in that there was much discussion about convenience for the patients. Some patients don't want to go to a hospital setting for a surgery. There was also discussion about in a very key part of the decision was a lower cost alternative to the Vermont patient, and do you agree with that? MS. COOPER: Yes. GHAIR MILLIN: So on the ophthalmology, which wasn't discussed previously and was discussed
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	a lot of Medicare patients and they are not part of our projections any more. So that changed our mix. MS. LLNEE: Great. Thank you for explaining that. Going back to condition 10 so you indicated today that you — or I should say that you mentioned you submitted to us evidence basis for the specialties that you were intending to provide. When we reviewed that I guess my question for you is are you also relying on any articles that you provided in your initial application because quite frankly in, for example, the materials that you provided for GI, just to pick one out, I was surprised to see that you only provided evidence basically around colonoscopies, but I assume that you intend to do other procedures in the GI specialty other than colonoscopies. MS. COOPER: We are also relying on all of the evidence that's been presented since the original application as well. MS. LLNEE: Okay. That's helpful	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	were three years ago two independent orthopedic practices in the state, one in Chittenden County with four physicians that did all kinds of general ortho cases, one in the central part of the state. Those physicians sold their practices and became employed in 2016. There's no other independent orthopedic surgeons that I know of right now that would want to use the center. CHAIR MILLIN: Would you agree that a central focus of the initial CON was a focus on the Vernont patient, the consumer, basically a focus on really access, quality, and cost in that there was much discussion about convenience for the patients. Some patients don't want to go to a hospital setting for a surgery. There was also discussion about in a very key part of the decision was a lower cost alternative to the Vernont patient, and do you agree with that? MS. COOPER: Yes. CHAIR MILLIN: So on the ophthalmology,

after I check my notes, but -

25 MS. COOPER: I'm not sure how to answer

future?

24

	85		87
1	that question.	1	said in your April 8 submission that quote "overall
2	CHAIR MULLIN: So, for example, a few	2	the payer mix profiles of UMMC for fiscal year 2018
3	years ago I had an eyelid that was scraped but the	3	and GMBC in our updated projection are essentially
4	surgery was done inside an eye doctor's office.	4	the same," and there's an $-$ in your documentation
5	Could that type of surgery be performed at your	5	that you have — and I agree with you — that UMMC
6	center?	6	had about 60 percent commercial, 9 percent Medicaid,
7	MS. COOPER: We do not have any plans to	7	and 30 percent Medicare. How does UMMC payer mix
8	do any surgery that is currently being performed in	8	and your numbers currently compare to that? Do you
9	an office in the surgery center.	9	know or have any sense as to where UM's payer mix
10	CHAIR MULLIN: Clkay. Do you have any	10	fits in terms of the rank order of payer mixes in the
11	plans to do any surgeries that are performed at the	11	state where the more favored commercial — the more
12	other anbulatory surgery center that is the only	12	favored payer mix would be a strong connercial and a
13	other one that's currently in Vermont?	13	strong Medicare and then a third place in terms of
14	MS. COOPER: So none of the surgeries	14	Medicatid, do you have any sense of where UMM fits in
15	that are in our updated ophthalmology projections	15	that hierarchy of the 14 hospitals in Vermont?
16	would be moving from one antuilatory surgery center to	16	MS. COOPER: I certainly have a sense of
17	another. All of the cases in the updated projections	17	the Chittenden County patient population payer mix
18	would be moving out of the hospital into an	18	versus the rest of the state from my work at Health
19	antuilatory surgery center for the first time.	19	First with the independent practices, and in — from
20	CHAIR MULLIN: So that's today. I'm	20	that information Chittenden County does have the
21	talking about in the future. What type of guarantees	21	highest percentage of connercial patients compared to
22	would we as Vermonters have that you are continuing	22	practices located in other counties or more rural
23	to offer a more convenient, lover cost setting for	23	areas. They tend to have higher Medicaid and
24	anything that could be performed there? You never	24	Medicare populations.
25	raised the issue of ophthalmology in the original	25	MR. PELHAM: That's correct. I think at
	ec.		00
1	86 (CN) You talked about being lover than beguitals	1	88 the 60 regrent level there's UM and (m)ev. So T'm
1	CON. You talked about being lower than hospitals	1	the 60 percent level there's UM and Copley. So I'm
2	CON. You talked about being lower than hospitals because the procedures that you were going to do were	2	the 60 percent level there's UM and Copley. So I'm trying to kind of walk through the changes in payer
2 3	CON. You talked about being lower than hospitals because the procedures that you were going to do were being done in hospitals, and so what I'm focusing on	2 3	the 60 percent level there's UM and Copley. So I'm trying to kind of walk through the changes in payer mix and your procedures mix since the earlier
2 3 4	CON. You talked about being lower than hospitals because the procedures that you were going to do were being done in hospitals, and so what I'm focusing on is what guarantees do we have that you won't be a	2 3 4	the 60 percent level there's UM and Copley. So I'm trying to kind of walk through the changes in payer mix and your procedures mix since the earlier applications and wondering what that might mean for
2 3 4 5	CON. You talked about being lower than hospitals because the procedures that you were going to do were being done in hospitals, and so what I'm focusing on is what guarantees do we have that you won't be a higher cost alternative to other options outside of	2 3 4 5	the 60 percent level there's UM and Copley. So I'm trying to kind of walk through the changes in payer mix and your procedures mix since the earlier applications and wondering what that might mean for the Northwestern Medical Center in the sense that you
2 3 4 5 6	CON. You talked about being lower than hospitals because the procedures that you were going to do were being done in hospitals, and so what I'm focusing on is what guarantees do we have that you won't be a higher cost alternative to other options outside of the hospital?	2 3 4 5 6	the 60 percent level there's UM and Copley. So I'm trying to kind of walk through the changes in payer mix and your procedures mix since the earlier applications and wondering what that might mean for the Northwestern Medical Center in the sense that you had previously said that about 170 or 2.7 percent of
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25

