STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-010-15con

IN RE: A CERTIFICATE OF NEED APPLICATION SUBMITTED BY ACTD, LLC, TO DEVELOP AN AMBULATORY SURGERY CENTER AT 535 HERCULES DRIVE IN COLCHESTER, VERMONT

April 13, 2017
1:00 p.m.
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133 State Street
Montpelier, Vermont

Day one of a public hearing held before the Green Mountain Care Board, at the Fourth Floor Boardroom, 133 State Street, Montpelier, Vermont, on April 13, 2017, beginning at 1:00 p.m.

P R E S E N T

BOARD MEMBERS: Noel Hudson, Hearing Officer
Jessica A. Holmes, Ph.D.
Con Hogan
Robin Lunge, JD, MHCDS
Judy Henkin, Esq.

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

P R E S E N T

Eileen Elliott, Esq., Dunkiel Saunders
Karen Tyler, Esq., Dunkiel Saunders
Drew Kervick, Esq., Dunkiel Saunders
Amy Cooper, MBA
Joan Dentler, Avanza Healthcare Strategies
Jack Amormino
Andrew Lasser, Dr.P.H.
Paul Reiss, MD, FAAFP
Elizabeth Wennar Rosenberg, PhD
Jeffrey Tieman, MA, VAHHS
Christina Oliver, UVMMC
Michael Del Trecco, VAHHS
James Medendorp, Kaufman Hall
Walter Morrissey, MD, Kaufman Hall
Anne Cramer, Esq., Primmer, Piper, Eggleston & Cramer
Jill Berry Bowen, CEO, NMC
Jane Catton, RN, NMC
Gregory Brophey, MD, FACS, NMC
Christopher Hickey, NMC
Kaili M. Kuiper, Esq., Office of the Health Care Advocate
Julia Shaw, MPH, Office of the Health Care Advocate

I N D E X

MR. HOGAN: Welcome to a hearing on the Green Mountain Surgery Center. We were in recess from this morning, so we're coming out of recess as a board. Our Hearing Officer today is Noel Hudson, Esquire, an attorney for the Green Mountain Care Board. Noel, the ball is in your court.

MR. HUDSON: Good afternoon, everybody. My name is Noel Hudson. I'm the Board's designated Hearing Officer in this hearing today. If I could ask everyone here to turn all cell phones off at this time so that we can have a quiet and distraction-free environment. It is April 13th 2017. This is a hearing in the matter of Green Mountain Surgery Center, Docket Number GMCB-010-15con. The Board's review of the application, and this hearing are conducted under Chapter 221, Title 18 of the Vermont Statutes as well as the Board's Certificate of Need Regulation Rule 4.000. The Board has authority to act in this matter with a majority of its members pursuant to 1 V.S.A. Section 172.

The Board will not make a decision in this matter today. In addition to public comment taken at this hearing, the Board will accept public comments as required by law for the next ten days. These may be submitted by the Board's website, by telephone, or by

US mail.

There is a sign-up sheet for audience members in attendance who wish to offer public comments at this hearing. That sheet will determine the order of commenters. The number of commenters expected today is expected to be high, so please limit commentary to two minutes per person. We have a court reporter with us today. She is making a transcript of the proceeding which will be available at a reasonable time.

And, at this point, I would like to ask all witnesses who will be testifying or who may be testifying to please stand and be sworn in by the court reporter.

(All witnesses sworn in by the court reporter.)

MR. HUDSON: The order of presentations today, we will first hear from the Applicant, ACTD, LLC. That's the legal entity proposing to construct the ambulatory surgical center under review. Then we will hear from the Vermont Association of Hospitals and Healthcare Systems, often referred to as VAHHS, its acronym. Third, we will hear from Northwestern Medical Center and its witnesses. That may be abbreviated and referred to as NMC.

I want to note for the audience and the parties as well that we have attorneys from the Vermont Office,

The Office of the Vermont Health Care Advocate with us today too. They, along with the Board, will be participating in some of the questioning of the parties. There will be -- following the presentation that will be followed by the public comment period.

And, at this point, if I could ask the Board and the ACA to engage in as limited an amount of questioning during the presentations as possible. If clarificatory questions are needed, that's fine, but please save the substantive questions for the end so we can keep things moving at a brisk pace.

And, at this point, I think we can move on to the presentations. So I will turn it over to the applicant, ACTD, LLC.

ATTORNEY ELLIOTT: Thank you very much. Good afternoon. My name is Eileen Elliott, and I'm from Dunkiel Saunders, and with me today are Karen Tyler, my colleague, and Drew Kervick, and we represent ACTD, LLC, which is the applicant in this Certificate of Need matter to run and operate a Green Mountain Surgery Center, and I will now, without further ado, turn things over to Amy Cooper, who is the member manager of ACTD, LLC.

MS. COOPER: Thank you very much, Eileen, and thank you very much, members of the Green Mountain Care

Board. I've been looking forward to this hearing for a long time. Before I get started and introduce the folks that I have with me here today on behalf of ACTD, LLC, I wanted to just take a couple of minutes to explain why we decided to form ACTD, our small, locally owned business, in the first place back in the summer and fall of 2014.

There were really two main motivations for us forming ACTD. One was what the physician members of Healthfirst were starting to come back and discuss that they were hearing about from their patients in the offices at that time. It was a few years after the passage of the Affordable Care Act. Many patients had been moved to higher deductible health plans. There began to develop among many of the patients much more consciousness about the cost of the procedures that they were receiving and concern when referrals were being made to imaging centers for procedures about the cost in discussion with the physicians.

So that was one element that was becoming much more in focus back in the summer and fall of 2014. The other element that was really motivating our development of this project was my situation at the time running a physician IPA-based ACO here in Vermont, ACCGM, and also being the Executive Director of an ACO

in the North Country of New York.

We were part of an umbrella organization that actually had about 30 different physician-based ACO's in 13 different states, and so, by virtue of that, I was able to discuss with the directors of ACO's in other areas what was working. We only had probably a few ACO's in that portfolio that were showing success in achieving shared savings and reducing total cost of care, and I talked to those directors and I said, What are the tools that you're using?

One thing that came back strongly from those conversations was, We're really encouraging patients to utilize lower cost care sites. So, for example, really encouraging patients to use their primary care offices after hours and on the weekends instead of going to the emergency room, encouraging patients who are getting discharged from the hospital to be evaluated by home health so they can maybe go home rather than go to a skilled nursing facility, and also encouraging patients to use options like ambulatory surgery centers where their care could be received at the same quality at about half the cost.

And so what we were hearing from the patients combined with what I was learning about the success of other ACO's led us to sit down and say, Well, why don't

we try and develop a lower cost outpatient surgical center here in Vermont? What I heard sort of from people around the community at the time was, Oh, that will never happen. We don't allow those here. So I actually went back and looked at the law and found out, oh, wait, they are legal here, and there's actually CON statutes that tell you what you need to present in order to meet the criteria for an ASC. So we decided to put it together, and we were on our way.

I want to emphasize one aspect of this project which is really how small it is in the grand scheme of the health care landscape here in Vermont. It's going to be a building of 12,800 square feet. That's much smaller than any new building project or renovation that I can remember that's been approved by the Board recently. We're going to have two OR's and four operating rooms. The startup capital will be $1.8 million, so less than $2 million here. Also, in comparison to other projects that have been in front of the Board, I think this is very, very small in scope.

And this is really an incremental step, I think, in the evolution of the Vermont health care system. This is not going to drastically alter the landscape of delivery here in Vermont. I think that's very important to keep in mind. Another important thing to

keep in mind is that, really, all of us in the room have the same goals. We all want health care for Vermonters in the future to be easier to access, more affordable, and of the same high quality.

It's important to remember that this project is not against the hospitals. This project is for the patients. We, in the independent practice community here in Vermont, believe that there's room for all types of providers in our Vermont health care landscape and that each brings something different and valuable to contribute to the system, to patients, to employers, and to the community at large.

So, with that, I'll introduce the team that I have with me here today. I have Joan Dentler from Avanza Strategies. She has been involved in opening over a hundred ASC's in her career, working with physician groups and hospitals alike. We engaged Avanza to do the initial feasibility study for this project. I have Jack Amormino with me from AMB Development Group. Jack has supervised the architecture and building of about the same number of ASC projects across the country.

I have Dr. Paul Reiss, the Chief Medical Officer of Healthfirst, and really one of the physician, primary care physician leaders in our community. I also have with me Dr. Elizabeth Wennar. She's led one

of the most successful physician-hospital organizations in the state for many years and is a fountain of knowledge about health care reform in Vermont. And I also have with me Dr. Andrew Lasser, also from Avanza Strategies, who has a long history of serving as an executive at all types of hospitals and at FQHC's.

With that, I'll turn to my slide presentation which is meant to be responsive primarily to the questions posed in the Application Closed Letter from the Board of March 10th. Key stats regarding the center, I've mentioned a few of these already. Project cost is $1.8 million. Located in Colchester, the greater Burlington area. The initial procedure types are gastroenterology, OB/GYN, pain management, general surgery, and orthopedics.

The size there is 12,879 square feet. I should note that that's an average size for New England ASC's and smaller than the average size nationally for ASC's. Two operating rooms, four procedure rooms. The number of physicians planning to utilize the Green Mountain Surgery Center are sixteen, according to our projections, all members of Healthfirst.

Surgery centers provide a secure patient experience at lower cost. The smaller environment based out in the community will improve access for

patients, also lead to shorter waiting times. Will also have ample, easily accessible parking outside the center. We will do a routine, predictable, focused amount of procedures. The nursing staff will be able to be focused on a few different specialties. Charges for procedures will be about half of the hospital rates.

Currently, Vermonters do not have access, suitable access, to high-quality, low-cost surgery centers. We have one single specialty eye surgery center in South Burlington. Vermont ranks 50 out of 50 states in procedures per capita done in surgery centers, and that's using Medicare data. There are between 5,000 and 600, 6,000 surgery centers nationwide, 5,400 or so certified by Medicare, but some surgery centers don't take that certification. There are 125 in New England. States with populations less than a million like Vermont have 16 ASC's on average each.

The Green Mountain Surgery Center will serve all Vermonters. Our financial projections assume 12 percent Medicaid cases and 2 percent charity care. I think it's important to note that our financial projections are based on the actual reported payer mix from the physicians who plan to utilize the center. So, in the data that they gave us, right now 12 percent

of their cases are Medicaid patients.

We have strict nondiscrimination language as part of our subscription and ownership documents at ACTD, LLC. We also have a quality improvement committee in place with a peer review function to help ensure that physicians are seeing all types of patients in the appropriate cases in the surgery center. We anticipate to have a regular reporting to the Green Mountain Care Board on our free care, charity care amounts and Medicaid amounts. We also, I think it's important to note, reviewed and matched the language from the charity care policies at our local hospitals in order to develop our own charity care policy, which I have submitted drafts of in the application materials.

It is our strong opinion that the Green Mountain Surgery Center meets key goals of Vermont's health care reform plan. There are fourteen principles of health care reform, and upon my initial review, I could see that the Green Mountain Surgery Center directly helps Vermont achieve at least seven of these goals.

Goal number one is that Vermont must ensure universal access and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers such as cost must not prevent people from accessing health care. We will provide lower cost

services to help reduce cost as a barrier to receiving services for Vermonters.

Two, overall health care costs must be contained, and growth in health care spending must balance the needs of the population with the ability to pay for such care. The second principle also deals directly with costs, and our center helps to lower those.

The fifth principle ensures that every Vermonter should be able to choose his or her health care providers. Vermonters, unlike citizens of every other state, cannot currently choose to have procedures done at a multispecialty surgery center.

Further, goal number six says that Vermonters should be aware of the cost of health services they receive and that costs should be transparent and easy to understand. We will help achieve this goal by giving patients costs in advance. We have dedicated a person at the center who will be working with patients on that, and we will also have a price transparency tool available on our website.

The ninth health care principle is about quality, and ASC's offer the same or better quality in several peer-reviewed studies as currently available outpatient surgeries in the hospital.

The tenth principle focuses on efficiency, and,

due to their very structure, ASC's operate more efficiently which means that we can provide services at lower prices which means that the gains from this efficiency are passed along directly to Vermonters in the form of savings on what they're paying for health care.

Vermont's health care system, Principle 13, must operate as a partnership between consumers, employers, and health care professionals. We have worked hard over the past two years to engage members of the employer community, the payer community, the consumer community, the patient community in this application and believe that we have created a strong coalition who supports the opening of this surgery center in Vermont.

You had also asked in the Application Closed Letter for more detail about our utilization projections. Here they are by specialty. This table is directly from our original application, and, as I said before, the projections are based on the actual historical outpatient case volume performed by the physicians who have expressed interest in the project. An annual case growth of 1 percent was used to grow the cases in years two, three, and four.

You also asked questions about utilization relative to the numbers of planned procedure rooms and

operating rooms. By year four we estimate that our total volume will be about 6,000 cases, and those break down between the procedure rooms and the operating rooms. Generally speaking, a lot of our volume, over 60 percent, is going to be GI cases. These are noninvasive, will be performed in procedure rooms. Generally speaking, the other procedures, OB/GYN, general surgery, and orthopedics, will be performed in the operating rooms, although a small minority of those cases will also go into the procedure rooms.

ASC benchmarking data is available and which is what we used to determine how many procedure rooms and how many OR's we should plan for based on our volume figures. So here I've given you some of the ranges which currently operational ASC's across the country have reported. In the procedure rooms approximately 900 to 1,400 cases can be performed annually based on existing ASC's, and 700 to 1,200 cases in each OR.

You also had asked about pricing. The Green Mountain Surgery Center hopes to move towards more transparency in prices. Our plan is to try as much as we can to have the same prices or allowed amounts for our procedures from any payer type, and we think that this works directly in line with what the goal of the all-payer model is so that we can have all payers

paying a uniform rate so that the cost and price of surgeries will be more predictable for providers and for patients. We think that our philosophy is right in line with those goals.

Now we'll talk about the overall cost savings that we believe the Green Mountain Surgery Center will achieve, and we have three of these charts dealing with Medicare, commercial, and then Medicaid. These charts take our projected revenue by payer category, which was in the original application on Table 7, and then we apply an adjustment factor, and we use that to estimate how much these cases are currently costing the system based on where they're performed in hospital outpatient departments today. Then the fourth line is the difference between what it costs the system today versus what the ASC revenue is.

So on Medicare we estimate we will save $2 million per year for Medicare based on those cases. For commercial, using the same methodology but an adjustment factor of 50 percent because that was what was in a couple of the cost studies that I had provided in the application, showing that, on average across the country, surgery centers get reimbursed by commercial payers 50 percent of what hospitals get reimbursed. Using that figure for adjustment, we estimate

commercial payers will save $3 million per year.

On Medicaid we estimate the savings will be $500,000 per year. The adjustment factor we used there was the same as the Medicare adjustment factor, not having a different assumption to make for the Vermont Medicaid. So, altogether, these are savings of $5.5 million a year, and these savings will accrue to patients, insurers, and employers in Vermont.

Green Mountain Surgery Center will improve the quality of care on a patient- and system-wide basis. We went back through all of the application materials submitted and found that we had provided seven national peer-reviewed studies from the last fifteen years or so, four showing that ASC's have equal quality and three showing better quality outcomes based on markers like adverse events, same-day ER admissions, and complications from surgery when you compare ASC's with hospital outpatient departments. Patient satisfaction scores are also better in ASC's according to that peer-reviewed literature, MedPAC and MVP Healthcare per the letter of support they submitted for this application.

I think it's also important to note that, in terms of accountability for quality, since 2012 ASC's have been required to report quality measures to Medicare or

face penalties just like hospitals are required to do. There are ten measures including burns, falls, hospital transfer rates, that ASC's have to report on, and those scores are reported publicly on the CMS website and have been for the past couple of years.

