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November 4, 2016

DELIVERED ELECTRONICALLY AND BY FIRST CLASS MAIL

Noel Hudson, Esq., Hearing Officer
Health Policy Director
Green Mountain Care Board
89 Main Street, Third Floor City Center
Montpelier, VT 05620

Re: Docket No. GMCB-010-15con, Proposed Ambulatory Surgical Center
Response to VAHHS and NMC Joint Request for Reconsideration of Decision Granting Confidentiality to Applicant dated 10/28/2016

Dear Mr. Hudson:

We are writing to respond to the Request for Reconsideration of Decision Granting Confidentiality to Applicant filed jointly by the Vermont Association of Hospitals and Health Systems ("VAHHS") and Northwestern Medical Center ("NMC") on October 28, 2016. We are also writing to clarify the Green Mountain Care Board's ("GMCB") October 20, 2016 decision granting limited confidentiality to the Applicant's investors by redacting the identity of the physician investors before releasing to the public the Applicant's response to questions posed by the GMCB on August 25, 2016. We argue that the names of the investors are confidential pursuant to 1 V.S.A. § § 317(c)(7) and 317(c)(9), and their health care experience can be provided in a way that allows the interested parties to assess the potential ASC's financial strength and governance without identifying the specific physicians who have chosen to invest in the ASC.

To summarize, the GMCB requested the name, percentage of ownership interest, amount of initial investment, description of relevant health care experience, including the names and locations of the health care institutions, and the terms of the investment for physician investors that ensure their investment is not based on referrals and none of the physician investors are lenders to the proposed ASC. Questions 16 and 17 (a) posed by the GMCB to the Proposed Ambulatory Surgical Center, August 25, 2016. We originally requested confidentiality for this response on October 5, 2016.

The GMCB ruled that the information requested was public except for the names of the physicians, which, due to their employment or business relationships with the hospitals, the GMCB proposes to redact from information released to the public. VAHHS and NMC have filed a request for reconsideration, taking issue with the GMCB's decision to grant limited confidentiality and protect the names from public disclosure due to the physicians' fear of retaliation, which the hospitals dismissed as conclusory and unfounded. VAHHS and NMC argue that the Applicant must come forward with a specific factual showing of actual acts of retaliation to overcome the presumption that records obtained by the GMCB during the CON process are public records. They wrote, in their request for reconsideration, "[t]

here is no evidence that the Interested Parties have ever engaged in retaliation against the parties for their involvement in the GMSC."

This statement is true but it is a non-sequitur that does not support the hospitals' argument. There have been no reports of retaliation against investors in the proposed ASC, but there has been no opportunity for retaliation either. The investors' identities have not been disclosed publicly, so the investors' involvement with the surgery center presumably is not known to the Interested Parties at this time.

According to VAHHS' and NMC's reasoning, unless there is actual evidence of retaliation, the identities of the physicians must be disclosed to the hospitals despite the significant potential ramifications to their practice and future as MDs if their connection to the ASC is disclosed. This position, if taken to its logical conclusion, would do away with any preventive law or action that seeks to stop something from occurring until it is too late. Imagine if there were no temporary or permanent injunctions and one had to wait for the harm to occur rather than proving "a likelihood of success on the merits."[1]

The power disparity between hospitals and employed or independent physicians makes the fear of retaliation real and justified. Hospitals exclusively own and control the ORs and PRs the physicians must use to practice.[2] When one party has exclusive control over a resource and another is beholden to it for use of that resource to make a living, there is a legitimate fear that the resource could be taken away.