absorbed most of it. I only have one question. You

Medicare. So it's in a less favored position, and if

	89	91
1 I — if you have any information that wou	uld grive a 1	MS. COOPER: Right.
2 more current bearing on how your services	smight 2	MS. USIFER: — in your billing?
3 affect Northwestern Medical, it would be	helpful. 3	MS. COOPER: Yes.
4 MS. COOPER: Ido. I haven'	t done the 4	MS. USIFER: All right. All my other
5 same analysis that I did in the original	CON in terms 5	questions were answered. Thanks.
6 of actual data around what may move. I d		MS. LLNCE: I have three left. I'm
7 though, that there are surgeries being da	· · · · · · · · · · · · · · · · · · ·	sorry. I know you will all find it hard —
8 Northwest by surgeons who have moved back		MR. BARBER: We're over time already.
9 expressly because of the ASC and only bec		MG. LUNCE: I'll be quick.
10 surgery center that are now doing cases a		MR. BARBER: Clay.
11 and have joined the medical staff at Nort		MS. LINCE: So just one followup on
12 patients who used to be in St. Albans wou		condition 10. I just want to clarify that the
13 travel to Burlington for their care are r		studies that you have provided in evidence either in
14 get their procedures done close to home a		this submission or the previous one offer a complete
15 Medical Center, and that the surgeons who		list of the procedures that you will be offering?
16 cases there would plan to continue doing		MS. COOPER: So they are not every — it
17 Northwest and at the surgery center.	17	depends on how you define procedure. These are the
18 I also have heard, though I'		procedures across specialties that there is evidence
19 yet, that some physicians who had planned		basis for that I could provide to you. They are on
20 to bring cases to the surgery center and	-	the CPT code level, if I said there's specific codes
21 original projections are now — have said		for parts of different procedures that don't have
22 retirement, I don't feel like making a d		evidence based studies associated with them, so that
23 going to leave my cases where they are, a	<b>J</b> ·	is what happened.
24 those cases are also at Northwest.	24	MS. LUNCE: Thank you. Thank you, and
25 So I don't know what the net		just to clarify are there any surgeries or procedures
	90	92
1 in terms of an answer, but I know that ha	•	that you're anticipating will be performed that are
2 facility here and the way that it helps w		solely cosmetic and not medically necessary or
3 recruit physicians who want to have this	•	whatever? That may not be the appropriate clinical
4 otherwise would not be in Vermont having		term, but I think you get the gist.
5 physicians stay here and oftentimes bring		M5. COOPER: Well it's interesting
6 cases to hospitals like Northwest is a go	xxd thring. 6	because who decides what's necessary. Medically
7 MR. PELHAM: Thank you.	7	necessary is a term used by conmercial insurers, but,
8 MS. USIFER: There's a benef		for example, a new area that is becoming much more
9 last. Most of my questions were answered	-	needed certainly from the patient's perspective is
10 have one question on the self pay policy,		gender affirmation, surgeries for folks who don't
		•
11 you talk about the discount on implants of		identify with the gender that they were born into.
11you talk about the discount on implants of12supply items in excess of \$200 and there	would be no 12	identify with the gender that they were born into. That is those surgeries are done by plastic surgeons.
11you talk about the discount on implants of12supply items in excess of \$200 and there13discount, just wordering why you wouldn't	would be no 12 t get what 13	identify with the gender that they were born into. That is those surgeries are done by plastic surgeons. Some elements of those surgeries may be considered
<ul> <li>you talk about the discount on implants of</li> <li>supply items in excess of \$200 and there</li> <li>discount, just wondering why you wouldn't</li> <li>commercial pays for those.</li> </ul>	would be no 12 t get what 13 14	identify with the gender that they were born into. That is those surgeries are done by plastic surgeons. Some elements of those surgeries may be considered medically necessary. Some may be considered not
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1	98	
	performed there are those on the CMS approved list?	1 - if you could tell me what those updates are, we can put
2	MS. CCOPER: Only those on the CMS	2 them into our free discounted care policy before we
3	approved list.	3 resubmit.
4	MS. LUNCE: I guess an exception might	4 Q. Sure. That would be great. Thank you, and I
5	be in the OB area where they may or may not have	5 just wanted to note also that in your materials I don't
6	tackled that for Medicare.	6 believe you said UMMC's complete policy so I wanted to
7	MS. CCOPER: Yes. Yes.	7 confirm. You — did I understand you're trying to do the
8	MS. LUNCE: And cosmettic. Thank you.	8 same policy? And I appreciate that. I just wanted to
9	I'm done, Mike.	9 confirm you did refer to UMMC's full policy when you were
10	MR. BARBER: Okay. So I think we're	10 developing your policy for the ASC?
11	behind schedule a little bit. Eric and Julia, if you	11 A. I pulled off everything I could find on UM's
12	can keep it concise and then I think what I would	12 web site to review.
13	like to do is take a five-minute break, resure, ask	13 Q. I'm wondering if you would be willing to work
14	Ms. Cramer to have her witness come up. Turn it over	14 with our office just to ensure that these discrepancies
15	to you now.	15 are just a policy and eligibility information are clear
16	MS. SHAW: Sure. Thank you.	16 and complete and readable for consumers?
17	EXAMINATION	17 A. Yes. We will make updates to the policy that
18	BY MS. SHAW:	18 have been mentioned here and then I can send it to you and
19	Q. I just have a few questions from the	19 have you suggest any updates which we will accept before
