Green Mountain Surgery Center

June 24, 2019

Kevin Mullin, Chair
Green Mountain Care Board
89 Main Street, Third Floor City Center
Montpelier, VT 05620

Re: Docket No. GMCB-010-15con, Green Mountain Surgery Center

Dear Chair Mullin:

We are writing in response to your letter from June 19, 2019.

1. **Have negotiated reimbursements with any commercial insurers yet?**
    a. **If so, whom?**

No, we have not. Our accreditation from the Joint Commission on May 30, 2019 was a necessary step in order to get the commercial insurers to engage in serious reimbursement discussions. We have only begun negotiating in earnest with Vermont's major commercial insurers this month. We are proceeding towards commercial reimbursement arrangements, but we have yet to finalize anything. We believe we can conclude these discussions in short order and in a timeframe that works with our already scheduled patients, absent further unforeseen events.

2. **Does "GMSC Charge" column in Table 2 reflect GMSC's negotiated or expected reimbursements for the listed procedures?**

The "GMSC Charge" column in Table 2 reflects GMSC's charges, which are different from but related to reimbursements. Charge data is the only pricing information that is legally available for us to use to demonstrate compliance with Condition 12.

    a. **If not, what kind of reimbursement arrangements have you negotiated or do you expect to negotiate with carriers (e.g., percentage off charge or fee schedule)?**

Given the current status of our conversations with payers, it seems that we will have reimbursement arrangements that are a blend of percentage off charges and fee schedule, however in no case will we be reimbursed any *more* than our charges.

    b. **what are the actual reimbursements you have negotiated or expect to negotiate?**

Per the terms of the payer contract templates that we have received, the reimbursements will have to be kept confidential (similar to the confidential nature of hospital reimbursements). However, we will not be reimbursed any more than our charges. Our June 12 letter has data that shows our *charges* are well below the *reimbursements* paid to the hospital for the same procedures/surgeries. For example, Table 2 of June 12 response shows that for CPT code 45378 "diagnostic colonoscopy" GMSC has a charge of $1,550. On

page 3 of our "EOBs Selection Redacted.pdf", in the second to last row, this appears to be the procedure that is being performed for that patient. The "Billed Charges" from the hospital on the EOB are $2,826, this charge can be found for CPT code 45378 on Table 2 in the UVMMC charge column. The reimbursement to UVMMC on the EOB is $2,295. Our *charge* for the procedure of $1,550 is well below what UVMMC is currently being *reimbursed* for the procedure (so our reimbursement will necessarily also be below the hospital's reimbursement). This EOB, which is from earlier this year, is for the same physician who will be performing the same procedure at the ASC instead of at UVMMC next month. In all cases, based on what we've observed on the EOBs, our charges for the same procedures/surgeries <u>are well below</u> what UVMMC currently gets reimbursed.

While we do not know our reimbursements yet because we have yet to finalize contracts, (and even if we did know we would be contractually obligated not to disclose them), we can make some reasonable estimates of what our reimbursements are likely to be. The selection of EOBs that we enclosed with our June 12 letter show a range of charges and paid amounts to UVMMC for equivalent procedures that will be performed at GMSC. While it is legally impermissible for us to know the exact contracting arrangements the hospital has with commercial payers, the effective percentage off charges that UVMMC gets reimbursed can be calculated from these EOBs. The percentage off charges that we've calculated ranges from 7% - 33%. Given this range, a reasonable estimate to use for where our reimbursements will likely land is near the middle somewhere more or less equivalent to the hospital, or about 20%, whether we contract in a percentage off charges, or fee schedule, or blended arrangement. Using this estimate, and another reasonable estimate for the reimbursement of ancillary charges* that the hospital bills for together with the charge data presented in our June 12 letter, we can confirm that the savings the ASC will produce for commercial insurers is in keeping with what we presented in our original application. Specifically, at the April 13, 2017 hearing we showed a chart with projected commercial overall cost savings of approximately $3 million a year, or $11 million total over the first 4 years. Below is the same analysis, but this time with a more detailed estimate of the Hospital Outpatient Department (HOPD) Adjustment Factor using actual charge and reimbursement comparisons to the hospital where the surgeries are currently being performed.

* We did not calculate all the reimbursement for ancillary services on every EOB, but 10% seems to be a conservative estimate of what they would amount to. Anything higher would just mean additional savings at the ASC.

UVMMC Average Charge for Top 25 GMSC Procedures	$2,700
Avg Percentage off Charges from EOBs	20%
Reimbursement for Primary Procedure Code	$2,160
Additional Reimbursement for ancillary services *	10%
Reimbursement per Procedure	$2,376
GMSC Average Charge for Top 25 Procedures	$1,471
Avg Percentage off Charges estimate	20%
Reimbursement for Primary Procedure Code	$1,177
Additional Reimbursement for ancillaries	0%
Reimbursement per Procedure	$1,177
Avg Savings Per Procedure	$1,199
HOPD Adjustment Factor (ASC Reimbursement/HOPD Reimbursement)	50%

Commercial Overall Cost Savings	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**TOTAL (4 years)**
Commercial Revenue (Revised Projections)	$2,107,860	$2,739,380	$2,850,513	$2,996,875	$10,694,628
HOPD Adjustment Factor	50.00%	50.00%	50.00%	50.00%	50.00%
HOPD Rev	$4,215,720	$5,478,760	$5,701,026	$5,993,750	$21,389,256
ASC Commercial Savings	$2,107,860	$2,739,380	$2,850,513	$2,996,875	$10,694,628

These tables show that using actual charges and reasonable estimates of reimbursements, the ASC will save commercial insurers and patients 50% of the cost of procedures/surgeries, and that our overall cost savings to commercial insurers will be about $3 million per year, just as we represented during the application process. While there may be different interpretations of what the exact language of Condition 12 was meant to imply, the spirit, we think, was to ensure that the ASC saves money and is a more affordable option for our patients; we are demonstrating here that it will be.