The Green Mountain Surgery Center is on track to raise our targeted debt and equity by the fall of 2017. We initially raised $240,000 in equity prior to submitting the application. We have raised an additional $50,000 since while the application has been in process. So we have $291,000 currently. In order to hit our target equity amount, we have another about $840,000 to raise. The bulk of this is working capital.

We used a conservative or high assumption of the working capital we would need to have on hand to be ready for our accreditations when we open and have the center staffed equipment-wise and operational-wise to pass those. So that's what the bulk of that is.

We have a loan to be secured from a commercial bank in the amount of $680,000. We hope to achieve that this summer as well. We have a preapproval letter secured from one local bank and have had talks with two additional interested local lenders. We hope to secure the loan as soon as the CON is approved, because we are

now in an environment of rising interest rates.

I think it's important to note here that we chose not to bring in equity investors from out of state for this project. This ACTD, LLC, will be owned by Vermonters, and I think that that is a unique aspect of this project.

These are the breakdown of costs allocated for our EMR, which was another point that the Board asked me to elaborate on during this hearing. I wanted to point out here the places on the expenses of the income statement where our ER costs are allocated. So we plan to lease the initial ER. That's in "Equipment Leases" there. We also will have ongoing maintenance and support expenses which are categorized in the computer expenses and the miscellany expenses line, miscellaneous expenses line on the EM statement.

I think it's also important to note in the quotes that we have provided the Board so far from our EMR vendor and our local IT vendor, those are prenegotiated, so those were the initial what we received from the vendor, so we're hoping, upon approval, to even negotiate further and get a better value on those EMR products.

We do have EMR policies and plans in place that are consistent with Vermont's Healthcare Information

Technology Plan principles. We plan to participate in the Vermont Program for Quality Health Care, VPQHC. We believe that this participation will help meet the Principle 1 in the plan, Support effective, efficient statewide use of electronic health information in patient care, policy making, clinical research, health care financing, and continuous quality improvement.

We also have twelve policies and procedures, procedures related to use of our EMR that will address issues related to data ownership, governance, and confidentiality and security of patient information. I have those printed out here and can submit those to the Board today so you can review those draft EMR policies.

The next slide is the just the table of contents for what I'll be giving you with the policies. To continue with the Vermont Health Information Technology Plan's key focus, which is on integration, the plan says that we shall include the implementation of an integrated EHR infrastructure for sharing electronic health information. A major reason that the proposed EMR that we're going to use at Green Mountain Surgery Center, AMPI Solutions, was selected is because integration and interoperability are part of the vendor's core philosophy.

AMPI's parent company, Surgical Information

Systems, is a member of the CommonWell Health Alliance, and they have two-thirds of the acute care EHR market, are also members of the National CommonWell Health Alliance. CommonWell is a nonprofit organization whose mission is creating and continuing a vendor-neutral platform that breaks down technological and process barriers that inhibit that health care exchange.

They are committed to defining and promoting national infrastructure with comments, standards, and policies, which I believe is some of the very same language that was used in the Vermont Health Care Information Technology Plan. So we're happy to be part of moving Vermont forward in that way as well.

The next issue I'll address is how we will participate in the all-payer model in ACO's. I think it's important just to sort of go back to basics sometimes with the ACO conversations because they tend to get quite complicated quite quickly. The Green Mountain Surgery Center will not employ any physicians. Physicians who are independent or who might be employed by others will use our facility to do procedures, but we will not have any employment contracts with physicians.

We will not have any attributed patients in any ACO program. Primary care providers with attributed

patients play a central role in ACO's responsible for the most care coordination and reporting on quality measures. However, we will play an active role collaborating with ACO's, sharing data, and adopting best practice evidence coordination protocols. We plan to participate in ACO's as an affiliated provider and partner.

Our board has reviewed the provider-patient agreements of the ACO's currently operating in Vermont, those being CHAC and OneCare currently, and we intend to sign those affiliate partner agreements. Responsibilities of affiliate participants include data sharing, care coordination, supporting the primary care, medical home. I do have Dr. Paul Reiss with me here who can talk more specifically about some of these issues being a primary care physician and very involved in health reform. I also have Dr. Beth Wennar who is going to speak more about how the ASC fits in with health reform later.

The final issue that I will -- oh, I'm sorry. I just, for me to close out my portion of the ACO conversation, reduced payments by insurers for the same amount of outpatient procedures offered at the same or higher quality will reduce expenditures and help Vermont meet their expenditure target in the all-payer

model agreement with CMS. That's how we think the ASC fits more broadly into the all-payer model that we're moving to here in Vermont.

Timely access to specialists and shorter waiting times due to the additional efficiency and capacity at the ASC will improve two ACO quality performance scores in particular. One is patient satisfaction scores measure, ACO-4, access to specialists. The other one that we expect to have an immediate positive impact on is the colorectal cancer screening scores, ACO-19, and then preventive care domain, because we will be offering easier access to those screening procedures.

In terms of how the spend on procedures at the ASC fits in with the total ACO budget, we think it's up to the ACO's to decide how to reduce hospital global budgets. If somehow appropriate outpatient procedure volume shifts out of the hospital and into the surgery center setting, we believe that ACO's will have mechanisms for this already developed because they will have to use similar methodologies to adjust for market share shifts between hospitals and the ACO.

How would Green Mountain Surgery Center impact overall costs of health care in Vermont? I think it's pretty clear from our presentation and the last two years of our application that we think the Green

Mountain Surgery Center will lower overall health care costs by providing equal quality or better quality services at lower cost. This is the definition of value in health care and really in any industry.

Those who claim that the Green Mountain Surgery Center will raise overall costs are pointing to what I call the "sacred cows". We are here in Vermont, so I thought that cows had to enter into the presentation at some point. The "sacred cows", these are things that are assumed to be true by those who may oppose our application. One is that providing ER services is not profitable for hospitals, another is that treating Medicaid patients is not profitable for hospitals, and the third is that most hospital costs are fixed costs.

But the parties who oppose our application have provided no evidence to support these assertions, and, in fact, there are evidence-based studies out there that suggest that these beliefs may not be true. Recent evidence-based studies suggest that providing ER services can be profitable for hospitals, especially post the Affordable Care Act passage. Studies also suggest that treating Medicaid patients is profitable for hospitals when all of the extra public subsidies that hospitals receive are also accounted for in the calculation, and, finally, there are studies that say

that most of what health care managers think of as fixed costs are actually under their control.

Thank you. That's all that I had to present.

AUDIENCE MEMBER: Just a quick question. We have a lot of people that are out there that want to see the slides. Is it possible for them to come in?

MR. HUDSON: Do we have any extra room? I think they're working on distributing some paper copies if that helps folks who can't quite see.

MS. HENKIN: And I do want to say I'm sorry that the room is cramped. We had to be over here for this afternoon's meeting, and I did not think that they were going to move out the big table. I thought we were going to have more chair space, and I'm sorry for all the people that are patiently hoping to get a better view, but we do have hard copies, I believe, of these handouts if you cannot see the board.

MS. COOPER: Shall we move to Joan from Avanza with her presentation?

MR. HUDSON: Please, proceed.

MS. DENTLER: Good afternoon, and thank you for this opportunity to speak to you today. Amy had asked me to attend this hearing to really serve a couple of points. One is to give you a little background about who we are, because I think our name

is mentioned throughout the application in some places. So, since we are not from Vermont, I wanted to make sure you knew who we were.

I'll also talk to you a little bit about what we have done for the Green Mountain Surgery Center so far and then also give you a little bit of background about the ASC industry in general. So we're going to go pretty quickly through the first few slides which go through who we are. We are a, we're a health care consulting firm. We've been in existence since 2007, originally under the name of ASC Strategies. Changed our name to Avanza in 2014 when our clients started asking us to do more work besides just surgery centers.

We work in lots of areas in the health care industry, but our core competency really is ambulatory surgery centers, and we approach our services very different from many other surgery center companies, and I think we need to make this really clear. We are not an equity-based surgery center development and management company the way so many are out there. We are strictly a boutique consulting firm that people pay to provide services, and then we leave. So I just want to be sure it's very clear we do not own any part of this project, nor would we own any part of this project. All of our engagements are customized to our

clients' needs.

Besides surgery centers we also work primarily with hospitals on relocation of outpatient services. When they would like to relocate acute services into a lower cost outpatient environment, they typically engage us to re-engineer those services and develop partnerships with hospitals, physicians, and community-based organizations.

In addition to those two areas, we also work with our clients in helping to develop community collaborations, typically bringing in community groups such as FQHC's. Several of our board, I mean, of our consultants have experience with FQHC's, other not-for-profit groups, hospitals, and physicians in the community and doing coalition building and community collaborations.

Again, this just visually shows you where we've worked and kind of what the type of clients that we have. Again, this just shows you a few of our clients in the area and our team, and I included in the presentation for the Board the bios of the two of us who are going to be speaking to you today so you have a little bit more background about us. I know you've got our CV's, but now you have pictures of us too.

And Avanza is often called upon to do

presentations and write articles and/or quoted in articles having to do with ambulatory surgery centers and outpatient services in general. So this slide just illustrates some of the groups that we've worked with. That's about us.

Typically, this is where I really want to spend our time is that, typically, what we do when a surgery center is being considered in an area is we are brought in by an organization, whether that, in this case, was a physician group, group of physicians, a hospital. Those are usually the two types of clients. Right now, primarily, our clients are hospitals as opposed to large physician groups. How we support each client is really dependent on the situation in their area and what they need and what their internal resources are and how much help they really need from us.

That's where the boutique of boutique consulting comes in, but, typically, if someone is considering a surgery center, it falls into one or all of these four buckets of work, scope of work, starting with a feasibility study and financial forecast. That is, We think we want to do this. We have no idea if it makes sense. We have no idea if we have enough cases. We have no idea if it's even legal. Help us figure that out. That's the piece of work we did for ACTD, yeah.

Then, organizational development, that is, after the feasibility piece, we want to move forward. How do we do that? There are lots and lots of regulations of the structure of ambulatory surgery centers. Certain types of people cannot own an ambulatory surgery center. It's very restrictive, and it's very highly regulated. So we go in and work with their legal counsel and help them with the organizational development.

If the hospital has been involved in this, then usually this is setting up a hospital-physician joint venture. What should that percentage split be? What should noncompetes be? Things like that. After that then we can work with licensing, accreditation, and opening support, getting the building open, and then after that operational oversight. We can do all of these. We can do one of these. It really varies from client to client.

In the feasibility engagement scope, which is what we've done here, I want to go through what we, both what we typically do and how it was handled here. Again, as Amy said, you know, you have a group of people that are sitting around talking about, Looks like we need a surgery center. How do we know if we should do one or not? Take it to the next step. They

call us. We ask them for some information, Who would be the key doctors? In this case, we were provided that list.

Then we conduct one-on-one meetings with those physicians, because we think it's very important to understand what their motivation is, to understand how they practice, and then we get their outpatient surgical data historic. We do not ever base anything on what we call surgical futures, not what we think we're going to do, what did you do for the trailing twelve months, trailing two years, something like that, so that we can review that.

We then analyze that data against what center, what procedures are allowed to be paid for in an outpatient surgery center, and that's kind of how we crunch down to, All right, this is your base number of cases that you have. That's where we came up with the numbers for this application. We then develop the financial models using industry, published industry assumptions, and, when I say local influences here, I mean those conversations with doctors, you know, How do they typically practice? What kinds of times should we expect out of this group?

In this case, they don't have experience in the surgery center. There's going to be a big ramp-up in

understanding how this works, because it is different than a hospital. It's much faster. Probably don't have trained staff who have worked in a surgery center. We're going to have to teach them to move quicker. And then we sit down and show the client what the next steps are. That's basically exactly the model that we followed here in 2014. Since I'm probably the one in the room with the longest history -- yeah. I'm sorry.

MR. HUDSON: I just wanted to check in on the length of this portion of the, of the presentation that was left. I think the Board is eager to move on to a more substantive give-and-take between the party witnesses and the Board at this point. We are closing in on 45 minutes if you want to, you know, just --

MR. HOGAN: And we're sorry about this, but your relationship is with the surgical center. Our relationship is with the surgical center. What you're saying is very important to you, but it is not important to the process we're into now. So my apology for that, but that's where we are.

MS. COOPER: That's fine. We had planned to move to questions after Joan's presentation. So I believe you guys have the evolution of the ASC industry infographic, so we can probably skip this portion.

MS. DENTLER: Stop here?

MS. COOPER: Do you want to finish up with one last slide?

MS. DENTLER: Yeah, I do want to just go through the last slide here and just say one thing. One thing I would like to talk about is what surgery centers aren't, and that is they, they are not unregulated entities. They're highly regulated by CMS. They must record quality and infection metrics. They are accredited by the Joint Commission or AAAHC. They must follow the same HIPAA guidelines as any other health care provider. They must be on required life safety standards, and they don't -- they are not seen as competitive in most markets to hospitals. They are seen as part of the portfolio of surgical services that are offered in a community, and, right now, the majority of ASC's have some affiliation with hospitals and work together very well. Thank you.

MR. HOGAN: Thank you.

MS. COOPER: So, however the Board wishes to proceed, I had thought, since our other witnesses are not speaking specifically to the details of the project, that we might do question-and-answer on the details of the project first, and then, if we had time after, to move to our other witnesses.

MR. HUDSON: I think, at this point, if

that's amenable to the Board, but I want to defer to the Board in terms of how they want to --

MS. HENKIN: I think we should move to questions, and then, if we have clarification from their witnesses and time left, I think that would work.

MR. HUDSON: That sounds good.

MS. HOLMES: I'll start, sure. Thank you for the presentation. I have a series of questions here. You've largely defined need as a function of cost, specifically saying the center would provide services in demand by patients that would be materially different from those available at hospitals through their lower cost, and we saw during the presentation and also in your application that the discounts would be roughly 50 to 59 percent below the hospital prices.

So one first question: Would you be willing to guarantee as a center policy to ensure that your prices will always be lower than hospitals and, in other words, put that policy on your website and, in your negotiations with commercial payers, effectively state that that's your policy and making sure that that stays true?

MS. COOPER: The answer to that is yes, and it hopefully will make you more comfortable to know that we have had a -- I have had conversations on a

high level with payers just explaining the project at the level that I've explained it to you, and the conversation has gone towards making, trying to make our rates at the surgery center here in Vermont competitive with surgery centers in adjoining states where we do see rates that are about half of hospitals. So that's going to be where our target is, and we will certainly be willing to make that part of our publicly stated policy.

MS. HOLMES: Along those lines, are there procedures or surgeries that your providers are currently going to offer that they currently offer in their office space setting that, when moving from the office space setting to the ambulatory surgical center, will actually have a higher rate than currently being reimbursed in an office space setting?

MS. COOPER: So none that I know of, with the exception of the pain management procedures. I know that what the physicians who have told us -- and, Joan, if you have something else to add from your conversations with them -- but those physicians have said that they currently aren't able to do certain pain management procedures. Certain ones don't maintain privileges at the hospital, and so they can't do them in their offices. So these would be new procedures

that they would be able to do in a surgery center because of the higher level of anesthesia and other safety in place.

So they currently do most of theirs in their offices, though, as you can see in the data that I submitted. So it would be some small minority that may move into the surgery center, and I can follow up if you need more detail on that.

MS. HOLMES: That would be helpful. Because I think, Joan, I think you wrote an article about this exact thing, about pain management, and to the extent that Medicare rates were being cut more so in the -- I think, if I'm remembering this -- in the offices, and then the rate cuts were higher, yeah, in the offices than in the ambulatory surgical center. You can remind me, but there were rate cuts that were higher in the ambulatory surgical centers than in the office-based practices, and so I'm trying to understand what would happen, because some of that volume that's happening in the office-based practices that might be cheaper.

