

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

IN RE: APPLICATION OF ACID, 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, MChDs
Tom Pelham

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

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

12 The other scheduling update is on
13 Wednesday, April 24 we'll be hearing from Springfield
14 Medical Center. We'll be hearing on a rate
15 adjustment to their budget as well as their
16 enforcement hearing. We had had Springfield
17 scheduled for today and due to Representative's
18 passing and a funeral we've rescheduled that to April
19 24, again in this auditorium, starting at 1 p.m., and
20 then we have finalized the date for our traveling
21 board meeting will occur at the end of this month —
22 next month May 29. It will be at Gifford Hospital,
23 and there will be more details on our web site, and,
24 lastly, if folks have not signed in, I would ask that
25 you sign in at the back table and that is all I have

HEALTH CARE ADVOCATES
Julia Shaw
Eric Shouldice

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1 to announce.

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

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

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

12 MS. USIFER: So moved.

13 MR. PELHAM: Second.

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

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

25 MR. BARBER: Thank you. So good

5

1 afternoon. This is a hearing in the case of in re:
 2 ACID, LLC doing business as Green Mountain Surgery
 3 Center. The docket number is GMB-010-15 CON. As
 4 the Chair said my name is Michael Barber. I'll be
 5 serving as the board's designated Hearing Officer for
 6 today. This is — this hearing will be conducted
 7 under Title 18 Chapter 221 of the Vermont statutes
 8 and the Board's Certificate of Need regulation GMB
 9 Rule 4. The provisions of the Administrative
 10 Procedures Act do not apply to these proceedings.
 11 ACT or ACID, the holder of the CON, is
 12 represented today by attorney Karen Tyler.
 13 Representing Vermont Association of Hospitals and
 14 Health Systems and Northwestern Medical Center who
 15 are interested parties is attorney Ann Crater, and
 16 representing the office of the Health Care Advocate,
 17 also an interested party, are attorneys Julia Shaw
 18 and Eric Shouldice.
 19 So the agenda for this afternoon's
 20 hearing is as follows. First we're going to hear
 21 from ACID. Based on our prehearing conference I
 22 expect your presentation to be 45 minutes or so. I
 23 have asked the Board Members to hold their questions
 24 until the end instead of interrupting it. I think
 25 that will make things go smoother. Following your

6

1 presentation there will be board questions, the
 2 opportunity for Health Care Advocate to ask some
 3 clarifying questions, and then we're going to hear
 4 from Northwestern Medical Center. We'll have one
 5 witness again followed by board questions and
 6 potentially questions from the Health Care Advocate.
 7 At the end we're going to have a public
 8 comment period. If you would like to make comments
 9 today, there is a sign-up sheet outside the door. I
 10 would ask that you please put your name down. The
 11 board will not be making any decisions today. So in
 12 addition to the comments that the board receives
 13 orally at the end of the hearing, the board will
 14 accept public comments for ten days. So through
 15 Monday, April 29. Those comments can be submitted
 16 via the board's web site, by telephone, or by U.S.
 17 mail.
 18 We have a court reporter here with us
 19 today and she's making a transcript of the
 20 proceeding, and before we move on and I turn it over
 21 to you, Ms. Tyler, I would like to ask the court
 22 reporter to swear in all the potential witnesses at
 23 one time. So if you were listed on the parties'
 24 witness list as a potential witness and you expect to
 25 testify today, if you would please stand up and raise

7

1 your right-hand so the court reporter can swear you
 2 in.
 3 (Potential witnesses were sworn.)
 4 MR. BARBER: Ms. Tyler, turn it over to
 5 you.
 6 MS. TYLER: Sure. I'm Karen Tyler with
 7 the firm of Dunkiel Saunders representing ACID, LLC.
 8 Thank you very much for the time today. We'll start
 9 with just an introduction of the folks at the table
 10 here and then we'll move directly into the
 11 presentation regarding condition compliance that they
 12 will be presenting.
 13 MS. COOPER: Thank you, Karen. I'm Amy
 14 Cooper, manager of ACID, LLC and the Green Mountain
 15 Surgery Center.
 16 MR. PAONI: I'm John Paoni. I'm the
 17 administrator of the Green Mountain Surgery Center.
 18 I would like to thank you for the opportunity since
 19 this is the first time I've been at the Green
 20 Mountain Care Board. I come from Utica, New York. I
 21 moved here in July of last year to operate and help
 22 build the Green Mountain Surgery Center. This is the
 23 third surgery center that I have had the opportunity
 24 to work in. The first surgery center built from the
 25 ground up it was a single specialty pain with six

8

1 ORS. The second surgery center was a
 2 gastroenterology with four procedure rooms in Lower
 3 Manhattan.
 4 So I'll tell you a little bit about an
 5 ambulatory surgery center as it's a fairly new
 6 concept for Vermont, but it's a really unique medical
 7 facility. We create a very team structured
 8 environment. Everyone pitches in and we all wear a
 9 lot of hats. The ASC runs extremely efficient.
 10 Procedures are scheduled and all procedures start on
 11 time. Patient wait times are very minimal. We are
 12 focused on that patient. There is no greater
 13 satisfaction for me than seeing a patient smile when
 14 they leave our facility. The Green Mountain Surgery
 15 Center will offer great service at an affordable cost
 16 to all the citizens of Vermont. We do not have any
 17 overnight stay for any patient. Our patients have
 18 the right to choose the facility that they will have
 19 their procedure performed. The Green Mountain
 20 Surgery Center will offer an alternative to those
 21 Vermonters. Thank you.
 22 MS. COOPER: Now I was going to start at
 23 the top with condition number one and go through the
 24 conditions sequentially to demonstrate how we are
 25 complying with those conditions of the CON.

9

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

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

10

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

15 Condition one also requires that the
 16 credentials of the physician be listed so we've done
 17 that here underneath. Condition one also requires
 18 that the physician's contact information for patients
 19 24/7 be available on the web site. That's down here
 20 at the bottom. These here are tabs that you would
 21 tab through, but the contact information always
 22 remains down at the bottom.

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

11

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

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

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

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

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

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

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

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

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

25 The next condition is condition 4, the

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

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

1 desires to transfer patients requiring emergency
2 services to UMMC and UMMC desires to accept such
3 patients; and, whereas, the patients also desire to
4 facilitate the continuity of care and to specify the
5 rights and duties of each party as well as the
6 procedure for ensuring appropriate timely transfer of
7 patients and records between the parties, now,
8 therefore, for mutual consideration sufficiency of
9 which is hereby acknowledged, the parties agree as
10 follows, and then the document reads with
11 explanations of how we will effectively transfer
12 patients and medical information from the Green
13 Mountain Surgery Center to the UM Medical Center.

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

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

1 memorandum of agreement from the ACO confirming that
2 it will enter into such a participation agreement
3 once the ASC becomes operational. We entered into a
4 Memorandum of Understanding with OneCare in March of
5 2018 and a copy of that agreement was submitted to
6 the board last year.

7 We have also submitted a letter of
8 interest to participate in the OneCare ACO program
9 for the next calendar year which starts January 1,
10 2020. A copy of that letter of interest was also
11 submitted to the board. I also gave an update on our
12 conversations with OneCare which had been pretty
13 consistent and evolving over the last few months in
14 the letter I wrote to the board on March 26th.

15 The next condition is condition 7, the
16 applicant shall obtain approval to enter into an
17 agreement with CMS to operate as a Medicare certified
18 ambulatory surgery center, and there are two ways to
19 obtain certification from CMS. One is to go through
20 a state agency that CMS has appointed and given
21 responsibility for certifying different health care
22 facilities, and the Department in Vermont that is
23 responsible for that is DFL. The other way to get
24 certified by Medicare is to go through one of the
25 national accrediting organizations that has dean

17

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

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

18

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

10 We plan to use the same format for the
 11 commercial self pay standard charges. It would have
 12 again the same 25 most common procedures and a PDF of
 13 similar format that would open. We do not have
 14 information on this finalized yet so this does not
 15 have prices in it yet, but that's what we are working
 16 towards over the next couple of months.

17 We also have provided on the left-hand
 18 side links to the insurance carrier web sites that we
 19 contract with so that patients can use the member
 20 sites on the insurance carriers to get an estimate as
 21 well from their insurers of what the out-of-pocket
 22 cost will be for their procedures.

23 Condition 9 is that we shall make the
 24 ASC's consumer web site available to the public no
 25 later than two weeks prior to commencing operations.

19

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

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

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

20

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

4 Condition 11 is that the applicant shall
 5 require that each physician that performs procedures
 6 or surgeries at the ASC have admitting privileges at
 7 one or more local hospitals. This requirement is
 8 stipulated in our medical staff bylaws in section 4
 9 where we say under 4.2, membership qualifications,
 10 that membership on the medical staff of the center
 11 shall be a privilege extended only to those
 12 professionally competent practitioners within the
 13 center's primary service area who maintain active
 14 privileges at a local hospital with credit approved
 15 by the governing board if they perform procedures
 16 surgeries at the center.

