STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

IN RE: APPLICATION OF ACTD, LLC)
FOR GREEN MOUNTAIN SURGERY CENTER) GMCB-010-15CON

Hearing held before the Green Mountain Care Board at the Pavilion Auditorium, 109 State Street, Montpelier, Vermont on April 17, 2019, beginning at 1 p.m.

BOARD MEMBERS:

Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Robin Lunge, JD, MHDS
Tom Pelham

STAFF MEMBERS

Susan Barrett, Esq., Executive Director
Michael Barber, General Counsel

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802/800) 863-6067
E-mail: info@capitolcourtreporters.com

HEALTH CARE ADVOCATES
Julia Shaw
Eric Shouldice

INDEX

CHAIR MULLIN: Good afternoon everyone. Welcome to the Green Mountain Surgery Center meeting. First item on the agenda is the Executive Director's report. Susan Barrett.

MS. BARRETT: Thank you, Mr. Chair. I have some scheduling announcements. First, this Friday, April 19 we will have a meeting here in this auditorium at 9 a.m. and we will be potentially voting on hospital budget enforcement hearings. Thank you. I think everyone can hear me. I'm pretty loud.

The other scheduling update is on Wednesday, April 24 we'll be hearing from Springfield Medical Center. We'll be hearing on a rate adjustment to their budget as well as their enforcement hearing. We had had Springfield scheduled for today and due to Representative's passing and a funeral we've rescheduled that to April 24, again in this auditorium, starting at 1 p.m., and then we have finalized the date for our traveling board meeting will occur at the end of this month — next month May 29. It will be at Gifford Hospital, and there will be more details on our web site, and, lastly, if folks have not signed in, I would ask that you sign in at the back table and that is all I have to announce.

MR. MULLIN: Representative Jickling is here. Do you want to recognize him?

MS. BARRETT: Oh yes. I want to recognize Representative Ben Jickling who is on the House Health Care Committee. Thank you. Thank you for coming.

CHAIR MULLIN: With that we have two minutes to approve. The first is Wednesday, April 10 and the second is Friday, April 12. Is there a motion?

MS. USIFER: So moved.

MR. PELHAM: Second.

CHAIR MULLIN: Been moved and seconded to approve both sets of minutes without any additions, deletions, or corrections. Is there any discussion? Hearing none all those in favor signify by saying aye. (Board members respond aye) Any opposed? (No verbal response.)

Thank you. So at this point we would like to turn to the CON hearing on Green Mountain Surgery Center and I am going to appoint Michael Barber to be the Hearing Officer and Michael will be running the rest of the afternoon.

MR. BARBER: Thank you. So good

5

afternoon. This is a hearing in the case of in re: ACTD, LLC doing business as Green Mountain Surgery Center. The docket number is GMCB-010-15 CON. As the Chair said my name is Michael Barber. I'll be serving as the board's designated Hearing Officer for today. This is — this hearing will be conducted under Title 18 Chapter 221 of the Vermont statutes and the Board's Certificate of Need regulation GMCB Rule 4. The provisions of the Administrative Procedures Act do not apply to these proceedings.

ACT or ACTD, the holder of the CON, is represented today by attorney Karen Tyler. Representing Vermont Association of Hospitals and Health Systems and Northwestern Medical Center who are interested parties is attorney Ann Cramer, and representing the office of the Health Care Advocate, also an interested party, are attorneys Julia Shaw and Eric Shouldice.

So the agenda for this afternoon's hearing is as follows. First we're going to hear from ACTD. Based on our prehearing conference I expect your presentation to be 45 minutes or so. I have asked the Board Members to hold their questions until the end instead of interrupting it. I think that will make things go smoother. Following your

6

presentation there will be board questions, the opportunity for Health Care Advocate to ask some clarifying questions, and then we're going to hear from Northwestern Medical Center. We'll have one witness again followed by board questions and potentially questions from the Health Care Advocate.

At the end we're going to have a public comment period. If you would like to make comments today, there is a sign-up sheet outside the door. I would ask that you please put your name down. The board will not be making any decisions today. So in addition to the comments that the board receives orally at the end of the hearing, the board will accept 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.

We have a court reporter here with us today and she's making a transcript of the proceeding, and before we move on and I turn it over 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 to testify today, if you would please stand up and raise

7

your right-hand so the court reporter can swear you in.

(Potential witnesses were sworn.)

MR. BARBER: Ms. Tyler, turn it over to you.

MS. TYLER: Sure. I'm Karen Tyler with the firm of Dunkiel Saunders representing ACTD, LLC. Thank you very much for the time today. We'll start with just an introduction of the folks at the table here and then we'll move directly into the presentation regarding condition compliance that they will be presenting.

MS. COOPER: Thank you, Karen. I'm Amy Cooper, manager of ACTD, LLC and the Green Mountain Surgery Center.

MR. PAONI: I'm John Paoni. I'm the administrator of the Green Mountain Surgery Center. I would like to thank you for the opportunity since this is the first time I've been at the Green Mountain Care Board. I come from Utica, New York. I moved here in July of last year to operate and help build the Green Mountain Surgery Center. This is the third 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 six

8

ORs. The second surgery center was a gastroenterology with four procedure rooms in lower Manhattan.

So I'll tell you a little bit about an ambulatory surgery center as it's a fairly new concept for Vermont, but it's a really unique medical facility. We create a very team structured environment. Everyone pitches in and we all wear a lot of hats. The ASC runs extremely efficient. Procedures are scheduled and all procedures start on time. Patient wait times are very minimal. We are focused on that patient. There is no greater satisfaction for me than seeing a patient smile when 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 Vermonters. Thank you.

MS. COOPER: Now I was going to start at the top with condition number one and go through the conditions sequentially to demonstrate how we are complying with those conditions of the CON.

9

Condition number one is that the applicant shall develop a consumer friendly web site which shall provide information about each physician planning to offer surgeries at the Green Mountain Surgery Center. So this is the consumer friendly web site that we have developed. This is currently on a development server. It is not live to the public yet. Per the CON we will launch our live to the public web site two weeks before we become operational, but we have developed the site on the development server so that is what I plan to show you today.

This is the home page here. The menu includes physicians, tour, a section for patients where we have frequently asked questions, careers, and contact information at the right. On the bottom of the web site we have a link to our pricing and quality measures, a link to our policies, and a link here that connects to the Medicare's ASC quality reporting program page where Medicare shows quality results for ASCs nationally across the country. The Green Mountain Surgery Center would be included there and patients can see the comparative quality results compared to other ambulatory surgery centers across the country.

10

To start with condition one I have pictures here now. That's Dr. Laub who is here with us today. I also have — we don't have pictures of all the physicians yet or the physicians fully loaded. I also have Dr. Young who you will be hearing from today. All of the physician profiles will follow the exact same format so I will go through and show you one of those profiles now. This is an example doctor in the field of gastroenterology. Up here is the introductory bit showing where this doctor practices, his years of experience, and whether the physician is one of the owners of the Green Mountain Surgery Center which is one of the conditions as part of condition one.

Condition one also requires that the credentials of the physician be listed so we've done that here underneath. Condition one also requires that the physician's contact information for patients 24/7 be available on the web site. That's down here at the bottom. These here are tabs that you would tab through, but the contact information always remains down at the bottom.

The hospital for this physician there is listed University of Vermont Medical Center and then common procedures that this physician does. This is

11

in response to condition 1B where we will list the types of procedure/surgery that this physician will perform and explain the evidence basis for recommending the procedure and how the procedure improves health.

So, for example, at the top are the procedures commonly performed by this gastroenterologist; colonoscopy, diagnostic colonoscopy, screening colonoscopy, and upper gastrointestinal endoscopies, and then we have some text regarding how colorectal screenings improve health by detecting cancers in people with no prior history of cancer. The object of these procedures is to reduce colorectal cancer. Colonoscopies are an effective way to screen for colon cancer because they have high sensitivity for early detection, require only a single session diagnosis and treatment, and have long intervals between examinations in patients who are over the age of 50.

For patients with symptoms of positive screening tests, diagnostic colonoscopies is generally the best choice for examination, and then endoscopy below is primarily used as a diagnostic tool to permit visual inspection of the esophagus, stomach, and small intestine which can be viewed by a

12

continuous flexible tube inserted through the mouth. Upper endoscopy also includes certain therapeutic procedures such as the removal of polyps which can be cancerous. We have the same information there for Dr. Laub and Dr. Young with descriptions of their procedures and how they improve health.

The next condition is that we shall develop and implement a policy which we will post to the web site requiring each physician use a patient decision aid such as shared decision making that fully informs the patient to the benefits and risks of all care alternatives, incorporates the best available scientific evidence, takes into account the patient's values, goals, and preferences, and advises the patients of the pros and cons, including the comparative costs, of having the procedure. The policy shall include a provision requiring certification by the provider of his or her compliance with such a policy.

This policy was submitted initially last year and is here on our web site shared decision making policy. I should also note that our web site that's live right now and open to the public, which is mostly a splash page, but also has all of our policies already up there. So this is on the dead

13

site but also on the live site, and there is our shared decision making policy there. This button opens into a PDF of the policy.

The certification page that each physician signs as part of the policy which was submitted when we submitted these policies last year to the board is signed and kept on file at the surgery center in each physician's credentialing file.

The next condition is condition 3. We shall develop and implement a policy which we shall post to the consumer web site certifying that each physician will accept patients without regard to payer type, insurance status, or their ability to pay for services. The physician shall further certify that he shall not consider the source of payment or a patient's ability to pay when determining whether to perform patient surgery at the ASC. We have our payment status non-discrimination policy listed right here. This was also submitted in full to the board last year, and this policy here also contains a certification page after the policy which each physician signs and we keep on file in their credentialing file at the surgery center.

The next condition is condition 4, the

14

applicant shall enter into a transfer agreement with at least one local hospital or obtain a binding memorandum of agreement from such hospital confirming that it will enter into a transfer agreement once the ASC becomes operational. We have completed an emergency transfer agreement with the University of Vermont Medical Center. That was also submitted to the board.

The transfer agreement reads, whereas, Green Mountain Surgery Center seeks to operate an ambulatory surgery center and is required to have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the Green Mountain Surgery Center; and, whereas, the hospital to which Green Mountain Surgery Center transfers patients requiring such emergency care must be a local Medicare participating hospital or a local non-participating hospital that meets the requirements for payment for emergency services by Medicar;e, whereas, UVM is a tertiary acute care hospital located in Burlington, Vermont and is the only hospital that is local to Green Mountain Surgery Center and meets the requirements for payment of emergency services by Medicare; whereas, Green Mountain Surgery Center

15

desires to transfer patients requiring emergency services to UVMMC and UVMMC desires to accept such patients; and, whereas, the patients also desire to facilitate the continuity of care and to specify the rights and duties of each party as well as the procedure for ensuring appropriate timely transfer of patients and records between the parties, now, therefore, for mutual consideration sufficiency of which is hereby acknowledged, the parties agree as follows, and then the document reads with explanations of how we will effectively transfer patients and medical information from the Green Mountain Surgery Center to the UVM Medical Center.

The next condition is condition 5, the applicant shall enter into a transfer agreement with EMS service for emergency patient transportation. We have entered into an agreement with the Colchester Rescue Squad. That agreement was entered into on March 7 and the copy of that agreement was also submitted to the board.