Also, the recent effort by NMC to require an additional implementation report from the sole operating ASC in Vermont, unconnected to the proposed ASC aside from the fact that Dr. Thomas Dowhan is an investor in both enterprises, has a whiff of retaliation about it. Dr. Dowhan's open disclosure of his investor role in both the Vermont Eye Surgery and Laser Center ("the Eye Center") and GMSC apparently caused NMC to ask the GMCB to revive the Eye Center's expired CON and seek additional and statutorily unauthorized reporting. The Eye Center received its CON in May 2007. It filed detailed implementation reports about its operations through May 2014, including its income, expenditures, bad debt and charity care percentages, the number of patients it served, the type of surgeries performed, and the number of surgeons providing services at the center. Yet NMC argued it needed an updated implementation report to assess the impact of an additional ASC on its operations, [3] based in part on Dr. Dowhan's involvement in both enterprises. "Further, Dr. Dowhan, a 'primary planner' and part owner of the GMSC, is also manager, member, and part-owner of [the Eye Center]. Without an updated

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[1] Movant for a preliminary injunction must show that "irreparable harm" will occur without an injunction, and further show either "(a) a likelihood of success on the merits or (b) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly in the movant's favor." *County of Nassau v. Leavitt*, 524 F. 3d 408, 414 (2d Cir. 2008) Losing one's livelihood can constitute irreparable harm, because it is more than just a financial loss. *Campbell Inns, Inc. v. Banholzer, Turnure & Co., Inc.*, 148 Vt. 1, 7 (1987).

[2] Some physicians are able to use their office for a limited number of procedures, but this is relatively rare.

[3] NMC had excess patient revenues in 2015 of $7M. http://gmcboard.vermont.gov/sites/gmcb/files/documents/A15-Hospital-System-Enforcement-Summary_FINAL-MAY16.pdf

implementation report, information regarding [the Eye Center's] utilization, services, costs and other essential details is available only to [the Eye Center] and, based on Dr. Dowhan's dual ownership roles, the proposed GMSC." Letter from Jonathan Billings, Vice President, Planning and Community Relations, NMC, to Donna Jerry, October 26, 2016.

Finally, VAHHS and NMC's concern that the public will not know who stands to profit from the ASC will be met when and if the CON is granted, and long before any profits are made. As the interested parties have noted, the names of the investors will be public when the Applicant enrolls in Medicare. And, at that time, the physician investors will no longer fear retaliation as there will be someplace else they can operate besides the hospitals who are inexplicably insistent that their names be public.

It is no secret that the hospitals openly oppose the ASC.[4] And, it is no secret that hospitals have abused their position nationwide through anti-competitive behavior against physicians.[5] While the Applicant sincerely hopes that Vermont's hospitals would not retaliate against physician investors in an ASC, its investors are understandably nervous about their future ability to practice medicine if their names and identifying information are released during the CON proceeding.

Public disclosure of the names of the investors is not necessary to assess the Applicant's ability to operate an ASC, or required by law. The Interested Parties can evaluate the Applicant's financial wherewithal based on the size and terms of each investment, and each investor's share of the business. They do not need to know the identity of the investors. While the investors' professional experience in the health care sector is relevant, this information should be public only if it cannot be "reverse engineered" to reveal the identity of the investors. For example, instead of detailing the names and locations of each health care facility the investor has been employed at, owned or operated, the Applicant supports supplying the unnamed investors' years and type of experience in different institutions without specifying the identifying names and locations. (Hospital credentialing offices have physicians' CVs on file and could figure out who has invested in the GMSC by matching up where and in what capacity the physicians worked.)

In sum, the Applicant agrees with the GMCB that the names of the investors should not be released to the hospitals due to a credible threat of retaliation. We submit, however, that the names of the physician investors and personally identifying information like the identifying details of their health care experience that appear on their resumes are exempt from public disclosure under 1 V.S.A. § 317 (c)(7) and/or (9).

The Public Records Act ("PRA") codifies the strong presumption that documents created or acquired by governmental entities in the course of their business are public. Nonetheless, the statute recognizes

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[4] http://www.burlingtonfreepress.com/story/opinion/my-turn/2016/04/11/opinion-profit-surgical-center/82784680/

[5] http://www.forbes.com/sites/davechase/2016/08/29/hospital-ceos-behaving-badly-the-devastating-consequences-on-the-middle-class/#713e10772417 (The article is also attached. See the section entitled "How hospitals use market dominance.")

that the interest in government transparency must be balanced against privacy rights, and for this reason contains roughly forty categories of non-public documents. “All people, however, have a right to privacy in their personal and economic pursuits, which ought to be protected unless specific information is needed to review the action of a government officer.” 1 V.S.A. 315.