17 We also have in the credentialing file
 18 for each physician at the center a copy of evidence
 19 of their admitting privileges at local hospitals,
 20 copy of the bylaws. The pertinent section was
 21 submitted to the board on March 18.

22 Condition 12 is that the applicant must
 23 successfully negotiate with Blue Cross/Blue Shield of
 24 Vermont to accept reimbursement that is below the
 25 community fee schedule rate for insurers that do not

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

18 Condition 13 is that the price of a procedure
 19 or surgery that is billed to patients that self pay
 20 may not exceed the lowest price billed to patients
 21 covered by commercial insurance. This is covered
 22 under our self pay policy, policy number 3.14, which
 23 we submitted to the board at the end of January. A
 24 policy states that a patient can be considered self
 25 pay if they are having a medically necessary

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

11 MR. BARBER: Miss Cooper, I'm a little
 12 cognizant of time here. If it's a policy you're
 13 going over, and I don't mean to break your — but if
 14 it's a policy, the board has it and has read it and I
 15 don't think you need to summarize it.

16 MS. COOPER: Okay. Thank you. The next
 17 three conditions relate to policies so I was going to
 18 ask John to give a brief overview of what those
 19 policies are without reading them please, John.

20 MR. PAONE: So the first one is the
 21 benefits verification policy and as part of our work
 22 flow that we would verify insurance benefits for all
 23 patients coming to the surgery center. Every patient
 24 gets a phone call prior to the procedure and a full
 25 explanation to them is given to what their

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

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

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

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

25 Condition 18 is that the applicant shall

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

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

10 MS. TYLER: Condition B21 requires the
 11 surgery center to submit on a quarterly basis
 12 information to the board and also publicly post it on
 13 its web site concerning each provider's productivity
 14 and payer mix. Specifically they are asked to submit
 15 for each individual provider a breakdown of the
 16 procedures and surgeries that person performed at the
 17 surgery center, a breakdown of the procedures and
 18 surgeries that person performed by payer mix at the
 19 surgery center, a breakdown of the procedures and
 20 surgeries that person performed at local hospitals by
 21 payer mix, and finally the number of patients that
 22 provider found inappropriate for care at the surgery
 23 center and the reason for that determination in each
 24 case.

25 So the information with this condition

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

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

1 give the board the information that it needs to
 2 oversee operations of the surgery center while not
 3 requiring the disclosure of again, you know, personal
 4 private, confidential, and competitively sensitive
 5 information on the public web site on the part of
 6 each individual provider.

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

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

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

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

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

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

1 ophthalmology procedures that we would plan to do.
 2 Every one, of course, has a much lower total cost and
 3 patient responsibility in the ambulatory surgery
 4 center versus the hospital outpatient department.

5 Okay, and at this point I would turn it
 6 over to the witnesses that I have asked to testify to
 7 further explain the need for ophthalmology and
 8 plastic surgery services at the Green Mountain
 9 Surgery Center.

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

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

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

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

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

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

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

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

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

1 room bound surgical patients. I see office based
 2 patients during all times outside of my operating
 3 room block time every work week, and very many of
 4 those patients' needs are no less pressing nor vision
 5 threatening than are those of the operating room
 6 bound patients. One can permanently lose vision just
 7 as quickly from age related macular degeneration that
 8 needs office based care, for example, medication
 9 injection into the eye, as from a retinal detachment
 10 that needs operating room based surgery. I care for
 11 far, far more urgently in need office based patients
 12 than I do urgently in need operating room based
 13 patients every single week.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 I separated from UMMC in October of
 14 2017 after 20 years there. At that time I thought
 15 about leaving the state entirely, but decided to stay
 16 partly because of the possibility of operating at the
 17 Green Mountain Surgery Center. When I worked at
 18 UMMC I operated five days a month consistently.
 19 After I separated from UMMC I was given less than
 20 one full day of scheduled operating room time per
 21 month after over five months of negotiation.
 22 Needless to say the severely reduced operating room
 23 time has led to many of my patients to have delays of
 24 months before having surgery. For example, one baby
 25 with a cleft palate had to wait three months later

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1 than the recommended time to have the surgery.
 2 In order to continue to serve my
 3 patients I have supplemented the lack of surgery days
 4 at UMMC by obtaining operating privileges at other
 5 smaller regional hospitals in St. Albans and
 6 Middlebury. Although this is a benefit for patients
 7 needing plastic surgery in Franklin or Addison
 8 County, most of my patients live in Chittenden County
 9 and they have additional driving time in order to
 10 have their surgery because of this. This is
 11 unfortunate that this means more time off work for
 12 their families and caregivers.

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

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1 quoted by UMMC.

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

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

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

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

18 MS. LUNGE: Shall I go first?

19 MR. BARBER: Sure.

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

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1 in 2015?

2 DR. WEISSGOLD: Yes.

3 MS. LUNGE: You have to verbalize it for

4 our court reporter.

5 DR. WEISSGOLD: Sorry.

6 MS. LUNGE: Thank you, and currently are

7 either of you doing stand alone cataract surgeries?

8 DR. WEISSGOLD: No.

9 DR. YOUNG: Well except in the context

10 — no except when it's a lens that's in the posterior

11 segment. So we may be — it depends how you define

12 stand alone cataract surgery, but yes there are times

13 the only reason we're going to the operating room is

14 to remove lens material from the eye, but when it's

15 caught up in the back of the eye we also must perform

16 a vitrectomy.

17 MS. LUNGE: Got it. Thank you.

18 DR. WEISSGOLD: When I do that surgery I

19 will sometimes also put in a lens implant.

20 MS. LUNGE: Great. Thank you for

21 explaining that. As you know we're not clinicians

22 here so it's helpful to have the layperson

23 explanation, and in terms of plastic surgery my

24 questions there were could you give us a sense of the

25 percentage perhaps, or you can tell me what the best

42

1 way to explain it is, but the percentage of your

2 practice that's medically necessary procedures versus

3 what I would call cosmetic? There might be a better

4 word for it than that.

5 DR. LAUB: Yes. Much less than 10

6 percent of my practice is cosmetic.

7 MS. LUNGE: Thank you, and for all of

8 your — the procedures for both of the specialties

9 are those procedures which are typically covered by

10 Medicare?

11 DR. WEISSGOLD: All of ours are.

12 DR. YOUNG: Yes.

13 DR. LAUB: Other than the small

14 percentage of my cases that are deemed cosmetic would

15 be covered by Medicare.

16 MS. LUNGE: Okay and is that also true

17 for commercial insurance?

18 DR. YOUNG: Yes.

19 DR. WEISSGOLD: Yes.

20 DR. LAUB: Yes.

21 MS. LUNGE: And what about Medicaid?

22 DR. YOUNG: Yes.

23 DR. WEISSGOLD: Yes.

24 DR. LAUB: Yes.

25 MS. LUNGE: Great. Thank you.

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1 CHAIR MULLIN: Just an expansion on

2 Robin's question. Can you go into more detail on why

3 you weren't successful in the 2015 discussion and

4 when you ultimately came back to that discussion?

5 DR. WEISSGOLD: Which discussion are you

6 referring to?

7 CHAIR MULLIN: The discussion with the

8 ambulatory surgical center to be able to conduct your

9 operations there.

10 DR. WEISSGOLD: The then existing one?

11 CHAIR MULLIN: No.

12 DR. WEISSGOLD: The Green Mountain

13 Surgery Center — oh we were not successful. It was

14 just very preliminary discussions and we were still

15 in discussion with other entities about whether we

16 could go there.

17 CHAIR MULLIN: So it was one long

18 continuing discussion?

19 DR. WEISSGOLD: No. I would say it was

20 punctuated every several months or so.

21 CHAIR MULLIN: Okay. Thank you.

22 MR. BARBER: While these three witnesses

23 are up Eric Shouldice, Julia Shaw, do you have

24 questions for these witnesses?

25 MS. SHAW: I don't believe we have any

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1 questions for these witnesses. Thank you.

2 MR. BARBER: I think so, Ms. Cooper and

3 Mr. Paori, if you could go back up on the stand, I

4 think the board does have questions for you guys.

5 Thank you.

6 MS. HOLMES: Okay. Looks like I'm going

7 to be taking it all. Can everybody hear me? Okay

8 great. So in your application and in our statement

9 of decision the primary need being met here was

10 really that the ASC was going to be a low cost

11 alternative for all Vermonters. So I'm going to

12 focus my — the beginning of my questions around

13 condition 12 which requires the Green Mountain

14 Surgery Center to accept reimbursements for

15 procedures and surgeries that are below the

16 reimbursements paid to hospitals. So we are very

17 clear on it being below the reimbursements paid to

18 hospitals.