The next condition is that the applicant shall enter into a participation agreement with one or more risk bearing ACOs to receive fixed payment reimbursement in lieu of fee for service payments for patients attributed to the ACO or obtain a binding

16

memorandum of agreement from the ACO confirming that it will enter into such a participation agreement 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 agreement with CMS to operate as a Medicare certified ambulatory surgery center, and there are two ways to obtain certification from CMS. One is to go through a state agency that CMS 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

17

status with Medicare which means Medicare will accept their recommendation on certification. One of those national bodies is the Joint Commission. We have as a later condition of our CON that we have to obtain Joint Commission certification. So we can accomplish both goals by getting, before we become operational, accreditation from the Joint Commission which also brings us dean status for Medicare. So that is the route that we are pursuing to meet the condition of obtaining CMS approval before we open.

Condition 8 is that the applicant shall establish and post to the ASC's web site the commercial self pay and Medicare prices for the 25 most frequently performed procedures and surgeries or the commercial self pay and Medicare prices that comprise at least 75 percent of the ASC's overall volume. The applicant shall regularly update and post this information no less than quarterly whether or not the prices or procedures have changed. So where we have allowed for that on our web site is at the pricing and quality measure page here. We have the Medicare prices and payment rates listed first. We also have provided a link here in the explanation to the Medicare procedure price look-up tool in the event that a patient is coming in for a procedure

18

that is not on our list of the 25 most common and have directed them they can go to that web site to type in that procedure and get an estimate of the cost in the ASC. We do have a PDF here which lists what we anticipate will be our 25 most common procedures and then the Green Mountain Surgery Center Medicare payment from Medicare's published outpatient ASC procedure fee schedule that they published in January of 2019.

We plan to use the same format for the 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 ASC's consumer web site available to the public no later than two weeks prior to commencing operations.

19

We are on track and plan to do that and would plan to notify the board when our web site is launched to the public.

Number 10 — condition number 10 is the applicant shall not offer services, procedures, or surgeries without first demonstrating to the board that such services, procedures, or surgeries are evidence based and fall within the scope of those approved in the Certificate of Need. I submitted on March 18 studies showing the evidence basis of procedures to be performed across our initial plan specialty list. The study submitted also showed the efficacy and safety of performing these procedures in an outpatient ambulatory surgery center environment.

The scope within the context of this condition seems to mean specifically those procedures that can be performed safely and reliably in an ambulatory surgery center. This way of defining the scope was articulated in the statement of decision of our CON findings of fact number 14 which says that pursuant to federal law physicians using the facility may only perform surgeries and procedures that are not expected to cause a significant safety risk to a patient when performed in an ASC and for which the standard medical practice dictates that the patient

20

would not typically be expected to require active medical monitoring and care after midnight following procedure.

Condition 11 is that the applicant shall require that each physician that performs procedures or surgeries at the ASC have admitting privileges at one or more local hospitals. This requirement is stipulated in our medical staff bylaws in section 4 where we say under 4.2, membership qualifications, that membership on the medical staff of the center 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 Vermont to accept reimbursement that is below the community fee schedule rate for insurers that do not

use the community hospital fee schedule. The applicant shall negotiate reimbursements that it can demonstrate are below reimbursements for the same procedures and surgeries when performed in a hospital setting. I explained our plan to comply with this condition in a letter I wrote to the board that was submitted on March 26. We are planning, as we negotiate with insurers over the next couple of months, to ask them after we've settled on reimbursement rates to provide us with a letter that confirms that the reimbursement rates provided to us are below the average reimbursement rates paid to local hospitals for the same procedure. We would plan to submit those letters to the board as we complete our contracting with the major commercial insurers including Blue Cross and Blue Shield of Vermont.

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 number 3.14, which we submitted to the board at the end of January. A policy states that a patient can be considered self pay if they are having a medically necessary

procedure and maintain no health benefits to the best of the center's knowledge. Health benefits cannot be verified if a patient maintains health benefits with an insurer with which the facility is not contracted. The following discount policy applies and that first bullet under the procedure is that the self pay rate billed to patients for any code or service that is medically necessary will be equal to the lowest amount that the center gets paid by contracted commercial insurers for the same procedures.

MR. BARBER: Miss Cooper, I'm a little 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 gets a phone call prior to the procedure and a full explanation to them is given to what their

co-insurance is, their co-payment, or any deductible. They are also offered to have that information sent to them either via post mail in writing or via e-mail.

The second one is our free or discounted care policy and we looked at our local hospitals to their policy to offer similar discounted care and so we used a simple form. It's very simple, and the patients can fill it out and be reviewed for free or discount care.

I'm trying to keep this short not to go into the deep policies. Our after hours care policy patients are given written instructions upon discharge from the facility on the discharge summary with contact information for the physician to give them 24 hour access to that physician and to an active telephone number to reach that physician.

MS. COOPER: Thank you. Condition 17 is that the applicant shall begin the process for accreditation by the Joint Commission, and like I said we've already started that process in conjunction with CMS certification and plan to earn accreditation from the Joint Commission before we become operational.

Condition 18 is that the applicant shall

require that physicians sign a collaborative care agreement. We have that agreement, submitted it to the board on March 18.

Now that we have gone through the initial 18 conditions that we were planning to address the one other element that we were planning to address at the hearing is our request to modify condition 21 and I will let Attorney Tyler speak to that.

MS. TYLER: Condition B21 requires the 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 case.

So the information with this condition

25

and the reason that we've asked to modify it is that the providers consider all of the information that's requested private information. It's information that they keep confidential, that they consider sensitive and competitively sensitive. So, for example, it's not information that would typically be available to a prospective employer of a physician unless the employer asked for it specifically and the provider chose to disclose it. So, you know, for these reasons as we've explained in the letter that we submitted in early January we believe this information qualifies for — to be withheld from public inspection under the Public Records Act, and we've cited the appropriate provisions which would be Section 317 C7 and C9.

So what the surgery center is asking for instead is to disclose all of the information that the board has requested but to disclose it on an aggregated basis by specialty rather than, you know, by individual provider. The board, of course, is charged with regulatory oversight of the surgery center as an entity and not with the conduct of each individual physician. So we believe that providing the information on the aggregated basis as we've requested will serve the purpose of the condition,

26

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 each individual provider.

MS. COOPER: The next part of our presentation would respond to the request in the board's hearing letter to provide information on the need for the ophthalmology and plastic surgery specialties, but if this is a better point to pause before getting into that section for questions, I'm happy to do that or we can move right along into that.

MR. BARBER: I think getting through the rest of the testimony and questions on everything that the board has heard will be the best course.

MS. COOPER: Great. So there was a specific request for information in the prehearing letter regarding cost savings and wait times for ophthalmology. We submitted a letter from Dr. Doyle's office, who is an eye surgeon in Berlin, who experiences wait times for his patients of between two and five months. We also submitted national data from an ASC benchmarking report showing that 83

27

percent of patients needing cataract surgeries access surgeries within four weeks.

We also submitted, and which I have here, information about the cost savings of ophthalmology services. The information we included comes from Medicare's procedure price look up and I'm just going to see how I can enlarge this view. Maybe it's big enough. I'm not sure. In any case the tool shows on the left if you were to type in at the top a procedure code — thank you — the procedure code here is 68700, plastic repair of tear, Medicare will provide you with the rate paid on average nationally to an ambulatory surgical center and the rate paid on nationally — on average to hospital outpatient departments. This tool is also very useful and consumer patient friendly in that it shows on the blue bars what the patient responsibility is per Medicare plan design, and the total cost there is on the bottom. The average total cost of this procedure in an ASC is 805 dollars. The average total cost in a hospital is 1812 dollars.

And this is another ophthalmology procedure. All procedures included in this presentation are for ophthalmology. I won't go through every one. I think we included about 15

28

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 over to the witnesses that I have asked to testify to further explain the need for ophthalmology and plastic surgery services at the Green Mountain Surgery Center.

DR. WEISSGOLD: Hello. Thank you for the opportunity to address you. My name is David Weissgold. I'm a vitreoretinal surgeon. I've practiced surgery in the Burlington, Vermont area since 1997 and as a part of Retina Center of Vermont since 2005. I currently perform retina surgery at University of Vermont Medical Center, Fletcher Allen Health Care before that. UVM has always been the sole hospital in the state equipped to accommodate retina services.

Retina Center of Vermont has tried for several years to gain access to an ambulatory surgical setting for its surgical patients. In 2015 my partner, Dr. Michelle Young, who is here and from whom you will hear, and I began conversations with the owners of the only existing ambulatory surgical

center in Vermont. At the time we explained that retinal surgeries are routinely performed in both single specialty and multi-specialty ambulatory surgical centers throughout the country and that we would like to offer our patients the convenience and affordability of having their procedures performed in a small outpatient surgical setting rather than exclusively at the academic medical center. While conversations were cordial and exploratory we were ultimately told that staffing constraints and scheduling complications would prohibit us from bringing our services to the existing ambulatory surgical center.

Discouraged but still determined we then approached smaller regional hospitals and began to explore with them the possibility of treating our patients there instead. These conversations conducted over the phone, via e-mail, and sometimes in person ultimately did not bear fruit either as the hospitals shied away from further conversations after citing a need to spend more time investigating how hosting retinal surgeries would fit in with participation in new payment models.

Then in 2017 we went back to the only existing ambulatory surgical center in the state and

reengaged that group in conversations, however, once again it was decided that offering retinal services would not be possible due to reasons related to reporting scheduling — reported scheduling conflicts and lack of general anesthesia capabilities. We also began conversations with the Green Mountain Surgery Center about the possibility of bringing our cases there in 2015, but not early enough in the process to be counted as part of the original set of projections they prepared for the project which was submitted in July of that year. No promises were made at that time when we began conversations with the Green Mountain Surgery Center as they still had to determine whether they would get a Certificate of Need and what sort of restrictions might accompany it.

They also had to understand — excuse me — whether costs for the retinal equipment would fit into their budget. We also continued pursuing other potential options to bring patients to the existing ambulatory surgical center or a smaller hospital through to the end of 2017. Now four years after we began searching for a more suitable option for our patients we finally have the opportunity to operate in a setting that will better meet the needs of our

practice and our patients.

UVMMC is not fully meeting the needs of my practice at this time. UVMMC recently announced a problematic policy change with respect to how operating room time is scheduled. We were informed recently that starting on April 29 of this year, this month, most surgeons, vitreoretinal services included, will be required to release to other surgeons operating room block time that is not fully scheduled with cases seven days in advance of the proposed date of surgery. This new hospital-wide rule does not work for Retina Center of Vermont and its patients as many vitreoretinal surgeries are urgently needed ones that cannot be scheduled more than a week in advance. Last year approximately 50 percent of our procedures were scheduled fewer than seven days in advance.

While I will be able to schedule separate operating room time outside of my normal block time for urgent and emergent procedures under the new policy, that would come at great expense to my other patients who have appointments for office based care whose appointments I would then have to cancel and reschedule in order to go to the hospital to meet UVMMC's scheduling demands for my operating

room bound surgical patients. I see office based patients during all times outside of my operating room block time every work week, and very many of those patients' needs are no less pressing nor vision threatening than are those of the operating room bound patients. One can permanently lose vision just 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.

UVMMC 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 UVMMC 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

33

reality of how retina practices across — access operating rooms across the country. The one size fits all approach adopted by UVMMC, obviously a large institution with many stakeholders to manage at the same time, does not meet the needs of my patients and my practice. This is why I'm interested in performing vitreoretinal surgeries in the Green Mountain Surgery Center. It is commonplace for vitreoretinal procedures to be performed in ambulatory surgery centers in other parts of the country for reasons of cost savings, quality, efficiency, and patient preference for the ASC environment.