In the instant case, we argued that the identity of the Applicant’s investors, when disclosed in connection with their financial information in this proceeding, is protected from public disclosure by 1 V.S.A. § 317(c)(7). The case law that construes § 317(c)(7) involves public employees, but there is no language on the face of the PRA (or in the General Assembly’s intent in enacting the exemptions) that restricts § 317(a) (7) to public employees. The exemption in § 317(a)(7) for “personal documents relating to an individual,” and “information in any files relating to personal finances . . . concerning any individual,” includes material in the personnel files of public employees, but the “including” language is only by way of explanation and not by way of limitation. Indeed, there is arguably greater reason to protect the confidentiality of a private individual’s personal and financial information.

We therefore submit that the balancing test articulated in *Trombley v. Bellows Falls Union High School District No. 27 et al.,* 160 Vt. 101 (1993) applies to private as well as public individuals.

> Because our primary goal in interpreting a statute is to implement the intent of the *Legislature, Martel v. Stafford,* 157 Vt. 604, 608 (1991), we must construe the term "personal documents" in a limited sense to apply only when the privacy of the individual is involved. Thus, it covers personal documents only if they reveal "intimate details of a person's life, including any information that might subject the person to embarrassment, harassment, disgrace, or loss of employment or friends." *Young v. Rice,* 308 Ark. 953, 826 S.W.2d 252, 255 (Ark.1992); see also *Kotulski v. Mt. Hood Community College,* 62 Or. App. 452, 660 P.2d 1083, 1086 (Or.Ct.App.1983) (information is personal if it normally would not be shared with strangers). Consistent with legislative intent, we must also examine the public interest in disclosure.

Trombley, at 110. For the reasons stated in the Applicant’s letter requesting confidentiality dated October 5, 2016, the identity of GMSC’s physician investors is personal information that is not subject to disclosure under § 317(c)(7), because its disclosure in the context of this proceeding could subject the investors to loss of employment and harassment.

The identity of the Applicant’s investors, when disclosed in connection with private financial information in this proceeding, is also protected from public disclosure by 1 V.S.A. § 317(c)(9), which applies to “confidential business . . . information,” which “gives its . . . owner an opportunity to obtain business advantage over competitors.” The Vermont Supreme Court has applied this exemption to private financial information. *Springfield Terminal Railway Company v. Agency of Transportation, et al.*, 174 Vt. 341 (2002). The names and identifying information in the occupational histories of the Applicant’s investors, who are each in business, if made public in this proceeding, could lead to retaliation by the hospitals that could undermine the competitive advantage of those investors to pursue their occupations.

The interested parties have not put forth any credible, counterbalancing argument as to why this private, identifying information is public. Accordingly, the names of the physician investors fall within

the exemptions outlined in § 317(c)(7) and/or (9); all the information requested will be provided to the GMCB but the investors will remain anonymous to the public, and their experience in the health care field will be likewise anonymized to reveal the types, capacities, and breadth of the investors' experience without revealing their identities.

Sincerely,

Eileen Elliott, Esq.

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Forbes

Dave Chase Subscriber
VC; Speaker; Author; Exec Producer, The Big Heist

PHARMA & HEALTHCARE 8/29/2016 @ 11:54AM | 4,994 views

Hospital CEOs Behaving Badly And The Devastating Consequences On The Middle Class

When big health insurers propose mergers, it makes for good antitrust enforcement theater to try to block them. However, if government officials want to address anti-competitive activities that have a dramatically bigger impact, they should shift their focus to local market provider M&A activity that consistently show prices increase after the deal is done. However, the most rapacious, anti-competitive practices I've seen in my entire career have come from hospitals–frequently from tax-exempt "nonprofits" that would make John D. Rockefeller blush with their brutal actions. The combined impact has created a middle class economic depression that has driven populist presidential campaign success, which was highlighted in a recently released Brookings study.