19 So, Ms. Cooper, in your testimony and in

20 your letter that was dated March 26th of 2019 you

21 state in order to satisfy condition 12 we plan to ask

22 commercial insurers that we contract with to provide

23 us with a letter stating that reimbursements that

24 were paid to the Green Mountain Surgery Center for

25 procedures and surgeries are below the average

1 equivalent reimbursement paid to hospitals for
 2 providing the same services. Can you tell me how
 3 that actually satisfies the condition 12?
 4 MS. COOPER: Sure. I think I tried to
 5 also in my letter explain that commercial payments,
 6 facility payments to hospitals for outpatient
 7 surgeries vary among different hospitals. There is
 8 no uniform community fee schedule for facility
 9 payments to hospitals for outpatient surgery in the
 10 commercial market like there is in the Medicare
 11 market. That makes it impossible for us as the Green
 12 Mountain Surgery Center to know what the hospital
 13 outpatient payment is from a different — from a
 14 commercial insurer for a particular surgery.
 15 I submitted a list of our initial
 16 planned procedures by CPT code which had between
 17 three or four hundred codes on it. I don't know what
 18 hospitals receive from commercial insurers in
 19 equivalent facility payments for those three hundred
 20 codes. It's very hard information to get. I don't
 21 think it's even possible to get. So I need to
 22 negotiate with commercial insurers and say here's
 23 what I think my costs are for providing this, here's
 24 what I would like in reimbursement, and they need to
 25 come back to me and say we think that one is too

1 high, this one is fine, okay, and that's how we'll
 2 have an agreement.
 3 I did attempt to ask Blue Cross Blue
 4 Shield for information about their payments to
 5 hospitals for the equivalent outpatient surgeries and
 6 they declined to provide me with any of that
 7 information. So the only way that I can think to
 8 achieve this, meeting this condition while also
 9 dealing with the realities of the commercial
 10 insurance contracting market in the state, is to
 11 agree to prices for payment with the commercial
 12 insurers and then have them attest to me, because
 13 they won't share their payment rates to hospitals
 14 what they are, that what they are paying us is lower
 15 than what they are paying hospitals.
 16 MS. HOLMES: Okay, but let me clarify.
 17 There's a difference between lower than what they are
 18 paying hospitals and lower than the average
 19 reimbursement. So let me remind you of — I asked
 20 you at the first hearing the testimony — I asked you
 21 a question would you be willing to guarantee as a
 22 center policy to ensure that your prices will always
 23 be lower than hospitals and put that policy on your
 24 web site and in your negotiations with commercial
 25 payers effectively state that that's your policy and

1 making sure that stays true, and you said the answer
 2 to that is yes.
 3 So there's a difference between ensuring
 4 that your prices are below the average and ensuring
 5 that your prices are below the minimum. Let me just
 6 finish, and so — and in particular if you look at
 7 the average reimbursement, if the average were the
 8 same as the median, then 50 percent of the hospitals
 9 would be cheaper than the ambulatory surgical center
 10 if you're pitching at the average, and so — and
 11 frankly the average is going to be higher than the
 12 median because you're going to have an outlier with
 13 the academic medical center pulling up the average.
 14 So the median is actually going to be lower than the
 15 average here.
 16 So my concern is that in your testimony
 17 when you first put forth the idea of a low cost
 18 alternative to Vermonters in the ambulatory surgical
 19 center, you know, you advocated this was going to be
 20 a lower cost than all hospitals, in fact there were
 21 numbers out there that the prices would be 50 percent
 22 less, there was lots of testimony that the prices
 23 would be about 50 percent less, the rates would be 50
 24 percent less than hospitals, and even in your
 25 response to some of the board's questions January of

1 2019, so just this past January you confirmed, this
 2 is a quote, "we confirm that surgeries and procedures
 3 offered at the Green Mountain Surgery Center will be
 4 offered at lower cost than the same surgeries and
 5 procedures in hospital outpatient settings, including
 6 surgeries and procedures offered in specialties of
 7 plastic surgery and ophthalmology." So that's
 8 suggesting it's lower than the minimum. It's cheaper
 9 than the hospitals. It's not cheaper than the
 10 average.
 11 MS. COOPER: So understanding again that
 12 the payments paid by commercial insurers to hospital
 13 outpatient departments for individual procedures are
 14 extremely varied and different from each other on the
 15 order of thousands of dollars sometimes, had the
 16 question been asked would you state as a policy that
 17 you will be lower than the minimum price paid to any
 18 hospital, I may not have answered in the affirmative.
 19 The question was asked will you be lower than the
 20 hospitals undefined whether that's the minimum price,
 21 the median price, or the average price, and I said
 22 yes I can confirm I'll be lower than the hospitals,
 23 and then I'm defining that now more specifically as
 24 the average of the hospital prices. It was never
 25 specifically defined prior to that.

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

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

1 MS. COOPER: I suppose there could be.
 2 Our hospital in our primary service area is the
 3 academic medical center. So when we consider what
 4 our charges will be we look at our own cost, and if
 5 we have any knowledge of what the local hospital in
 6 our primary service area is, we certainly ensure that
 7 our standard charges will be below that and in a lot
 8 of cases half of the price that we know of at the
 9 local hospital in our primary service area if we know
 10 what that charge is.

11 There was at the beginning of 2019 a
 12 rule passed by Medicare that hospitals have to list
 13 charges on their web site for patients to see. The
 14 hospitals here in Vermont do have price lists posted
 15 on their web site, but there are holes all over it in
 16 terms of different CPT codes have no prices next to
 17 them or are not on the list. Some codes are on the
 18 list and have prices. So where we can find data on
 19 what the local hospital price is we are ensuring that
 20 our standard charges that we are planning to offer
 21 are well below that and in a lot of cases 50 percent
 22 below that price.

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

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

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

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

1 all providers to accept all patients regardless of
 2 ability to pay. They must base their determination
 3 of venue on factors other than type or a
 4 reimbursement. So a question I have for you is how
 5 will you enforce such a policy? What data will you
 6 be using to ensure all patients are served and there
 7 isn't cream skimming going on, and what consequences
 8 would exist if there was evidence of that within the
 9 providers in your group? How are you going to
 10 enforce this policy? I see you have it on your web
 11 site. How are you going to enforce it? How are you
 12 going to check that is not happening?

13 MS. COOPER: So we have — we are going
 14 to be compiling our payer mix data quarterly, also to
 15 post to our web site. So we will be reviewing all of
 16 the cases that come to the center and which —
 17 whether they were covered by Medicare or commercial
 18 or other insurance, and that way we will have insight
 19 into certain physicians if they are bringing us only
 20 commercial cases or only self pay cases. We also
 21 have a peer review policy where surgeons review other
 22 surgeons looking at their cases and chart notes. We
 23 have also talked about putting as part of our peer
 24 review policy that that also include reviewing case
 25 mix and payer mix from other surgeons so that could

1 be included.

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

7 MS. COOPER: Yes.

8 MS. HOLMES: Okay, and also similar to
9 that you have — we have conditioned approval on the
10 adoption of shared decision making policy. So again
11 how will you enforce that providers are providing
12 patients with all the information they need and they
13 are engaging patients in that decision making? How
14 do you enforce that policy?

15 MS. COOPER: So I haven't thought in
16 depth about how we're going to enforce that policy.
17 It is something when I talk to all the physicians
18 about shared decision making policy here's what it
19 is, here's what it says you have to do, the response
20 that I have gotten from nearly everyone is yes this
21 is the normal part of how we talk with our patients
22 about their procedures, we do this in the office, we
23 do it in an informed consent procedure which happens
24 at all hospitals and surgery centers. We — this is
25 the normal part of our practice given that need back

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

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

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

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

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

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

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

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

20 MS. HOLMES: I did it.

21 MS. COOPER: We just tried to match it.

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

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

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

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

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

23 MS. HOLMES: Discount off the commercial
24 charges?

25 MS. COOPER: Yes. Yes.

1 MS. HOLMES: Okay.

2 MS. COOPER: And we do not plan to have

3 any asset checking as part of our free and discounted

4 care policy so we can remove — when we resubmit the

5 policy with a more clearly defined what procedures

6 are excluded we'll also remove the reference to asset

7 check.

8 MS. HOLMES: Fantastic. Thank you.

9 MS. LUNGE: Hi, Amy, good to see you. I

10 just want to return first to the question of price.

11 Do you recall when we were here during the hearing

12 talking about charging one price for your procedures?

13 MS. COOPER: Yes.

14 MS. LUNGE: Regardless of payer type?

15 MS. COOPER: Yes.

16 MS. LUNGE: Have you in your commercial

17 negotiation suggested the Medicare price as the

18 discounted reimbursement level?

19 MS. COOPER: No.

20 MS. LUNGE: Thank you, and are you in

21 negotiations with more than one commercial payer at

22 this point?

