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 19, 2017
1:00 p.m.
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89 Main Street
Montpelier, Vermont

Day two of a public hearing held before the Green Mountain Care Board, at the Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on April 19, 2017, beginning at 1:00 p.m.

P R E S E N T

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I N D E X

MS. HOLMES: Welcome, everybody. It is Wednesday April 19th, and I'm going to call the board meeting of the Green Mountain Care Board to order, and we are today continuing our CON hearing on the Green Mountain Surgery Center, and, before I turn it over to Noel Hudson, who is our Hearing Officer, I want to express sincere thanks to everybody. We've been getting many, many public comments, and we very much appreciate all the time and effort that people took to send us written comments and just wanted to say I've read through all of them so far, and I'll be rereading them again, but I just want to thank everybody for that. So, Noel, I will turn it over to you.

MR. HUDSON: All right. Good afternoon, everybody. Thanks for coming. This is a continuation of the hearing begun on April 13th. If we could ask everyone to turn off all cell phones at this time. It is April 19th 2017. This is a continuation of a hearing in the matter of Green Mountain Surgery Center, Docket Number GMCB-010-15con.

At the first portion of this hearing conducted last week on April 13th, some time constraints precluded hearing testimony from all of the present witnesses and from finishing the public comment period, and, accordingly, the Board has added this additional

hearing time to complete the witness testimony and the public comment period. 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.

Today's witnesses were present at the hearing on April 13th and were duly sworn in by the court reporter at that time. The order of business today is, first, we will be hearing from Christopher Hickey, the Senior Vice President and Chief Financial Officer of Northwestern Medical Center, then Dr. Elizabeth Wennar Rosenberg on behalf of ACTD, the Applicant, and then finally a conclusion portion by Amy Cooper, a principal of ACTD, and then followed by the public comment period.

For people who are coming in, please sign up to speak at the public comment period. Anyone who was here at the April 13th portion of the hearing and signed up at that time will be called first. We, depending on the volume of commenters, we may need to impose a two-minute time limit, but we have plenty of time blocked off today to hear any public comments that need to come in, and we look forward to hearing from all of you.

So, at this point, I'd like to call to the stand Mr. Christopher Hickey.

MR. HICKEY: Thanks for the opportunity to just finish what I had prepared for last week. I know that Jill and Jane and Dr. Brophey gave you a lot of information, but we just wanted to follow up on a couple of specific points, I think, that are a little bit more data-related.

The first one is we want to talk a little bit about the impact of the Vermont Eye Surgery and Laser Center on us. I think there was some questions asked in relationship to that. Since the eye center opened, we estimate that, on an annual basis, we lose about 250 patients that seek surgical services at the eye center rather than at NMC. Because the proposed surgery center is multispecialty and, if granted a CON, will be unlimited in the types of services it offers, the number of services siphoned away from NMC by the Green Mountain Surgery Center will increase exponentially over the effects of the eye center. So I think it needs to be taken in context.

There was some discussion in relationship to payer mix, because I think this is a critical aspect and a significant impact to us as an organization. When the eye center opened and entered the market, we saw a

sharp contrast in the types of cases that were moved to the eye center versus those that continued to be treated at NMC.

We have one particular physician who does care at our facility but also much of his work at the eye center. Since he has left in 2016, 95 percent of the cases that he does in our facility are done by governmental payer, are governmental payer individuals, either Medicare or Medicaid. Almost all of his higher paid, commercially insured cases are taken down to the eye center. A significant impact to us, for sure.

If this payer mix is applied to all surgical services offered by NMC, it will become increasingly difficult for NMC to provide critical service to the community such as emergency room service, urgent care, our birthing center, comprehensive pain and addiction services, and population health services, those things that we're able to do as we -- I think, when I talked last week, we do make money on those services that potentially would be lost down at the surgery center.

There was, in the presentation provided by the Applicant, the Green Mountain Surgery Center had estimated that they will collect only 53 percent of what we collect in aggregate, 50 percent for some of the payers, 56 percent of some of the other payers. It

aggregates out to about 53 percent.

Although we don't know all the specific procedures that the Applicant plans to offer, we can say that, based on our average actual reimbursement per case for those that we do know we may lose, that the Green Mountain Surgery Center will likely collect 80 percent of what we currently collect, a stark difference between what was originally projected. This means the $5.5 million that they, in savings to the system that the Applicant estimates would really be around one-and-a-half million dollars in savings to the system, a pretty significant difference.

I want to talk a little bit about the whole issue associated with taking on risk and payment reform, because I think that's a critical part of the decision that you have to make. NMC is participating in the Vermont Medicaid Next Gen Payment Pilot which has put the services provided to nearly 30,000 Medicaid enrollees at risk. Payments are based on a per member per month payment for all services provided to these patients. Services that continue to be paid on a fee-for-service such as those that the Green Mountain Surgery Center would do will be taken out of that per member per month budget.

This will adversely affect the success of managing

the costs of these patients of the overall health care system. This issue will only become increasingly critical as it is estimated that the 30,000 lives that will grow to an estimated 167,000 lives next year as additional hospitals and insurers grow this initiative to its ultimate goal, which is an all-payer model.