20	information you provided. So in your Certificate of Need	20 it goes for final review.
21		20 Regues for final review. 21 Q. Thank you very much, and then I just wanted to
22	15 requiring the applicant to establish and implement a	
		22 also — I know your policy is in general simpler than the
23	policy to provide care on par with UM and Northwestern	23 hospitals, but I wanted to ask if you would be willing —
	Medical Center. So I first wanted to note on our review	24 one of the requirements for hospitals is to provide a
25	we noted a few differences between your policy and the	25 plain language summary, if you would be willing to also
	94	96
-	policies at UMMC. For example, UMMC provides two	1 provide a plain language summary of your policy sort of
2	policies at UMMC. For example, UMMC provides two opportunities for patients with income above 400 percent	<ol> <li>provide a plain language summary of your policy sort of</li> <li>summarizing the basics to be available to consumers?</li> </ol>
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	surgery center. Everybody gets actually two phone calls;		their choice.
2	one from the business office explaining, we verify our	2	MS. SH4W: Thank you. That's all our
3	demographic information with the patient, make sure they	3	questions.
	understand the times involved in the procedure, and then	4	MR. BARBER: Okay. Thanks. So five
5	we cover everything as far as insurance. So we're going	5	minutes. We'll get a drink of water, go to the
6	to explain fully any financial obligations, any out of	6	bathroom, and reconvene at 3:30.
7	pockets, what their co-insurance is, what their deductible	7	(Recess.)
8	is, and what their co-pay is so they have a complete	8	MR. BARBER: All right. It's 3:30 so
9	understanding.	9	we're going to reconvene here. I'll turn it over to
10	we also offer it to them in writing if they	10	Ms. Cramer. I think we missed swearing in Ms. Berry
	wish to have it. I can e-mail it to them or I can put it	11	Bowen so I would ask the court reporter to please
12	in regular U.S. post office mail. So I hope that answers	12	swear in Ms. Berry Bowen.
13	your question.	13	(Ms. Berry Bowen was duly sworn.)
14	Q. I have one followup which is I think so part	14	MS. CRAMER: Thank you, Michael. I'm
15	of my question is about, so I think some of the	15	here representing Northwestern Medical Center. As
16	ophthalmologists would be an example, sometimes you don't	16	you know I also represent the Vermont Association of
17	know what you're going to find until you're in the	17	Hospitals and Health Systems. I just want to
18	procedure. So if patients are given information you know	18	adknowledge that at the prehearing conference we
19	this is the cost for what we know you're going in for, 10	19	spoke about the parties filing briefs on the legal
20	percent of patients we find there's complication, 50	20	issue following the hearing with regard to the
21		21	question of the scope of the CON. It is briefly our
22		22	position that this CON should be amended to add any
23	A. (Mr. Paoni) So we bill off CPT code. Those	23	specialties beyond the five that all of the
	supplies or any additionals beyond that is included within	24	projections and financials were based on when the
25	that CPT code when they draw up the bill. So there's very	25	application was considered two years ago, and so
	~		100
1	98	1	100 today you have received some information and
2	few surprises, you know, and if, for example, they found a foreign body that required — that is going to create	1	testimony on the applicant's belief of a need for
3	additional charge, that's fully explained to the patient	3	additional procedures, and consequently I would like
	prior to the surgery usually by the physician in the	4	to have Jill Berry Bowen comment on potential impact
4 5		5	that that could have on both Northwestern, and I just
5	office. If not, it's explained to the patient in the preoperative area. We require the — Medicare and	6	want to acknowledge that with her today is Tristan
7	·	7	Glanville who is the new interim CPO at Northwestern
_	file with the patient within the last 350 days. So they	8	Medical Center, and so should there be a question she
9	will review all of that information with the patient prior	9	might confer with him if it happened to hit the
10		10	financial area.
11	Q. Thank you. Did you want to — so my final	11	MS. BERRY BOWEN: Great. Good afternoon
	question is on your benefits verification policy it states	12	and thank you for the opportunity to speak to you
13	that if payment is not secured within 24 hours of the	13	today. The application for the Certificate of Need
14		14	for the ambulatory surgery center was developed by
15	may proceed with the case. We were just wondering if you	15	the Green Mountain Surgery Center and considered by
	would commit to adding to that policy that patients also	16	the Green Mountain Care Board based on performance
17	would comme to adding to that portey that patients also would have the opportunity to choose to reschedule a	17	and projections in five identified specialties. We
18	procedure rather than proceeding? Technical point but —	18	are now facing a request to expand the scope of the
19	A. (Mr. Paorii) Absolutely. Absolutely because	19	surgery center beyond those special ties.
20		20	As one of the decision criteria within
20		20	the CON process includes consideration of whether the
22	explain to them listen I can't get your insurance. We'll	22	perceived benefits of a project outweigh the
	back out ahead of time so we have plenty of time to make	23	detriments of the project on hospitals and other
	sure you get that information and verify the insurance.	23	settings, it is crucial that you understand the
64			further detrimental impact with an expansion of scope
25	So if the patient wants to reschedule, certainly it's	25	TINTER (PERMENTAL INFORT WITH IN EVALUATION OF COME