MS. DENTLER: We do not -- we only accounted for, first of all, in the numbers that we gave you were the cases that could be, were paid for in a surgery center. The regulations -- that article, I think, is a little bit old, a little bit dated, because the

regulations are shifting, and when it comes to office space procedures and what can and can't be done in an office or can and can't be reimbursed in an office. So there is a move that those cases that are now traditionally done in office base are going to move to surgery centers, and, in fact, a big part of our work is being, converting some of those office-based centers into ASC's, because they're not getting reimbursement anymore. We can go through that and look for you, but --

MS. HOLMES: That's helpful to understand. It sounds like a lot of the conversation's been around from hospitals and ambulatory surgical centers. I'd be interested in understanding what's happened in office-based and what happens to the costs there.

MS. DENTLER: Right. And what happens when the physician's doing them in the office, because they get a higher professional feel for doing them in the office and a lower professional fee -- their professional fee will go down when they do it in the surgery center. So, basically, the net-sum gain, I mean, it's the same when it comes to the overall cost to the system.

MS. HOLMES: So I think some more clarity on that would be helpful. Throughout the application you

talk about greater price transparency critical to the successful reform of the healthcare system, and you talk about how lower prices, making those lower prices transparent fills in on that need and, in fact, the simplicity of having one price, one negotiated price. So I'm also wondering if you would also -- you talk about having, on your website, moving to a -- in some places in the application it talks about having one-on-one conversation with providers, and in other places it talks about moving to a price transparency on your website.

I'm wondering if you could guarantee at the open of the ambulatory surgical center that all of your prices will be available on the website for all of your procedures completely transparent to everybody, regardless of whether they've had an interaction with a provider or not so they can do comparison shopping on their own by looking at the website.

MS. COOPER: I would like to have that in place. The reason I would hesitate to agree to that is only that I know there are rules around having to have the same price for everyone or every payer, which is partly why this idea of charges and negotiations by payers has developed so that the allotted amount is actually different than the price but the price is the

same.

I know also in some payer contracts there are restrictions on sharing prices, and so I would have to work towards that goal with the payers that we contract with and would hope that they -- I would certainly state that as my position on the outset, and if payers agree to that and we can work through that in contracting, then I would say, Yes, that is where we would go.

MS. HOLMES: Okay. The other piece, you talk about the surgery center being committed to providing free and discounted care to needy patients at a level on par with Vermont nonprofits and that you promise to serve a broad cross-section of the community including low-income patients without regard for ability to pay, which I think is a wonderful goal.

With that in mind, I'm wondering if you're willing to commit to a policy to only grant privileges to providers whose practices remain open to Medicaid patients as a first and then, taken as a whole, whether you would be willing to commit to a policy where the patient mix of those served in the ambulatory surgical center reflects the patient mix of the hospitals, the five hospitals in the Northwestern region, the catchment area, the area that you speak to.

So will you commit to granting privileges only to providers whose practices who remain open to Medicaid patients and to have the mix of patients in your surgical center match the mix of patients in the outlying areas, commit to that goal, broad range, broad cross-section of the community including low income?

MS. COOPER: So I think that the Board is probably aware of the Medicaid-enhanced primary care payments that came through as part of the Medicaid expansion in 2013 and 2014. Those Medicaid-enhanced rates were then reduced back to the old Medicaid levels in 2015. That reason was cited as a reason that several Healthfirst pediatric and adult primary care practices closed their doors in Franklin County in the end of 2015, which led to really an access in primary care mostly for children, about 6,000, who lost their continuous primary care providers in that area.

The reason I hesitate to commit to, to closing privileges at our center for any private practice that does not stay open for new Medicaid patients is that I have seen what happens when independent practices do accept Medicaid with no quotas and then can't depend on Medicaid having their rates at the right level, and I think that that causes more pain for patients in the community than if those practices had managed to stay

open and serving all their patients.

So I am hesitant to say that we would not accept anyone with privileges who doesn't currently see Medicaid patients. However, in the data that I gave you, our current physicians, 15 out of the 16 do accept Medicaid patients. There is one practice that does not because he could not keep his practice open if he did. He was close to closing and made the decision to not see Medicaid patients.

It is certainly, though, our intention to serve Medicaid patients in the community, and, as I mentioned, a great majority of our physicians do. We are also -- in CON's in other states, Medicaid, the proportion of Medicaid patients that must be seen by surgery centers is specified, and there are comps out there for the rates that get specified, and we would be happy to commit to that and to report on numbers in those ranges.

Further, I think what sometimes gets forgotten in discussions of what our surgery center will contribute to the public good is, because of our different organization than hospitals or other health care nonprofits, is that we will be paying property taxes, and we will be paying income taxes, and those taxes will go directly to the State and municipalities, and

they will be used for other things that are not health care that are building roads and that are paying teachers.

It is a big issue right now nationally in health care. There have been several experts -- Bill Gates gave a large TED talk on this recently, about how health care is sucking the life out of public funds for education, for teachers, for our roads, and this is an issue that we are going to have to deal with everywhere across the country, including here in Vermont, and one, the one elegant element of the surgery center is that it takes the health care, the dollars that are generated in health care and gives them directly back to the taxing entities to use for those other services that are good for the community.

MS. HOLMES: You talk about the surgery center adopting statewide payment performance issues developed by the Green Mountain Care Board which will address payment for quality, not just quantity of care, yet the structure that you're presenting is largely based in fee-for-service, and you talk about plans to participate in bundled payments in the future, and I guess I would wonder, in this world of trying to get an all-payer model up and going in the ACO's, whether you would consider doing bundled payments sooner or these

quality pay for value sooner.

MS. COOPER: Yes, yes, we would consider doing them as soon as possible, and we've actually, in our conversations with the large self-insured employers in Vermont who have written letters of support for this application, a lot of the conversations I've already had with them have been around, What sort of bundled payment could we do for your patient base on these specific procedures where it makes sense?

I think another -- you know, sometimes the surgery center's sort of model of payment gets cast as, you know, in the past, but I think the history of surgery centers, which Joan is an expert on and may have gotten into, but I'll just summarize this part. Surgery centers, since the beginning, have been paid a flat fee for an episode, a colonoscopy or a hysterectomy or another procedure. So there was never -- this flat fee is a step towards bundled payments. There was never any separate charge for the medications, separate charge for the splints or things used by the patients in the surgery center, separate charge for the time of different nurses or different level of people.

When surgery centers began in their payment system, it was always a flat fee. So they already, in a way, are making a step towards bundled payments, and

which is why we're, you know, going to be ready from the day we open to take that on in a much greater degree, and, during our planning process before we open, we'll hope to negotiate some of those bundled payment contracts that we can share news about with you.

MS. HOLMES: Okay. Two quick questions, and then I'll pass on to my colleagues here. There was some conversation around the professional fees would be the same in the hospital or in the ASC setting, or maybe perhaps lower. The balance sheet suggests no retained earnings over the course of, you know, the budgeting, and the cash flow statements have no cash available for distributions, and I'm curious about the incentives. Professional fees are the same for the providers that would do it in the hospital setting or do it in the ambulatory surgical center, and the investors, you know, in terms of retained earnings and cash available for distributions, I'm curious about the incentives to join to do this. What are the ROI for them?

And, Joan, one of the things, I was struck by something that you had said in one of your articles that is related to this that the growth of ASC's being stagnant, you talk about that and the centers,

"Scrambling to increase case loads month after month. In many communities the available outpatient OR capacity far exceeds their needs resulting in smaller bottom lines and reduced or nonexistent distribution to partners".

So if we're seeing that here in terms of the planning, so I'm just wondering from both of you what is the incentive or the attraction to physician partners to get involved?

MS. COOPER: I'll let Joan, since you had the interviews with the physicians, I'll let you answer that. I'll just say quickly that monetary rewards were not high on the list. There has been a push for having an option like this that is more efficient and that the physicians have more control over the operating environment, just for those two reasons alone for a long time, in addition to what the physicians think it would offer their patients, but I'll let Joan talk more.

MS. DENTLER: Yeah. I was going to say, in the early days of surgery centers, I will say that a lot of physicians did this as a way to have a cash flow stream. Those of us from the surgery center world will tell you that is not the motivation anymore. The physicians and your doctors were no different than the

ones I talked to around the country.

They want control of their surgical environment. They need to be back in their office seeing cases. They actually want to be home now. One thing that's different, they want to be home with their families seeing their kids. They spend more time in hospital lounges than they spend in the OR's, and so the idea of being able to go in, do our cases, and leave is what they're looking for. They're not looking for big returns.

In this community I think more -- and I've seen it before. It's like somebody needs to put up the seed money to get this going, and we're going to have this run. We don't really care about returns. They don't want to lose money. They're not stupid. I mean, they don't want to do this from that standpoint, but they do want to -- this isn't their primary source of income, and that's what you're seeing all over the country, and there was a glut in some areas. If you go to Florida and Texas and California, and you'll see that excess capacity of what I was talking about where people were building surgery centers on every corner.

MS. HOLMES: My last question is, I'm not a doctor, as all of you, most of you know, but procedure list, I was surprised I didn't recognize a lot of these

procedures, but mastectomies and hysterectomies, these are really safe to do one day and no overnights?

MS. DENTLER: On a healthy patient. That list comes from CMS's, what they will pay for in the surgery center. So that was -- and what is done at this surgery center and the delegation of privileges, delineation of privileges and what is, what this, what physicians are allowed to do here will be determined locally, and I want to stress that as well. And so, starting off, those, some of those procedures may not be day one, and they may have to feel like they have a comfort level, and anaesthesia providers need to have a comfort level, but those are standardly done in the ASC's.

MS. HOLMES: Okay. Thank you very much.

MS. LUNGE: Can everybody hear me okay without me moving the mic? Okay, all right. Thank you. Whoa, that's loud. So I had some questions that I would really put in the clarification category. So, Amy, I'm going to give you slide numbers, because I wrote my questions on your slides.

So, in terms of -- I just had a quick clarification on Slide 5 where your financial projections assume 12 percent Medicaid cases and 2 percent charity care cases. I was curious about the

change in the charity care number. On Page 28 of your application, you had indicated 5 percent charity care.

MS. COOPER: That includes charity care and bad debt.

MS. LUNGE: Okay. So the 2 percent is the charity care, and the other 3 percent would be the bad debt?

MS. COOPER: Yes.

MS. LUNGE: Thank you. So then on Slide 8 on the utilization projections, I have a couple different questions here. So, when I was looking at the materials that you filed, it looked to me like you created your utilization projections as you've explained based on what your current expected physicians have done historically, and we had asked several questions about trying to really pin down what, exactly, what exact types of cases do you expect to do in the surgical center, which was part of why we asked for the CPT codes.

And in your, in your materials that you submitted on July 15th of 2016, you indicated that you're providing general expectations based on what the historical procedures were, but, at this time, you couldn't really say for certain because it depends in part on what equipment you would buy and that you'd

make the equipment decision later.

So I'd like to hear a little bit more about that, because I think what we're asked to look at legally is whether or not there's a need for the center, and so part of the need goes down to what procedures are being done, and so I feel like I'm in a bit of a circular place where we're trying to get a handle on what you're going to do and you're giving us a general idea, but that idea may change later. So then I'm back to, How do I know if you've met the need if I don't know if you're going to do what you said you were going to because it might change? So, if you could just talk to me a little bit about that.

MS. COOPER: Sure, sure. So what we've provided is the number of cases by specialty, and that that's a number that we can be fairly confident with, although that may change based on a practice that currently has three GYN surgeons, for example, and one of them decides to move and leave and then those volumes come down and then we have another practice that's a GI practice and they hire another doctor and so then those volumes go up, and that's already, you know, happened a little bit over the past two years. So that's one thing is that this is sort of dynamic based on the physicians, especially when you're dealing

with a small group.

The other thing is that physician, individual physicians evolve what they do, and, you know, five years ago a physician may have done, been doing primarily 99275's, and now he's learned a new technique to do 99278's and it's faster and it's more advanced and better, and so now his mix is, instead of 80 percent 99215's, it's 20 percent 99215's. So that's why I couldn't perhaps be as specific about projections by CPT code as the Board may have been looking for. Joan, do you have more clarification?

MS. DENTLER: No. I mean, and I would just say that what is being done in an outpatient setting keeps changing due to technology, due to anesthetics, and things are getting pushed down in that direction all the time. So that's where it is. It's difficult to say it's going to be exactly these cases. I think you could -- what we typically, I would think, here and in talking to these doctors, these are what we call bread-and-butter surgeries that are cases.

So it's the GI, the OB/GYN. There's some certain cases, and I'm not a clinician, so I don't want to start quoting numbers and stuff, but it's just the typical knee scopes, knee scopes and ortho is a perfect example of a noninvasive, minimally invasive surgery

that's done in an ASC. So it would be those types of cases.

MS. LUNGE: Okay, thank you. And then, in terms of the volume estimates, so by year four when you're at 6,043, I think, when I compared the capacity chart, that that would be just under 60 percent capacity. Does that sound right?

MS. COOPER: Um-hum.

MS. LUNGE: Okay. And could you talk a little bit about why you billed excess capacity?

MS. COOPER: Sure. So we, the capacity figures or the utilization figures of 60 percent are based on a turnover time that was given to us by Joan based on benchmarks nationally for ASC's that have been operating probably on average at least ten years. So these are surgery centers that have gotten their processes pretty well down and are running pretty smoothly.

We used those turnover times initially because they were the ASC industry benchmarks, but upon relooking at our utilization projections, which I did in one the question submissions, I thought, upon discussion with our consultants and the physicians, that it might be a stretch to assume that we could start off in year one, two, three meeting those sorts

of turnover times without having nursing staff here, support staff here that is trained in the ASC environment, without having physicians for the most part that have adapted to a more efficient surgery time.

And so we actually flexed those turnover times based on what, in realistically looking at those things, what the turnover times might be. When you lengthen those turnover times, then you get to utilization rates of between 65 and 90 percent, I think, based on how much you flex those. So, using our current volumes in the current space. So, you know, given that, we thought that this was a very reasonable size for the surgery center with those utilization figures.

MS. LUNGE: Thank you. On the pricing philosophy, so I wanted to ask a little bit about the plan for getting a uniform price. Do you just mean for commercial payers? Because, of course, you don't -- Medicaid and Medicare will set the price. So were you saying you're going to try and get the commercial payers, like, to a uniform place with Medicaid or Medicare? I don't think so, but I wanted to clarify that.

MS. COOPER: Yes. You know, it's important.

A uniform place with each other and then also for self-pay patients.

MS. LUNGE: Got it. Okay.

MS. COOPER: So those are the ones we can control. Medicaid and Medicare already made transparent and public their rates.

MS. LUNGE: Thank you. Yes. So which, actually, one other question I had is I had sort of been expecting you to provide us with the Medicaid and Medicare rates for the most common procedures that you were expecting to do, because your argument is that your price is lower, and so that, since the Medicaid and Medicare do have publicly available pricing, that seemed like that would be pretty easy math for you to show with more specificity. So I don't know if you want to speak to that a little bit. You don't have to. I'm just -- it was something I was surprised about, so I wanted to give you an opportunity to speak to it if you wanted to.

MS. COOPER: Yeah. I think what we did is, again, what we did give is, based on all of the different specialties that we have --

MS. LUNGE: Yeah.

MS. COOPER: -- what the average Medicare reimbursement per case was, I believe, and that's how

we created our ASC savings and then compared that to what a hospital rate might be, but we didn't -- we can. We actually looked at those rate lists for CPT codes for Medicare, Medicaid. We just didn't provide them.

MS. LUNGE: Okay, thank you. Just moving to the cost saving estimates for the free payers, so when you, when you look to doing the cost savings estimates, did you have an assumption you made about the physicians who would be using the surgical center whether about their total volume, not just the volume in the surgery center, but potentially the, any, the volume that they might still be doing in the hospital?

MS. COOPER: So, Joan, you correct me if I'm wrong, but I believe that the payer mix that the physicians reported was based on their total volume because that's how physicians track it in their office.