23 MS. COOPER: Just to clarify I believe

24 that I indicated that the price for the procedure

25 ought to be the same no matter who the commercial

1 payers were because they are often different based on

2 which commercial insurer you have. That was the

3 intent. I have found through learning about the

4 commercial insurance contracting market more, having

5 actually been involved now in commercial contracting

6 situations, that we are one tiny player in a very

7 large well established contracting market, and are

8 not in a position to dictate terms except to ensure

9 we are offering good value and lower prices than

10 other facilities based on the information that we

11 have.

12 MS. LUNGE: So your assertion is that a

13 commercial payer would prefer to pay a higher

14 reimbursement than Medicare?

15 MS. COOPER: I don't — I don't think

16 that they would prefer to pay a higher reimbursement

17 than Medicare. I think that they would prefer to pay

18 as low as possible given what the center would

19 require to cover its cost.

20 MS. LUNGE: Thank you. Are you — my

21 question was actually are you negotiating with more

22 than one commercial payer at this time?

23 MS. COOPER: Yes.

24 MS. LUNGE: So going back to the

25 conditions do you have an estimate of the date when

1 you will have your public web site available? I know

2 it's two weeks before opening. Is that currently

3 June 1 for opening?

4 MS. COOPER: So the way that the Joint

5 Commission and CMS certification process works is

6 that I have to give them my calendar of when we'll be

7 available to be surveyed for two months and they come

8 whenever they want. So they might come on week two,

9 they might come on week six, week eight. So I don't

10 know when we're going to get our Joint Commission

11 accreditation CMS certification, but then everything

12 flows from that date afterwards. We would hope to

13 open as soon as possible after that date.

14 MS. LUNGE: Okay. Thank you. So you'll

15 keep us posted on how that's going?

16 MS. COOPER: Yes.

17 MS. LUNGE: In terms of shared decision

18 making and in condition 2 are you — will you have

19 decision aides available for the services offered by

20 the surgeons performing surgeries at your center?

21 MS. COOPER: We still have work to do in

22 terms of working with the surgeons on what they

23 currently use and what are the right decision aides.

24 We at the center do not have that knowledge and would

25 rely on our surgeons to provide guidance which I

1 believe is how the policy is written as well.

2 MS. LUNGE: Great, but I guess my

3 question was obviously the surgeons would be going

4 over the decision aides with their own patients, but

5 would those decision aides be available from your web

6 site?

7 MS. COOPER: I don't know that we've

8 thought about that yet at this time.

9 MS. LUNGE: Okay. Thank you. In terms

10 of ACO participation, the participation agreement or

11 the intent to participate for 2020 is a non-binding

12 document. Do you have any reason to believe that you

13 won't participate in 2020 at least based on your

14 knowledge today?

15 MS. COOPER: No I have no reason to

16 believe that we won't.

17 MS. LUNGE: Would you be amenable to

18 having some sort of participation deadline included?

19 MS. COOPER: Yes and I think I talked

20 with Kevin Stone and Vicky Loaner recently about

21 this. You know there — and we talked about when

22 their contracting cycle is. I believe that final

23 contracts are due in the September/October period and

24 we would certainly be amenable and would sign that

25 contract, and if the board wants to put a condition

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

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

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

25 MS. LUNGE: Thank you. In reference to

1 the transfer agreement with UMM and the agreement
2 with the ambulance service, it's actually related
3 also to BILL, I was curious to know if all of the
4 physicians practicing with you would have privileges
5 at UMMC. I just wanted to understand if there might
6 be a circumstance where there was a surgeon who
7 didn't have a relationship with UMMC but would have
8 a patient with you that would then get transferred to
9 UMMC so there could be a continuity of care issue.

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

25 MS. LUNGE: Okay. Thank you for

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

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

1 survey.

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

8 MS. COOPER: Yes. So we are just having
9 preliminary patients only scheduled for the purpose
10 of OMS certification. We are not charging anything
11 or receiving any kind of reimbursement for services.
12 These patients essentially get a free service from
13 the facility. We are only doing it in order to meet
14 OMS certification. There are no other patients
15 scheduled for any reason and we are not charging
16 anything for these patients.

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

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

23 MS. LUNGE: Not the allowed amount.

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

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

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

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

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1 insurance information about. So who — if they are
 2 covered by Unitas or Aetna or CIGNA, and so we can
 3 look up what our arrangement is with those insurers
 4 and say here's what the procedure price will be. For
 5 people who are not currently our patients we won't
 6 have access to their insurance information. So they
 7 might call us and tell us and ask us and we certainly
 8 want to encourage them to have that information. So
 9 we can tell them what our standard charges are. If
 10 they say this is my insurance, we can look up and say
 11 okay this is what it looks like the procedure would
 12 cost with us based on that insurance.

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

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

25 MS. COOPER: Yes. It doesn't include

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1 cosmetic procedures.

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

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

25 MS. LUNGE: Yes.

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

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

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

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

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

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

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

20 MS. LUNGE: Would you please consider
 21 that?

22 MS. COOPER: Yes.

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

1 sensitive for future employment. Are you — do you
 2 think that there are other issues where that
 3 disclosure of that information would be a problem?
 4 MS. TYLER: I think — a couple things.
 5 we mentioned in the letter — we mentioned back in
 6 January the employment context and also basically the
 7 information that's to be disclosed reveals the
 8 physician's productivity, the financial productivity
 9 of the physician's practice for someone who chooses
 10 you know to figure that out, and of course it also
 11 shows how many of the physician's patients he or she
 12 is referring to the surgery center as opposed to the
 13 local hospital.
 14 So I think there was also concern about
 15 that relationship because of course all the providers
 16 who do surgery at the surgery center will continue to
 17 do some procedures at the hospital and I think they
 18 are sensitive about displaying, you know, how that
 19 breaks down because they do continue to depend on
 20 access to hospital facilities to operate their
 21 practice overall. There has been tremendous
 22 opposition to the surgery center in general from the
 23 hospitals. When we submitted the application there
 24 was concern about retaliation against physicians that
 25 chose to participate as owners, and I think that

1 there continues to be a degree of sensitivity about
 2 publicizing for each doctor how many of my patients
 3 am I referring to the surgery center as opposed to,
 4 you know, the local hospital.
 5 MS. LUNGE: Well the purpose behind that
 6 condition was to ensure that there wasn't steering
 7 going on essentially. So how else would we be able
 8 to monitor that?
 9 MS. TYLER: Well I think what I said
 10 earlier is you know the board is —
 11 MS. LUNGE: Thank you. I can see now.
 12 MS. TYLER: What I said earlier is that
 13 the board's purpose is to oversee the surgery center
 14 area operations as an entity, and I think that if the
 15 surgery center provides the data that you're
 16 interested in on a specialty basis, that should be
 17 adequate to indicate whether there's an unexpected —
 18 there's something unexpected in the data. So if you
 19 look at all the data for GI services and you see an
 20 unexpectedly low percentage of Medicaid patients that
 21 are receiving those services at the center, I think
 22 so that's something that you could ask Any about, you
 23 know, how do you explain this, and she was asked
 24 earlier you know how do you intend to enforce this
 25 internally, and you know I think she responded as she

1 did, and if you were to come to her and say, you
 2 know, we see a strange trend in this data for this
 3 practice area, then I think that would give Any an
 4 opportunity internally to think about well who are
 5 those practitioners and address the issue on a
 6 provider-by-provider basis internally.
 7 MS. COOPER: Thank you. I would also
 8 add that I did a memo that I submitted to the board
 9 to show our projected payer mix compared with the
 10 local hospital in Chittenden County payer mix, and
 11 those two payer mixes were quite similar. I think
 12 that there will always be that benchmark available,
 13 and if the surgery center's payer mix were to become
 14 out of line with the local hospital, that also speaks
 15 to the same patient base that would be maybe a cause
 16 for concern, and that is a way that we could monitor
 17 that.
 18 There's also, Karen mentioned, the
 19 physician's personal productivity data as being
 20 sensitive financially and competitively. When
 21 physicians become employed by a hospital or sell
 22 their practice to the hospital there's often a long
 23 negotiation around whether the practice will be paid
 24 anything for the value of the practice and of their
 25 patient base, and a lot of those discussions get into

1 exactly this kind of data; what's the payment, what's
 2 the payer mix, what's the patient base, how active is
 3 the surgeon, and so to have individual physicians who
 4 may need to or want to in the future sell their
 5 practice to the hospital have all that data publicly
 6 available would harm them immensely in those
 7 negotiations about potential sale of their practices.
 8 MS. LUNGE: Thank you. That was
 9 helpful. Since you brought up payer mix let's turn
 10 to payer mix. So in the memo that you provided on
 11 April 8, 2019 that you just referred to you include
 12 your payer mix which is based on the revenue before
 13 deductions by payer category. So am I correct in
 14 assuming that that does not include any reductions
 15 from charges?
 16 MS. COOPER: No. All of our data that
 17 we presented during the application and always is
 18 net.
 19 MS. LUNGE: So what does before
 20 deductions mean?
 21 MS. COOPER: So we have in our original
 22 projections deductions for bad debt and free care
 23 which we estimated at two and a half percent each.
 24 So it's before those deductions are taken.
 25 MS. LUNGE: Okay. I was noticing that