Based on discussions I have had with Green Mountain Surgery Center management over the past few months I expect that the Green Mountain Surgery Center will be much better able to accommodate my scheduling needs than UVMMC, and I understand that Green Mountain Surgery Center will be able to provide all equipment and staffing that I need to care for nearly all of my operating room bound patients. Green Mountain Surgery Center's small size will enable nimbleness that will be a huge improvement over Retina Center of Vermont's current experience.

34

I've been asked to address as part of this testimony whether it would be feasible for the Green Mountain Surgery Center to offer vitreoretinal but not cataract surgeries. It would not make sense from a care centric standpoint to authorize the Green Mountain Surgery Center to offer only some of the surgical eye services that are appropriately performed in an ambulatory surgical center. Some patients needing vitreoretinal surgeries also need cataract surgeries. It is not rare for a patient undergoing vitreoretinal surgical repair of a complex retinal detachment, for example, to also need a cataract removed to enable the highest quality, safest vitreoretinal repair. Sometimes the needs for those patients' cataract extractions is known in advance. For a variety of reasons it has been nearly impossible to schedule cataract surgeons to perform those cataract extractions simultaneous with vitreoretinal surgical repairs at UVMMC.

I understand Green Mountain Surgery Center has already planned to meet this need with same session same day planned cataract extractions by cataract surgeons and vitreoretinal procedures by vitreoretinal surgeons. This offering is near universal in all other states but has yet to be

35

afforded to those Vermonters who might benefit from it. In addition, it makes no patient care related sense whatsoever to prohibit cataract extractions by vitreoretinal surgeons in instances wherein the need for those extractions only becomes evident right in the middle of a vitreoretinal surgical procedure and/or in instances where in simultaneous interocular lens prosthesis placement by second lens dedicated surgeons is not needed and/or is contraindicated medically.

In conclusion, one size fits all does not work for vitreoretinal surgical services for an entire state. Vermont patients deserve options and cost competition. Having gone to great lengths to explore all of the possible options, I have no doubt that the Green Mountain Surgery Center is the best suited to meet my patients and my practice's needs. Thank you.

DR. YOUNG: My name is Michelle Young and I am a vitreoretinal surgeon. I've been practicing ophthalmology in Vermont since 2004 first at the UVM Medical Center and at Retina Center of Vermont since 2009. I perform surgeries at the UVM Medical Center which is currently the only facility in Vermont with the necessary equipment and staff

36

trained to handle vitreoretinal surgeries.

Like my partner Dr. Weissgold I am concerned about UVMMC's recent policy change regarding OR block scheduling which requires surgeons to release unscheduled block time seven days in advance. Most vitreoretinal surgeries need to be scheduled within one to seven days, and as a result I'm now being offered OR time for emergent and urgent procedures during weekdays when I have fully blocked clinics and after I have released my block time which means I'll be forced into a situation that will necessitate rescheduling my clinic patients some with potential blinding diseases and whose care is just as urgent as the patient needing surgery in the operating room.

I would like to have the option to perform vitreoretinal surgeries in the Green Mountain Surgery Center. In states where ASCs are present vitreoretinal procedures are often performed there at lower cost for the patient. ASCs can provide equivalent or higher quality and greater efficiency than regional medical centers. I expect that the Green Mountain Surgery Center will provide a high quality facility that meets my scheduling needs which is ultimately for the well being of my patients.

37

I have been asked to consider whether it would be possible for me to perform vitreoretinal procedures at the Green Mountain Surgery Center but perform no cataract surgery at the same center. My answer is this is just not possible. I do not perform routine cataract surgery, but I do perform cataract surgeries in conjunction with complicated vitreoretinal procedures as I need to. I also perform cataract surgery in patients in whom previous cataract surgeries have become complicated by loss of lens material into the posterior segment. During any vitreoretinal surgery it's possible that I will need to perform cataract surgery as part of the procedure and it's not always possible to know in advance whether or not a patient will need a lens procedure done in addition to their scheduled vitreoretinal surgery.

I've tried for years along with Dr. Weissgold to find an operating environment that will better meet the needs of my practice and my patients. There is no question in my mind that having access to an ASC environment at the Green Mountain Surgery Center will improve the efficiency and effectiveness of both my clinical and my surgical practices for the benefit of my patients. Thank you.

38

DR. LAUB: Thank you for the opportunity to make some comments here today. My name is Donald Laub. I've been a practicing plastic surgeon in Vermont since I was hired by the old Fletcher Allen in August of 1997. I'm currently in private practice at Four Seasons Dermatology in Colchester. Since I started with Fletcher Allen in 1997 I have had a busy reconstructive surgery practice including working with the orthopedic department at UVMC and serving as the medical director of the craniofacial center providing a wide variety of other necessary medical treatment for Vermont residents.

I separated from UVMC in October of 2017 after 20 years there. At that time I thought about leaving the state entirely, but decided to stay partly because of the possibility of operating at the Green Mountain Surgery Center. When I worked at UVMC I operated five days a month consistently. After I separated from UVMC I was given less than one full day of scheduled operating room time per month after over five months of negotiation. Needless to say the severely reduced operating room time has led to many of my patients to have delays of months before having surgery. For example, one baby with a cleft palate had to wait three months later

39

than the recommended time to have the surgery.

In order to continue to serve my patients I have supplemented the lack of surgery days at UVMC by obtaining operating privileges at other smaller regional hospitals in St. Albans and Middlebury. Although this is a benefit for patients needing plastic surgery in Franklin or Addison County, most of my patients live in Chittenden County and they have additional driving time in order to have their surgery because of this. This is unfortunate that this means more time off work for their families and caregivers.

The high cost of surgery at the academic medical center in Burlington is also a barrier to care for me and my patients. One of my patients desired to have surgery that was not covered by his insurance and was quoted an almost — almost $20,000 institutional or hospital fee for his surgery at UVMC. This surgery is the same day outpatient surgery that takes less than a few hours. If that were his only option, the patient would need to forego having the surgery altogether. However, thank goodness for him he is now scheduled to have his surgery at the Green Mountain Surgery Center for an institutional fee less than a tenth of that figure

40

quoted by UVMC.

In conclusion, I would like to say, I can't emphasize this enough, there's a great benefit for the people of Vermont that they now have the option for timely and affordable surgical care in the form of the ambulatory surgery center like the Green Mountain Surgery Center. Thank you.

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

MS. TYLER: 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. LUNGE: Shall I go first?

MR. BARBER: Sure.

MS. LUNGE: 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 ophthalmology surgery that you initially approached the applicant

41

in 2015?
DR. WEISSGOLD: Yes.
MS. LUNGE: You have to verbalize it for our court reporter.
DR. WEISSGOLD: Sorry.
MS. LUNGE: Thank you, and currently are either of you doing stand alone cataract surgeries?
DR. WEISSGOLD: No.
DR. YOUNG: Well except in the context — no except when it's a lens that's in the posterior segment. So we may be — it depends how you define stand alone cataract surgery, but yes there are times the only reason we're going to the operating room is to remove lens material from the eye, but when it's caught up in the back of the eye we also must perform a vitrectomy.
MS. LUNGE: Got it. Thank you.
DR. WEISSGOLD: When I do that surgery I will sometimes also put in a lens implant.
MS. LUNGE: Great. Thank you for explaining that. As you know we're not clinicians here so it's helpful to have the layperson explanation, and in terms of plastic surgery my questions there were could you give us a sense of the percentage perhaps, or you can tell me what the best

42

way to explain it is, but the percentage of your practice that's medically necessary procedures versus what I would call cosmetic? There might be a better word for it than that.
DR. LAUB: Yes. Much less than 10 percent of my practice is cosmetic.
MS. LUNGE: Thank you, and for all of your — the procedures for both of the specialties are those procedures which are typically covered by Medicare?
DR. WEISSGOLD: All of ours are.
DR. YOUNG: Yes.
DR. LAUB: Other than the small percentage of my cases that are deemed cosmetic would be covered by Medicare.
MS. LUNGE: Okay and is that also true for commercial insurance?
DR. YOUNG: Yes.
DR. WEISSGOLD: Yes.
DR. LAUB: Yes.
MS. LUNGE: And what about Medicaid?
DR. YOUNG: Yes.
DR. WEISSGOLD: Yes.
DR. LAUB: Yes.
MS. LUNGE: Great. Thank you.

43

CHAIR MULLIN: Just an expansion on Robin's question. Can you go into more detail on why you weren't successful in the 2015 discussion and when you ultimately came back to that discussion?
DR. WEISSGOLD: Which discussion are you referring to?
CHAIR MULLIN: The discussion with the ambulatory surgical center to be able to conduct your operations there.
DR. WEISSGOLD: The then existing one?
CHAIR MULLIN: No.
DR. WEISSGOLD: The Green Mountain Surgery Center — oh we were not successful. It was just very preliminary discussions and we were still in discussion with other entities about whether we could go there.
CHAIR MULLIN: So it was one long continuing discussion?
DR. WEISSGOLD: No. I would say it was punctuated every several months or so.
CHAIR MULLIN: Okay. Thank you.
MR. BARBER: While these three witnesses are up Eric Shouldice, Julia Shaw, do you have questions for these witnesses?
MS. SHAW: I don't believe we have any

44

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. Thank you.
MS. HOLMES: Okay. Looks like I'm going to be taking it all. Can everybody hear me? Okay great. So in your application and in our statement of decision the primary need being met here was really that the ASC was going to be a low cost alternative for all Vermonters. So I'm going to focus my — the beginning of my questions around condition 12 which requires the Green Mountain Surgery Center to accept reimbursements for procedures and surgeries that are below the reimbursements paid to hospitals. So we are very clear on it being below the reimbursements paid to hospitals.
So, Ms. Cooper, in your testimony and in your letter that was dated March 26th of 2019 you state in order to satisfy condition 12 we plan to ask commercial insurers that we contract with to provide us with a letter stating that reimbursements that were paid to the Green Mountain Surgery Center for procedures and surgeries are below the average

45

equivalent reimbursement paid to hospitals for providing the same services. Can you tell me how that actually satisfies the condition 12?

MS. COOPER: Sure. I think I tried to also in my letter explain that commercial payments, facility payments to hospitals for outpatient surgeries vary among different hospitals. There is no uniform community fee schedule for facility payments to hospitals for outpatient surgery in the commercial market like there is in the Medicare market. That makes it impossible for us as the Green Mountain Surgery Center to know what the hospital outpatient payment is from a different — from a commercial insurer for a particular surgery.

I submitted a list of our initial planned procedures by CPT code which had between three or four hundred codes on it. I don't know what hospitals receive from commercial insurers in equivalent facility payments for those three hundred codes. It's very hard information to get. I don't think it's even possible to get. So I need to negotiate with commercial insurers and say here's what I think my costs are for providing this, here's what I would like in reimbursement, and they need to come back to me and say we think that one is too

46

high, this one is fine, okay, and that's how we'll have an agreement.

I did attempt to ask Blue Cross Blue Shield for information about their payments to hospitals for the equivalent outpatient surgeries and they declined to provide me with any of that information. So the only way that I can think to achieve this, meeting this condition while also dealing with the realities of the commercial insurance contracting market in the state, is to agree to prices for payment with the commercial insurers and then have them attest to me, because they won't share their payment rates to hospitals what they are, that what they are paying us is lower than what they are paying hospitals.

MS. HOLMES: Okay, but let me clarify. There's a difference between lower than what they are paying hospitals and lower than the average reimbursement. So let me remind you of — I asked you at the first hearing the testimony — I asked you a question would you be willing to guarantee as a center policy to ensure that your prices will always be lower than hospitals and put that policy on your web site and in your negotiations with commercial payers effectively state that that's your policy and

47

making sure that stays true, and you said the answer to that is yes.