Many CEOs of tax-exempt hospitals are acting with impunity. Frankly, it reminds me of clergy abuses where they think they are above the law. Doctors have described Mafioso-like threats that are stomach-turning. Before I share representative examples of what I hear on a nearly daily basis, I should make one thing clear: There are nonprofit hospitals and health systems that are doing their best to fulfill the missions started by the faith-based and community leaders who originally founded their organizations. For example, Ascension is investing in new care delivery models and payment innovations. Unfortunately, it's not one or two outliers that are acting with impunity. These are organizations that are causing their founders to roll over in their graves.

Health insurers and pharma are often held out as the villains of healthcare's hyperinflation. I'm not going to say they are blameless; however, the majority of healthcare spending is spent at hospitals and health system-owned practices. Sarah Kliff (previously with the *Washington Post* and now with Vox) has done excellent reporting on the cost differentials with other countries–most of her examples are disparities at the hospital

level. The single biggest driver of healthcare's hyperinflation is pricing failure. That is, there is no correlation between price and value in the U.S. healthcare system. If there is any correlation, it's inversely correlated (e.g., best surgeons do the most procedures and that leads to efficiency and reduced complications). The graphic put together below by Oliver Wyman shows several examples.

The Price of Common In-Patient Episodes (for Medicare Patients)
& the potential impact of price transparency

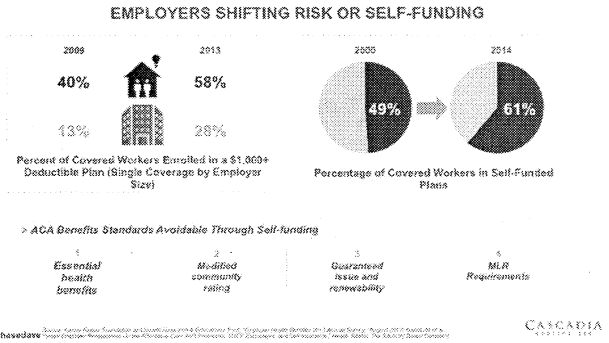
DRG Code	Common In-Patient Procedures / Episodes	Min Price	Median Price	Max Price	Average % Change in Price**
190	Chronic Obstructive Pulmonary Disease Hospitalization	$3,184	$15,462	$99,690	-27%
638	Diabetes-Related Hospitalization	$4,191	$18,549	$130,696	-27%
195	"Simple" Pneumonia Hospitalization	$4,078	$15,487	$88,521	-26%
293	Congestive Heart Failure Hospitalization	$3,334	$14,864	$92,057	-26%
683	Renal Failure-Related Hospitalization	$5,173	$21,436	$111,517	-26%
698	Kidney & Urinary Tract Infection	$3,638	$17,074	$91,695	-26%
247	Coronary Angioplasty with Drug Eluting Stent	$11,538	$55,808	$223,905	-20%
870	Major Hip / Knee Replacement	$5,304	$45,455	$223,373	-20%
243	Permanent Pacemaker Implant	$15,126	$49,356	$167,628	-19%
238	Major Cardiovascular Procedures	$22,461	$78,407	$303,921	-18%

* Selected episodes are those that are potentially subject to price shopping either by patients themselves or by smart care teams on behalf of patients
** This represents the change in the weighted average price that hospitals would be able to charge, if CMS capped refused to pay anything priced above the market median, FY2011 prices

Source: CMS, Oliver Wyman

Price Variance Transparency examples (courtesy of Oliver Wyman)