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1	beyond what was discussed within the CON will have.	1	this comes with overhead and regulation costs that
2	In recent days the Green Mountain Care	2	challenge cur ability to compete.
3	Board has heard from small Vermont hospitals on the	3	If the scope of the Green Mountain
4	significant negative impact that the loss of a	4	Surgery Center expansion is allowed to happen, the
5	surgeon or a reduction in surgical procedures has on	5	negative financial impact of additional surgical
6	the finances of the hospital. By the way we're	6	procedures will show as a clear detriment in future
7	losing already two physicians to the surgery center.	7	reports to the Green Mountain Care Board of
8	It is real and impactful and you have seen it in	8	Northwestern Medical Center's performance.
9	hospitals' financial performance reports including	9	Thank you for the time to share this
10	ours at Northwestern Medical Center. Now we face an	10	important insight on our future. We're going to
11	additional expansion of the initiative that will draw	11	continue to lead and work across our local community
12	more surgical procedures away from hospitals that	12	for integration and collaboration, the accountable
13	will be detrimental.	13	comunity for health, that focuses on population
14	Northwestern Medical Center, as you	14	health transforming from a fee for service to a
15	know, is committed to the transformation of Vermont's	15	capitated system. Thank you.
16	health care system from fee for service to a	16	MR. BARBER: Thank you. Before I turn
17	capitated population health based system. Hospitals	17	it over to the board for questions to the extent that
18	are funding this future. We were the first hospital	18	any questions may be better answered by your OFO who,
19	outside of the UM Health Network to take on risk	19	I'm sorry, I have already forgotten his name.
20	with an all payer model. In this model NMC has a per	20	MS. BERRY BOWEN: Tristan Glanville.
21	member per month payment to sustain our hospital,	21	MR. BARBER: I would also prefer that
22	however, every time patients are drawn away to have	22	you also get swom in so if you could now please
23	procedures at an outside provider such as a surgery	23	stand and raise your right-hand so the court reporter
24	center this is less revenue for the hospital which is	24	can swear you in.
25	carrying the fixed expenses necessary to care for its	25	(Mr. Glanvile was duly swom.)
	100		104
1	102 community Bentuelly the cap between variable	1	104 MR RADRER: Thank you so now T'm
1 2	community. Eventually the gap between variable	1	MR. BARBER: Thank you. So now I'm
2	community. Eventually the gap between variable revenue and fixed expenses become unsustainable.	2	MR. BARBER: Thank you. So now I'm going to turn it over to the board for questions.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	comunity. Eventually the gap between variable revenue and fixed expenses become unsustainable. What is the future definition of the comunity hospital? The surgery center is counter to the integrated comunity care model we are all investing in for the success of a capitated system. Northwestern Medical Center has previously testified to the detrimental impact of eye surgeries drawn off by the eye center. That same kind of detrimental impact will come with this anbulatory surgery center as Colchester is not far from St. Albans. This detriment will only be exacerbated by an expansion of scope beyond the specialities and procedures which were part of the CON consideration and the Green Mountain Care Board's decision. Today, as outlined in our previous testimony, we are following through on our commitment to realign our whole surgical program to be an	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	MR. BARBER: Thank you. So now I'm going to turn it over to the board for questions. Starting at that end of the table. MS. LLNCE: Thank you for coming. Do you have any information that you could provide about the number or volume of surgeries that are happening in your hospital related to the two specialties under discussion today, the ophthalmology and plastic surgery? MS. BERRY BOWEN: So as far as ophthalmology we did 511 cases. MS. LLNCE: And are those the types of procedures that were talked about today do you know? MS. BERRY BOWEN: The specialty procedures? No. This would be more cataract surgeries. MS. LLNCE: Ckay. MS. BERRY BOWEN: You know I don't have the plastics that we're talking about, but it's a
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	comunity. Eventually the gap between variable revenue and fixed expenses become unsustainable. What is the future definition of the comunity hospital? The surgery center is counter to the integrated comunity care model we are all investing in for the success of a capitated system. Northwestern Medical Center has previously testified to the detrimental impact of eye surgeries drawn off by the eye center. That same kind of detrimental impact will come with this ambulatory surgery center as Colchester is not far from St. Albans. This detriment will only be exacerbated by an expansion of scope beyond the specialties and procedures which were part of the CON consideration and the Green Mountain Care Board's decision. Today, as outlined in our previous testimony, we are following through on our commitment to realign our whole surgical program to be an anbulatory surgery center like in operation. As you	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	MR. BARBER: Thark you. So now I'm going to turn it over to the board for questions. Starting at that end of the table. MS. LLNCE: Thark you for coming. Do you have any information that you could provide about the number or volume of surgeries that are happening in your hospital related to the two specialties under discussion today, the ophthalmology and plastic surgery? MS. BERRY BOWEN: So as far as ophthalmology we did 511 cases. MS. LLNCE: And are those the types of procedures that were talked about today do you know? MS. BERRY BOWEN: The specialty procedures? No. This would be more cataract surgeries. MS. LLNCE: Okay. MS. BERRY BOWEN: You know I don't have the plastics that we're talking about, but it's a very small runber at this time because the plastic