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1 you didn't include a deduction for bad debt or free
 2 care then for UMMC.
 3 MS. COOPER: No because it wasn't
 4 included in others so we didn't include it in
 5 their's. That's the most apples-to-apples
 6 comparison.
 7 MS. LUNGE: But you did include DSH?
 8 MS. COOPER: Yes which we could have not
 9 included DSH as well. If we don't include DSH, it
 10 makes the payer mix shift more towards commercial for
 11 UMMC.
 12 MS. LUNGE: Did you look at the payer
 13 mix for Northwestern?
 14 MS. COOPER: No.
 15 MS. LUNGE: So let me get organized
 16 here. So turning to scope, of the initial physicians
 17 provided in your application 10 remain the same; is
 18 that correct?
 19 MS. COOPER: Versus the initial
 20 projections and the updated projections, yes.
 21 MS. LUNGE: And that was out of how many
 22 original docs participating?
 23 MS. COOPER: 16.
 24 MS. LUNGE: And there are 14 new
 25 physicians included in the updated projections?

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1 MS. COOPER: Yes. Yes.
 2 MS. LUNGE: And in your updated
 3 projections you're currently showing a 17 percent —
 4 between 4 percent and 17 percent decrease in GI for
 5 cases?
 6 MS. COOPER: I think that's correct. I
 7 don't have it in front of me.
 8 MS. LUNGE: It's page 2 of your November
 9 19 memo if that helps.
 10 MS. COOPER: Yes.
 11 MS. LUNGE: GI was originally 60
 12 percent. You were projecting 60 percent of your
 13 volume to be related to GI originally?
 14 MS. COOPER: Yes.
 15 MS. LUNGE: And the change there is why?
 16 MS. COOPER: So the changes — you can
 17 see the changes in year two and year three and year
 18 four are between 4 and 8 percent.
 19 MS. LUNGE: Why is it changing?
 20 MS. COOPER: The change in year one is
 21 more pronounced because in our updated projections we
 22 think it's going to take us longer to ramp up than we
 23 did initially. So in our initial projections we had
 24 a higher number of initial patients in year one.
 25 Here we have a lower number because our assumption

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1 changed in year one. So just to say that the year
 2 one numbers the change is more pronounced than a
 3 steady state change going forward which will be 4 to
 4 8 percent less per year because we resurveyed the
 5 physicians and said what are your monthly volumes now
 6 and used those numbers for our updated projections as
 7 opposed to the monthly volume numbers for 2014 that
 8 they put in the original projection. So it was just
 9 a change in their monthly volume between those three
 10 years and intervening time.
 11 MS. LUNGE: Thank you, and the change in
 12 OB/GYN is between 38 and 47 percent in cases in that
 13 chart?
 14 MS. COOPER: Yes.
 15 MS. LUNGE: According to your narrative
 16 that's due to retirements?
 17 MS. COOPER: Yes.
 18 MS. LUNGE: Orthopedics is an increase
 19 between 41 and 63 percent due to practice changes?
 20 MS. COOPER: Yeah. Busier. More
 21 volume.
 22 MS. LUNGE: And then 93 to 94 percent
 23 reduction in pain management?
 24 MS. COOPER: Yeah. We had two original
 25 busy physicians in pain management who have changed

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1 their practices to not do procedures that would work
 2 in an ASC any more.
 3 MS. LUNGE: Thank you, and I noticed in
 4 your narrative that you indicated that that was due
 5 to change in patient demand, reimbursement levels,
 6 and practice patterns as you just explained. Can you
 7 talk about the reimbursement level piece of that?
 8 MS. COOPER: The payment rates for
 9 certain pain procedures sometimes commercial insurers
 10 here in the state have decided to stop covering
 11 procedures that they used to cover. So when I
 12 reached out to these physicians after they did not
 13 have updated projections I said what's going on and
 14 they said well the commercial insurers decided to
 15 stop covering some of the stuff we were doing.
 16 MS. LUNGE: Got it. Thank you, and then
 17 a reduction in general surgery between 36 and 45
 18 percent as well. This chart indicates that you
 19 didn't originally project cases for plastic surgery
 20 or ophthalmology, right?
 21 MS. COOPER: Yes that's true.
 22 MS. LUNGE: Thank you.
 23 MS. COOPER: I just — also our actuals
 24 when we are actually operating may look different
 25 than the projections also just because these changes

1 that I mentioned in that submission that have been
 2 occurring since 2015; physicians retiring, moving, et
 3 cetera, that it continues to be a dynamic
 4 environment.
 5 MS. LUNGE: Yes. The hearing on this
 6 Certificate of Need was April 13, 2017, was it not?
 7 MS. COOPER: Yes it was.
 8 MS. LUNGE: And did you update these
 9 projections at that time?
 10 MS. COOPER: No.
 11 MS. LUNGE: Thank you. In terms of why
 12 plastic surgery was not included in the initial
 13 projections you indicated there at the time of your
 14 application there were no independent plastic
 15 surgeons practicing in Chittenden County?
 16 MS. COOPER: Yes.
 17 MS. LUNGE: Thanks, and how many — do
 18 you happen to know how many independent plastic
 19 surgeons are practicing in Chittenden County?
 20 MS. COOPER: I believe there's two.
 21 MS. LUNGE: Thank you.
 22 MS. COOPER: I also would say if it were
 23 easy for us to do updated projections, we would do
 24 them more frequently. It is a very involved process
 25 of reaching out to individual physicians with

1 surveys. This was run by our consultants Awanza
 2 Strategies, and getting information from them or
 3 their practice managers, or whichever person in the
 4 practice keeps track of that information, getting it
 5 from all different physicians in a uniform format,
 6 and then engaging Awanza and paying their consultant
 7 basically to put together projections. So
 8 projections and updated financials is not something
 9 that we're doing regularly at all. The ones that I
 10 do have I have submitted to the board.
 11 MS. LUNGE: Thank you, and in terms of
 12 ophthalmology in your application you explained at
 13 the time of the application those services were not
 14 included because you did not have as many interested
 15 surgeons as you did now and had not completed due
 16 diligence on cost and efficiency of moving
 17 vitreoretinal cases; is that right?
 18 MS. COOPER: Yes.
 19 MS. LUNGE: So in terms of your
 20 projected cases by physician — this is on page 4 and
 21 5 of that same submission — I was noticing that in
 22 your original — it looks like the physicians listed
 23 in your original projections compared to your — the
 24 new physician list are a little bit hard to track
 25 because you've reused the letters. So, for example,

1 physician M who was a pain management specialist in
 2 the original projection is obviously a different
 3 person or went back and got a new specialty in
 4 OB/GN. I was wondering if you could please update
 5 this so that we can see apples-to-apples with
 6 physicians and not — it's a little hard to track
 7 when we can't see where there's actually people who
 8 left and people who have been added.
 9 MS. COOPER: I'll have to check with
 10 Awanza, my consultants who I mentioned who filled all
 11 these tables and did the projections for me.
 12 MS. LUNGE: Great. Thank you. So just
 13 in terms of again just finalizing questions around
 14 the projections, so in your original submission
 15 because you were focused on the specialties GI,
 16 OB/GN, ortho, pain management, and general surgery
 17 your revenue projections also did not include plastic
 18 surgery, ophthalmology, or any other specialty; is
 19 that right?
 20 MS. COOPER: That's correct.
 21 MS. LUNGE: In terms of payer mix I was
 22 noticing that your revenue projections by payer mix
 23 have also changed significantly from your original
 24 projection. So your new projections, which are on
 25 page 7 of that submission, indicate that you're

1 expecting between 42 and 49 percent less revenue from
 2 Medicare, 23 to 33 percent less revenue from
 3 Medicaid, 1 to 13 percent less revenue from
 4 commercial, 23 to 33 percent from self pay; is that
 5 right?
 6 MS. COOPER: Yes.
 7 MS. LUNGE: So what's causing that shift
 8 particularly downward in Medicare and Medicaid?
 9 MS. COOPER: Well that's just a function
 10 of the different physicians that we have in the mix
 11 now than the ones that we had earlier. When we do
 12 updated projections we also ask the physicians for
 13 their current payer mix, and again their practice
 14 manager or someone in their office gives it to us.
 15 Because our group of physicians has changed so much
 16 it would be a natural result of that, that our payer
 17 mix would change. For example, physicians in
 18 different specialties often have very different payer
 19 mixes. GI, for example, basically the American Task
 20 Force on Preventative Health Metrics — I'm saying
 21 that wrong — but recently updated their
 22 recommendations and commercial insurers have started
 23 covering colon cancer screening starting at age 45
 24 which then makes the payer mix for GI doctors more
 25 slanted towards commercial because all of a sudden