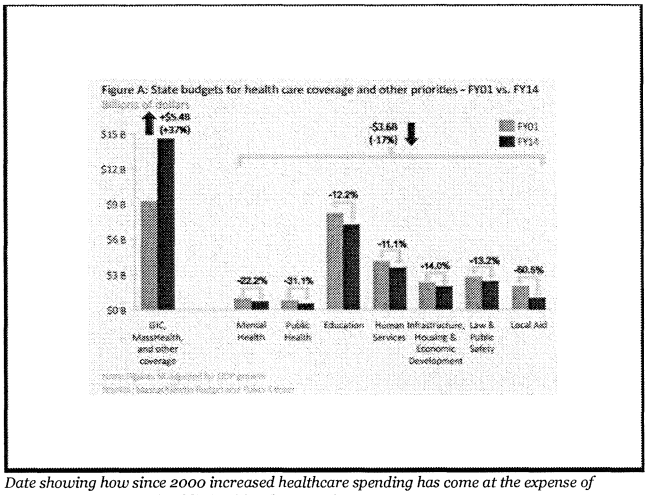
This kind of monopolist pricing power is what's behind our price disparities. Ironically, healthcare prices are sometimes blamed on insurance companies. As leading benefits consultant David Contorno says, "Blaming insurance companies for high healthcare prices is like blaming the mailman for a high cable bill." I wouldn't go that far, as insurance companies actually have a clear profit motive to keep prices going up. If you have any doubt about that, read David Goldhill's outstanding book that debunked any notion that insurance companies have a motivation to keep costs down. In reality, they are often an enabler of increased costs, particularly as the trend towards self-insurance rises. Decades of results make evident that health plans aren't a bulwark against healthcare inflation.



High Deductible Health Plans and Self Insurance trends. Source: The Future Health Ecosystem Today from Cascadia Capital

Athenahealth CEO Jonathan Bush gave examples from his hometown of how the local health system (Partners) successfully ended the one time when healthcare costs actually decreased as a percentage of the GDP. There is no evidence that I have seen that the quality of care has increased since Partners gained monopoly-like power.

The consequences of healthcare's under-performance aren't without consequence–they've been devastating for our country. Taking it down to a state level, the graphic below depicts what has happened in Massachusetts, but you'd find similar data in any other state. In fact, Bill Gates devoted an entire TED talk to how healthcare has cratered education budgets. Bringing it down to the Boston classroom level makes it clear what the collateral damage has been from healthcare's inflation in Massachusetts (go to the 4:04 mark in the video).



Date showing how since 2000 increased healthcare spending has come at the expense of funding for mental and public health, education, human services, etc.

How hospitals use market dominance

If I were an investigative reporter, there is a Pulitzer waiting for someone to grab to highlight the magnitude of anti-competitive practices that are pervasive in local communities. These are just examples that have been emailed to me recently by various innovators who are trying to improve healthcare and getting thwarted. The following is a small sampling of the stories I get:

- From the head of a large, independent medical practice: "Hospitals threatening and literally blackmailing doctors that if they don't join their clinically integrated network, ACO or medical group, they will stop referring business to them (e.g., when a patient from the ER needs to see a cardiologist), they will cancel all medical directorships (hospitals routinely pay physicians $50k here or $75k to control them), and they will not give them any preferred times for surgeries/procedures (for the proceduralists), and

if the docs don't join, then 'we will use our billion-dollar balance sheet to open up clinics and urgent care facilities right next door to you.' You would not believe the bad behavior we've encountered. It's not even subtle. There are literally hospital presidents themselves making direct threats to small-practice doctors. We have too many examples to even count. These are nonprofit, tax-exempt community hospitals that receive lots of preference and subsidies for their community mission, that are threatening and blackmailing doctors for deciding to stay independent and join groups that are focused on quality and outcomes. It's sickening."

- From a value-based primary care organization: "One of the largest Catholic nonprofit health systems in the country threatened electoral retaliation to a mayor. Like most cities, this mayor's city is struggling with their healthcare costs which is the top driver of their budget challenges. They wanted to follow in the footsteps of another city nearby and put in a workplace clinic. Five executives descended on the city crying poor (ironically, their combined salaries alone were over $2M per year). Since their hospital in that community is also a large employer and well known in the community, they threatened the mayor with electoral retaliation if he moved ahead. Guess what? The mayor backed down so the city will likely have to offer fewer services and worse health benefits."