reduce cost, balancing an effort to continue to meet MS. LUNGE: Okay. Thank you. That's 23 24 all I have. needed development in primary care and also wellness

CHAIR MULLIN: So I think just as a

the mission of needs of our comunity such as the

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	105		107
1	followp to Member Lunge's question could you submit	1	want.
2	to us the number of vitreoretinal surgeries that are	2	MS. BERRY BOWEN: I think now that it's
3	being performed at Northwest?	3	getting closer to opening I think we have a better
4	MS. BERRY BOMEN: Sure.	4	idea who might be migrating there.
5	CHAIR MULLIN: Thank you.	5	MR. BARBER: So there's briefing I think
6	MR. PELHAM: Thris is a followup. So in	6	from the parties due on May 3rd now. So just to give
7	the original proposal there was 170 surgeries that	7	everyone enough time to review what you're going to
8	were projected that Northwest might lose to the	8	submit I ask that you get that in as soon as
9	surgical center given its initial inventory of	9	possible, preferably by next week, mid to beginning
10	procedures, and when you saw that number did that	10	of the week.
11	make sense to you, and, if it did, could you put an	11	MS. BERRY BOWEN: That sounds great. I
12	economic value on it?	12	think the assumptions have shifted so now we can
13	MS. BERRY BOMEN: Are you talking about	13	update that — what we believe to be true.
14	the surgeries related to these new ophthalmology and	14	MR. BARBER: That's all the questions
15	plastics or the previous ones?	15	from the board members, right? Now, Julia, do you
16	MR. PELHAM: No. I'm talking about in	16	have questions?
17	the original proposal the presentation was that it	17	EXAMINATION OF MS. BERRY BOWEN
18	was 170 surgeries might migrate from your operation		BY MS. SHAW:
19	to the surgical center and that that would comprise	19	Q. I just have a couple brief questions. Do you
20	about 2.7 percent of the volume at the surgical		consider Chittenden County to be part of your service
21	center.		area?
22	MS. BERRY BOWEN: Originally the	22	A. No. We do Franklin and Grand Isle County.
23	surgeries were GI and OB/GAN. Clearly in addition to	23	Q. Thank you. That's my only question then.
24	that there is an orthopedic surgeon that will be	24	MS. BERRY BOWEN: Thank you.
25	moving as well. So those numbers have increased	25	CHAIR MULLIN: Okay. Thank you for your
	-		
_	106	_	108
	since our last discussion.	1	testimony. Now we're going to move into public
2	MS. HOLMES: Maybe a clarification. I	2	comment section of the hearing. We're scheduled to
3	think we're all asking the same question, but there's	3	adjourn at 4. We can stay in the room up until 4:25
4	been a change so there were some pain management.	4	or so if we need to, but there's only six individuals