1 they have all these patients who are 45 who are
 2 commercially insured that they didn't have before.
 3 Also if you have OB/GYN doctors, they
 4 generally don't have any Medicare patients because
 5 Medicare is old. If you have eye doctors, they
 6 generally have mostly Medicare patients. Retina
 7 surgery is a low volume surgery — low volume
 8 specialty in ophthalmology, very low volume compared
 9 to cataract or others. So while those are mostly
 10 Medicare patients it's not a large part of our mix
 11 compared to the high volume GI, for example.
 12 MS. LUNGE: Okay. It also looks in your
 13 cases by payer category that you're expecting a
 14 significant decrease in Medicare cases overall,
 15 between 30 and 40 percent, over the course of the
 16 four years. That's on page 9.
 17 MS. COOPER: Yes.
 18 MS. LUNGE: And again that's related to
 19 the shift in how many cases are coming from which
 20 specialty?
 21 MS. COOPER: From which specialty. So,
 22 for example, we also previously had pain management
 23 is a very high volume specialty. It's, you know,
 24 injectable things that are done quickly and a lot of
 25 them usually. Those two physicians in particular had

1 a lot of Medicare patients and they are not part of
 2 our projections any more. So that changed our mix.
 3 MS. LUNGE: Great. Thank you for
 4 explaining that. Going back to condition 10 so you
 5 indicated today that you — or I should say that you
 6 mentioned you submitted to us evidence basis for the
 7 specialties that you were intending to provide. When
 8 we reviewed that I guess my question for you is are
 9 you also relying on any articles that you provided in
 10 your initial application because quite frankly in,
 11 for example, the materials that you provided for GI,
 12 just to pick one out, I was surprised to see that you
 13 only provided evidence basically around
 14 colonoscopies, but I assume that you intend to do
 15 other procedures in the GI specialty other than
 16 colonoscopies.
 17 MS. COOPER: We are also relying on all
 18 of the evidence that's been presented since the
 19 original application as well.
 20 MS. LUNGE: Okay. That's helpful
 21 because I was trying to get a sense of what you
 22 wanted us to consider when we were looking at
 23 factually whether or not you had met that condition.
 24 I think I'm done for now. I may have some followup
 25 after I check my notes, but —

1 CHAIR MULLIN: So I'll be brief because
 2 the two previous members have been very thorough, but
 3 I wanted to ask you what you envisioned could
 4 possibly be in the future as far as the expansion of
 5 scope. You could start with ophthalmology, we could
 6 talk about each one of the specialties, but I'm just
 7 curious what you think the bounds of what the
 8 expansion of the scope would be.
 9 MS. COOPER: In terms of specialties
 10 that we would consider bringing on in the near term
 11 the only other that I have had conversations about
 12 would be pediatric dentistry. There is a need for
 13 children who have to get teeth pulled and need
 14 general anesthesia for that to be done in procedure
 15 rooms or operating rooms, and I have heard from two
 16 dental providers and the Community Health Center in
 17 Burlington that there is a need for general
 18 anesthesia services in procedure rooms to do that
 19 sort of work. So that's the only one that I have had
 20 conversations about in the near term.
 21 CHAIR MULLIN: On the ortho looks like
 22 primarily hand surgeries. What do you see as future
 23 possibilities being performed at your facility?
 24 MS. COOPER: That is entirely dependent
 25 on whether there's any physician interest. There

1 were three years ago two independent orthopedic
 2 practices in the state, one in Chittenden County with
 3 four physicians that did all kinds of general ortho
 4 cases, one in the central part of the state. Those
 5 physicians sold their practices and became employed
 6 in 2016. There's no other independent orthopedic
 7 surgeons that I know of right now that would want to
 8 use the center.
 9 CHAIR MULLIN: Would you agree that a
 10 central focus of the initial CON was a focus on the
 11 Vermont patient, the consumer, basically a focus on
 12 really access, quality, and cost in that there was
 13 much discussion about convenience for the patients.
 14 Some patients don't want to go to a hospital setting
 15 for a surgery. There was also discussion about in a
 16 very key part of the decision was a lower cost
 17 alternative to the Vermont patient, and do you agree
 18 with that?
 19 MS. COOPER: Yes.
 20 CHAIR MULLIN: So on the ophthalmology,
 21 which wasn't discussed previously and was discussed
 22 now, how broad a scope do you think could occur in
 23 the expansion of services provided there in the
 24 future?
 25 MS. COOPER: I'm not sure how to answer

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1 that question.

2 CHAIR MULLIN: So, for example, a few

3 years ago I had an eyelid that was scraped but the

4 surgery was done inside an eye doctor's office.

5 Could that type of surgery be performed at your

6 center?

7 MS. COOPER: We do not have any plans to

8 do any surgery that is currently being performed in

9 an office in the surgery center.

10 CHAIR MULLIN: Okay. Do you have any

11 plans to do any surgeries that are performed at the

12 other ambulatory surgery center that is the only

13 other one that's currently in Vermont?

14 MS. COOPER: So none of the surgeries

15 that are in our updated ophthalmology projections

16 would be moving from one ambulatory surgery center to

17 another. All of the cases in the updated projections

18 would be moving out of the hospital into an

19 ambulatory surgery center for the first time.

20 CHAIR MULLIN: So that's today. I'm

21 talking about in the future. What type of guarantees

22 would we as Vermonters have that you are continuing

23 to offer a more convenient, lower cost setting for

24 anything that could be performed there? You never

25 raised the issue of ophthalmology in the original

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1 CON. You talked about being lower than hospitals

2 because the procedures that you were going to do were

3 being done in hospitals, and so what I'm focusing on

4 is what guarantees do we have that you won't be a

5 higher cost alternative to other options outside of

6 the hospital?

7 MS. COOPER: All I can say is that all

8 of the ophthalmology cases that we plan to do are

9 currently being performed in hospitals and we are

10 confident that we will be a lower price, particularly

11 because most ophthalmology patients are Medicare

12 patients than where those procedures are currently

13 being performed.

14 CHAIR MULLIN: I'm listening very

15 carefully to your words and you're saying currently

16 planning to do and I'm just worried about what

17 protections there are for future decisions on what

18 could be done.

19 MS. COOPER: I'm not sure. I guess I

20 would have to leave it up to the board.

21 CHAIR MULLIN: Okay. Thank you.

22 MR. PELHAM: Well welcome back. It's my

23 first experience with you folks. Looks like a very

24 long trail since 2015 which hopefully I have read and

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

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1 said in your April 8 submission that quote "overall

2 the payer mix profiles of UMMC for fiscal year 2018

3 and GMS in our updated projection are essentially

4 the same," and there's an — in your documentation

5 that you have — and I agree with you — that UMMC

6 had about 60 percent commercial, 9 percent Medicaid,

7 and 30 percent Medicare. How does UMMC payer mix

8 and your numbers currently compare to that? Do you

9 know or have any sense as to where UMM's payer mix

10 fits in terms of the rank order of payer mixes in the

11 state where the more favored commercial — the more

12 favored payer mix would be a strong commercial and a

13 strong Medicare and then a third place in terms of

14 Medicaid, do you have any sense of where UMM fits in

15 that hierarchy of the 14 hospitals in Vermont?

16 MS. COOPER: I certainly have a sense of

17 the Chittenden County patient population payer mix

18 versus the rest of the state from my work at Health

19 First with the independent practices, and in — from

20 that information Chittenden County does have the

21 highest percentage of commercial patients compared to

22 practices located in other counties or more rural

23 areas. They tend to have higher Medicaid and

24 Medicare populations.

25 MR. PELHAM: That's correct. I think at

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1 the 60 percent level there's UMM and Copley. So I'm

2 trying to kind of walk through the changes in payer

3 mix and your procedures mix since the earlier

4 applications and wondering what that might mean for

5 the Northwestern Medical Center in the sense that you

6 had previously said that about 170 or 2.7 percent of

7 the surgeries that you performed you thought might be

8 migrating from the Northwestern Medical Center, and

9 so I guess I have two questions. Do you have any

10 sense given the changes in payer mix and the changes

11 in the mix of procedures that you're doing as to how

12 that might similarly affect the Northwest Medical

13 Center, and, if so, do you have a dollar value

14 associated with that, and I ask that because we're

15 dealing with small numbers at the margin here.