MS. DENTLER: We use the current practice payments.

MS. COOPER: And then we used that same mix for the ASC.

MS. LUNGE: Yeah. So but, when you're thinking -- so part of what -- I think the way, part of your argument is that the ambulatory surgical center will provide a more efficient site, if you will, for physicians to practice. Are you expecting that for,

let's just say, for Physician A, whoever that may be, would their total volume of surgeries go up for their entire practice, or would you expect that, even though they're seeing more efficient turnover within the surgery center, that they would use that time, you know, for spending with their kids or whatever? I'm trying to get a total cost of care type of information.

MS. COOPER: So I think the answer really is that that depends on the needs of the patient. So we have defined need partly on cost, but we've also defined need on more timely access to care. We have heard from patients anecdotally, and physicians have reported wait times for procedures of two months or three months, sometimes more. We hope that the surgery center will enable patients to receive procedures more quickly than that.

The other thing that patients in this community have expressed a desire for more is better access to physician consults with specialists, and I know, Dr. Reiss, you talk about this issue a lot as well. In order for specialists to be available for a physician consult, they need to have hours in their office that are not spent in the OR or in the OR lounge waiting for a room to be turned over.

So the experience of Healthfirst members who are

currently operating in the eye surgery center in South Burlington is that they were able to open up another day of office consult time to see patients that way when they switched to operating in the surgery center. So we're hopeful that that will also come into play.

MS. LUNGE: Thank you. My other question about your Medicare estimates, do these Medicare estimates take into consideration any recent site neutrality changes in Medicare payment policy?

MS. COOPER: No.

MS. LUNGE: On the commercial, I'm sorry if I missed it, but can you give us a sense of what the adjustment factor is based on? Is it based on the study that you provided?

MS. COOPER: Yes. There's a study from the Health Care Cost Institute which data was contributed by all the large self-funded auto-employers about ten years, I think, of claims data where they compared ASC's and outpatient.

MS. LUNGE: And it looked to me, if that's the study that was in the binder, which I think it was, that that study was done in metropolitan markets and that limited data, markets with limited data were excluded. Do you happen to know if Vermont was included as one of the markets?

MS. COOPER: I believe it was not included.
MS. LUNGE: Thank you.
MS. COOPER: Because I remember looking at those notes at the time.
MS. LUNGE: Yeah, thanks. I am almost done. On your ACO slide which is the first one which is 20, thank you, it's always helpful to go back to the basics and remind us of the structure that you're proposing, and, certainly, I understand you're not employing physicians and, therefore, you, yourself, as an entity would not have attributed patients, but, presumably, if your physicians are primary care physicians and they're participating in an ACO, they will have attributed patients who may be using the center and that the costs in the center would be included in the total cost of care.
MS. COOPER: Yes, yes, that's absolutely right.
MS. LUNGE: I thought so, but I wanted to double-check.
MS. COOPER: Yes. Um-hum.
MS. LUNGE: All right. Let me just check one more place, and I think I am done. Okay. Yeah, I think I'm good. Thank you.
MR. HOGAN: All right. The Green Mountain

Care Board is charged with a couple fundamentals, and one of them is controlling the overall cost of health care, particularly as we move toward the ACO and the 3.4 percent requirements, and, fairly or unfairly, the burden of proving that is on your shoulders, not ours.
So and I saw your piece on the sacred cows. Didn't quite do it, okay? I think you can admit that. How do we get to the bottom of that subject? How does the Board get to the point where we know or don't know that this project is either going to reduce overall health care costs or increase them?
MS. COOPER: Paul, would you?
DR. REISS: You know, as a primary care physician, if I have attributed patients under an ACO and I'm responsible in some way to control their overall costs of care, how do I do that? What are my tools that I can do that? We know across the country that the ACO's that have been successful have done it and have been very successful by moving patients to lower cost sites of service. That's how they get their shared savings.
We have not been successful here in Vermont in our shared savings programs because we actually already have very low utilization and very high quality, but what we don't have is opportunity for lower costs. So

the only way we're going to get to lower costs is to move care to lower cost sites of service, and that's not just ASC's. That would ideally be imaging centers. They do that elsewhere. They do that by having patients have transparency where they can choose to go to a lower cost site of service.
I had a patient -- he actually wrote a letter to you folks in the Green Mountain Care Board -- who asked me about where he can get a lower cost MRI. I don't know. Check with Blue Cross. Call around. He went to Glens Falls to get his MRI and saved $3,000. Rest of the country, they're complaining about paying $1,000 instead of $700.
The only way we're going to get to lower cost sites, lower cost care and that I can control my patient total costs is not much on utilization, because we're low. We have low hospitalization rates, readmission rates. We have very high quality across all the ACO metrics that we've participated in for the Medicare ACO. So it's not there.
It's moving from hospital to home care or to nursing home care, nursing home care to home care, ER to urgent care centers, urgent care centers to primary care physicians office. Pay more for primary care and less for acute hospital care.

I'm on the Board of the VCO. One of the things we talked about early on was, What's the main thing? What are we going to do? We're going to move money from the acute care hospitals to primary care --
MR. HOGAN: And beyond.
DR. REISS: -- and community care. And how do we do that? Hasn't been figured out yet. We haven't worked it out yet. But moving to lower cost sites of service where they're effective and just as high quality is what we have to do. That's how we have to get there.
And so the proof is in what's going on in the rest of the country and where this works. This is the tool that other places use and have used. We're behind on this. We would like to be ahead on this, but we're way behind on moving to lower cost sites of service for patients to choose from and for me, as a primary care doc, to control the costs of care for my patients. I need that ability to have choices and to know what those costs are, and my patients really want that too. Every day I send people from very high-cost care who ask me if there's alternatives, and I don't have them.
MR. HOGAN: I'm hearing the logic, but I can't find the evidence. That's what I need.
MS. COOPER: So I think that we have provided

evidence that we will provide surgeries and procedures at lower costs.

MR. HOGAN: That, I got.

MS. COOPER: So, therefore, if we're currently paying 100 and in the future we're going to pay maybe 50, then the overall costs come down, unless the hospitals raise their prices as a result of those procedures moving out. Is that right? That logic seems right. If the hospitals don't raise prices and don't have that volume, then the total system cost comes down because we were paying "X" and now we're paying "Y".

MS. LUNGE: As long as utilization stays the same. If utilization increases, there will be a tipping point where, even at a lower cost, utilization will still increase the total cost of care for Vermont.

MS. COOPER: Sure. And that comes back to the question of access and whether patients have the right access today or whether they should have more access which might cost more. So I think that -- I'm not sure that it, that it should, that we should be asked to be proved, to prove beyond --

MR. HOGAN: I said it could be unfair. I said that.

MS. COOPER: Okay.

MR. HOGAN: Okay? I mean that, that it's an, almost an unfair requirement. My other question, and this is a clarification question. Will you be in or out of regulation, budget regulation by the Green Mountain Care Board and/or the ACO in the all-payer process, whatever that's going to look like?

MS. COOPER: We're planning to join the ACO.

MR. HOGAN: Okay.

MS. COOPER: So we'll participate in the processes that they've developed for mechanisms for paying for outpatient procedures.

MR. HOGAN: Okay. That's helpful. I understood the question on IT, but let me raise it to an even more basic question. Will your IT system be consistent and participate with the local regional hospitals and the ACO?

MS. COOPER: Yes, we expect that it will.

MR. HOGAN: Okay. I think I've asked my questions. I'm all set. Thank you.

MR. HUDSON: If there are no further questions from the Board, does the Health Care Advocate have questions at this point?

MS. SHAW: Yeah, we have a few. So, first, thank you for your presentation. So you mentioned in your presentation that language in your financial

assistance policy is based on language that's used by other local hospitals. I was wondering if you could specify which hospital or hospitals that language was drawn from.

MS. COOPER: Karen, you helped us work on that.

MS. TYLER: Yeah. My name is Karen Tyler. I'm with Dunkiel Saunders, the Applicant.

MR. HOGAN: Ma'am, I'm sorry, but the reporter here is trying to record you, so you've really got to speak loudly.

MS. TYLER: Oh, I'm sorry. What we looked at were the regulations that govern what hospitals are required to do in this area. So we didn't take a policy that is in place at a local hospital. We looked at the rules that hospitals are required to comply with, and we made sure that their policy would comply with all those same requirements, even though, you know, it's interesting to note that the hospitals are subject to those requirements because they're tax-exempt, 501(c)(3) entities, which the Applicant obviously won't be, but nonetheless, they voluntarily have elected to comply with those same rules.

MS. SHAW: Okay, thank you. And, in follow-up to that, you also mentioned that you'll be,

or you stated that you'll be providing free care and financial assistance at a rate comparable to other local hospitals, and I was wondering which hospitals have comparable rates in terms of the income requirements, asset requirements, and then the percentage beyond that that will be provided to patients?

MS. COOPER: So I believe that we looked at UVMMC primarily and found charity care rates of between 1 and 2 percent. So we plan to match those and know that the surgery center that's currently in existence does match those as well.

MS. SHAW: So you're talking about matching, like, the rate, like a percentage of your revenue?

MS. COOPER: Yes, yes.

MS. SHAW: Okay. Thank you for that clarification. Will patients be eligible for financial assistance regardless of their insurance status, so whether they're uninsured or if they have an unaffordable deductible with their insurance plan?

MS. COOPER: Yes.

MS. SHAW: And do all of your providers currently accept uninsured patients?

MS. COOPER: Yes.

MS. SHAW: Okay. So that's it on that topic

for me. So, moving on to your pricing plan, just a follow-up on a question that Robin Lunge asked. So are you not intending to negotiate your rates with individual payers? Is that what you mean by charging the same rate to all commercial?

MS. COOPER: Yes. The commercial payers will have to agree to reimburse the rate that we think is reasonable, and we would hope that all the payers would agree to the same rate so that we can have one rate for commercial.

MS. SHAW: Okay. So do you anticipate, say, in your first year having lower rates for certain commercial insurers than others?

MS. COOPER: Meaning a lower rate for Blue Cross Blue Shield than we do for MVP?

MS. SHAW: That, yeah, or any other commercial insurer.

MS. COOPER: No. We anticipate having the same rates.

MS. SHAW: The same rates? Okay. So, moving on to another topic, do you believe that the ambulatory surgery center will affect the hospitals', the local hospitals' payer mix for the procedures that you will be performing?

MS. COOPER: No.

MS. SHAW: Okay. And just one final question. If you would, please, clarify how you intend to support the primary care medical home model.

MS. COOPER: Sure. Within Healthfirst a few years ago, we recognized that, in order to support the primary care medical home, we needed to create protocols around patient handoffs from primary care to specialty care, protocols around what information should be provided from primary care to specialists in order for them to do their job, what information needed to be provided back to primary care so that the patient's care could be continuous, the time periods that information should be provided.

We had called together a group of member specialists and member primary care physicians who actually hashed out what they could agree to on either side, created a collaborative care network-wide agreement which all the specialists at the center are participating in as well as the primary care physicians who are part of medical homes.

MS. SHAW: Okay, thank you. That's all for us. Thank you.

MR. HOGAN: All right. Do we have a board member with a question?

MS. HOLMES: No, I think I'm fine. Thank

you.

MR. HOGAN: Okay, all right.

MR. HUDSON: Well, at this point, we are exactly on the schedule that we hammered out at the prehearing conference, and, at the risk of departing from that, we do have a request from the Board for a no-more-than-five-minute recess. I think it makes sense to do that now while the parties switch places at the table.

(A recess was taken from 2:29 p.m. to 2:34 p.m.)

MR. HUDSON: All right. Welcome back, everybody. Thank you for making that recess as brief as possible. At this point, we have at the witness stand and ready to present the Vermont Association of Hospitals and Healthcare Systems.

MR. TIEMAN: Thank you. I'm Jeff Tieman. I'm the President of the Vermont Association of Hospitals and Health Systems, and I appreciate the opportunity to talk with you this afternoon, Board Members. By way of introduction, to my far left is James Medendorp, Vice President of Kaufman Hall. Also, his colleague is on the telephone, Walter Morrissey, a physician who is a managing director at Kaufman Hall. Then we have Chris Oliver to right here, Vice President of Clinical Services for the University of Vermont

Medical Center. To my left right here is Mike Del Trecco, Vice President of Finance at the Hospital Association, and to my right Anne Cramer, our attorney with Primmer, Piper, Eggleston & Cramer.

So thank you again for the opportunity. We want to be -- I want to begin by providing kind of an overarching sense of this from our perspective. I am still fairly new to Vermont, having arrived here just last August, and one thing that compelled me to come represent this state's hospitals was an entirely nonprofit system whose focus is on quality, on value, and on reform. I've always worked with nonprofit, mission-based hospitals because I believe strongly in their singular focus on doing right by the people they serve. All of the hospitals VAHHS represents exist to serve and benefit their communities, not shareholders.

In many states around the country, as I'm sure you know, there are, hospitals are for-profit enterprises that answer to boards of directors and people who own stock in the company. It is well worth noting, I think, that our system is remarkable for having a very, very small for-profit footprint to this point.

So, whether it is direct medical care that we provide or investments in public health and health reform and primary prevention, the mission of Vermont's

hospitals is to treat everyone who comes through our door and needs our attention and also to help improve the health status of our communities, which is expected by both the State of Vermont and its citizens and also by federal law under the Affordable Care Act, which requires that nonprofit hospitals, as you know, conduct a community health needs assessment, develop a plan to meet those needs, and then spend resources, effort, and energy to carry out those plans. The ambulatory surgical center we're talking about here today, of course, would not be part of that process.

And our system works. Recently, as you probably know -- oh, I'm sorry. I'm not doing the slides. There we go. Recently, the Commonwealth fund named Vermont the number one health care system in the country based on, in their report, aiming higher, results from the second scorecard on state health system performance. Their evaluation is based on several key metrics of an effective health care system including access, quality, outcomes, and controlling avoidable costs. And how nice is that air?

(Referring to the open window in the room.)

On the cost front, of course, there is always work to do, but last year, as these Board members know very well, net patient revenue grew at 4.4 percent compared

with 5 percent in the previous year and in the range of 9 percent a decade ago. Over the past ten years, $600 million in avoidable costs have been taken out of Vermont's system, which has also helped put downward pressure on premium inflation. We argue that this is definitely no accident. It is in large part the product of Vermont's very carefully chosen and carried out regulatory framework. That involves, as you know better than anyone, a high degree of scrutiny of hospital budgeting, construction, and operation.

Few, if any other, states in the country are subject to this kind of oversight, review, and enforcement. This work has created a very carefully calibrated system in Vermont where the Green Mountain Care Board helps ensure that hospitals are meeting community need and managing themselves effectively and efficiently.

So, unlike our state's 14 not-for-profit hospitals which, as you know, include critical access, midsize PPS hospitals, and an academic medical center, the surgical center would not have to participate in budget review or oversight.

From a public health standpoint, the surgical center would not be licensed by the State. This raises questions for consumers, especially in a state that has

taken such a proactive approach to consumer protection. We contend that the Green Mountain Care Board should not approve a surgery facility for which the State has not developed licensing requirements and standards.

One of the most important components of this application and one that you will hear more about this afternoon is how the surgical center would affect existing hospitals including, not just those right now in Chittenden County, but down the road potentially others in other communities where the effect of a surgical center could be even more impactful than this one.

By providing only select services, the ones they select, the ASC can choose the most profitable ones and take away those more profitable services from hospitals. The effect, of course, being that those services enable the hospital to cross-subsidize unprofitable services, to invest in facilities and improvements, and to be there for the community into the future.

Enabling a for-profit provider, which would be a real first in Vermont, to step into this space creates a competitive advantage for the new surgical center, and that surgical center does not have to maintain the emergency room -- in fact, it would depend on hours --

or provide money-losing services or treat anyone who wants or needs to be treated regardless of their income. And, as I will say when we reach the conclusion, this application before you today simply does not meet the majority of the criteria set forth to grant a Certificate of Need.