5 procedures, there were some, you know, fever ortho, 5 who have signed up to comment so I'm just going to go 6 now there's more ortho. There's been a change. I'm 6 through the list starting with David Weissgold and 7 wondering do you have the net effect of what you 7 Dr. Laub. I guess do you have anything else to say? 8 DR. WEISSCOLD: No. We probably didn't anticipated before migrating and what you anticipate 8 9 now migrating within the change of scope? 9 understand what the word public comment -10 MS. BERRY BOWEN: We suspect who the 10 MR. BARBER: Fair enough. Four people. If you could, when you're giving a comment please 11 doctors are. We don't know exactly and I know 11 12 originally there was a thought that there might be a 12 just stand up, identify yourself, if you're 13 general surgeon that might be coming from our area. 13 representing an organization identify the organization you're representing, what your position 14 I think that general surgeon potentially has retired. 14 15 So right now what I really know that's 15 is. That would be helpful and speak loudly. Yes. 16 going to — would like — is going to move is the 16 First one up is Diane Zeller. 17 orthopedic surgeon, hand surgeon, who has announced 17 MS. ZELLER: I'm a registered nurse at UMMC. I've been there since I've been a RN at 18 her departure to go to the surgery center, and also 18 19 as was mentioned earlier there was probably some of 19 UMMC. I've been working there since 12 of '08 and I 20 the OB/GAN that would go to the surgery center that 20 work in the minor procedure unit, and I'm here to 21 is now here. So I think what we could do in our represent and support the opening in a timely 21 22 followp submission is now that we have a better 22 fashion, which is this summer, for Green Mountain 23 understanding that we might be able to put a number 23 ASC. We need it. Patients need it. In my 24 to those specifically. Would that be dray? 24 department they closed down one of our rooms so we

MS. HOLMES: I think that's what people

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don't have any patients to come to do what we did for

	109		111
1	them before they have taken it away. I know	1	cost of care, I happen to be one of those people who
2	personally that neighbors, friends of mine are	2	believes the cost will probably be lower on average
3	waiting extended long lengths of time to have	3	through this independent network than through the
4	anything done. It's not safe for our patients, and	4	existing hospital network, but I cannot believe that
5	we as nurses and any other caregivers know that every	5	eight years of work of the Green Mountain Care Board
6	one of those patients that we take care of is	6	and I don't think there's anybody in this room who
7	somebody else's loved one, and that's very important	7	can tell me how much any one of these procedures now
8	to all of us and only want the best for them, and	8	costs in a hospital setting which to me is a very,
9	opening this surgery center would help all our	9	very sad indictment of the lack of transparency when
10	patients in our community to get the service they	10	it comes to this issue of cost.
11	need in a timely fashion that they need it. Thank	11	So I guess one of the questions that I
12	you for listening.	12	hope everybody will consider is assuming that this
13	MR. BARBER: Thank you. Next up we have	13	CON is approved and the center opens up how are you
14	Kathy O'Reilly.	14	really going to determine one of the key indicators
15	MS. O'REILLY: Kathy O'Reilly, Director	15	is the cost less, equal, or more of this new model
16	of Economic Development for the Town of Colchester.	16	unless you have more transparency that shows us what
17	I just wanted to say that the Selectboard, the Town	17	the hospitals now are charging for similar
18	Manager, and I support the Green Mountain Surgery	18	techniques, and the failure to do that makes health
19	Center. Their 25 jobs are value added jobs that we	19	care reform seriously endangered in my opinion.
20	are looking for not just in Colchester but in the	20	So, in summary, the way I interpret this
21	surrounding communities, and these jobs coupled with	21	debate is it's a step in the direction of creating a
22	the new employees who are coming for these opening	22	patient centered care system, and I hope that you
23	positions is exactly what the work force investment	23	will review it favorably. Thanks.
24	objective is in Vermont. We need more jobs. We need	24	MR. BARBER: Thank you, and this is
25	value added jobs and we support this wholeheartedly.	25	reminding me I should have done a better job
	110		112

1	Thank you.	1
2	MR. BARBER: Thank you. Up next is Ken	2
3	Libertoff.	3
4	MR. LIBERTOFF: Yes. Ken Libertoff	4
5	representing myself today. Clearly this is an	5
6	important debate and an important decision that the	6
7	board has to make, and over the last eight years	7
8	there's been a lot of conversation, particularly with	8
9	the Green Mountain Care Board, before the Green	9
10	Mountain Care Board, about trying to define what	10
11	patient centered care would look like in Vermont, and	11
12	I rise today to simply say I think that the proposal	12
13	by the Green Mountain Surgery Center is a	13
14	demonstration of what patient centered care should	14
15	look like I think in terms of cost, quality, and	15
16	access to care. This is something that patients,	16
17	consumers really need, and I hope that you will look	17
18	favorably in deciding the CON.	18
19	I do have to say a couple words, though,	19
20	about cost which is an issue that I talked about	20
21	before. One of the things that certainly an	21
22	assumption is that the cost of our health care system	22
23	here in Vermont, as well as the nation, is not	23
24	sustainable, and it is troublesome to me that while	24
25	there's correctly a lot of focus on what the possible	25

clarifying the scope of this at the beginning. The CON has been issued. This is dealing with whether they have satisfied a series of conditions that have to be satisfied prior to opening and then dealing with some changes to the project. So just to clarify that for the benefit of the public. And next up we have Julie Larsen.