So there's a difference between ensuring that your prices are below the average and ensuring that your prices are below the minimum. Let me just finish, and so — and in particular if you look at the average reimbursement, if the average were the same as the median, then 50 percent of the hospitals would be cheaper than the ambulatory surgical center if you're pitching at the average, and so — and frankly the average is going to be higher than the median because you're going to have an outlier with the academic medical center pulling up the average. So the median is actually going to be lower than the average here.

So my concern is that in your testimony when you first put forth the idea of a low cost alternative to Vermonters in the ambulatory surgical center, you know, you advocated this was going to be a lower cost than all hospitals, in fact there were numbers out there that the prices would be 50 percent less, there was lots of testimony that the prices would be about 50 percent less, the rates would be 50 percent less than hospitals, and even in your response to some of the board's questions January of

48

2019, so just this past January you confirmed, this is a quote, "We confirm that surgeries and procedures offered at the Green Mountain Surgery Center will be offered at lower cost than the same surgeries and procedures in hospital outpatient settings, including surgeries and procedures offered in specialties of plastic surgery and ophthalmology." So that's suggesting it's lower than the minimum. It's cheaper than the hospitals. It's not cheaper than the average.

MS. COOPER: So understanding again that the payments paid by commercial insurers to hospital outpatient departments for individual procedures are extremely varied and different from each other on the order of thousands of dollars sometimes, had the question been asked would you state as a policy that you will be lower than the minimum price paid to any hospital, I may not have answered in the affirmative. The question was asked will you be lower than the hospitals undefined whether that's the minimum price, the median price, or the average price, and I said yes I can confirm I'll be lower than the hospitals, and then I'm defining that now more specifically as the average of the hospital prices. It was never specifically defined prior to that.

49

There also is no doubt that the hospitals see us as a major threat and are — have been opposed to our opening this whole time, and could, because we offer a very limited set of procedures, artificially lower their prices on certain procedures that we offer and then we would have to match that minimum price had we agreed to contract at lower than the minimum hospital price, and that would be a threat to the existence of our business if our competitors, because they offer a much wider array of services that they get other reimbursements for and wouldn't threaten our business, to have artificially lowered their prices on certain procedures that we do, that is a scenario that I could quickly see playing itself out had we agreed to have prices that are only always below the minimum price of any hospital.

MS. HOLMES: Well I just want to remind you, you said the answer to the question was yes your prices will always be lower than hospitals. That was the question I asked you and you've answered yes, and so I'm just going to remind you of that. So it is possible in your current negotiations that there could be hospitals that will be cheaper than your center for some of these procedures?

50

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 CPT 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 below that price.

MS. HOLMES: But at this point you're unwilling to ask the commercial insurers to attest to a letter saying that your prices — the negotiated

51

reimbursed prices for the ambulatory surgical center are always lower than the other hospital prices in the state?

MS. COOPER: So what I have done in terms of looking at price comparisons we often quote Medicare and Medicare prices to payment rates to ambulatory surgery centers are 44 percent lower than payment rates to hospitals on average, but if you look at a whole list of 350 CPT codes and you compare an ambulatory surgery center rate to a hospital rate, there are some payments in there where the hospital gets paid hundreds of dollars for a code that an ambulatory surgery center gets paid $20 for, and so that level of variation exists and may exist for all I know in the commercial market. There may be a hospital for all I know, where anyone knows, that is taking some ridiculously low payment on a procedure that we would do and that I could not accept and still have a business. So I can't make a promise that in the commercial market without knowing what all the prices are that we would be below any minimum price that an insurer — a commercial insurer contracted for with a hospital.

MS. HOLMES: Another condition that we had is that the ASC implement a policy that requires

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 surgeons looking at their cases and chart notes. We have also talked about putting as part of our peer review policy that that also include reviewing case mix and payer mix from other surgeons so that could

53

be included.

MS. HOLMES: So that whole process if somebody was only bringing in say commercial, there would be some action that would be taken, say hey you got to rebalance your payer mix here at the ambulatory surgical center?

MS. COOPER: Yes.

MS. HOLMES: Okay, and also similar to that you have — we have conditioned approval on the adoption of shared decision making policy. So again how 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?

MS. COOPER: 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 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 consent procedure which happens at all hospitals and surgery centers. We — this is the normal part of our practice given that need back

54

from all the surgeons who I sat with and discussed the policy with, I have not contemplated needing an audit review process on that policy.

MS. HOLMES: Patient satisfaction — you do patient satisfaction surveys. That might be another way, vehicle, to find out actually if they were informed of all the alternatives and all of that.

On your self pay policy, which is another aspect of some of our conditions, your self pay policy only applies to medically necessary services. So I'm curious what is excluded from that?

MS. COOPER: So there is another policy that addresses cosmetic procedures and payment rates for elective procedures and so this is just to indicate — and those would be fully paid by the patient because we would not offer discounts on elective cosmetic procedures.

MS. HOLMES: Okay, and actually that brings up a second question because the charity care policy, which there was a condition that must be on par with UVM and Northwestern's, in that policy you state that services connected with elective or cosmetic procedures are not included, and so I was actually curious and looked up what's elective

55

procedure exactly mean, and according to like Johns Hopkins the definition of elective surgery is not emergent and planned in advance, which strikes me as probably most of the procedures that the ambulatory surgical center is doing.

So I guess I wanted some clarification on what you meant, and I'm sure that wasn't what you meant, but what is it that you meant by the charity care policy not including elective or cosmetic procedure?

MS. COOPER: So what we meant by that was again cosmetic procedures that the patient decides that they want to have and decides that they want to pay for. We certainly would anticipate that the great majority of all procedures at the center would come under the free and discounted care policy. I believe actually that language is probably directly from UVMMC or Northwest policies. I don't know if you checked that.

MS. HOLMES: I did it.

MS. COOPER: We just tried to match it.

MS. HOLMES: Interestingly UVMMC they lay out what they exclude; sterilization, reversal IVF, and cosmetic, teeth extraction, sterilization, cosmetic and routine eye exams. So they lay out very

56

specifically what they exclude. Yours was elective or cosmetic. So I was questioning what is in the elective category.

MS. COOPER: We have not defined it specifically, but I think the understanding involved in drafting it would be that would be cosmetic procedures. We can define it more specifically and resubmit the policy with more specific definitions to match.

MS. HOLMES: Okay. That would be fantastic, and I have two other questions about the charity care.; The financial aspect of it, the policy specific income criteria, and it also mentions asset criteria, but I actually couldn't find a threshold for the asset value on that. So maybe as you're looking at that again perhaps you could look at that, and then the policy also specifies discount off charges for various income levels, but I was not sure the discount off of what charge would that be.

MS. COOPER: So that would be the standard charges that we have which will be listed on our web site.

MS. HOLMES: Discount off the commercial charges?

MS. COOPER: Yes. Yes.

57

MS. HOLMES: Okay.
MS. COOPER: And we do not plan to have any asset checking as part of our free and discounted care policy so we can remove — when we resubmit the policy with a more clearly defined what procedures are excluded we'll also remove the reference to asset check.
MS. HOLMES: Fantastic. Thank you.
MS. LUNGE: Hi, Amy, good to see you. I just want to return first to the question of price. Do you recall when we were here during the hearing talking about charging one price for your procedures?
MS. COOPER: Yes.
MS. LUNGE: Regardless of payer type?
MS. COOPER: Yes.
MS. LUNGE: Have you in your commercial negotiation suggested the Medicare price as the discounted reimbursement level?
MS. COOPER: No.
MS. LUNGE: Thank you, and are you in negotiations with more than one commercial payer at this point?
MS. COOPER: Just to clarify I believe that I indicated that the price for the procedure ought to be the same no matter who the commercial

58

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 actually been involved now in commercial contracting situations, that we are one tiny player in a very large well established contracting market, and are not in a position to dictate terms except to ensure we are offering good value and lower prices than other facilities based on the information that we have.
MS. LUNGE: So your assertion is that a commercial payer would prefer to pay a higher reimbursement than Medicare?
MS. COOPER: I don't — I don't think that they would prefer to pay a higher reimbursement than Medicare. I think that they would prefer to pay as low as possible given what the center would require to cover its cost.
MS. LUNGE: Thank you. Are you — my question was actually are you negotiating with more than one commercial payer at this time?
MS. COOPER: Yes.
MS. LUNGE: So going back to the conditions do you have an estimate of the date when

59

you will have your public web site available? I know it's two weeks before opening. Is that currently June 1 for opening?
MS. COOPER: So the way that the Joint Commission and CMS certification process works is that I have to give them my calendar of when we'll be available to be surveyed for two months and they come whenever they want. So they might come on week two, they might come on week six, week eight. So I don't know when we're going to get our Joint Commission accreditation CMS certification, but then everything flows from that date afterwards. We would hope to open as soon as possible after that date.
MS. LUNGE: Okay. Thank you. So you'll keep us posted on how that's going?
MS. COOPER: Yes.
MS. LUNGE: In terms of shared decision making and in condition 2 are you — will you have decision aides available for the services offered by the surgeons performing surgeries at your center?
MS. COOPER: We still have work to do in terms of working with the surgeons on what they currently use and what are the right decision aides. We at the center do not have that knowledge and would rely on our surgeons to provide guidance which I

60

believe is how the policy is written as well.
MS. LUNGE: Great, but I guess my question was obviously the surgeons would be going over the decision aides with their own patients, but would those decision aides be available from your web site?
MS. COOPER: I don't know that we've thought about that yet at this time.
MS. LUNGE: Okay. Thank you. In terms of ACO participation, the participation agreement or the intent to participate for 2020 is a non-binding document. Do you have any reason to believe that you won't participate in 2020 at least based on your knowledge today?
MS. COOPER: No I have no reason to believe that we won't.
MS. LUNGE: Would you be amenable to having some sort of participation deadline included?
MS. COOPER: Yes and I think I talked with Kevin Stone and Vicky Loaner recently about this. You know there — and we talked about when their contracting cycle is. I believe that final contracts are due in the September/October period and we would certainly be amenable and would sign that contract, and if the board wants to put a condition

61

that we sign that contract, we are comfortable with that as well.

MS. LUNGE: Thank you, and it's probably premature since you're still in your negotiations on the — with your payers, but have you — do you have any thoughts on alternative payment models that you would participate in should the ACO be amenable to that?

MS. COOPER: Yeah we have discussed doing episode based bundled payments where we would get our surgeons, anesthesia, and the facility together. We work with the ACO on which procedures, you know, are most — they would be most interested in based on volumes I suppose of attributed patients, and that if we could work out a bundled rate between the facility and the surgeon and the anesthesiologist, all of our providers and surgeons and anesthesiologists in the facility are very open to that. We have educated that that would be part of our plan as we go forward, and that was the same ideas that Vicki Loaner and Kevin Stone reflected to me in our recent conversation about what they were thinking would be the first alternative payment model that we might get into.

MS. LUNGE: Thank you. In reference to

62

the transfer agreement with UVM and the agreement with the ambulance service, it's actually related also to B11, I was curious to know if all of the physicians practicing with you would have privileges at UVMMC. I just wanted to understand if there might be a circumstance where there was a surgeon who didn't have a relationship with UVMMC but would have a patient with you that would then get transferred to UVMMC so there could be a continuity of care issue.