MR. MEDENDORP: Good afternoon. As we've mentioned, I'm Jim Medendorp. I'm the Vice President with Kaufman Hall. On the phone is one of our managing directors, Walter Morrissey. We looked at capacity requirements within the Northwest Vermont area, applied population growth projections to look at, What is the overall need for services in this market?

Certainly, as you look at Certificate of Need applications, the need for capacity is a key criteria by which we base the validity of the Certificate of Need. Our findings as we looked at these supplying the market today is that there's available capacity within the operating rooms and the procedural suites that are currently in existence within the market.

When we look forward, we look out at population growth. The population growth is, you know, in Chittenden County is projected to be lower than half a percent per year. We apply that against the inpatient and outpatient use rates for volumes. There is a

shifting of volumes from inpatient cases to outpatient cases, outpatient cases certainly being done at a faster pace than inpatient cases, shorter time per room, and then we also look at things like in-migration and out-migration.

When we look at the market here today, there's very low out-migration to other areas to seek surgical or procedural care, and there's actually some in-migration from areas outside of the county, so that would lend us to believe that there's significant capacity today in the market.

Looking out over the next projected timeframe, we feel that the OR capacity is more than adequate to meet the demand for the foreseeable future, regardless of how we define the market. If you look at the Northwest Vermont area and the number of operating rooms that are available today, that supply should carry us out way past 2030, 2040. As the market definition expands, you know, we kind of look at the supply, not only in Chittenden County, but also the greater market which then leads us to believe that capacity is not a constrained issue.

Overall, the assumptions that go into looking at capacity relate around projections, as I mentioned, in population growth, inpatient and outpatient usage rate

changes, procedure times, and then looking at surgical projections based on holding the, projecting our surgical projections based on holding the current operating room constant. So we weren't adding rooms. We weren't subtracting rooms from the market. And, based off of that, we had identified the surplus capacity that's within the market.

Our general thoughts on this is that, if we added additional OR capacity into this market, we will have an oversupply of rooms which will increase the price for some services that are being provided at the hospital. We have a certain level of fixed costs that have to be maintained if we have an operating room that needs to be heated, cooled, maintained, staff needs to be available. So those costs certainly will continue to be incurred by the hospitals even if the volume were to shift to another location.

There are changes in technology and the way in which procedures are done that are shortening procedure times and also changing what procedures are being done in an operating room versus a procedure room, and we foresee those continuing to change going forward.

And then, access for patients overall, as we look at this, is really a function of multiple factors, certainly, operating rooms being one component, but the

other piece of it which is equally as important is the availability of physicians supplying the market as well as staff to support these operating rooms and procedure rooms. Increasing our available operating space will not really do anything to address those patient supply shortages that we currently experience.

MS. OLIVER: Hello. My name is Chris Oliver. I'm the Vice President of Clinical Services at the University of Vermont Medical Center. Thank you for having us here today. I want to first start with providing an overview of our surgical operations at the medical center.

We have a sizable surgical program with ample surgical capacity. Between our two main campuses we have 22 operating rooms. 17 are on the main campus in Burlington, and 5 are on the Fanny Allen campus. We also have 7 procedure rooms where we do less invasive type procedures such as ear tubes or cyst removals. In addition, in our Ambulatory Care Center we have 8 dedicated procedure rooms for endoscopy procedures, and those are primarily colonoscopy type procedures.

Annually, we perform 20,000 surgeries per year and 13,000 endoscopic procedures a year. We are very proud of our patient satisfaction scores. We utilize Press Ganey, and for the past three years our ambulatory

surgery scores have been 94 percent for overall patient satisfaction. For our endoscopy suites the overall patient satisfaction over the last three years has been 95 percent.

We strive for a 75 percent utilization rate. This is a national benchmark that most all hospital use, most all hospitals use in order to run efficiently and effectively. As you can see from our numbers, we're not hitting 75 percent in all of these areas. Our main campus OR's are running at 74 percent, Fanny Allen at 63 percent, endoscopy at 71 percent utilization, and our procedure rooms are only running at 41 percent utilization. About two years ago, we actually reduced hours on our Fanny Allen campus in order to bring up our utilization rates because we were running in the 60's.

With our current volumes, we can easily accommodate all urgent, emergent, and elective cases. If our volumes were to increase, we have substantial capacity and would simply increase our hours of operation. We would begin with the Fanny Allen campus, where we closed two of our rooms, and go to 5:30 like all of our other rooms go. On our main campus we have 17 main OR's, and each of those run to 5:30 at night, but after 5:30 only four rooms run extended hours. So

we have capacity for many other rooms to run later into the evening if the need were there.

As you can see, our procedure rooms we're only running at 41 percent capacity, which is extremely low, yet we have no requests for block time and no requests to fill them. So we have a queue that we keep, and there is no requests to fill that procedure room.

Endoscopy is a similar situation. We're running at 71 percent, which is a little bit better, but we have numerous block times available with no requests to fill them. For example, every Monday from 7:30 to noon is open, every single Monday. Every single Wednesday is open from 7:30 to noon, and then every other Tuesday and Thursday has available block time with no requests in our queue, no complaints from surgeons that couldn't get access, and nobody waiting to get access. Every day there is time in our OR and in our endoscopy suite that is staffed but goes unused.

Our surgical facilities are a community resource, and we manage our block time very closely in order to run most effectively. We have 154 surgeons. 22 percent of those are independent surgeons, and they all have block time in our OR's. By block time what we mean is a surgeon or a surgical group such as orthopedics has reserved time on a certain day of the

week for a certain time during the day, and that time is used for them to solely block their patients into that time.

Both employed and independent surgeons have equal access to block time. Our OR Operations Committee is the team that manages our block time, and they follow the rules by the oversight committee, which is the OR Steering Committee. Both our community and our employed physicians all have the same access, and they all follow the same guidelines.

Surgeons schedule into their block time at their convenience. And this is one of the reasons why we don't use wait time as an acceptable measurement. If a surgeon doesn't have a case to put in their block time, then that time gets converted to open time, and then any surgeon can use open time at their convenience. We have open time available every day that is staffed but is unused.

We, like other hospitals in Vermont, feel it is incumbent upon us to be responsible stewards of our OR's. They are a valuable and a precious resource. We, actually, at the medical center, send out an open report weekly which shows our surgeons for the next month what blocks of time are available so that we can try to effectively fill our blocks. So, instead of

letting our surgeons come to us to try to schedule, we're actually sending a report to them to say, These times are available for you to book your patients, and that report goes out weekly.

Before I turn the presentation over to Mike Del Trecco, I'd just like to comment on one thing that you may have heard about recently, and that is the LNA issue, and I want to assure you that has nothing to do with our OR's, our OR capacity. That was strictly related to our inpatient census, and that is being dealt with already by the hospital.

While most hospitals, and particularly operating rooms, struggle with staffing nationally, we track turnover rates, and at the medical center our turnover rate is only 4 percent. Nationally, the turnover rate of staff in the OR is 14 percent. We have highly tenured staff and highly dedicated staff, but to be proactive and to prepare for either staff retirement or staff turnover, we developed an OR intern program over 18 years ago, and what that is is a 9-month program where RN's can actually come to an RN internship program in our operating rooms and be trained to become an operating room nurse, and, most recently, we started a program for an OR scrub tech program, again, to be proactive and prepare for vacancies. This provides a

steady pipeline of qualified and highly skilled staff. Thank you.

MR. DEL TRECCO: Hi. My name is Mike Del Trecco. I'm the Vice President of Finance at the Hospital Association, and I want to cover a few items today. I'm going to start with the services offered.

Clearly, by their very nature, ambulatory surgical centers treat healthier patients and provide services of lower severity. These cases certainly will have a lower cost structure. They'll inevitably be more profitable, and, as a result, it will be more difficult for organizations to cover overhead or contribute to margin.

Another very important part of this conversation is that hospitals will be there 24/7, 365 to provide emergency room services for the unanticipated events of, of complications that occur within the ambulatory surgical center. So, as we see this, this market shift, it becomes very problematic, not only in Chittenden County, but may affect other areas of Vermont just as dramatically.

A couple of final points, in contrast to what the Applicant indicated, our payer mix is about 60 percent public, Medicare and Medicaid. 20 percent of that's Medicaid, and, additionally, the Applicant indicated

paying taxes. Well, I can assure you that we pay a provider tax that goes into the Health Vermont Trust Fund, and without that there would be no Medicaid payments. So it's very important for the group in the room to understand that, the element of the provider tax.

Impact on system costs, there's certainly hydraulics at play here. It's unclear whether there's more cases or less case in the conversation. It's unclear that, if there are more cases or less cases that we're talking about here, but we, we know that, with little or no population growth and a denominator that remains flat, that system costs will rise. Unlike most industries when there's excess capacity, the consumer wins, in health care when there's excess capacity, the consumer ultimately pays the cost.

So, ownership structure, I, I personally have a hard time with this one. Highly controversial practice to refer patients to an ASC where the referring physician has an equity stake. As indicated before, our organizations are not-for-profit. For-profit investors is much different than a not-for-profit setting. Health care dollars in a for-profit setting go to the shareholder wealth. There's no requirement to invest in the community as in the not-for-profit

setting.

So in health care reform, certainly, this is a swirling environment as we talk today, and it's anxiety-producing, but I can tell you firsthand that I work with a committed group of Vermont hospitals that are engaged in the reform efforts, and it's a true testament to our leadership. Although the Applicant indicates that they are participating in reform, it's not quite clear to me or evident how they will be part of the community care delivery system.

The Applicant has no requirement to participate in community needs assessments and understand the community at large, and, ultimately, for-profit ASC's create misaligned incentives in Vermont. Under the all-payer model, Vermont has embraced paying for value over volume. I can tell you, bundled payments are still volume-based. Clearly not in line with the goals and directions of reform. So, as we're dedicated to moving away from fee-for-service and towards this value concept, real reform is happening today, and I think the ASC piece of driving volume is only at odds with where we're heading. Thank you. Jeff?

MR. TIEMAN: So, ultimately, whatever you may think of the ambulatory surgical center or its value proposition, the question before this Board today is

whether the application meets the criteria that need to be met to grant the application, and as you'll see from our slide here, we have concluded that the application fails to meet four of the seven criteria including that it does not serve the public good as we've described, and with existing capacity there is not evidence of demonstrated need. You heard from Kaufman Hall about this oversupply of rooms. You heard from UVMMC about no requests being in their queue, open operating room time every single day, and no doctors requesting access.

To my earlier point about Vermont's system, the surgical center does not significantly help meet the needs of uninsured people, which is a priority in Vermont, or expand access beyond what is evidently already available or offer a helpful addition to our existing highly effective not-for-profit system.

And I just want to add one other point here, too, to complement what Mike said about the Medicaid provider tax. It not only -- so we pay the provider tax, but, to the issue of other ways we benefit the community, those could be listed out, and it would be a long, long list, and you hear about it all the time in Green Mountain Care Board hearings, and that includes everything from community improvement and development

efforts across the state, drug and addiction treatment, primary prevention efforts, health education, housing and homeless initiatives. All of those things are work that hospitals do every day both because of the community health needs assessments and, I believe quite strongly, because they know it's the right thing for Vermont, the right thing for patients, and the right thing for the communities that our hospitals exist to serve.

So, with that, I would just say I believe our, both our written and our verbal testimony has demonstrated that this application falls short of the criteria needed to grant the application. Thank you.

MR. HUDSON: Questions?

MR. HOGAN: Well, I've got one question. First of all, thank you for the testimony. What impact has the eye center had on the hospitals?

MS. OLIVER: I can comment on the medical center. We lost about 1,500 eye cases in about 2012 when the center opened, and we had declining OR volumes for at least the next four years. We are finally starting to pick up again, but we have nowhere gotten near the point of where we were when those eye cases were coming to the medical center.

MR. HOGAN: And you went a little deeper than

the earlier testimony on the impact on hospitals as a result of the surgical center. Would you deepen that for me?

MR. TIEMAN: Well, I think, you know, overall, I think the most important point that I think needs to be made is that, when you siphon off the most profitable services that help cross-subsidize, as I said, those unprofitable services in the hospital, then those unprofitable services are more and more difficult to provide over time.

And I think it's also important to note a difference between us and some of the other markets on this point. We are a much smaller market. So, when you talk about putting an ambulatory surgical center in a place like Boston or Denver, that's quite a different proposition where there's plenty of population and demand so that everybody can play, and, clearly, in Vermont we have a much smaller population, and you heard about the need.

MR. HOGAN: If we were to approve the surgical center, would the prices in hospitals increase --

MR. DEL TRECCO: You know --

MR. HOGAN: -- or not?

MR. DEL TRECCO: Con, that's a very difficult

answer to know at this point in time, but, as I indicated, if volume stays flat and overhead would need to be covered, surgical center overhead and hospital overhead, there would need, there would be the need for prices to be increased.

MR. HOGAN: The same question back to the eye center. Did the prices increase as a result of the loss of that volume?

MS. OLIVER: We did not increase prices, but we lost revenue.

MR. HOGAN: Okay.

MS. LUNGE: I had a couple questions on the Kaufman Hall information. When you were looking at the migration trends indicating that there's migration that comes into Chittenden County, I was curious to know if you looked at the migration from New York.

MR. MEDENDORP: I believe we looked at all in-migration, but Walter would have to confirm that.

MR. MORRISSEY: Yes. We looked at and included all surgical volume in Northwest Vermont regardless of location of origin of where their patients homes were.

MS. LUNGE: Thank you. And in your slide you specifically look at OR demand. Did you also look at procedure rooms, or is this both OR's and procedure

rooms?

MR. MORRISSEY: We looked at both. I'm assuming you're looking at the slide that summarized it.

MS. LUNGE: If you could repeat that, sorry.

MR. MORRISSEY: No, go ahead.

MR. MEDENDORP: We looked at both procedure rooms and operating room capacity.

MS. LUNGE: Okay, thank you. And then, when you looked at population estimates, I think in the materials submitted you had breakouts by, on population by over age 65. Did you look at population estimates for over 50 or just look at the breakouts as it was included in the materials?

MR. MEDENDORP: We broke out the populations as they were indicated in the materials. It was the -- that's a typical way that we look at population forecasts, because these rates vary. Really, when you're looking at in the 50 range, it's not too dramatically different than the use rates for the 45's.

MS. LUNGE: Okay.

MR. HOGAN: Related question. I was struck by the difference in population forecasts by the surgical center and the hospitals. Can somebody shed some light on that?

MR. MEDENDORP: I can speak to the forecast tool that we used. We used a service called Claritas. They're a national demographer. They're a component of Nielsen, so they use big data in looking at population trends. They also take into account the Census Bureau information, but they go a level, several levels beyond just the Census Bureau information to get their numbers, and they update them annually. So we used the most current forecast from them.

MR. HOGAN: And the result of that was a pretty modest increase in population in the Chittenden area?

MR. MEDENDORP: Yeah. The Chittenden County population growth was less than half a percent per year.

MR. HOGAN: Right, okay. Just wanted to make sure.

MS. LUNGE: In your "Summary of Implications", which is Slide 11, you have a bullet around patient access as a function of available operating space and available physician supply. Wouldn't there also be -- wouldn't efficiency of use of rooms also be a factor when looking at it?

MR. MEDENDORP: Absolutely. So the amount of time allocated for a room over a given day, the use of

that is really dependent on, Are the physicians and the patients there and capable of, you know, performing the case, and then, What is the turnaround time? Hospitals for inpatient cases have a longer turnaround time than for outpatient cases, but in a lot of our clients, we're seeing their outpatient turnover times coming down significantly.

MS. LUNGE: Thank you. The other questions I had were about the capacity slide around UVM's capacity. Can you talk just a little bit about why the procedure rooms might be at 41 percent, if you know? You may not know.