DR. LARSEN: Thank you. Sorry I have my back to people, but I'll try to speak loudly. Thank you for the opportunity to speak to you about such an important matter. My name is Dr. Julie Larsen. I'm an ophthalmologist. I've practiced in the area for over 25 years. I have had the pleasure of operating on thousands of Vermonters and I'm the founder of the first CON approved freestanding anbulatory surgery center in Vermont, the Eye Surgery Center.

Today I appear in a personal capacity not as an agent for the Eye Surgery Center. Offering a broader scope of ASC based medical services to Vermonters is a good thing. Thus, I'm happy to support the Green Mountain Surgery Center in offering more ASC based medical services explicitly stated in its CON and the board statement of their decision.

However, their late addition of cataract surgeries appears to circumvent the CON process.

	113		115
1	Green Mountain Surgery Center's addition of routine	1	with CON criteria was not demonstrated on a specialty
2	cataract surgery is based on absolutely no proof of	2	specific basis, and the CON was not approved as
3	need. I understand that showing need and avoiding	3	restricted to specific specialties. So that would be
4	unnecessary duplication of services are key elements	4	our position.
5	of the state CON law. Today the Eye Surgery Center	5	I think as Ms. Cramer indicated, NMC and
6	is running at approximately 60 percent capacity, over	6	VAHHS are taking the position that the ASC can only
7	more than 10 years with ample availability for	7	operate in the specialty areas for which projections
8	additional cases. Hearing Dr. Weissgold and Young's	8	were provided and that a CON amendment would be
9	testimony today I advnowledge that on rare	9	required to expand services into other specialties
10	occurrences there will be a need to perform cataract	10	such as ophthalmology or plastic surgery. So I think
11	surgery in conjunction with vitreoretinal surgery. I	11	those are either of the two physicians' positions
12	do not oppose that type of non-routine cataract	12	that have been advanced. I don't think that anyone
13	surgery.	13	is suggesting that the surgery center was approved
14	In summary, approving Green Mountain	14	with respect to the specific individual doctors who
15	Surgery Center's request to duplicate our CON scope	15	would be participating and providing services. So I
16	would not result in any savings to Vermont patients	16	was a little confused by the testimony about the
17	— any cost savings, excuse me, to Vermont patients.	17	surgery center might have a different impact on NMC
18	That's — all ASC's are reimbursed the same. It	18	because different physicians are now potentially
19	will, however, result in unnecessary duplication of	19	participating who might draw more patients from NMC,
20	care that's already available in an established ASC	20	and you know I just want to clarify that I don't
21	which specializes in eye surgeries only. Therefore,	21	think that ACO is being asked to relitigate whether
22	I respectfully request that the board deny Green	22	it can provide surgery or service in the areas with
23	Mountain Surgery Center's request to offer	23	respect to which projections are provided, and a CON
24	ophthalmology procedures that are currently being	24	amendment is not required each time a different
25	performed at the Eye Surgery Center. Thank you.	25	doctor, you know, opts to provide services at the
	114		116
1			

	114		116
1	MR. BARBER: Thank you. So that unless	1	surgery center, you know, in OB or in orthopedics,
2	there's anything else from the parties —	2	for example. So — so I don't see why it would be
3	MS. TYLER: I have a couple things to	3	relevant to present that particular information that
4	clarify if you wouldn't mind. Should I go back up to	4	there's a different orthopedist now potentially
5	the microphone?	5	participating in the center and that person might
6	MR. BARBER: NO.	6	draw more patients from NMC. So that was one thing.
7	MS. TYLER: The first thing is that I	7	The second thing was I think there was
8	think Ms. Cooper during her testimony agreed to do a	8	an interest on the part of the board in information
9	few things that were asked of her by several members	9	from NMC concerning its assessment of the impact of
10	of the board. I think it would be mice for us to	10	adding ophthalmology services and plastic surgery
11	have a summary from your point of view to make sure	11	services, and if the board is interested in receiving
12	that we have all of them. We caught everything. So	12	that information from NMC, the ACTD, LLC was not
13	that would be helpful just to confirm what's expected	13	asked to provide that information from its
14	in terms of changing the policies and things of that	14	perspective and based on the information that it has
15	nature, and then I had — I had a question. I feel	15	regarding its participating providers and where they
16	the need I guess to clarify what the board is	16	currently provide services. So we would ask to
17	considering with respect to the expansion of scope	17	provide that information as well based on our
18	following the discussion just at the end with NMC.	18	understanding of what's expected.
19	So it's our position that the CON was	19	MR. BARBER: So first issue I would
20	approved for a multi-specialty ASC. That's the	20	expect that to be addressed in the written arguments
21	language that's used in the CON and it wasn't	21	both parties are going to be presenting. With
22	approved for specific specialties. So projections	22	respect to the evidence that was asked from NMC if
23	were provided based on interest that had been	23	you have evidence that you would like to present on
24	expressed by physicians in the community at the time	24	that, the board would be willing to accept that I
25	the application was put together, but the compliance	25	think, but I think if I'm understanding the
		L	