MS. COOPER: Yes there may be a case that the surgeon would not have privileges at UVMMC, but their patient would get transferred to UVMMC. That shouldn't be a problem, though, in terms of continuity of care. The communication would still work between the physician and the — and UVMMC. Often a lot of community physicians don't follow their patients in the hospital. Patients often are taken over their care by a hospitalist in the hospital. The surgeon or other physician remains in the community and communicates with the hospitalist about the care of the patient. So that's — there is a working system set up in the event that we were to have a patient who is a patient of a non-UVMMC credentialed physician admitted to UVMMC.

MS. LUNGE: Okay. Thank you for

63

addressing that. So in terms of the Joint Commission review I think you had mentioned in some of your materials that the Joint Commission review includes reviewing surgeries. So can you just explain a little bit more about how that process works?

MS. COOPER: Yes absolutely, and I apologize to Representative Jickling who is here from House Health Care. I just went through this yesterday. Susan, you were there as well, but the — I have materials describing the accreditation process of the Joint Commission. So a survey lasts two to three days and surveyors will come and visit the ambulatory surgery center and interview staff and patients to validate the meeting of the Joint Commission's and CMS requirement. They actually will trace two patients throughout the facility from their check-in to their pre-op, into their procedures, their post-op, their discharge conversation, and instruction, and audit all that to make sure that the facility is meeting all of the requirements. They don't just rely on interviews with staff or management. It is actually a condition of being eligible for a survey that a center has — even a new center has seen at least 10 patients before you can ask the Joint Commission or CMS to come in to do a

64

survey.

MS. LUNGE: 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?

MS. 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 reimbursement for services. These patients essentially get a free service from the facility. We are only doing it in order to meet CMS certification. There are no other patients scheduled for any reason and we are not charging anything for these patients.

MS. LUNGE: 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. LUNGE: Not the allowed amount.

MS. COOPER: Right. The allowed amount from the commercial insurers. So the allowed amount

65

from different commercial insurers will likely be different. So we had thought about well should we show an average of the allowed amount or should — what should we show here. The only consistent number will be the standard charge and then the allowed amount with commercial insurers will always be below that because the way the negotiations work is they want discounts off the standard charges. So we thought that the best way from a consumer perspective to present the information would be to say here's the charge that's standard and the same throughout, but if you have commercial insurance, this is the absolute maximum it would be and it's most likely much, much lower than this charge. It also would be consistent with the way that other facilities are showing their prices now since the Medicare rule passed where hospital outpatient departments must show their charges.

MS. LUNGE: You also indicated that you will work with patients to make sure they understand the transparent cost of their procedure. Are you also doing that with people who are trying to shop for services?

MS. COOPER: So our patients are the only people that we will have access to their

66

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 and say here's what the procedure price will be. For people who are not currently our patients we won't have access to their insurance information. So they might call us and tell us and ask us and we certainly want to encourage them to have that information. So we can tell them what our standard charges are. If they say this is my insurance, we can look up and say okay this is what it looks like the procedure would cost with us based on that insurance.

MS. LUNGE: Okay. We had quite a bit of discussion around price transparency at the last hearing so I wanted to clarify what would happen as opposed to what had previously been testified to.

In terms of condition 13, which is the self pay policy, Jess I think asked a couple questions about this to clarify, in the self pay policy it indicates that a patient would be considered self pay if they are having a medically necessary procedure. So that would not include all procedures that you may be offering. Is that a fair assumption?

MS. COOPER: Yes. It doesn't include

67

cosmetic procedures.

MS. LUNGE: And the — so in the second piece of your procedure the self pay patient undergoes multiple procedures. Procedures subsequent to the first shall be subject to a 50 percent discount off of self pay rates. That's a little bit unclear in terms of ensuring that it is also equal to or lower than the commercial rate. So I'm hoping that you will be willing to add a little more clarity in your self pay policy because I think it's not clear exactly what people would be expected to pay when.

MS. COOPER: Okay, and just so this is just meant to mirror the way that it typically works on a commercial contract where the first procedure — multiple procedures are done. The first procedure is paid at a hundred percent of the rate and then subsequent procedures are paid at 50 percent of the rate. So I guess just the clarifying words that might need to be added would be that the second procedure will be subject to a 50 percent discount off the lowest allowed amount that the center gets paid by contract for commercial insurers for the same procedure. Would that satisfy?

MS. LUNGE: Yes.

68

MS. COOPER: We can update that policy and resubmit it.

MS. LUNGE: Thank you. How are you going to determine what the lowest amount paid by contracted commercial insurers?

MS. COOPER: We review all of our commercial insurance contracts and see what the lowest payment rate is for that procedure code.

MS. LUNGE: Okay. Thank you. On the B15, the free — the charity care policy, how will you make potential patients aware of your free or discounted care policy?

MS. COOPER: It's going to be available on our web site and we will also have copies available in the waiting room.

MS. LUNGE: Have you thought about potentially also providing it with people's bills?

MS. COOPER: No I hadn't — we hadn't considered that yet.

MS. LUNGE: Would you please consider that?

MS. COOPER: Yes.

MS. LUNGE: Thank you. For the amendment request for B21 so you talked a little bit about the information potentially being competitively

69

sensitive for future employment. Are you — do you think that there are other issues where that disclosure of that information would be a problem?

MS. TYLER: I think — a couple things. We mentioned in the letter — we mentioned back in January the employment context and also basically the information that's to be disclosed reveals the physician's productivity, the financial productivity of the physician's practice for someone who chooses you know to figure that out, and of course it also shows how many of the physician's patients he or she is referring to the surgery center as opposed to the local hospital.

So I think there was also concern about that relationship because of course all the providers who do surgery at the surgery center will continue to do some procedures at the hospital and I think they are sensitive about displaying, you know, how that breaks down because they do continue to depend on access to hospital facilities to operate their practice overall. There has been tremendous opposition to the surgery center in general from the hospitals. When we submitted the application there was concern about retaliation against physicians that chose to participate as owners, and I think that

70

there continues to be a degree of sensitivity about publicizing for each doctor how many of my patients am I referring to the surgery center as opposed to, you know, the local hospital.

MS. LUNGE: Well the purpose behind that condition was to ensure that there wasn't steering going on essentially. So how else would we be able to monitor that?

MS. TYLER: Well I think what I said earlier is you know the board is —

MS. LUNGE: Thank you. I can see now.

MS. TYLER: What I said earlier is that the board's purpose is to oversee the surgery center area operations as an entity, and I think that if the surgery center provides the data that you're interested in on a specialty basis, that should be adequate to indicate whether there's an unexpected — there's something unexpected in the data. So if you look at all the data for GI services and you see an unexpectedly low percentage of Medicaid patients that are receiving those services at the center, I think so that's something that you could ask Amy about, you know, how do you explain this, and she was asked earlier you know how do you intend to enforce this internally, and you know I think she responded as she

71

did, and if you were to come to her and say, you know, we see a strange trend in this data for this practice area, then I think that would give Amy an opportunity internally to think about well who are those practitioners and address the issue on a provider-by-provider basis internally.

MS. COOPER: Thank you. I would also add that I did a memo that I submitted to the board to show our projected payer mix compared with the local hospital in Chittenden County payer mix, and those two payer mixes were quite similar. I think that there will always be that benchmark available, and if the surgery center's payer mix were to become out of line with the local hospital, that also speaks to the same patient base that would be maybe a cause for concern, and that is a way that we could monitor that.

There's also, Karen mentioned, the physician's personal productivity data as being sensitive financially and competitively. When physicians become employed by a hospital or sell their practice to the hospital there's often a long negotiation around whether the practice will be paid anything for the value of the practice and of their patient base, and a lot of those discussions get into

72

exactly this kind of data; what's the payment, what's the payer mix, what's the patient base, how active is the surgeon, and so to have individual physicians who may need to or want to in the future sell their practice to the hospital have all that data publicly available would harm them immensely in those negotiations about potential sale of their practices.

MS. LUNGE: Thank you. That was helpful. Since you brought up payer mix let's turn to payer mix. So in the memo that you provided on April 8, 2019 that you just referred to you include your payer mix which is based on the revenue before deductions by payer category. So am I correct in assuming that that does not include any reductions from charges?

MS. COOPER: No. All of our data that we presented during the application and always is net.

MS. LUNGE: So what does before deductions mean?

MS. COOPER: So we have in our original projections deductions for bad debt and free care which we estimated at two and a half percent each. So it's before those deductions are taken.

MS. LUNGE: Okay. I was noticing that

73

you didn't include a deduction for bad debt or free care then for UVMC.

MS. COOPER: No because it wasn't included in others so we didn't include it in their's. That's the most apples-to-apples comparison.

MS. LUNGE: But you did include DSH?

MS. COOPER: Yes which we could have not included DSH as well. If we don't include DSH, it makes the payer mix shift more towards commercial for UVMC.

MS. LUNGE: Did you look at the payer mix for Northwestern?

MS. COOPER: No.

MS. LUNGE: So let me get organized here. So turning to scope, of the initial physicians provided in your application 10 remain the same; is that correct?

MS. COOPER: Versus the initial projections and the updated projections, yes.

MS. LUNGE: And that was out of how many original docs participating?

MS. COOPER: 16.

MS. LUNGE: And there are 14 new physicians included in the updated projections?

74

MS. COOPER: Yes. Yes.

MS. LUNGE: And in your updated projections you're currently showing a 17 percent — between 4 percent and 17 percent decrease in GI for cases?

MS. COOPER: I think that's correct. I don't have it in front of me.

MS. LUNGE: It's page 2 of your November 19 memo if that helps.

MS. COOPER: Yes.

MS. LUNGE: GI was originally 60 percent. You were projecting 60 percent of your volume to be related to GI originally?

MS. COOPER: Yes.

MS. LUNGE: And the change there is why?

MS. COOPER: So the changes — you can see the changes in year two and year three and year four are between 4 and 8 percent.

MS. LUNGE: Why is it changing?

MS. COOPER: The change in year one is more pronounced because in our updated projections we think it's going to take us longer to ramp up than we did initially. So in our initial projections we had a higher number of initial patients in year one. Here we have a lower number because our assumption

75

changed in year one. So just to say that the year one numbers the change is more pronounced than a steady state change going forward which will be 4 to 8 percent less per year because we resurveyed the physicians and said what are your monthly volumes now and used those numbers for our updated projections as opposed to the monthly volume numbers for 2014 that they put in the original projection. So it was just a change in their monthly volume between those three years and intervening time.

MS. LUNGE: Thank you, and the change in OB/GYN is between 38 and 47 percent in cases in that chart?

MS. COOPER: Yes.

MS. LUNGE: According to your narrative that's due to retirements?

MS. COOPER: Yes.

MS. LUNGE: Orthopedics is an increase between 41 and 63 percent due to practice changes?

MS. COOPER: Yeah. Busier. More volume.

MS. LUNGE: And then 93 to 94 percent reduction in pain management?

MS. COOPER: Yeah. We had two original busy physicians in pain management who have changed

76

their practices to not do procedures that would work in an ASC any more.

MS. LUNGE: Thank you, and I noticed in your narrative that you indicated that that was due to change in patient demand, reimbursement levels, and practice patterns as you just explained. Can you talk about the reimbursement level piece of that?

MS. COOPER: The payment rates for certain pain procedures sometimes commercial insurers here in the state have decided to stop covering procedures that they used to cover. So when I reached out to these physicians after they did not have updated projections I said what's going on and they said well the commercial insurers decided to stop covering some of the stuff we were doing.

MS. LUNGE: Got it. Thank you, and then a reduction in general surgery between 36 and 45 percent as well. This chart indicates that you didn't originally project cases for plastic surgery or ophthalmology, right?