MS. OLIVER: It is hard to tell. I mean, we staff them. We're available to do procedures. We're just not getting -- there's not -- I don't think there's the demand.

MS. LUNGE: And have you considered not staffing them for as many hours?

MS. OLIVER: Absolutely. So and we play with those numbers all the time. So we'll start off in the morning fully staffed, because you never know what emergencies add on as a tertiary care. On any given day, that we can have 20 add-ons that we need to disperse all over our rooms, but we start off with the regular staffing, and then we back it off.

MS. LUNGE: I need another minute if you want to go. I can formulate the rest of my thoughts.

MS. HOLMES: Okay. A quick question about Kaufman Hall. The capacity calculations, what were the hours of operation assumed in those capacity calculations?

MR. MEDENDORP: We utilized the current available OR time schedule.

MS. HOLMES: Okay. And so this is actually a related question. This might go to Jeff too. It mentioned in the middle of opposition that both UVM Medical Center and Northwestern could operate on Saturdays and Sundays and expand, you know, operating hours, which was an interesting, struck me interestingly, because I remember, when Copley came in with their surgical suite CON, this is what I said to them. I said, Why don't you increase your hours of operation and go to Saturdays and Sundays to expand, you know, capacity? And the answer was a very stern, Doctors, providers will not work on Saturdays and Sundays, and they won't work past 5:30, so that's not a possibility.

So, when I was reading this, I was struck by this as an answer. So I'm wondering if you could speak a little bit to that, either Jeff or Chris, the

willingness of providers to work on Saturdays and Sundays and after 5:00.

MS. OLIVER: We do a lot of cases on weekends. They're typically urgent and emergent type cases. So doctors do work on Saturdays, but, as a rule of thumb, I think they would prefer to have their weekends off, but that is another area where we could absolutely expand.

I first talked about expanding where we've already cut back hours and in going into 7:30 at night, because prime time, 7:00 to 5:30 is our typical prime time. 7:30 is not outrageous to go those hours, but weekends is another total possibility. We haven't closed the door on that. I think there's other triggers that we would put in place before we got to that point, one of them being to make sure that all of our surgeons --

And, not only do we track room utilization, but we track surgeon utilization. So many surgeons have block time that are not using it up to the benchmark. So every three months we do a report, and, if the surgeon is not using their time, we give them a notice that, after another three months of not meeting the benchmark, we're going to take time away. And, conversely, if some surgeons are using more time, then that's our impetus to increase block. So we would

always want to make sure that our surgeons are using the time first, then expand hours.

MS. HOLMES: I know that in that same document there was a conversation around the five northwestern hospitals that sort of serve this area, and that included Copley, since I just mentioned Copley, that includes Copley, and my understanding is that they've just submitted a request for a second procedure room because of increasing demand in their area. So how does that jibe with excess capacity and their need now for another procedure room?

MR. TIEMAN: Yeah. I think that could be situational and based on, you know, sort of just the geography, and Art is here behind you.

AUDIENCE MEMBER: Yeah, I could speak to that if you want me to.

MR. TIEMAN: I know he's not a sworn witness today, but I don't know a lot of the specifics around that.

MS. HOLMES: Okay. And that's fine. I will -- so let me ask another sort of a line of questioning in terms of it's hard to -- one of the things that I struggle with is we see the data on the capacity and the excess capacity here at these hospitals, and we also hear about waiting times for specialty services,

and that's something that we've been hearing about at the board level. So there may be excess capacity for procedures in particular OR and, you know, procedure rooms, but how does that jibe with people's ability to get a specialty care appointment?

And the reason I think that they are linked, to the extent that, if the Applicant is correct and that, if there's inefficiencies in the hours that providers have to wait in the OR's that could be spent with patients, then there is a link between specialty just office hour time and excess capacity or non-excess capacity in these OR's. How do we jibe with that?

MS. OLIVER: I can first comment on our turnover time, because that's something that we closely track, and our turnover time is 24 minutes, which is, when we benchmark, that's good turnover time. So there is not -- we aim to be efficient. I mean, we don't want anybody sitting around, because we're paying to staff, not only nurses, anesthesia, pre-op, packing, recovery. It's a very expensive area to staff, so we don't want people sitting around. We want to run as efficiently as possible. So I can only speak for the medical center, but that's what we do there.

MR. TIEMAN: And I think, you know, it might also be worth pointing out that, as you are aware,

there's a specialist shortage that impacts the situation here in Vermont as well.

MS. HOLMES: Okay, thank you. And I guess my last, well, but one question is, The cross-subsidies between profitable and unprofitable services makes a tremendous amount of sense in the fee-for-service world, but as we're moving into a world of potentially global payments that are going to hopefully cover base costs, how does that affect your logic behind whether or not this ambulatory surgical center should exist?

MR. DEL TRECCO: Sure. So, under this movement to a fixed-value for, fixed-value proposition, that per member per month payment would have to be sufficient enough to support overhead variable costs of the whole cost structure as described here. So, if it's insufficient, we'll have the same sort of situation. So, if there's a, if there's a fixed 3.5 percent growth rate of money and it's being siphoned off, you'll have lower, lower dollar values or PMPM values for the organizations that are taking those fixed payments.

So each one of these organizations, whether it be a hospital, surgical center, fill in the blank, will have a contract with that Accountable Care Organization for services. So I don't know the ASC's method of

directly contracting with a commercial carrier, but I can tell you that hospitals will contract with the, excuse me, the ACO for those services, and I think the, the pot of money is only so big.

MS. HOLMES: And, I guess, as a follow-up to that, I mean, we do want to move patients to, you know, low-resource cost settings, right, for their care? So, to the extent that there is lost volume from the hospitals, one way to deal with that is to increase the price for the per member per month fee, but the other way is to think about repurposing space and/or just reducing staff and reducing costs so that that care that used to be provided in a high-cost setting would no longer be. And so how do you think about that?

MR. DEL TRECCO: Well, I would think that you'd have to do a really pretty significant study of departments' overhead structures, and think that, as you look at emergency departments, for instance, we have eight critical access hospitals that, guess what, they need a doctor, nurse, registration people no matter what. So certain overhead can be looked at, and others, you know, maybe not so much. So that's how I think about that equation.

MS. HOLMES: Thank you.

MS. LUNGE: I'm actually good.

MR. HOGAN: I am too.

MR. HUDSON: Any questions from the Health Care Advocate?

MS. SHAW: Yeah, we've got a few. So, first, I just wanted to state my name. I didn't state my name previously, so I just wanted to state my name, Julia Shaw, Health Care Advocate, and I'm here with Kaili Kuiper, also from the Office of the Health Care Advocate.

So, first, so you acknowledged that physician availability is one of the causes of current access issues related to specialty care. I'm wondering if you have any evidence to refute the Applicant's assertion that the ambulatory surgical center will help with physician recruitment in the region.

MR. TIEMAN: I don't think we have anything to speak to that. We can look into it.

MS. SHAW: Okay. And, in terms of operating room time, do you consider all operating room time and procedure times to be equal, or do you assess problems, you know, or do you see access problems because of the kind of time that you have available? So is it the time slots that you have available are not desirable to physicians, or is there something else causing that time not to be used?

MS. OLIVER: I can speak for the medical center, but the utilization rates that we speak to are from 7:00 to 5:30, so they're the prime time, so that would not be the barrier.

MS. SHAW: Okay. So you don't see a variation within those times that -- okay, thank you. And I'm wondering -- and this is for, I think, for Jeff, probably. How many of your member hospitals have volume-based incentives for their physicians?

MR. TIEMAN: I, actually, I don't know the answer to that question off the top of my head. Mike, do you?

MR. DEL TRECCO: I would only add that there's, within the transitioning all-payer model piece, that our facilities are looking at changing their contract structures, and there's certainly always going to have to be a balance of volume incentive versus the value equation that we've been, we talk about in reform.

MS. SHAW: Okay. Do you have a timeframe for phasing out volume incentives or reducing them significantly for the hospital -- I'm sorry. I just asked if, if the Hospital Association has a timeframe for phasing out or reducing the volume incentives for its physicians.

MR. DEL TRECCO: So we don't employ physicians, but I can tell you, within the construct of reform, it's one of those fundamental components of preparedness that each one of our organizations is evaluating. As far as a timeframe, I can't say, but as organizations take risk, that will be a fundamental principle that needs to be addressed. And, for that matter, taking risk is a very, very prominent piece of reform that, again, I'm not so sure that the Applicant will take risk. Again, a bundled payment is not risk.

MS. SHAW: So I just want to push a little bit on the context of the all-payer model and the limits that it sets to growth in the system, and I'm wondering if you can explain a little bit further how you see something like the ambulatory surgery center increasing costs for consumers within the growth constraints of the all-payer model.

MR. DEL TRECCO: So I think that the fundamental principle here is system cost. Clearly, their high deductibles are a challenge. System costs, if there is, if there's no increased access because of physician shortages, if there's flat volume, then, then price has to cover more overhead. So I think that's the challenge on the table.

MS. SHAW: And then what kind of

participation would you suggest in the community health needs assessment process for something like the ambulatory surgery center?

MR. TIEMAN: Yeah. I think that's a great question and probably one that you would want to direct to them. But, as a health care provider in the State of Vermont, we would, you know, expect some level of participation in that really important work, because it's a federal requirement and, I think, because Vermonters have sort of come to, you know, expect that that's part of what hospitals do, and so I would, I would certainly hope that there could be a mechanism for that.

MS. SHAW: Okay. Do you have any reason to believe that they wouldn't be agreeable to participating in that process?

MR. TIEMAN: I can't answer that.

MS. SHAW: Okay. That's all my questions. Thank you.

MR. HUDSON: All right. Thank you very much to the Vermont Association of Hospitals and Health Care Systems, and next on the schedule is to hear from Northwestern Medical Center, and before beginning I just want to note that we are somewhat behind schedule. So, if we can have a relatively restrained questioning

from both the Board and the Health Care Authority, there's a, you know, there is a possibility of issuing post-hearing questions and stuff, but it would be good to keep things moving so we can get to the public comment period that is required by statute. Go ahead.

MS. BOWEN: Well, thank you again. We're from Northwestern Medical Center, and I'll introduce myself. It's Jill Berry Bowen, the CEO. Also that's going to be speaking is Jane Catton who is our Chief Nursing Officer and Chief Operating Officer. Dr. Greg Brophey, ophthalmologist, will be speaking and Chris Hickey, who is our Chief Financial Officer. I also want to mention we've got board members here. We've got leaders from our hospital. We have the mayor of our city. We have business leaders and physicians with us today as well.

As you know, Northwestern Medical Center is a not-for-profit, mission-driven hospital dedicated to serving our community by providing high-quality care in a setting with providers who patients know and trust. We were recently recognized as a top 100 rural and community hospital in the United States based on criteria of quality, satisfaction, cost containment, and productivity.

As you know already, we're passionate about

providing services to the public, their need, and we're a leading example of containing costs and ensuring the provision of high-quality health services and resources for all Vermonters. We've been very committed to building collaborative, transparent relationships and partnerships with all of our providers across our community. We're committed to the work, and we're also talking about the work today that we do every day, and we're more efficient at it every single day.

We've talked about the big blue "H" on the road signs in these meetings before, and it doesn't stand for a hospital in our community. It stands for a community focus on health with a hospital facilitating community connectedness and care coordination, a vision that the Green Mountain Care Board has sponsored with us and lauded.

We're a leader in health care reform. Vermont has chosen to operate its health care system in a manner that minimizes competition and supports a highly regulated system. Vermont is like no other state with a revenue cap for hospitals. Competition is truly understood when the rules for all are the same.

Hospitals are subject to significant oversight and are heavily regulated. A for-profit ambulatory surgery center would not be subject to these regulations or any

oversight. Simply said, this is not level competition. The ambulatory surgery center will not be accountable to the State. No license or quality measure reporting is required, nor will the ASC be subject to State patient safety and quality assurance laws. The State has no authority to oversee or regulate the ASC. There are no State laws that govern the ASC's operation, and the Green Mountain Care Board has no authority to regulate the entity except through imposing some conditions through the CON, if issued.

Unlike NMC and other hospitals, we pay an annual provider tax, and this revenue goes to support medical assistance programs and is subject to the budget oversight of the Green Mountain Care Board, and the ASC will be operating without any financial obligations to support medical assistance programs or budget oversight from the State. Unless the Green Mountain Care Board imposes reporting requirements or net patient revenue limits, the ASC would operate completely outside of State scrutiny if granted a CON. The ASC will be able to add procedures as they wish, no limitations and no caps.

As you know, NMC is at the table with health care reform. We're focused on getting the health care coster to invest in coordinating evidence-based primary

prevention efforts in our community and now across the State. We're collaborating with the State health care community and our local community to promote the development of an integrated health care delivery system which will manage the population's health collectively throughout one coordinated model.

Our efforts have been directed toward establishing a unified, wholistic approach to patient care, accepting responsibility and accepting risk for the health of the whole patient rather than getting paid per service. In lieu of the all-payer waiver money that we thought we were hoping that would come in, hospitals are now being asked to fund the Accountable Care Organization to support this transformation, and we're at the table.

In our community we've been committed to developing collaborative partnerships. We've established a Regional Clinical Performance Council that's brought all of the community providers together in social agencies across our health service area to make sure that patients have one community plan that is well-coordinated across the system, making sure that every patient gets the care they need in the most appropriate setting. We're focused on making sure a patient can access services efficiently on one

integrated care plan.

From that we've even stepped it up to develop a Unified Community Collaborative. It's actually a governance board that has oversight to set priorities for clinical and community care integrations made up of community leaders as we advance our population health, work through social determinants, money for housing, for transportation, for medication, for food, and support each individual with community case management.

We're funding primary prevention in Franklin and Grand Isle County through RiseVT, an organization dedicated to the community efforts to embrace healthier life styles, to improve the quality of life. If we really want to bend the cost curve, this is where we need to be to stop chronic conditions, to lower health care and providing education and environmental changes that facilitate access to healthier choices. That's the true accomplishment goals for the Unified Community Collaborative.

On the State level, I think you already know this, but we're participating in the Next Gen Pilot as one of four hospitals, and we're really working on capitated payments, and we're treating collectively 30,000 patients in this pilot, and we're at risk in two ways. One is operating with capitated dollars to ensure care

for the population served, and, for two, the care provided to these patients at sites not at one of the four participating providers for fee-for-service payments.

NMC, in collaboration with this Board and other Vermont hospitals, were devoting substantial time and resources to reform health care payment, culminating in our participation in the population health all-payer waiver system. We have also proactively signed up for risk for Medicare and Medicaid and commercial, and if we look at this annualized, that's $2.6 million for our organization for risk. We're active players. We're taking risk for all populations and payments.

The ambulatory surgery center is using a largely fee-for-service model which is outdated and contrary to these efforts to reform our health care system. Establishing this fee-for-service entity will create silos in our system which have invested significantly in collaboration and patient care coordination. It would be a step backward for Vermont health care reform to grant an unregulated fee-for-service provider a CON in the face of plenty of capacity throughout Northwestern Vermont as closely regulated nonprofit hospitals.

So funneling dollars into for-profit investors at

the ASC does not meet community need, and taking the funds away from hospitals undermines our efforts to address community health needs assessment that you've already heard and creating an integrated community health system. We are leading and investing in an effort to transform this health care delivery system.

There are so many things that are actively in progress to make the necessary shift from fee-for-service to value-based payer. These efforts will culminate in a readiness to survive in an integrated, patient-centered, capitated payment system. From an integrated medical record to community case management of the population, this transformation centers on hospital leadership, our investment, and our action. We need to stay laser focused on these goals without needless distractions in order to deliver results for Vermont and the requirements of the all-payer waiver with the federal government.