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1	questioning correctly, the questions were around the	1	(whereupon, the proceeding was
2	additional impact that the $-$ so a number $-$ like Ms.	2	adjourned at 4 p.m.)
3	Berry Bowen said the number of projections changed	3	
4	both in terms of new services and in terms of	4	<u>CERTIFICATE</u>
5	volumes, and getting an understanding as to what that	5	
6	new effect is on NMC because that's the way they were	6	
7	going. So —	7	
8	MS. TYLER: Okay. I just would ask to	8	I, JOAM Q. Carson, Certified Shorthand
9	clarify the purpose of that report, though, because I	9	Reporter and Notary Public, do hereby certify that
10	want to make sure that ACTD is not being asked to	10	the foregoing pages numbered 1 - 119 inclusive are a true
11	relitigate the permit that's already been approved.	11	and accurate transcription of my stenographic notes to the
12	So ACTD is not being asked to demonstrate that the	12	best of my ability of the proceedings in re: Application
13	permit that's already been approved still stands now	13	of ACID, LLC before the Green Mountain Care Board held on
14	that a different doctor is providing orthopedic	14	April 17, 2019, at the Pavilion Auditorium, State Street,
15	services.	15	Montpelier, Vermont, beginning at 1 p.m.
16	MR. BARBER: I don't think anyone is	16	
17	trying — that's not my understanding is we're	17	
18	relitigating this CON that was issued. We're dealing	18	
19	with changes in scope and those changes relate to new	19	JoAnn Q. Carson
20	services. They also relate to changes in the	20	Registered Merit Reporter
21	projections in payer mix, volume, all those sorts of	21	Certified Real Time Reporter
22	things that were drawn out in the questions and	22	
23	answers that preceded this hearing. So maybe what	23	
24	might be best is we have a post-hearing status	24	
25	conference. It might be best that we have a post-	25	
[			
	118		
1	hearing status conference instead of continuing these		
2	discussions in this vein. Does that make sense?		
3	MS. TYLER: Sure. I'm — unfortunately		

2	discussions in this vein. Does that make sense?
3	MS. TYLER: Sure. I'm — unfortunately
4	I'm out of town next week so if we could do it
5	tonorrow or Friday, that would be ideal.
6	MR. BARBER: I will send an e-mail
7	around seeing if folks are available maybe Friday.
8	MS. TYLER: Sounds good. Thank you.
9	MR. BARBER: Anything else, Ms. Cramer?
10	MS. CRAMER: No. That's fine. I think
11	a followp will be helpful.
12	MR. BARBER: Okay. So I think we're
13	going to end the hearing portion of this meeting and
14	turn it back over to the Chair.
15	CHAIR MULLIN: Is there any old business
16	to come before the board? (No verbal response.)
17	Seeing none is there any new business to come before
18	the board? (No verbal response.) Seeing none is
19	there a motion to adjourn?
20	MR. PELHAM: I'll move.
21	MS. LUNGE: Seconded.
22	CHAIR MULLIN: It's been moved and
23	seconded to adjourn. All those in favor signify by
24	saying aye? (Board members respond aye.) All
25	opposed? (No verbal response.) Thank you.

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		March 19	, 2019		Page: 120 \$20 - April
\$	80.2, 80.4 24 [5] Vol. 1 -	1.24	<b>add [3]</b> Vol. 1 - 67.9, 71.8, 99.22	agent Vol. 1 - 112.18	Vol. 1 - 30.5, 61.11, 83.14,
\$20 Vol. 1 - 51.13 \$20,000 Vol. 1 -	3.13, 3.19, 23.16, 96.24, 98.13 <b>24/7</b> vol. 1 -	<b>9</b> [4] vol 1 - 3 8	<b>added [5]</b> Vol. 1 - 67.20, 79.8, 89.15, 109.19,	<b>aggregated [2]</b> Vol. 1 - 25.19, 25.24	83.18 anesthesiologist Vol. 1 - 61.17
39.17 <b>\$200</b> Vol. 1 -	10.19 25 [7] Vol. 1 - 17.13, 18.1, 18.5,	<b>9 [4]</b> Vol. 1 - 3.8, 18.23, 81.16, 87.6 <b>93 [2]</b> Vol. 1 -	109.25 <b>adding [2]</b> Vol. 1 - 98.16, 116.10	<b>agree [5]</b> Vol. 1 - 15.9, 46.11, 84.9, 84.17, 87.5	<b>anesthesiologist</b> Vol. 1 - 61.18 <b>Ann</b> Vol. 1 - 5.15
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