MS. COOPER: Yes that's true.

MS. LUNGE: Thank you.

MS. COOPER: I just — also our actuals when we are actually operating may look different than the projections also just because these changes

77

that I mentioned in that submission that have been occurring since 2015; physicians retiring, moving, et cetera, that it continues to be a dynamic environment.

MS. LUNGE: Yes. The hearing on this Certificate of Need was April 13, 2017, was it not?

MS. COOPER: Yes it was.

MS. LUNGE: And did you update these projections at that time?

MS. COOPER: No.

MS. LUNGE: Thank you. In terms of why plastic surgery was not included in the initial projections you indicated there at the time of your application there were no independent plastic surgeons practicing in Chittenden County?

MS. COOPER: Yes.

MS. LUNGE: Thanks, and how many — do you happen to know how many independent plastic surgeons are practicing in Chittenden County?

MS. COOPER: I believe there's two.

MS. LUNGE: Thank you.

MS. COOPER: I also would say if it were easy for us to do updated projections, we would do them more frequently. It is a very involved process of reaching out to individual physicians with

78

surveys. This was run by our consultants Avanza Strategies, and getting information from them or their practice managers, or whichever person in the practice keeps track of that information, getting it from all different physicians in a uniform format, and then engaging Avanza and paying their consultant basically to put together projections. So projections and updated financials is not something that we're doing regularly at all. The ones that I do have I have submitted to the board.

MS. LUNGE: Thank you, and in terms of ophthalmology in your application you explained at the time of the application those services were not included because you did not have as many interested surgeons as you did now and had not completed due diligence on cost and efficiency of moving vitreoretinal cases; is that right?

MS. COOPER: Yes.

MS. LUNGE: So in terms of your projected cases by physician — this is on page 4 and 5 of that same submission — I was noticing that in your original — it looks like the physicians listed in your original projections compared to your — the new physician list are a little bit hard to track because you've reused the letters. So, for example,

79

physician M who was a pain management specialist in the original projection is obviously a different person or went back and got a new specialty in OB/GYN. I was wondering if you could please update this so that we can see apples-to-apples with physicians and not — it's a little hard to track when we can't see where there's actually people who left and people who have been added.

MS. COOPER: I'll have to check with Avanza, my consultants who I mentioned who filled all these tables and did the projections for me.

MS. LUNGE: Great. Thank you. So just in terms of again just finalizing questions around the projections, so in your original submission because you were focused on the specialties GI, OB/GYN, ortho, pain management, and general surgery your revenue projections also did not include plastic surgery, ophthalmology, or any other specialty; is that right?

MS. COOPER: That's correct.

MS. LUNGE: In terms of payer mix I was noticing that your revenue projections by payer mix have also changed significantly from your original projection. So your new projections, which are on page 7 of that submission, indicate that you're

80

expecting between 42 and 49 percent less revenue from Medicare, 23 to 33 percent less revenue from Medicaid, 1 to 13 percent less revenue from commercial, 23 to 33 percent from self pay; is that right?

MS. COOPER: Yes.

MS. LUNGE: So what's causing that shift particularly downward in Medicare and Medicaid?

MS. COOPER: Well that's just a function of the different physicians that we have in the mix now than the ones that we had earlier. When we do updated projections we also ask the physicians for their current payer mix, and again their practice manager or someone in their office gives it to us. Because our group of physicians has changed so much it would be a natural result of that, that our payer mix would change. For example, physicians in different specialties often have very different payer mixes. GI, for example, basically the American Task Force on Preventative Health Metrics — I'm saying that wrong — but recently updated their recommendations and commercial insurers have started covering colon cancer screening starting at age 45 which then makes the payer mix for GI doctors more slanted towards commercial because all of a sudden

81

they have all these patients who are 45 who are commercially insured that they didn't have before.

Also if you have OB/GYN doctors, they generally don't have any Medicare patients because Medicare is old. If you have eye doctors, they generally have mostly Medicare patients. Retina surgery is a low volume surgery — low volume specialty in ophthalmology, very low volume compared to cataract or others. So while those are mostly Medicare patients it's not a large part of our mix compared to the high volume GI, for example.

MS. LUNGE: Okay. It also looks in your cases by payer category that you're expecting a significant decrease in Medicare cases overall, between 30 and 40 percent, over the course of the four years. That's on page 9.

MS. COOPER: Yes.

MS. LUNGE: And again that's related to the shift in how many cases are coming from which specialty?

MS. COOPER: From which specialty. So, for example, we also previously had pain management is a very high volume specialty. It's, you know, injectable things that are done quickly and a lot of them usually. Those two physicians in particular had

82

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 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. LUNGE: Okay. That's helpful because I was trying to get a sense of what you wanted us to consider when we were looking at factually whether or not you had met that condition. I think I'm done for now. I may have some followup after I check my notes, but —

83

CHAIR MULLIN: So I'll be brief because the two previous members have been very thorough, but I wanted to ask you what you envisioned could possibly be in the future as far as the expansion of scope. You could start with ophthalmology, we could talk about each one of the specialties, but I'm just curious what you think the bounds of what the expansion of the scope would be.

MS. COOPER: In terms of specialties that we would consider bringing on in the near term the only other that I have had conversations about would be pediatric dentistry. There is a need for children who have to get teeth pulled and need general anesthesia for that to be done in procedure rooms or operating rooms, and I have heard from two dental providers and the Community Health Center in Burlington that there is a need for general anesthesia services in procedure rooms to do that sort of work. So that's the only one that I have had conversations about in the near term.

CHAIR MULLIN: On the ortho looks like primarily hand surgeries. What do you see as future possibilities being performed at your facility?

MS. COOPER: That is entirely dependent on whether there's any physician interest. There

84

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 MULLIN: 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.

CHAIR MULLIN: So on the ophthalmology, which wasn't discussed previously and was discussed now, how broad a scope do you think could occur in the expansion of services provided there in the future?

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

85

that question.
CHAIR MULLIN: So, for example, a few years ago I had an eyelid that was scraped but the surgery was done inside an eye doctor's office. Could that type of surgery be performed at your center?
MS. COOPER: We do not have any plans to do any surgery that is currently being performed in an office in the surgery center.
CHAIR MULLIN: Okay. Do you have any plans to do any surgeries that are performed at the other ambulatory surgery center that is the only other one that's currently in Vermont?
MS. COOPER: So none of the surgeries that are in our updated ophthalmology projections would be moving from one ambulatory surgery center to another. All of the cases in the updated projections would be moving out of the hospital into an ambulatory surgery center for the first time.
CHAIR MULLIN: So that's today. I'm talking about in the future. What type of guarantees would we as Vermonters have that you are continuing to offer a more convenient, lower cost setting for anything that could be performed there? You never raised the issue of ophthalmology in the original

86

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?
MS. COOPER: All I can say is that all of the ophthalmology cases that we plan to do are currently being performed in hospitals and we are confident that we will be a lower price, particularly because most ophthalmology patients are Medicare patients than where those procedures are currently being performed.
CHAIR MULLIN: I'm listening very carefully to your words and you're saying currently planning to do and I'm just worried about what protections there are for future decisions on what could be done.
MS. COOPER: I'm not sure. I guess I would have to leave it up to the board.
CHAIR MULLIN: Okay. Thank you.
MR. PELHAM: Well welcome back. It's my first experience with you folks. Looks like a very long trail since 2015 which hopefully I have read and absorbed most of it. I only have one question. You

87

said in your April 8 submission that quote "overall the payer mix profiles of UVMMC for fiscal year 2018 and GMSC in our updated projection are essentially the same," and there's an — in your documentation that you have — and I agree with you — that UVMMC had about 60 percent commercial, 9 percent Medicaid, and 30 percent Medicare. How does UVMMC payer mix and your numbers currently compare to that? Do you know or have any sense as to where UVM's payer mix fits in terms of the rank order of payer mixes in the state where the more favored commercial — the more favored payer mix would be a strong commercial and a strong Medicare and then a third place in terms of Medicaid, do you have any sense of where UVM fits in that hierarchy of the 14 hospitals in Vermont?
MS. COOPER: I certainly have a sense of the Chittenden County patient population payer mix versus the rest of the state from my work at Health First with the independent practices, and in — from that information Chittenden County does have the highest percentage of commercial patients compared to practices located in other counties or more rural areas. They tend to have higher Medicaid and Medicare populations.
MR. PELHAM: That's correct. I think at

88

the 60 percent level there's UVM 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 the surgeries that you performed you thought might be migrating from the Northwestern Medical Center, and so I guess I have two questions. Do you have any sense given the changes in payer mix and the changes in the mix of procedures that you're doing as to how that might similarly affect the Northwest Medical Center, and, if so, do you have a dollar value associated with that, and I ask that because we're dealing with small numbers at the margin here.
If you take the four million dollars in NPR that you folks are talking about today, that's one-tenth of one percent of the total hospital statewide NPR. So we're really in a very small corner of the world, and — but as you get kind of closer and the neighbors that you have may be more or less affected, and so I know that the Northwest Medical Center's payer mix is 48.8 percent commercial, 17.8 percent Medicaid, and 33.4 percent Medicare. So it's in a less favored position, and if

89

I — if you have any information that would give a more current bearing on how your services might affect Northwestern Medical, it would be helpful.

MS. COOPER: I do. I haven't done the same analysis that I did in the original CON in terms of actual data around what may move. I do know, though, that there are surgeries being done at Northwest by surgeons who have moved back to the area expressly because of the ASC and only because of the surgery center that are now doing cases at Northwest and have joined the medical staff at Northwest and patients who used to be in St. Albans would have to travel to Burlington for their care are now able to get their procedures done close to home at Northwest Medical Center, and that the surgeons who have added cases there would plan to continue doing cases at Northwest and at the surgery center.

I also have heard, though I'm not sure yet, that some physicians who had planned initially to bring cases to the surgery center and were in our original projections are now — have said I'm nearing retirement, I don't feel like making a change, I'm going to leave my cases where they are, and some of those cases are also at Northwest.

So I don't know what the net analysis is

90

in terms of an answer, but I know that having this facility here and the way that it helps Vermont recruit physicians who want to have this option that otherwise would not be in Vermont having those physicians stay here and oftentimes bringing new cases to hospitals like Northwest is a good thing.

MR. PELHAM: Thank you.

MS. USIFER: There's a benefit to going last. Most of my questions were answered. I just have one question on the self pay policy, and where you talk about the discount on implants or individual supply items in excess of $200 and there would be no discount, just wondering why you wouldn't get what commercial pays for those.

MS. COOPER: So those are not covered by commercial insurance. An example is for cataract surgeries there's a — you can get a standard kind of lens or a new super improved kind of lens, and if the patient wants the super lens, they have to pay for it out of pocket. So there's different implants and things that aren't covered by commercial insurance that that was meant to apply to.

MS. USIFER: Okay. So individual supply items and things like that those are all things that wouldn't be covered under commercial —

91

MS. COOPER: Right.

MS. USIFER: — in your billing?

MS. COOPER: Yes.

MS. USIFER: All right. All my other questions were answered. Thanks.

MS. LUNGE: I have three left. I'm sorry. I know you will all find it hard —

MR. BARBER: We're over time already.

MS. LUNGE: I'll be quick.

MR. BARBER: Okay.

MS. LUNGE: So just one followup on condition 10. I just want to clarify that the studies that you have provided in evidence either in this submission or the previous one offer a complete list of the procedures that you will be offering?