Locally and regionally, we are planning and integrating very differently. This is about caring for our community. We've been an accountable community health initiative. That was what we were charged to do, and I am so proud of our engaged community working together like no other to do what is best for the population with quality and cost effectiveness at the

core of our patient-centered work.

An ASC does not fit this model for transformation. Managing the population under a capitated system which hospitals and community partners with one ACO or VCO are partnering with you, the Green Mountain Care Board, to develop and to execute. And now Jane will take us further.

MS. CATTON: Thank you. Thank you all for allowing me to speak today. My name is Jane Catton. I'm the Chief Operating Officer and Chief Nursing Officer at Northwestern Medical Center, and I'd like to focus on three key areas this afternoon, and that is our efficiency efforts, our surgery capacity, and our waiting times.

So, with regard to our efficiency efforts, NMC has been working diligently on efficiencies particularly since 2009. If you recall, the Green Mountain Care Board has seen our work with our ED utilization pilot project to reduce avoidable visits in our emergency room. Our focus is on the right care, the right setting, decreasing costs, connecting our patients to their medical home, and coordinating care to reduce these avoidable visits.

Now NMC is actively making changes in our operating and procedure room processes in an effort to

realize further efficiencies and enhance the patient experience. In partnership with our physicians, we engaged a consultant to assess and recommend alternative OR and procedure room processes in relation to the function of an ambulatory surgery center. Our processes for efficiency were commended.

We sent staff to best practice settings to see how other providers deal with OR and procedural inefficiencies, and with this experience NMC has evaluated and redefined how we prepare our facilities, staffing patients, and guide our patients through the outpatient operating room system. We've relocated some appropriate procedures to ensure treatment in appropriate settings, reevaluated our current staffing work flows, explored plant updates to our clinical protocols for conscious sedation to improve throughput and made other improvements as well.

We've recently conducted a pilot of new processes and protocols in our eye surgery operations. We were able to reduce overall operating case time by one-and-a-half to two hours mainly by decreasing procedure turnaround times and more efficiently managing our OR room processes and patient work flows. At the same time, we were able to meet or exceed all of our quality measures and outcomes including maintaining

very high patient satisfaction scores greater than 94 percent in our surgical services arena, 99 percent in our provider practices, and we've won national awards for patient satisfaction at our hospital as well. During our pilot phase as well, we had no infections, no adverse events, and no patients returning to our OR due to increased efficiencies, which oftentimes may be a concern.

We anticipate that these changes will further increase our available OR and procedure room capacity and will generate approximately $400,000 in savings, and this is extrapolated only over one provider case type. Overall, in our OR systems we have a .42 percent surgical site infection rate against a 1.1 national average. We'll be piloting further changes for our colonoscopy procedures starting in May through the end of June.

With regard to surgical capacity, there's no need for the additional operating room and procedure space that the Green Mountain Surgery Center plans to build. We're only 24 miles away from the proposed site, and the drive time is estimated at 30 minutes. With regard to our surgical capacity, we have five OR's, four procedure rooms, two endoscopy suites. Currently, four of the five OR's are staffed and available from 7:30

a.m. to 3:00 p.m. Monday through Friday, and the other OR is staffed available for an extra two hours from 7:30 a.m. to 5:00 p.m. Monday through Friday. Additionally, the four procedure rooms and two endoscopy suites are available from 8:00 a.m. to 4:00 p.m. five days a week, and we have on-call coverage, and we're fully staffed every day.

Our OR's operate at about 50 percent of available capacity, and our procedure rooms used at about 13 percent capacity. NMC can easily expand its OR and procedure room hours and has offered to make these facilities available to providers on Saturdays if they need to operate then depending on their practices' and their patients' needs. Our ambulatory unit consists of twelve private rooms and a five-bay eye room where we admit and provide pre- and post-care which offers great flexibility.

With regard to wait times, the Green Mountain Surgery Center has made much of so-called wait times for OR and procedure room space at hospitals. There's no standard for OR wait times, for hospital OR wait times, so it's unclear what the Applicant is alleging. Wait times is a term generally used and understood only in the context of getting an appointment with a provider.

If the Applicant is suggesting that patients are unable to schedule procedures or surgeries when they desire to have the surgeries done, we must reiterate that this is an issue that's downstream to NMC. Providers determine their practice schedules and may not be available because they've scheduled other patient surgeries, may be out of town or on vacation or not available to see patients in their practices.

NMC, however, has not received complaints from providers or patients about delays in scheduling. We involve our employed and independent providers in our surgical council which determines block times in our operating rooms. We work through that together as a team.

MR. HUDSON: Attorney Cramer, at this point, I think, because of --

MS. CRAMER: Let me just ask. Dr. Brophey is the one physician here to testify, and he took his whole afternoon off. Excuse me. So I think, given that he will be the only physician testifying in this procedure, that it would be worth two minutes on his experience with regard to the eye center and his current practice at NMC.

MR. HOGAN: I have no problem with that, but you have to realize this room is being used for

something else, and we were to be out by 3:30.

MS. CRAMER: I totally understand that, but in this instance for fairness, I think -- okay, thank you.

DR. BROPHEY: I'll be brief. Thanks for inviting us today to talk. I'm Dr. Brophey. I'm an ophthalmologist. I'm also the Executive Medical Director of Physician Services at the hospital. I'm also an examiner for the American Board of Ophthalmology.

I've had kind of a unique background. I've done training and work for my whole professional career in both surgery centers and in the hospital setting, and I've realized the benefits of both. Namely, we've talked a lot today about efficiency within the ambulatory surgical center setting, and I'm not here to argue that. There's also benefits to working in the hospital setting with staff support and giving patients a stronger sense of community in where they can proceed with their case.

One of the key central things we've worked on over the past year or two has been whether or not we can bring that sort of efficiency into the hospital setting, and, as Jane alluded to, there was a process whereby we looked exactly at how we were turning cases

over, how many minutes we were spending in between patient cases, where were our patients going from the moment they stepped in the door until the moment that they were discharged, and how we were utilizing our space and equipment.

We, after review of that data, we involved an entire multidisciplinary team of anesthesia, nurses, doctors, and staff and also involved our surgical council, our Surgical Advisory Committee, and discussed the game plan on how to improve efficiencies. The net result of that, as Jane alluded to, were certainly shorter turnaround times and case times and a shortening of my OR day. So, as before where I may have spent almost a full day in the operating room, I can then go to the office and see patients in the afternoon. I think this really did improve the patient experience at our hospital. We were able to maintain quality and provide a safe environment for our patients.

I've worked at NMC for almost ten years and done probably upwards of several thousand cases there. I have a zero percent infection rate, and, as Jane alluded to, my Press Ganey score is 99 percent. We're 99 percent on our scores. We're very proud of that.

I think this is all important because, the moment

we start to move volume away from hospitals and move patients away and move them away from the experience of our -- if we move patients out of the hospital, my fear is that nursing staff will not be exposed to the number and complexity of cases that we deal with. I think, also, when complications happen, and they do happen rarely, it's important for our operating room staff to anticipate what we might need. Also, after hours in the operating room, not in the ASC, but in the operating room, our staff has to be skilled and efficient, and they have to anticipate what I would need in order to take care of a patient after hours.

MR. HOGAN: Could someone in 30 seconds tell me. This is supposed to be a hearing about an application of a surgical center. Can you connect what you just told us to that? Because I'm missing it.

MS. BOWEN: Starting with what Greg just said?

MR. HOGAN: I don't care who answers.

MS. BOWEN: Well, I think what Greg was referring to is that --

MR. HOGAN: Not just Greg, all of your --

MS. BOWEN: Oh, I'm sorry. Oh, the whole thing?

MR. HOGAN: Yeah.

MS. BOWEN: Well, I think what we're trying to say is that the whole hospital's accountable. We have excess capacity in our OR's, in our infrastructure. Hold us accountable to an ambulatory surgery center like. We don't need additional infrastructure. We need to retool what we have, and, under our pressure to transform the health care delivery system, we are doing that amongst many other things to create an integrated system that can accept capitated payments. We've got the infrastructure. Let's retool it.

MR. HOGAN: So that was a great answer.

MR. HICKEY: Con, can I just add to that? Because part of my presentation was we make a million dollars on endoscopies. That's a fact. Don't deny that one bit. But that million dollars is invested in many, many services that the ambulatory surgery center will not be required to do or obligated to do, number one.

Number 2, we pay a provider tax. Mike mentioned it before. We pay $5.9 million in provider tax. If there was a provider tax applied to this service, they wouldn't be here. Their provider tax would be $1.5 million over the four-year period of their pro forma. They would go from a profit of $700,000 to a loss of

almost $900,000. Amy mentioned before that they're going to pay property taxes and they're going to pay income taxes on their profit. It would pale in comparison to what a provider tax would be.

MR. HOGAN: Appreciate it. Thank you.

MR. HUDSON: Thank you. And, at this point, I think the schedule is dictating that we move on to the statutorily required public comment period, unless there are -- okay. Thank you very much for talking to us today. So the first person we have on the list is Jane Evans. On deck is David Weissgold.

MS. HENKIN: Can I also add for the Board, the Board wants to hear every comment. We have a very short amount of time. We're limiting you to about two minutes or under. If you brought a written statement and cannot finish it in that time, you may submit it to us. We are also taking written comments.

MS. EVANS: Thank you. I'll speak quickly. I've heard throughout this hearing that UVM feels that their current system is effective and that there's no need to increase capacity, but I'm just a citizen, and my experience has been completely different from that. Last summer I hurt my back. The soonest the UVM Spine Center could get me in was four months later. By then my back actually felt better, thankfully, so I no

longer needed treatment. It's a personal experience. I'm currently waiting again at the UVM Center for just a simple knee injection. I have a bad knee, right? They told me, Oh, well, we know you need it, but you've got to wait at least a month to get it. That's a simple, little procedure.

So I think that there is a need. I understand what they're saying about if we, also, if we build the Green Mountain Surgery Center, that we would also need more doctors. That did make sense to me, and that there's just not enough of them in Vermont, period, but I think, if we had this beautiful new surgical center, more doctors would come to Vermont, and maybe that would solve some other problems like a lack of primary care physicians too. Who knows?

Another family personal experience, my husband Greg tore his ACL last spring in a ski accident. There was such a long waiting list to see a doctor at the UVM orthopedic center we decided to seek an independent physician who could get in him sooner. We found a doctor at Associates in Orthopedics. He was able to see him quickly. The other two reasons we chose his office is because we didn't like to go to hospitals. We kind of think they're gross. You know, you can get more sick in a hospital building. And, because of the

parking situation, it's always really hard to park. I know those are just silly reasons.

But, shortly after we had begun with Dr. Kaplan, UVM purchased his practice, so now there's no other choice left, and we like choice. And the experience of care, the quality of care after the purchase by UVM compared to before really declined. We were no longer able to call and get an appointment. Greg had to drive on his lunch hour to make an appointment. That's ridiculous. And then one day he was there when the UVM admin team was, had come in and taken over, and he felt completely kind of ignored as a patient. He felt like the quality of care had really decreased, that he didn't feel important.

All right. And then, lastly, we have had to take a loan out to pay for the surgery. We both have great jobs. My husband's an accountant, and it's because the facility fee was over $10,000. That's just one reason, but I don't think cost is the reason this should be approved. I think we need choice. That's what America's built on.

MR. HUDSON: Thank you. This is Dr. Weissgold, and after that Liz Gamache is on deck.

DR. WEISSGOLD: Thank you. My name is David Weissgold. I'm an ophthalmologist in community-based

practice in Chittenden County. I've been practicing here for 20 years. I want to thank Chris Oliver -- she's here somewhere -- not just for speaking but because, in her tenure in the operating rooms at Fletcher Allen and now UVMMC, she's done a great job, and things are definitely better there.

That being said, I take some issue with some of UVMMC's contentions about the operating room environment, particularly with respect to access and with respect to efficiency. So I can state unequivocally that the notion that, of all of the, I think, I think, 150 or so surgeons who operate in the operating rooms at UVMMC, the notion that nobody has complaints about access to the operating room is really, it's kind of silly. That's just not true. I've made I've lost count how many complaints over the years about inability to get into the operating room.

The thought that there's so much time available that surgeons can just call and request time and get in in a timely fashion simply isn't true. Despite the operating room open time reports that come out regularly, if I call the medical center to say, I've got a patient in my office with a retinal detachment. I need to get this patient in sometime this week. I don't have any patients to see in my office all

afternoon Tuesday afternoon. I have nobody to see all afternoon Thursday afternoon. If you really needed me to come some other time during the week, I could shuffle my schedule around. It's very, very rare that I get a response.

Lastly, I would just say that it's just not accurate that there's an average 24-minute turnaround in the operating room. Our turnarounds in my room range between 45 and 60 minutes. Thank you.

MR. HUDSON: Okay. Ms. Gamache, and on deck is Tim Smith.

MS. GAMACHE: Good afternoon. My name is Liz Gamache. I'm the Mayor of the City of St. Albans, a city with a population of 7,000 in the rural county of Franklin, Vermont. I'd like to share with you what my concerns are with regard to issuing the Certificate of Need and the impacts that it might have on our community. As a mayor, I look to building policies and setting priorities that reflect the needs of our community to build a stronger, healthier community, physical and mental health and well-being, economic vitality, and environmental well-being. We take a systems approach to serving the community.

Northwestern Medical Center, as a rural, community-based hospital of excellence, serves our

community members and delivers benefits to the individuals but also to the community at large. They know our community. They understand our community. They are a trusted partner for decades in our community.

They build the strength and foundation of the relationships within the community, and my fear is that, to issue a Certificate of Need to an unregulated, for-profit entity at the expense of system benefits will harm our rural, community-based hospital and impact its impact on our community in terms, not only of health care delivery, preventative, for example, the RiseVT program, the community-based, population-based approach, but also the impact the hospital has on our economy. A large employer, it fuels our local economy which is going through a transformation, and also the hospital's involvement on environmental issues that come up as we set policies within the city that all tie back to the health and well-being of our community.

So I ask you to consider the Certificate of Need if there are duplications of efforts that are unnecessary that benefit a for-profit entity at the expense of a community nonprofit hospital. Thank you.

MR. HOGAN: Thank you.

MR. HUDSON: So next up is Tim Smith. On

deck is Dr. K. Montague. Greetings, Mr. Smith.

MR. SMITH: Thank you. Thank you for your time. Rest assured, I will have no stats on infection rate or occupancy time. I'm looking more at the 30,000-foot level. My name is Tim Smith. I'm the Executive Director of Franklin County Industrial Development. I've been in the position for 17 years, born and raised in St. Albans. Our mission from a greater standpoint is the need to create an environment which is conducive to job creation, job retention, and capital investment.

And, over the history, our, the organization I belong to was created 45 years ago mainly due to the fact that St. Albans had a double-digit unemployment rate of 12 to 14 percent. This was due mainly to the fact that the decline of the railroad, automation of the dairy industry, and the loss of some value-added wood products. Over the 45 years, we've been able to pull together as a community, as a county, to grow the economy. Our unemployment rate now is 3.1 percent. During the Great Recession, we had the least job loss of any county in the state.

So we've made great strides, and making those strides is due to the fact that it's a whole aggregate approach, strong health care, strong downtown, strong

work force, strong education, strong infrastructure, and the hospital definitely goes to that infrastructure. So we've been able to build this over time with the help of all the communities in the county.

Just recently, we donated $10,000 to Northwest Medical to name a room after our long-time chair Bill Choffee, and, as we walked through the addition, we joked about how far that the health care has come. When my mother gave birth to my younger sister, we had to go around to the window and say hello and see the child because no one under twelve could go into the hospital. Also, she was in a room with two other people with a curtain, and so we had to deal with that.

But the three population bases that are growing in Vermont, Chittenden, Grand Isle, and Franklin County. We're continuing to grow. We have a strong economy. My fear is that, if we start to erode this, the hospital, it's only going to put us back to the start of where we were 45 years ago. So that's my concern.