16 If you take the four million dollars in

17 NPR that you folks are talking about today, that's

18 one-tenth of one percent of the total hospital

19 statewide NPR. So we're really in a very small

20 corner of the world, and — but as you get kind of

21 closer and the neighbors that you have may be more or

22 less affected, and so I know that the Northwest

23 Medical Center's payer mix is 48.8 percent

24 commercial, 17.8 percent Medicaid, and 33.4 percent

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

1 I — if you have any information that would give a
 2 more current bearing on how your services might
 3 affect Northwestern Medical, it would be helpful.
 4 MS. COOPER: I do. I haven't done the
 5 same analysis that I did in the original CON in terms
 6 of actual data around what may move. I do know,
 7 though, that there are surgeries being done at
 8 Northwest by surgeons who have moved back to the area
 9 expressly because of the ASC and only because of the
 10 surgery center that are now doing cases at Northwest
 11 and have joined the medical staff at Northwest and
 12 patients who used to be in St. Albans would have to
 13 travel to Burlington for their care are now able to
 14 get their procedures done close to home at Northwest
 15 Medical Center, and that the surgeons who have added
 16 cases there would plan to continue doing cases at
 17 Northwest and at the surgery center.
 18 I also have heard, though I'm not sure
 19 yet, that some physicians who had planned initially
 20 to bring cases to the surgery center and were in our
 21 original projections are now — have said I'm nearing
 22 retirement, I don't feel like making a change, I'm
 23 going to leave my cases where they are, and some of
 24 those cases are also at Northwest.
 25 So I don't know what the net analysis is

1 in terms of an answer, but I know that having this
 2 facility here and the way that it helps Vermont
 3 recruit physicians who want to have this option that
 4 otherwise would not be in Vermont having those
 5 physicians stay here and oftentimes bringing new
 6 cases to hospitals like Northwest is a good thing.
 7 MR. PELHAM: Thank you.
 8 MS. USIFER: There's a benefit to going
 9 last. Most of my questions were answered. I just
 10 have one question on the self pay policy, and where
 11 you talk about the discount on implants or individual
 12 supply items in excess of \$200 and there would be no
 13 discount, just wondering why you wouldn't get what
 14 commercial pays for those.
 15 MS. COOPER: So those are not covered by
 16 commercial insurance. An example is for cataract
 17 surgeries there's a — you can get a standard kind of
 18 lens or a new super improved kind of lens, and if the
 19 patient wants the super lens, they have to pay for it
 20 out of pocket. So there's different implants and
 21 things that aren't covered by commercial insurance
 22 that that was meant to apply to.
 23 MS. USIFER: Okay. So individual supply
 24 items and things like that those are all things that
 25 wouldn't be covered under commercial —

1 MS. COOPER: Right.
 2 MS. USIFER: — in your billing?
 3 MS. COOPER: Yes.
 4 MS. USIFER: All right. All my other
 5 questions were answered. Thanks.
 6 MS. LUNGE: I have three left. I'm
 7 sorry. I know you will all find it hard —
 8 MR. BARBER: We're over time already.
 9 MS. LUNGE: I'll be quick.
 10 MR. BARBER: Okay.
 11 MS. LUNGE: So just one followup on
 12 condition 10. I just want to clarify that the
 13 studies that you have provided in evidence either in
 14 this submission or the previous one offer a complete
 15 list of the procedures that you will be offering?
 16 MS. COOPER: So they are not every — it
 17 depends on how you define procedure. These are the
 18 procedures across specialties that there is evidence
 19 basis for that I could provide to you. They are on
 20 the CPT code level, if I said there's specific codes
 21 for parts of different procedures that don't have
 22 evidence based studies associated with them, so that
 23 is what happened.
 24 MS. LUNGE: Thank you. Thank you, and
 25 just to clarify are there any surgeries or procedures

1 that you're anticipating will be performed that are
 2 solely cosmetic and not medically necessary or
 3 whatever? That may not be the appropriate clinical
 4 term, but I think you get the gist.
 5 MS. COOPER: Well it's interesting
 6 because who decides what's necessary. Medically
 7 necessary is a term used by commercial insurers, but,
 8 for example, a new area that is becoming much more
 9 needed certainly from the patient's perspective is
 10 gender affirmation, surgeries for folks who don't
 11 identify with the gender that they were born into.
 12 That is those surgeries are done by plastic surgeons.
 13 Some elements of those surgeries may be considered
 14 medically necessary. Some may be considered not
 15 cosmetic. You know it's hard to find a definition
 16 specifically of what's medically necessary versus
 17 cosmetic and what's medically needed versus not
 18 needed.
 19 MS. LUNGE: Okay, and then I know QMS in
 20 their process has certain kinds of surgeries that
 21 they will pay for in an ASC versus others they have
 22 not yet approved for that setting. Are you
 23 anticipating offering procedures that are outside of
 24 that list or would you expect that most of the
 25 procedures or all of the procedures that will be

1 performed there are those on the CMS approved list?
 2 MS. COOPER: Only those on the CMS
 3 approved list.
 4 MS. LUNGE: I guess an exception might
 5 be in the OB area where they may or may not have
 6 tackled that for Medicare.
 7 MS. COOPER: Yes. Yes.
 8 MS. LUNGE: And cosmetic. Thank you.
 9 I'm done, Mike.
 10 MR. BARBER: Okay. So I think we're
 11 behind schedule a little bit. Eric and Julia, if you
 12 can keep it concise and then I think what I would
 13 like to do is take a five-minute break, resume, ask
 14 Ms. Craner to have her witness come up. Turn it over
 15 to you now.
 16 MS. SHAW: Sure. Thank you.
 17 EXAMINATION
 18 BY MS. SHAW:
 19 Q. I just have a few questions from the
 20 information you provided. So in your Certificate of Need
 21 the board — as we discussed the board imposed condition
 22 15 requiring the applicant to establish and implement a
 23 policy to provide care on par with UMC and Northwestern
 24 Medical Center. So I first wanted to note on our review
 25 we noted a few differences between your policy and the

1 policies at UMMC. For example, UMMC provides two
 2 opportunities for patients with income above 400 percent
 3 FPL to get financial assistance and provides an option for
 4 a payment plan and both MNC and UMMC offer the
 5 opportunity to appeal a denial. So I'm wondering if you
 6 would commit to bringing your policy in line with UMMC
 7 and MNC prior to starting operations?
 8 A. (Ms. Cooper) Yes and we can make those
 9 updates as well. They weren't intentionally left off.
 10 Our policy is much simpler than UMMC and Northwest or
 11 hospitals generally. That's the standard for ambulatory
 12 surgery centers to have a simpler policy. We don't
 13 require the same level of personal financial spreadsheets
 14 that are often quite difficult and arduous to fill out and
 15 patients of limited means may not even know how to fill
 16 out those spreadsheets which is often a barrier to
 17 accessing free and discounted care.
 18 The intent of our policy was to be
 19 straightforward and easy to fill out, and not to require
 20 the level — assure a level of financial sophistication
 21 that many patients don't have. That's also why we just
 22 require a piece of substantiation, whether it be income or
 23 a W-2 or something similar rather than multiple pieces
 24 like are required often by hospital policies. So we
 25 certainly did not intend to leave off anything and I would

1 — if you could tell me what those updates are, we can put
 2 them into our free discounted care policy before we
 3 resubmit.
 4 Q. Sure. That would be great. Thank you, and I
 5 just wanted to note also that in your materials I don't
 6 believe you said UMMC's complete policy so I wanted to
 7 confirm. You — did I understand you're trying to do the
 8 same policy? And I appreciate that. I just wanted to
 9 confirm you did refer to UMMC's full policy when you were
 10 developing your policy for the ASC?
 11 A. I pulled off everything I could find on UMC's
 12 web site to review.
 13 Q. I'm wondering if you would be willing to work
 14 with our office just to ensure that these discrepancies
 15 are just a policy and eligibility information are clear
 16 and complete and readable for consumers?
 17 A. Yes. We will make updates to the policy that
 18 have been mentioned here and then I can send it to you and
 19 have you suggest any updates which we will accept before
 20 it goes for final review.
 21 Q. Thank you very much, and then I just wanted to
 22 also — I know your policy is in general simpler than the
 23 hospitals, but I wanted to ask if you would be willing —
 24 one of the requirements for hospitals is to provide a
 25 plain language summary, if you would be willing to also

1 provide a plain language summary of your policy sort of
 2 summarizing the basics to be available to consumers?
 3 A. Yes, and I would ask for your help in ensuring
 4 that it is in fact plain language, but I can take the
 5 first draft of that.
 6 Q. Sure. I would be happy to help with that.
 7 A. Great.
 8 Q. And then my only other questions are about
 9 condition 14, the applicant shall dedicate a staff member
 10 to provide patients with price estimates for surgeries,
 11 and I'm not sure if I'm — in your presentation today I
 12 wasn't quite clear, but I just wanted to ask if the
 13 current estimates provided to patients, like when they get
 14 their detail, have their detailed conversation with your
 15 staff person, if they will include the possibility of
 16 complications and maybe arrange what patients normally end
 17 up paying for a procedure, whether they are median or a
 18 range?
 19 A. (Mr. Paoni) So the way it works in our
 20 surgery center our HR will implement, through the
 21 clearinghouse, benefit verification process with the
 22 insurance carrier. Then it will come back and it's fairly
 23 quick and almost instant, and it tells us exactly where
 24 they are within the last 24 hours. It tells us even the
 25 deductible. So we're very transparent in an ambulatory

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

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

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

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

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

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

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

1 their choice.