- From a benefits advisor: "One hospital exec told me 'that if you think you are going to start moving things like orthopedic procedures and heart surgeries away from our hospital you are sadly mistaken. You are playing a zero sum game. If I found out that any of that is happening what do you think I'm going to do when one of these employees ends up in our ER or our burn center? Those prices will go up and they will go up so high you won't have any chance to save money.' When I started having conversations with hospitals about publicly reporting their quality scores I got a NO everywhere I went. One even said, 'You realize if we start measuring these things people will expect us to fix them.'"

- From a startup health plan with its own clinics: "We regularly have to respond to state regulators, as they are obligated to respond to complaints filed by the local hospital that is politically connected at the state house (translation: campaign donors). The regulators are good people who know what's going on. Unfortunately, they are obligated to respond to the complaint and investigate. We are one of the low-price offerings in the public exchanges with superior services and convenience–something the state should love. Yet, we get bogged down with frivolous complaints meant to bog us down."

- From the CEO of a large provider organization: "Health systems are creating health plans...then giving exclusive hospital discounts to only their own health plan of 15-20% so that the plan can go out and undercut the others payors and win market share. But the whole narrow network around that plan is all or mostly hospital-related, so designed simply to capture patients into the highest cost setting. Even though the hospital is discounting 15-20% on fee schedule, they are still in many cases 300%+ higher than non-hospital on stuff like MRIs. But that increase in high cost utilization does not show up on the benefits brokers' software systems...those are all simply built off fee schedule

discounts so if the hospital looks 15-20% cheaper in the health system's plan than it does in Cigna, the broker's software will spit out that plan is cheaper... even though utilization of higher-cost services will go through the roof."

- From a next generation primary care leader: "Most health systems that are purchasing or employing primary care physician practices are locking them down to geographic non-competes that last for two years. That prevents true competition for talent. In California, companies are not allowed to have strong employee non-competes. That allows employees in Silicon Valley to flow to wherever the talent proposition is strongest. This legal environment has supported the creation of a highly competitive environment for talent as a result. If innovative new companies had a great physician value proposition, the reduction of this barrier would allow for talent to readily flow to the innovators. The legal authority for these non-competes are at the state level. The states could make an argument that they have invested public resources in the physician level training and as a public good should not be restricted from seeking a job anywhere."

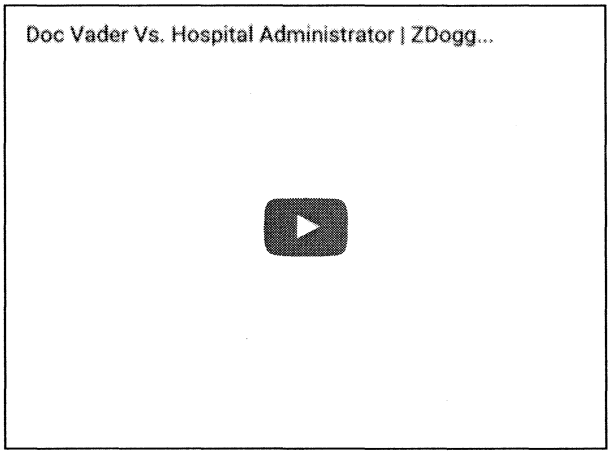
- From the leader of a large primary care organization: "Latest examples we're seeing A LOT are hospitals blackmailing the doctors that if they don't join their medical group or their ACO/network, then they will be carved/narrowed out of the health plan network that includes the hospital's employees...and, particularly in smaller regional markets, the hospital/health system is likely by far the largest employer in the area...so the blackmail is very effective because it would significantly reduce patients to practices that stay independent and don't give in and join the hospital. Problem there, of course, is that the hospital's ACO is only really organized to capture market share and direct referrals into the high-cost facility. Great example is latest 2015 ACO results...our ACO saved Medicare over 5% (with 98% quality score) while the local hospital's ACO lost Medicare 5%. That's a 10% cost swing (huge) of doctors/patients in the same geographies. And that's on Medicare rates. The commercial spread would be *far* worse because of commercial rate prices at the hospital. We've allowed these health systems to become big monopolistic business empires focused on cash (with CEOs making $2-6m+ per year) and no one is really that motivated or empowered to keep pricing in check."