3. **In the June 4 Decision & Order, we said that we would find Condition 12 satisfied if GMSC provided attestations or confirmations from commercial insurers that the rates they pay GMSC for procedures and surgeries are lower than the rates they pay for the same procedures and surgeries when performed in any hospital outpatient setting in Vermont.**
    a. **Have you asked carries for such a letter?**

We have reached out to the carriers to see if they would be willing to write a letter confirming that they expect to pay less for surgeries performed at the ASC and we will submit those letters to the Board when/if we receive them. However, we have not asked them to try to write letters saying that payments to GMSC will be lower than payments to any and all hospitals in Vermont for the same procedures and surgeries. We believe that this standard would be fiscally, practically and legally impossible for us to meet. During our application process, we said our rates would be about half of "hospitals" and our prices

would always be lower than "hospitals," in each instance implying "a group of hospitals" or a rate that represents a group of hospitals, like an average reimbursement rate.

The first problem is that we have no way of knowing what the reimbursement rates are for the same procedures/surgeries at any hospital in Vermont, as we said in our post hearing brief.[1] Secondly, while we don't know all the specific rates, we do know that there is a large amount of variation in payment rates to Vermont hospitals. Several studies have demonstrated this in the case of payments for outpatient surgical procedures.[2] There are extremely high payments to some hospitals for some procedures, and extremely low payments to some hospitals for some procedures. Given the high level of variation, it would be unreasonable for us to commit to being lower than any and all hospitals because one extremely low rate on a high-volume surgery for us, but perhaps not high-volume for the hospital with the lowest rate, could easily endanger our solvency. Finally, reimbursement comparisons are not meaningful from a patient or system perspective unless they are comparisons to a hospital where the patient might otherwise have the surgery. A patient from Burlington is extremely unlikely to travel to St Johnsbury to have a routine procedure/surgery performed, so the price of the procedure at Northeastern Vermont Regional Hospital is not a relevant factor to consider when determining if the ASC will be more affordable for that patient or the system. The relevant consideration is whether our ASC in Chittenden County is more affordable then the alternative setting where the patient would realistically otherwise have the procedure.

4. **In prior correspondence, you indicated that you planned to provide letters from carriers comparing GMSC's reimbursements to reimbursements paid to hospitals for providing the same services (inclusive of recovery room and medication charges). In the June 12 letter, you seem to suggest that this kind of analysis (looking at the total cost of the procedure at a hospital) is not feasible for insurers to do, at least not in a reasonable time frame.**
    a. **What accounts for the apparent change?**

In prior correspondence we indicated that we planned to ask carriers for letters stating that reimbursements that will be paid to GMSC are below an average equivalent reimbursement paid to hospitals. This might have been a reasonable attestation to ask for because it would have only required insurers to determine a hospital system-wide average payment for procedures to use as a point of comparison. However, asking carriers to undertake the analysis on a per hospital, per procedure, per product basis for 14 different hospitals individually is a request that is several levels of magnitude more difficult and one we did not feel comfortable making for many of the reasons previously stated. Additionally, we

[1] While UVMMC has posted pretty comprehensive data on charges to its website, the charge data posted from other hospitals is inconsistent and incomplete for comparison purposes.
[2] 2013 Vermont Health Systems Payment Variation Report by the Vermont Association of Hospitals and Health Systems - Network Services Organization (VAHHS-NSO); 2014 Price Variation Analysis report by UVM, U. Mass, and the Wakely Consulting Group: Vermont Blueprint for Health 2017 Price Transparency Report - Phase I - Commercial; 2016 Report to the General Assembly and the Green Mountain Care Board Health Care Price Transparency Part II: Act 54 and Beyond

don't believe such a lengthy analysis achievable given the time frame, especially after reviewing all the previous price variation reports that have been produced.[3]

Given the detailed information we have provided here, and in our June 12 letter, we believe we have complied, to the best of our ability, with Condition 12 as written in the original CON. However, if it would help to clarify things, we suggest the language below would be an improvement to Condition 12 and more clearly achieve the overall goal of the original condition.

12. The applicant shall demonstrate that the savings for commercial patients/insurers will be meaningful on an absolute dollar and percentage basis and in keeping with representations made during the application process.

As shown on pages 2-3 of this letter, we will save $2 million - $3 million per year for commercial patients due to our offering surgeries and 50% lower costs. Hence we believe we have satisfied both the letter and the spirit of Condition 12 as written in our 2017 CON as well as Condition 12 as re-written above. Most importantly, we believe we have made good on our promise to our patients and our community to help lower their health care costs.

We stand ready to deliver on our promise to provide more affordable, high-quality surgical services, and to improve much-needed access to specialist care, as soon as our doors are open. We have Medicare patients scheduled for services at the ASC starting on June 26 and we look forward to opening our doors to all patients in July.

Thank you for your consideration.

Respectfully,

Amy Cooper

Manager, ACTD LLC

[3] Ibid. In particular see 2013 Vermont Health Systems Payment Variation Report by the Vermont Association of Hospitals and Health Systems - Network Services Organization (VAHHS-NSO), pages 23 – 29.