MR. HUDSON: Thank you, sir. Dr. Montague. And on deck is John Casavant? Can't quite read it but --

DR. MONTAGNE: So Katy Montagne, a physician anesthesiologist at Northwestern Medical Center, but,

prior to that, I was a Public Health Nurse for the St. Albans Department, Vermont Department of Health. Mother and child as well of elderly parents. So speaking on a couple different fronts. I had a planned kind of speech, but I'll get to some of the points that kind of haven't been covered.

And we talk about access. Access for who? When I was going to medical school at University of Vermont, I'd often tell my cohorts, You need to get out of Chittenden County to experience Vermont. And so, when we talk about access, we're looking at access to people who can actually make it to Chittenden County for these, you know, lower cost, potential lower cost services.

So that leaves us kind of supporting the public health initiatives that are often covered by the reimbursable parts that support some of our less reimbursed to the extent of the cost of, like, maternity care, addiction specialties, and we've come leaps and bounds since I've left the public health field in 2007. We pretty much had no addiction coverage, and now, with the work of our hospital and our local health department, like our mayor has said, it's a community initiative, and that's at the heart of it, and I think a surgery center would just undermine

those efforts.

MR. HOGAN: Would you have a written statement?

DR. MONTAGNE: I can provide it, yeah.

MR. HOGAN: Would you?

MR. CASAVANT: Hi. I'm John Casavant. I live in St. Albans. I'm the son of a general practice physician and a nurse. My wife's a hospital clinician, and two of my sisters are. I've served twelve years in two different stints on the Northwestern Medical Center Board of Directors, a couple years as the president of the board. I'm also an insurance guy, so I think I'm as educated a person that's not involved in the system at all as anyone is. I think I understand pretty well.

I'm also a very libertarian guy and very pragmatic, so I'd love to sit here and say, you know, tell you stories about what the hospital looked like 40 years ago, and the fact that none of you guys would have been in this room 40 years ago and that I don't believe in the government intervention in the hospital arena, but that horse is out of the barn, as the Franklin County dairy farmers will tell you.

We live in a regulated state, and so to be talking about an unregulated organization coming in to provide kind of market pressures probably doesn't make sense.

I think we've already decided that we're going down the road of population health. We've built ACO's. You know, we've spent a lot of time on the blueprints. That's, that's wasted dollars now if we decide that we're going in a different direction.

So what I'd say is, The question isn't really about the surgery center. The question is, What direction are we going here in the State of Vermont? And, as I said, I think that horse is out of the barn. I think we've already made that decision. So it, really, it seems counterintuitive to me to be either having this conversation now, or, if we are, we've kind of got the cart in front of the horse because we've got to make a decision about what kind of system that we want. Thank you.

MR. HOGAN: And, as a board member, I take it that you paid close attention to Jill's budget.

MR. CASAVANT: Very close, yes.

MR. HUDSON: And next up is another NMC board member. This is Jake -- I can't read these names. And, after that, Dr. Larry -- I can't read it.

MR. HOLZSCHEITER: Good afternoon. My name is Jake Holzscheiter. I'm the President and CEO of AN Deringer in St. Albans, Vermont. We have about 100 Vermonters that work for us, almost all of them in

Franklin County. Our community hospital is really important to us, Northwestern Medical Center, and the care and the ability for it to thrive in our community is necessary, not just for the insured, but especially for the underserviced, the uninsured, and those that receive uncompensated care.

I do not feel that this application will provide the proposed cost reduction to our state health system and will instead have a very negative effect on our community that Northwestern Medical Center services. Especially with the current risk of the increased uncompensated care due to potential Medicare cuts, it's an unknown that we have to figure that will affect this system.

The needs of our community hospital to remain viable, I believe, is more important than the risk of the unlikely proposed cost reductions to our state health system. NMC has reduced their rates by 11 percent over the past two years despite the system they're in. As a business owner, I, too, would like to see the rates reduced. They're my second most expensive cost. But I do not want to see them reduced at the greater need of our community health system. Thank you.

MR. HUDSON: On deck we have Tom Dowling.

DR. SULLIVAN: Good afternoon. I'm Lowrey Sullivan. I'm an OB/GYN physician in St. Albans, and I've been there for about 18 years. I'm also the Chief Medical Officer at Northwestern Medical Center for the last five or six years. And others in the community have spoken very passionately about our hospital and the importance to the community and the work we're doing as an organization for preventative health care, improving the health and integration of health care in our community, and we often have many conversations about how we can extend that work we're doing in our community across the whole state. So we have very actively involved medical staff, actively involved board, and actively involved administrative staff.

I caution the acceptance of this Certificate of Need as setting a precedence that maybe it's -- we talked about one organization in Burlington and it will fit in in the structure in the population in Burlington, but what does that mean as we roll out across the rest of the population in the more rural areas of the state and the impact that might have? As Katy mentioned earlier, Burlington is one portion of the population of the state, but it really doesn't increase the access to most of the state, the majority of our patients.

So hospitals have been in Vermont, 14 hospitals, for decades, and we all have a similar fiscal responsibility but also have a social mission, and I am concerned that the surgery care center lacks both those parts, and both of those are really integral to what we do in our communities. So I would emphasize that it's really critical that any application of this sort really take into account that social mission of our organizations.

MR. HOGAN: Thank you.

MR. HUDSON: Next we have on the list is Mike Del Trecco. I assume that's a mistake. We've heard quite a bit from him already. So we'll move on to Robert McDowell, please, and on deck is Robert Holland.

DR. DOWLING: I'm not Robert McDowell, but I am Thomas Dowling, and I am a board-certified eye surgeon here practicing in Vermont and one of the owners of the ASC in South Burlington. This afternoon I've heard a number of reasons expressed in opposition to the CON by the hospitals, the same unsubstantiated reasons that were offered at the hearing back in 2006 in opposition to the ASC in South Burlington.

The hospitals predicted then that the ASC would be devastating to their revenues and bottom line. It seems clear enough to me that the prediction of

financial devastation was inaccurate, both in that the University Medical Center as well as Northwestern Medical Center have exceeded their revenue budget caps this year and have shown significant growth since our ASC has opened.

NMC has recently been granted a CON and presently has constructed an addition, an addition that includes 24,000 square feet of shelf space, empty, vacant space with no identified, no use identified on that application but was still granted a CON to build that.

University Health Center recently identified present health care needs including operating room shortages in Chittenden County in a CON filed shortly before the Green Mountain Surgery Center filed their CON. The University Health Center CON was retracted, however the unmet need identified and clearly illustrated in that CON has not vanished.

The independent doctors are the only competition the hospitals have. Competition is healthy. It spurs innovation and makes both sides better, and, if anyone would suggest that competition is a bad idea, please just give me one example of where competition hurts the consumer. Not all doctors want to work for a hospital.

This CON for an ambulatory surgery center is vital to the continued viability of the independent doctors

here in Vermont. I don't think that can be overstated. So I've asked the Board, Why shouldn't the independent doctors be given the same opportunity that the eye surgeons were given to compete? Why shouldn't the independent doctors be given the same opportunity to save patients, Medicare, Medicaid, and us taxpayers a significant amount of money?

We need our hospitals, but we need to make health care here in Vermont more affordable. For these reasons I strongly support this CON and urge the Board to approve the proposed ASC in Chittenden County, and I thank the Board for your time in consideration of this small but truly important venture.

MR. HUDSON: And I believe I've got Robert McDowell is next.

MR. McDOWELL: I'm much better looking.

MR. HUDSON: And Robert Holland is up next.

MR. McDOWELL: I'm Bob McDowell. I've been in Newport since 1981. I was, I came as a pathologist at the hospital, but I'm going to be very brief. During those years when I was at North Country Hospital, it was always helpful that there were two tertiary care centers that we could play off against the other, and I welcome a third, that, to put it, not a tertiary care center, but another provider who can,

group who can add to the, the mix, set them against each other.

My other concern is that we're now stuck with high copays, and, you know, we can talk about systems. What I'm talking about, you know, is a retiree whose wife is still on Blue Cross, and those high copays are killers. Thank you.

MR. HUDSON: Thank you, sir. Robert Holland is next, and on deck is Katharine Hikel.

DR. HOLLAND: My name is Dr. Holland. I'm an emergency physician, and I was, I wanted to briefly expand on a concept that I think Dr. Holmes mentioned which was called repurposing space, and I also wanted to, to bring some factors to put on the table that haven't been discussed today that I think it would be good for you to consider when you make your decision.

So, in terms of repurposing space, we're basically talking about six rooms, six part-time health care rooms, and those rooms happen to be both in hospitals and part of this new proposal. So let's think about it in terms of rooms, and I want to give you a piece of data that hasn't been mentioned that I think should be mentioned, and I think you've had some misleading information presented to you. Well, while the information was true, it is misleading.

The misleading piece of information has to do with the population growth in Chittenden County. So that's, it is true that it's a very small population growth, but, if you look at the average age of that population given that what's happening with the Baby Boomers coming through, that population is getting older, and that population is getting sicker.

At 2:00 a.m. Wednesday morning, I was working in the emergency room. I had two patients, one of them on a ventilator that needed an intensive care unit bed. I got on the phone. I called UVM Medical Center. I got the person who is in charge of transfer. The conversation was this, conversation was this: You can talk to the doctor. I'll tell you what he's going to say. We have no room for your patient. Our intensive care units are full, and we have 14 patients in the emergency room that are boarding, okay?

So I'm proposing that you should think about this in the larger system and not just this small six-bed thing and that repurposing six beds at UVM Medical Center for intensive care, for other inpatient services would have alleviated some of that problem, and the two patients that I had would have gotten more timely health care.

So I'm just saying, Broaden your vision. Think

about the interests of the people of Vermont and not the interests of the current health care providers.

MR. HUDSON: Thank you, sir. Next up is Katharine Hikel to be followed by Jake Holzscheiter.

DR. HIKEL: Thank you. I'll be quick. I've got kind of a good news, bad news. The bad news is I think the old model that everyone is so passionately defending kind of because it's what we know and what we're used to. I mean, I was trained there, you know? But it's changed, and to call this old model, to keep pushing the sort of depiction of this that it's nonprofit, you know, I think that's a little bit of a mistake, because, as you know, they depend very heavily on the for-profit world to keep their bond ratings up. That means operating margins. That means revenues.

So for-profit, you know, the definitions are a little bleary these days. Perhaps it may be time for a new model, whether it's for a nonprofit, and I'm sure it will be regulated despite that other kind of myth that we don't regulate hospital facilities. I think we do, and I think the other thing will be that it will be great to get some outcome data, long-term, short-term, from another model.

The other thing I was worried about was that, you know, I love St. Albans. My kid was born there, and

they said the patients from St. Albans don't go to Chittenden County. Well, why should patients in Chittenden County go up to St. Albans? You know what I'm saying? Even patients with family issues and transportation issues and money issues. It's a long haul to St. Albans. I know. I used to drive it.

To be sure, the one thing I want to watch further in the nonprofit model, overuse and overtreatment are things we are looking out for, and among the procedures that we have to look at, uterectomy -- let's call these things what they are. It's the 21st Century -- uterectomy, surgical birth, meniscus surgeries, these are all things that, you know, are in overuse -- okay.

The other thing is that maybe it's time to show these big, overbuilt hospitals that need their bond ratings to raise all that money to build all that stuff how to downsize. This may be the first way. Thank you very much.

MR. HUDSON: Jake Holzscheiter to be followed by Greg Marchildon. Oh, he already went? Okay. Greg Marchildon to be followed by Katy Bailey. Kathy Bailey, sorry.

MR. MARCHILDON: Good afternoon. My name is Greg Marchildon, and I'm the Executive Director of AARP Vermont. AARP Vermont represents about 140,000 people

in our state. AARP Vermont submitted a letter in support of the Certificate of Need application for the Green Mountain Surgery Center. AARP's support for this project is in line with our mission and a long history of striving for health care reform that will expand access and lower costs to Vermonters, particularly older ones. Excuse me.

As it becomes more and more difficult for older Vermonters to make it economically, we must, as a state, support projects that help bring down costs in all aspects of people's lives, and that includes health care. We believe that cost containment should be an explicit consideration in decisions relating to the distribution and allocation of health care resources, capital, technology, and personnel whereby innovation, efficiency, cost-effectiveness, and reasonable access to services are all encouraged.

Outpatient surgery has become an increasingly important part of the medical care in the United States over the last 30 years with the number of outpatient procedures rising dramatically since 1981. In 2011 more than 60 percent of all US surgeries were outpatient procedures compared to 19 percent in 1981. This is due in part because there is more convenience for patients than hospitals and getting them back home

more quickly as well as being less costly.

According to a 2014 study published in "Health Affairs", ambulatory surgery centers offer lower cost alternatives to hospitals as venues for outpatient surgeries. By analyzing survey data from the CDC, the study found that, on average, procedures performed by ASC's took about 25 percent less time than the same procedures performed at a hospital and with equal levels of patient satisfaction. The study's findings suggest that ASC's are an efficient way to meet future growth and demand for outpatient surgeries and can help fulfill the Affordable Care Act's goals of reducing costs while improving the quality for health care delivery.

Vermont is exceptional in many ways, however we should no longer remain exceptional in being the only state in the country that does not allow its citizens to access multiple specialty outpatient surgical care.

MR. HOGAN: Would you mind submitting that? Thank you.

MS. HENKIN: I have to also let everyone know that the next people that are using this room will be here momentarily if they're not waiting outside. We're going to have to continue this taking public comment next week. We'll take a few more very quickly, but we

will have to clear the room very quickly.

MS. LUNGE: Well, it's 4:15.

MR. HUDSON: Kathi Bailey was the next person called, so we can cap it at that. Or sorry. That's probably Kathi O'Reilly.

MS. O'REILLY: I waited for Kathy Bailey. She didn't show up. I'm sorry. It's my scribble. I will be very quick. Pressure's on. My name is Kathi O'Reilly. I'm the Director of Economic Development for the Town of Colchester. Colchester is pleased to be the home to some large and small medical and doctors' offices including UVM Medical Center's Fanny Allen campus and Colchester Family Practice.

We offer patients many services from doctors' office to rehabilitation. They employ hundreds of Vermonters in our community. Our medical community is and integral part of Colchester and the State's economic success. The proposed Green Mountain Surgical Center would employ 22 technicians, nurses, and office staff. They would be conveniently located at Exit 16, which is only 30 miles from the Canadian border.

Although I'm not qualified to speak on the analysis that you are being charged with today, I am charged with growing the economy and growing jobs in Colchester, the State, and our region, and we believe

that the Green, pardon me, the surgical center would bring high-quality jobs to our area, and we believe it is a good investment in the State. Thank you. I think I'm under two minutes.

MR. HUDSON: Thank you. We have quite a few to go, so we're not going to be able to fit them in today, but we will extend the public comment section into our next scheduled board meeting.

MS. HENKIN: There's already ten days follow the close of hearing, but I think we can keep this hearing open to take an hour's worth -- our executive director is here somewhere -- at the beginning of next week's meeting, which is on the 19th on Wednesday.

MR. HOGAN: You know, I've got to tell you that written comments in whatever length you want mean a whole lot more to us than a short two minutes. So feel free to send us what you've got, and we will read it.

MR. HUDSON: So, at this point, this hearing's going to be in recess, and we will be posting the details of how it reconvenes on the Green Mountain Care Board website.

(Whereupon at 4:15 p.m. the hearing was suspended.)

C E R T I F I C A T E

I, Sunnie Donath, RPR, do hereby certify that I recorded by stenographic means the public hearing Re: Docket Number GMCB-010-15con, at the Fourth Floor Boardroom, 133 State Street, Montpelier, Vermont, on April 13, 2017, beginning at 1:00 p.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 139 pages are a transcript of the stenographic notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Westminster, Vermont, this 19th day of April, 2017.

// Sunnie E. Donath