MS. COOPER: So they are not every — it depends on how you define procedure. These are the procedures across specialties that there is evidence basis for that I could provide to you. They are on the CPT code level, if I said there's specific codes for parts of different procedures that don't have evidence based studies associated with them, so that is what happened.

MS. LUNGE: Thank you. Thank you, and just to clarify are there any surgeries or procedures

92

that you're anticipating will be performed that are solely cosmetic and not medically necessary or whatever? That may not be the appropriate clinical term, but I think you get the gist.

MS. COOPER: Well it's interesting because who decides what's necessary. Medically necessary is a term used by commercial insurers, but, for example, a new area that is becoming much more needed certainly from the patient's perspective is gender affirmation, surgeries for folks who don't 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 cosmetic. You know it's hard to find a definition specifically of what's medically necessary versus cosmetic and what's medically needed versus not needed.

MS. LUNGE: Okay, and then I know CMS in their process has certain kinds of surgeries that they will pay for in an ASC versus others they have not yet approved for that setting. Are you anticipating offering procedures that are outside of that list or would you expect that most of the procedures or all of the procedures that will be

93

performed there are those on the CMS approved list?

MS. COOPER: Only those on the CMS approved list.

MS. LUNGE: I guess an exception might be in the OB area where they may or may not have tackled that for Medicare.

MS. COOPER: Yes. Yes.

MS. LUNGE: And cosmetic. Thank you. I'm done, Mike.

MR. BARBER: Okay. So I think we're behind schedule a little bit. Eric and Julia, if you can keep it concise and then I think what I would like to do is take a five-minute break, resume, ask Ms. Cramer to have her witness come up. Turn it over to you now.

MS. SHAW: Sure. Thank you.

EXAMINATION

BY MS. SHAW:

Q. I just have a few questions from the information you provided. So in your Certificate of Need the board — as we discussed the board imposed condition 15 requiring the applicant to establish and implement a policy to provide care on par with UVM and Northwestern Medical Center. So I first wanted to note on our review we noted a few differences between your policy and the

94

policies at UVMMC. For example, UVMMC provides two opportunities for patients with income above 400 percent FPL to get financial assistance and provides an option for a payment plan and both NMC and UVMMC offer the opportunity to appeal a denial. So I'm wondering if you would commit to bringing your policy in line with UVMMC and NMC prior to starting operations?

A. (Ms. Cooper) Yes and we can make those updates as well. They weren't intentionally left off. Our policy is much simpler than UVMMC and Northwest or hospitals generally. That's the standard for ambulatory surgery centers to have a simpler policy. We don't require the same level of personal financial spreadsheets that are often quite difficult and arduous to fill out and patients of limited means may not even know how to fill out those spreadsheets which is often a barrier to accessing free and discounted care.

The intent of our policy was to be straightforward and easy to fill out, and not to require the level — assume a level of financial sophistication that many patients don't have. That's also why we just require a piece of substantiation, whether it be income or a W-2 or something similar rather than multiple pieces like are required often by hospital policies. So we certainly did not intend to leave off anything and I would

95

— if you could tell me what those updates are, we can put them into our free discounted care policy before we resubmit.

Q. Sure. That would be great. Thank you, and I just wanted to note also that in your materials I don't believe you said UVMMC's complete policy so I wanted to confirm. You — did I understand you're trying to do the same policy? And I appreciate that. I just wanted to confirm you did refer to UVMMC's full policy when you were developing your policy for the ASC?

A. I pulled off everything I could find on UVM's web site to review.

Q. I'm wondering if you would be willing to work with our office just to ensure that these discrepancies are just a policy and eligibility information are clear and complete and readable for consumers?

A. Yes. We will make updates to the policy that have been mentioned here and then I can send it to you and have you suggest any updates which we will accept before it goes for final review.

Q. Thank you very much, and then I just wanted to also — I know your policy is in general simpler than the hospitals, but I wanted to ask if you would be willing — one of the requirements for hospitals is to provide a plain language summary, if you would be willing to also

96

provide a plain language summary of your policy sort of summarizing the basics to be available to consumers?

A. Yes, and I would ask for your help in ensuring that it is in fact plain language, but I can take the first draft of that.

Q. Sure. I would be happy to help with that.

A. Great.

Q. And then my only other questions are about condition 14, the applicant shall dedicate a staff member to provide patients with price estimates for surgeries, and I'm not sure if I'm — in your presentation today I wasn't quite clear, but I just wanted to ask if the current estimates provided to patients, like when they get their detail, have their detailed conversation with your staff person, if they will include the possibility of complications and maybe arrange what patients normally end up paying for a procedure, whether they are median or a range?

A. (Mr. Paoni) So the way it works in our surgery center our HR will implement, through the clearinghouse, benefit verification process with the insurance carrier. Then it will come back and it's fairly quick and almost instant, and it tells us exactly where they are within the last 24 hours. It tells us even the deductible. So we're very transparent in an ambulatory

97

surgery center. Everybody gets actually two phone calls; one from the business office explaining, we verify our demographic information with the patient, make sure they understand the times involved in the procedure, and then we cover everything as far as insurance. So we're going to explain fully any financial obligations, any out of pockets, what their co-insurance is, what their deductible is, and what their co-pay is so they have a complete understanding.

We also offer it to them in writing if they wish to have it. I can e-mail it to them or I can put it in regular U.S. post office mail. So I hope that answers your question.

Q. I have one followup which is I think so part of my question is about, so I think some of the ophthalmologists would be an example, sometimes you don't know what you're going to find until you're in the procedure. So if patients are given information you know this is the cost for what we know you're going in for, 10 percent of patients we find there's complication, 50 percent of patients we find this further complication, that type of information will be shared with patients?

A. (Mr. Paoni) So we bill off CPT code. Those supplies or any additionals beyond that is included within that CPT code when they draw up the bill. So there's very

98

few surprises, you know, and if, for example, they found a foreign body that required — that is going to create additional charge, that's fully explained to the patient prior to the surgery usually by the physician in the office. If not, it's explained to the patient in the preoperative area. We require the — Medicare and Medicaid is required to have a history and physical on file with the patient within the last 350 days. So they will review all of that information with the patient prior to the procedure.

Q. Thank you. Did you want to — so my final question is on your benefits verification policy it states that if payment is not secured within 24 hours of the surgery, the surgery center may choose to reschedule or may proceed with the case. We were just wondering if you would commit to adding to that policy that patients also would have the opportunity to choose to reschedule a procedure rather than proceeding? Technical point but —

A. (Mr. Paoni) Absolutely. Absolutely because it's up — it's always the patient's choice whether they want to have a procedure or not, and so we would always explain to them listen I can't get your insurance. We'll back out ahead of time so we have plenty of time to make sure you get that information and verify the insurance. So if the patient wants to reschedule, certainly it's

99

their choice.

MS. SHAW: Thank you. That's all our questions.

MR. BARBER: Okay. Thanks. So five minutes. We'll get a drink of water, go to the bathroom, and reconvene at 3:30.

(Recess.)

MR. BARBER: All right. It's 3:30 so we're going to reconvene here. I'll turn it over to Ms. Cramer. I think we missed swearing in Ms. Berry Bowen so I would ask the court reporter to please swear in Ms. Berry Bowen.

(Ms. Berry Bowen was duly sworn.)

MS. CRAMER: Thank you, Michael. I'm here representing Northwestern Medical Center. As you know I also represent the Vermont Association of Hospitals and Health Systems. I just want to acknowledge that at the prehearing conference we spoke about the parties filing briefs on the legal issue following the hearing with regard to the question of the scope of the CON. It is briefly our position that this CON should be amended to add any specialties beyond the five that all of the projections and financials were based on when the application was considered two years ago, and so

100

today you have received some information and testimony on the applicant's belief of a need for additional procedures, and consequently I would like to have Jill Berry Bowen comment on potential impact that that could have on both Northwestern, and I just want to acknowledge that with her today is Tristan Glanville who is the new interim CFO at Northwestern Medical Center, and so should there be a question she might confer with him if it happened to hit the financial area.

MS. BERRY BOWEN: Great. Good afternoon and thank you for the opportunity to speak to you today. The application for the Certificate of Need for the ambulatory surgery center was developed by the Green Mountain Surgery Center and considered by the Green Mountain Care Board based on performance and projections in five identified specialties. We are now facing a request to expand the scope of the surgery center beyond those specialties.

As one of the decision criteria within the CON process includes consideration of whether the perceived benefits of a project outweigh the detriments of the project on hospitals and other settings, it is crucial that you understand the further detrimental impact with an expansion of scope

101

beyond what was discussed within the CON will have.

In recent days the Green Mountain Care Board has heard from small Vermont hospitals on the significant negative impact that the loss of a surgeon or a reduction in surgical procedures has on the finances of the hospital. By the way we're losing already two physicians to the surgery center. It is real and impactful and you have seen it in hospitals' financial performance reports including ours at Northwestern Medical Center. Now we face an additional expansion of the initiative that will draw more surgical procedures away from hospitals that will be detrimental.

Northwestern Medical Center, as you know, is committed to the transformation of Vermont's health care system from fee for service to a capitated population health based system. Hospitals are funding this future. We were the first hospital outside of the UVM Health Network to take on risk with an all payer model. In this model NMC has a per member per month payment to sustain our hospital, however, every time patients are drawn away to have procedures at an outside provider such as a surgery center this is less revenue for the hospital which is carrying the fixed expenses necessary to care for its

102

community. Eventually the gap between variable revenue and fixed expenses become unsustainable. What is the future definition of the community hospital? The surgery center is counter to the integrated community 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 ambulatory surgery center like in operation. As you know we are a leader in transformation and that means internally as well. No matter how much we do to reduce cost, balancing an effort to continue to meet the mission of needs of our community such as the needed development in primary care and also wellness

103

this comes with overhead and regulation costs that challenge our ability to compete.

If the scope of the Green Mountain Surgery Center expansion is allowed to happen, the negative financial impact of additional surgical procedures will show as a clear detriment in future reports to the Green Mountain Care Board of Northwestern Medical Center's performance.

Thank you for the time to share this important insight on our future. We're going to continue to lead and work across our local community for integration and collaboration, the accountable community for health, that focuses on population health transforming from a fee for service to a capitated system. Thank you.

MR. BARBER: Thank you. Before I turn it over to the board for questions to the extent that any questions may be better answered by your CFO who, I'm sorry, I have already forgotten his name.

MS. BERRY BOWEN: Tristan Glanville.

MR. BARBER: I would also prefer that you also get sworn in so if you could now please stand and raise your right-hand so the court reporter can swear you in.

(Mr. Glanvile was duly sworn.)

104

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. LUNGE: 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. LUNGE: 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. LUNGE: Okay.

MS. BERRY BOWEN: You know I don't have the plastics that we're talking about, but it's a very small number at this time because the plastic surgeon just joined our medical staff. So it's not clear about the number of surgeries.

MS. LUNGE: Okay. Thank you. That's all I have.

CHAIR MULLIN: So I think just as a

105

followup to Member Lunge's question could you submit to us the number of vitreoretinal surgeries that are being performed at Northwest?

MS. BERRY BOWEN: Sure.

CHAIR MULLIN: Thank you.

MR. PELHAM: This is a followup. So in the original proposal there was 170 surgeries that were projected that Northwest might lose to the surgical center given its initial inventory of procedures, and when you saw that number did that make sense to you, and, if it did, could you put an economic value on it?

MS. BERRY BOWEN: Are you talking about the surgeries related to these new ophthalmology and plastics or the previous ones?