Health 3.0 movement: Liberty for doctors from hospital CEOs' bad behavior

Some folks who are very much free-market advocates have made an interesting suggestion. That is, creating an organization that can defend frivolous cases and pursue anti-competitive cases that is dedicated to the liberty of individual doctors and wants to foster innovation. The idea is that large incumbents with deep balance sheets (sometimes in the billions) can stifle competition with the threat of ruinous lawsuits against smaller organizations and individual doctors. There are foundations such as the Peterson Foundation that are devoted to transforming healthcare. Of all of the many impediments I've seen to transforming healthcare, none would be more impactful than fostering local competition. The government would have a much bigger impact on the middle class by thwarting anti-competitive

practices at the local level. At the federal level, there is one rule clarification that I believe would have a bigger impact on the middle class than Obamacare.

Healthcare purchasers tacitly support anti-competitive practices by continuing to support these types of practices. Fortunately, as has been shown in Orlando, Kirkland, Tulsa, Pittsburgh and other locales, wise companies find ways to thwart the tricks the industry plays to redistribute profits from companies. The primary requirement is for employers to have a stiff backbone against the inevitable FUD (fear, uncertainty and doubt) that will come their way. At least for self-insured employers, as long as they have a properly written ERISA plan, they are able to thwart the common tricks that foil most employers. In future pieces, I'll write more about the Health 3.0 movement that forward-looking employers are supporting. This humorous ZDoggMD video is the tip of the iceberg on the frustration employed doctors are feeling–abused doctors and nurses has clinical consequence so it's something we all have a stake in fixing. This pent up frustration is being released in the form of doctors declaring their independence from the status quo but too often they are bogged down by the slow adoption of modern care delivery and payment models by employers.



When I hear the myriad tales of hospital CEOs anti-competitive practices, I'm reminded of a kid I grew up with (his name was Ted). Ted was a smart and charismatic guy. However, when it came to school, he came up with elaborate schemes to cheat on homework and tests. It always struck me that if Ted put the same energy into studying for tests and doing his homework, he'd be a straight-A student. Too many hospital CEOs are acting like Ted. If they put their organizations' time and treasure into fulfilling their mission statement, they'd be doing amazing things.

I'll use the example of Partners in Boston since Jonathan Bush highlighted one of their hospitals (Mass General) as his favorite hospital. In many ways, they represent the best and worst of healthcare. They do some remarkable things just as the Boston Archdiocese has done great things over the last few centuries. However, we are usually judged on our worst behaviors–good acts don't cancel out damaging impacts. Commonwealth Magazine describes how Partners' CEO has a stack of 24 charts to make the case that they are not Massachusetts' Public Enemy No. 1. That's never a good sign when it takes 24 well-crafted charts to make that case. Of course, Partners has pockets of

brilliance but at what cost? The Massachusetts data above shows the catastrophic impact on all of the social determinants of health.

I'll focus on one example of how health systems are misdirecting investment since I'm a venture investor myself. Partners is reportedly spending $1.7 billion on a "new" healthIT system–a figure that makes one think of a defense appropriation, not the amount for a modern IT system. Let's say they "only" spent $700 million, which is still astronomical. That would leave a cool $1 billion, which could be the largest venture fund in healthcare. Given the prestige of the Harvard-affiliated health system, there's little doubt they could get co-investors who could effectively make that a $5-10 billion fund. With that war chest, they could foster the growth of new care payment and delivery models and countless other innovations that would improve the health of their community. Instead they are deploying a system built for the last era of healthcare. Partners may be able to weather that scale of mistake. Many smaller organizations won't.

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