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

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

7 (Recess.)

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

13 (Ms. Berry Bowen was duly sworn.)

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

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

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

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

1 beyond what was discussed within the CON will have.
 2 In recent days the Green Mountain Care
 3 Board has heard from small Vermont hospitals on the
 4 significant negative impact that the loss of a
 5 surgeon or a reduction in surgical procedures has on
 6 the finances of the hospital. By the way we're
 7 losing already two physicians to the surgery center.
 8 It is real and impactful and you have seen it in
 9 hospitals' financial performance reports including
 10 ours at Northwestern Medical Center. Now we face an
 11 additional expansion of the initiative that will draw
 12 more surgical procedures away from hospitals that
 13 will be detrimental.

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

1 community. Eventually the gap between variable
 2 revenue and fixed expenses become unsustainable.
 3 What is the future definition of the community
 4 hospital? The surgery center is counter to the
 5 integrated community care model we are all investing
 6 in for the success of a capitated system.

7 Northwestern Medical Center has
 8 previously testified to the detrimental impact of eye
 9 surgeries drawn off by the eye center. That same
 10 kind of detrimental impact will come with this
 11 ambulatory surgery center as Colchester is not far
 12 from St. Albans. This detriment will only be
 13 exacerbated by an expansion of scope beyond the
 14 specialties and procedures which were part of the CON
 15 consideration and the Green Mountain Care Board's
 16 decision.

17 Today, as outlined in our previous
 18 testimony, we are following through on our commitment
 19 to realign our whole surgical program to be an
 20 ambulatory surgery center like in operation. As you
 21 know we are a leader in transformation and that means
 22 internally as well. No matter how much we do to
 23 reduce cost, balancing an effort to continue to meet
 24 the mission of needs of our community such as the
 25 needed development in primary care and also wellness

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

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

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

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

20 MS. BERRY BOWEN: Tristan Glanville.
 21 MR. BARBER: I would also prefer that
 22 you also get sworn in so if you could now please
 23 stand and raise your right-hand so the court reporter
 24 can swear you in.
 25 (Mr. Glanville was duly sworn.)

1 MR. BARBER: Thank you. So now I'm
 2 going to turn it over to the board for questions.
 3 Starting at that end of the table.

4 MS. LUNGE: Thank you for coming. Do
 5 you have any information that you could provide about
 6 the number or volume of surgeries that are happening
 7 in your hospital related to the two specialties under
 8 discussion today, the ophthalmology and plastic
 9 surgery?

10 MS. BERRY BOWEN: So as far as
 11 ophthalmology we did 511 cases.

12 MS. LUNGE: And are those the types of
 13 procedures that were talked about today do you know?

14 MS. BERRY BOWEN: The specialty
 15 procedures? No. This would be more cataract
 16 surgeries.

17 MS. LUNGE: Okay.

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

23 MS. LUNGE: Okay. Thank you. That's
 24 all I have.
 25 CHAIR MULLIN: So I think just as a

1 followup to Member Lunge's question could you submit
 2 to us the number of vitreoretinal surgeries that are
 3 being performed at Northwest?
 4 MS. BERRY BOWEN: Sure.
 5 CHAIR MULLIN: Thank you.
 6 MR. PELHAM: This is a followup. So in
 7 the original proposal there was 170 surgeries that
 8 were projected that Northwest might lose to the
 9 surgical center given its initial inventory of
 10 procedures, and when you saw that number did that
 11 make sense to you, and, if it did, could you put an
 12 economic value on it?
 13 MS. BERRY BOWEN: Are you talking about
 14 the surgeries related to these new ophthalmology and
 15 plastics or the previous ones?
 16 MR. PELHAM: No. I'm talking about in
 17 the original proposal the presentation was that it
 18 was 170 surgeries might migrate from your operation
 19 to the surgical center and that that would comprise
 20 about 2.7 percent of the volume at the surgical
 21 center.
 22 MS. BERRY BOWEN: Originally the
 23 surgeries were GI and OB/GYN. Clearly in addition to
 24 that there is an orthopedic surgeon that will be
 25 moving as well. So those numbers have increased

1 since our last discussion.
 2 MS. HOLMES: Maybe a clarification. I
 3 think we're all asking the same question, but there's
 4 been a change so there were some pain management
 5 procedures, there were some, you know, fewer ortho,
 6 now there's more ortho. There's been a change. I'm
 7 wondering do you have the net effect of what you
 8 anticipated before migrating and what you anticipate
 9 now migrating within the change of scope?
 10 MS. BERRY BOWEN: We suspect who the
 11 doctors are. We don't know exactly and I know
 12 originally there was a thought that there might be a
 13 general surgeon that might be coming from our area.
 14 I think that general surgeon potentially has retired.
 15 So right now what I really know that's
 16 going to — would like — is going to move is the
 17 orthopedic surgeon, hand surgeon, who has announced
 18 her departure to go to the surgery center, and also
 19 as was mentioned earlier there was probably some of
 20 the OB/GYN that would go to the surgery center that
 21 is now here. So I think what we could do in our
 22 followup submission is now that we have a better
 23 understanding that we might be able to put a number
 24 to those specifically. Would that be okay?
 25 MS. HOLMES: I think that's what people

1 want.
 2 MS. BERRY BOWEN: I think now that it's
 3 getting closer to opening I think we have a better
 4 idea who might be migrating there.
 5 MR. BARBER: So there's briefing I think
 6 from the parties due on May 3rd now. So just to give
 7 everyone enough time to review what you're going to
 8 submit I ask that you get that in as soon as
 9 possible, preferably by next week, mid to beginning
 10 of the week.
 11 MS. BERRY BOWEN: That sounds great. I
 12 think the assumptions have shifted so now we can
 13 update that — what we believe to be true.
 14 MR. BARBER: That's all the questions
 15 from the board members, right? Now, Julia, do you
 16 have questions?
 17 EXAMINATION OF MS. BERRY BOWEN
 18 BY MS. SHAW:
 19 Q. I just have a couple brief questions. Do you
 20 consider Chittenden County to be part of your service
 21 area?
 22 A. No. We do Franklin and Grand Isle County.
 23 Q. Thank you. That's my only question then.
 24 MS. BERRY BOWEN: Thank you.
 25 CHAIR MULLIN: Okay. Thank you for your

1 testimony. Now we're going to move into public
 2 comment section of the hearing. We're scheduled to
 3 adjourn at 4. We can stay in the room up until 4:25
 4 or so if we need to, but there's only six individuals
 5 who have signed up to comment so I'm just going to go
 6 through the list starting with David Weissgold and
 7 Dr. Laub. I guess do you have anything else to say?
 8 DR. WEISSGOLD: No. We probably didn't
 9 understand what the word public comment —
 10 MR. BARBER: Fair enough. Four people.
 11 If you could, when you're giving a comment please
 12 just stand up, identify yourself, if you're
 13 representing an organization identify the
 14 organization you're representing, what your position
 15 is. That would be helpful and speak loudly. Yes.
 16 First one up is Diane Zeller.
 17 MS. ZELLER: I'm a registered nurse at
 18 UMMC. I've been there since I've been a RN at
 19 UMMC. I've been working there since 12 of '08 and I
 20 work in the minor procedure unit, and I'm here to
 21 represent and support the opening in a timely
 22 fashion, which is this summer, for Green Mountain
 23 ASC. We need it. Patients need it. In my
 24 department they closed down one of our rooms so we
 25 don't have any patients to come to do what we did for

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

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

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

1 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. BARBER: No.

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MS. TYLER: Sounds good. Thank you.

9 MR. BARBER: Anything else, Ms. Cramer?

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

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

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

20 MR. PELHAM: I'll move.

21 MS. LUNGE: Seconded.

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

1 (whereupon, the proceeding was
2 adjourned at 4 p.m.)

3
4 C E R T I F I C A T E
5

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7
8 I, JoAnn Q. Carson, Certified Shorthand
9 Reporter and Notary Public, do hereby certify that
10 the foregoing pages numbered 1 - 119 inclusive are a true
11 and accurate transcription of my stenographic notes to the
12 best of my ability of the proceedings in re: Application
13 of ACTD, LLC before the Green Mountain Care Board held on
14 April 17, 2019, at the Pavilion Auditorium, State Street,
15 Montpelier, Vermont, beginning at 1 p.m.

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19 _____
20 JoAnn Q. Carson
21 Registered Merit Reporter
22 Certified Real Time Reporter
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