MR. PELHAM: No. I'm talking about in the original proposal the presentation was that it was 170 surgeries might migrate from your operation to the surgical center and that that would comprise about 2.7 percent of the volume at the surgical center.

MS. BERRY BOWEN: Originally the surgeries were GI and OB/GYN. Clearly in addition to that there is an orthopedic surgeon that will be moving as well. So those numbers have increased

106

since our last discussion.

MS. HOLMES: Maybe a clarification. I think we're all asking the same question, but there's been a change so there were some pain management procedures, there were some, you know, fewer ortho, now there's more ortho. There's been a change. I'm wondering do you have the net effect of what you anticipated before migrating and what you anticipate now migrating within the change of scope?

MS. BERRY BOWEN: We suspect who the doctors are. We don't know exactly and I know originally there was a thought that there might be a general surgeon that might be coming from our area. I think that general surgeon potentially has retired.

So right now what I really know that's going to — would like — is going to move is the orthopedic surgeon, hand surgeon, who has announced her departure to go to the surgery center, and also as was mentioned earlier there was probably some of the OB/GYN that would go to the surgery center that is now here. So I think what we could do in our followup submission is now that we have a better understanding that we might be able to put a number to those specifically. Would that be okay?

MS. HOLMES: I think that's what people

107

want.

MS. BERRY BOWEN: I think now that it's getting closer to opening I think we have a better idea who might be migrating there.

MR. BARBER: So there's briefing I think from the parties due on May 3rd now. So just to give everyone enough time to review what you're going to submit I ask that you get that in as soon as possible, preferably by next week, mid to beginning of the week.

MS. BERRY BOWEN: That sounds great. I think the assumptions have shifted so now we can update that — what we believe to be true.

MR. BARBER: That's all the questions from the board members, right? Now, Julia, do you have questions?

EXAMINATION OF MS. BERRY BOWEN

BY MS. SHAW:

Q. I just have a couple brief questions. Do you consider Chittenden County to be part of your service area?

A. No. We do Franklin and Grand Isle County.

Q. Thank you. That's my only question then.

MS. BERRY BOWEN: Thank you.

CHAIR MULLIN: Okay. Thank you for your

108

testimony. Now we're going to move into public comment section of the hearing. We're scheduled to adjourn at 4. We can stay in the room up until 4:25 or so if we need to, but there's only six individuals who have signed up to comment so I'm just going to go through the list starting with David Weissgold and Dr. Laub. I guess do you have anything else to say?

DR. WEISSGOLD: No. We probably didn't understand what the word public comment —

MR. BARBER: Fair enough. Four people. If you could, when you're giving a comment please just stand up, identify yourself, if you're representing an organization identify the organization you're representing, what your position is. That would be helpful and speak loudly. Yes. First one up is Diane Zeller.

MS. ZELLER: I'm a registered nurse at UVMMC. I've been there since I've been a RN at UVMMC. I've been working there since 12 of '08 and I work in the minor procedure unit, and I'm here to represent and support the opening in a timely fashion, which is this summer, for Green Mountain ASC. We need it. Patients need it. In my department they closed down one of our rooms so we don't have any patients to come to do what we did for

109

them before they have taken it away. I know personally that neighbors, friends of mine are waiting extended long lengths of time to have anything done. It's not safe for our patients, and we as nurses and any other caregivers know that every one of those patients that we take care of is somebody else's loved one, and that's very important to all of us and only want the best for them, and opening this surgery center would help all our patients in our community to get the service they need in a timely fashion that they need it. Thank you for listening.

MR. BARBER: Thank you. Next up we have Kathy O'Reilly.

MS. O'REILLY: Kathy O'Reilly, Director of Economic Development for the Town of Colchester. I just wanted to say that the Selectboard, the Town Manager, and I support the Green Mountain Surgery Center. Their 25 jobs are value added jobs that we are looking for not just in Colchester but in the surrounding communities, and these jobs coupled with the new employees who are coming for these opening positions is exactly what the work force investment objective is in Vermont. We need more jobs. We need value added jobs and we support this wholeheartedly.

110

Thank you.

MR. BARBER: Thank you. Up next is Ken Libertoff.

MR. LIBERTOFF: Yes. Ken Libertoff representing myself today. Clearly this is an important debate and an important decision that the board has to make, and over the last eight years there's been a lot of conversation, particularly with the Green Mountain Care Board, before the Green Mountain Care Board, about trying to define what patient centered care would look like in Vermont, and I rise today to simply say I think that the proposal by the Green Mountain Surgery Center is a demonstration of what patient centered care should look like I think in terms of cost, quality, and access to care. This is something that patients, consumers really need, and I hope that you will look favorably in deciding the CON.

I do have to say a couple words, though, about cost which is an issue that I talked about before. One of the things that certainly an assumption is that the cost of our health care system here in Vermont, as well as the nation, is not sustainable, and it is troublesome to me that while there's correctly a lot of focus on what the possible

111

cost of care, I happen to be one of those people who believes the cost will probably be lower on average through this independent network than through the existing hospital network, but I cannot believe that eight years of work of the Green Mountain Care Board and I don't think there's anybody in this room who can tell me how much any one of these procedures now costs in a hospital setting which to me is a very, very sad indictment of the lack of transparency when it comes to this issue of cost.

So I guess one of the questions that I hope everybody will consider is assuming that this CON is approved and the center opens up how are you really going to determine one of the key indicators is the cost less, equal, or more of this new model unless you have more transparency that shows us what the hospitals now are charging for similar techniques, and the failure to do that makes health care reform seriously endangered in my opinion.

So, in summary, the way I interpret this debate is it's a step in the direction of creating a patient centered care system, and I hope that you will review it favorably. Thanks.

MR. BARBER: Thank you, and this is reminding me I should have done a better job

112

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 ambulatory 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

Green Mountain Surgery Center's addition of routine cataract surgery is based on absolutely no proof of need. I understand that showing need and avoiding unnecessary duplication of services are key elements of the state CON law. Today the Eye Surgery Center is running at approximately 60 percent capacity, over more than 10 years with ample availability for additional cases. Hearing Dr. Weissgold and Young's testimony today I acknowledge that on rare occurrences there will be a need to perform cataract surgery in conjunction with vitreoretinal surgery. I do not oppose that type of non-routine cataract surgery.

In summary, approving Green Mountain Surgery Center's request to duplicate our CON scope would not result in any savings to Vermont patients — any cost savings, excuse me, to Vermont patients. That's — all ASC's are reimbursed the same. It will, however, result in unnecessary duplication of care that's already available in an established ASC which specializes in eye surgeries only. Therefore, I respectfully request that the board deny Green Mountain Surgery Center's request to offer ophthalmology procedures that are currently being performed at the Eye Surgery Center. Thank you.

114

MR. BARBER: Thank you. So that unless there's anything else from the parties —

MS. TYLER: I have a couple things to clarify if you wouldn't mind. Should I go back up to the microphone?

MR. BARBER: No.

MS. TYLER: The first thing is that I think Ms. Cooper during her testimony agreed to do a few things that were asked of her by several members of the board. I think it would be nice for us to have a summary from your point of view to make sure that we have all of them. We caught everything. So that would be helpful just to confirm what's expected in terms of changing the policies and things of that nature, and then I had — I had a question. I feel the need I guess to clarify what the board is considering with respect to the expansion of scope following the discussion just at the end with NMC.

So it's our position that the CON was approved for a multi-specialty ASC. That's the language that's used in the CON and it wasn't approved for specific specialties. So projections were provided based on interest that had been expressed by physicians in the community at the time the application was put together, but the compliance

115

with CON criteria was not demonstrated on a specialty specific basis, and the CON was not approved as restricted to specific specialties. So that would be our position.

I think as Ms. Cramer indicated, NMC and VAHHS are taking the position that the ASC can only operate in the specialty areas for which projections were provided and that a CON amendment would be required to expand services into other specialties such as ophthalmology or plastic surgery. So I think those are either of the two physicians' positions that have been advanced. I don't think that anyone is suggesting that the surgery center was approved with respect to the specific individual doctors who would be participating and providing services. So I was a little confused by the testimony about the surgery center might have a different impact on NMC because different physicians are now potentially participating who might draw more patients from NMC, and you know I just want to clarify that I don't think that ACO is being asked to relitigate whether it can provide surgery or service in the areas with respect to which projections are provided, and a CON amendment is not required each time a different doctor, you know, opts to provide services at the

116

surgery center, you know, in OB or in orthopedics, for example. So — so I don't see why it would be relevant to present that particular information that there's a different orthopedist now potentially participating in the center and that person might draw more patients from NMC. So that was one thing.

The second thing was I think there was an interest on the part of the board in information from NMC concerning its assessment of the impact of adding ophthalmology services and plastic surgery services, and if the board is interested in receiving that information from NMC, the ACTD, LLC was not asked to provide that information from its perspective and based on the information that it has regarding its participating providers and where they currently provide services. So we would ask to provide that information as well based on our understanding of what's expected.

MR. BARBER: So first issue I would expect that to be addressed in the written arguments both parties are going to be presenting. With respect to the evidence that was asked from NMC if you have evidence that you would like to present on that, the board would be willing to accept that I think, but I think if I'm understanding the

117

questioning correctly, the questions were around the additional impact that the — so a number — like Ms. Berry Bowen said the number of projections changed both in terms of new services and in terms of volumes, and getting an understanding as to what that new effect is on NMC because that's the way they were going. So —

MS. TYLER: Okay. I just would ask to clarify the purpose of that report, though, because I want to make sure that ACTD is not being asked to relitigate the permit that's already been approved. So ACTD is not being asked to demonstrate that the permit that's already been approved still stands now that a different doctor is providing orthopedic services.

MR. BARBER: I don't think anyone is trying — that's not my understanding is we're relitigating this CON that was issued. We're dealing with changes in scope and those changes relate to new services. They also relate to changes in the projections in payer mix, volume, all those sorts of things that were drawn out in the questions and answers that preceded this hearing. So maybe what might be best is we have a post-hearing status conference. It might be best that we have a post-

118

hearing status conference instead of continuing these discussions in this vein. Does that make sense?

MS. TYLER: Sure. I'm — unfortunately I'm out of town next week so if we could do it tomorrow or Friday, that would be ideal.

MR. BARBER: I will send an e-mail around seeing if folks are available maybe Friday.

MS. TYLER: Sounds good. Thank you.

MR. BARBER: Anything else, Ms. Cramer?

MS. CRAMER: No. That's fine. I think a followup will be helpful.

MR. BARBER: Okay. So I think we're going to end the hearing portion of this meeting and turn it back over to the Chair.

CHAIR MULLIN: Is there any old business to come before the board? (No verbal response.) Seeing none is there any new business to come before the board? (No verbal response.) Seeing none is there a motion to adjourn?

MR. PELHAM: I'll move.

MS. LUNGE: Seconded.

CHAIR MULLIN: It's been moved and seconded to adjourn. All those in favor signify by saying aye? (Board members respond aye.) All opposed? (No verbal response.) Thank you.

119

(Whereupon, the proceeding was adjourned at 4 p.m.)

CERTIFICATE

I, JoAnn Q. Carson, Certified Shorthand Reporter and Notary Public, do hereby certify that the foregoing pages numbered 1 - 119 inclusive are a true and accurate transcription of my stenographic notes to the best of my ability of the proceedings in re: Application of ACTD, LLC before the Green Mountain Care Board held on April 17, 2019, at the Pavilion Auditorium, State Street, Montpelier, Vermont, beginning at 1 p.m.

_____

JoAnn Q. Carson
Registered Merit Reporter
Certified Real Time Reporter

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

Y

Z