I want to mention a little bit about the shelf space since it was mentioned. As you know, you approved a Certificate of Need to allow NMC to make significant changes to our facility through our Master Facilities Plan. The hospital was allowed to construct a second-floor shelf space to our new medical office building. The purpose of this space is to help address the crisis in addiction, mental health, and substance abuse in our community and was never intended to provide outpatient surgical services. Therefore, the establishment of the ASC will not obviate the need to finish this space. I think that was mentioned at one of the, at the hearing last week.

It is important to note that 50 percent of the shelf space project is being funded with hospital revenue that has been generated over the years by services like those that may be diverted to the Green Mountain Surgery Center. This is a perfect example of how those funds, rather than going into an investor's

pocket, are being reinvested to meet critical needs of the community.

As another example of NMC working with partners to benefit patients in our community, NMC is currently working closely with BAART to find space on our campus to help them temporarily as they find permanent space for the local Suboxone clinic. Again, I think what I'm trying to make sure I emphasize is that partnering and collaboration with the community.

I'm going to summarize and conclude on one point, and it's really circling back to what Jill said when she first sat in front of you last week. We're not opposed to competition. Competition is a good thing, And I think that's the primary point that the Applicant is trying to make. The problem is it must be on a level playing field. Clearly, this is not a level playing field.

They will not be subject to a provider tax. They will not be subject to budget oversight. They will not be subject to a net patient revenue cap. They won't have all the costs associated with running a 24-hour, 7-day-a-week, 365-day-a-year facility, and the list can go on in terms of the regulatory oversight that they would not be subject to. Thank you for the time to point out those few issues, and glad to answer any

questions.

MS. LUNGE: I don't have any questions.

MR. HOGAN: No, I think we're here to listen today. Yeah, thank you.

MR. HICKEY: Okay, all right. Thanks.

MR. HUDSON: Does the HCA have any questions?

MS. SHAW: I believe we do. I have a question, just a procedural question first. Are we, is, are the Board and we asking NMC questions on all of its presentation or just on the testimony that's being given today?

MR. HUDSON: Do you have questions for NMC on other testimony?

MS. SHAW: We have a few, but I just wanted to clarify what the, what the plan was for this part of the hearing.

MR. HUDSON: Okay. I'm not sure if we have -- do we have every --

ATTORNEY CRAMER: We have our witnesses, yes. Jill and Jane are here.

MR. HUDSON: If we can keep that questioning period limited to five minutes, I'll allow it.

MS. SHAW: Sure. Do you want us to do that now or --

MR. HUDSON: If you have questions for Mr.

Hickey, why don't you ask him first since he's here?

MS. SHAW: Okay. I guess I'll direct our questions to whoever can best answer them. So, first off, I'm wondering if any of the providers at NMC receive incentives related to the volume of care that they provide, payment incentives.

MR. HICKEY: That's a very good question. Right now we employee a fair amount of physicians. Some of those contracts have incentive for production. It's actually something that we are in the process of trying to grapple with the difference between a capitated arrangement and a, you know, methodology to reimburse our doctors. We just moved a significant number of our physicians to a newer model that makes less emphasis in relationship to incentive compensation, but, yes, right now we do do that.

MS. SHAW: And so, in follow-up to that, can you explain a little bit further how, under a capitated payment system, NMC would benefit from retaining these services versus having them at a potentially lower cost setting?

MR. HICKEY: Yeah, absolutely. I think, you know, the primary issue is how much whoever is taking the risk must pay to a nonrisk-bearing entity. So I think the issue here is that we're taking the risk,

we're assuming all financial responsibility for that population for that per member per month amount. We still are going to have to take that money and pay that out to fee-for-service type providers such as the ambulatory surgery center.

So they really have no risk, no responsibility to be able to control that other than a contract that they might have with us. So it will be a payment that gets made out of the Accountable Care Organization specifically to the provider that provides the service.

MS. SHAW: So, just to clarify a little bit further, under, so, in the example that somebody is getting a necessary procedure done and they were either going to get it at NMC or at a lower cost setting, I guess I'm just confused at how, how it would hurt the hospital to have the lower, to pay out less for the same procedure than it would otherwise.

MR. HICKEY: Yeah. No. The reason is is because, as we pay additional money out to nonrisk-bearing entities, that's less revenue that's in our system to cover those individuals that do come and provide services to us. I mean, one of the things you don't want to have happen is that everything gets paid out on a fee-for-service basis because it narrows the amount of revenue that's there to take care of the

individuals that continue to receive services at the hospital.

MS. SHAW: And can you clarify how you expect your payer mix to be affected by the ASC and explain what evidence you have to support your estimate?

MR. HICKEY: Well, that goes back to the point that I made earlier in relationship to payer mix for that we saw. I mean, our best estimate is that we, we believe we will see the same sort of payer mix change that we saw when the eye center went into place, which was that the majority of the higher paid commercially insured payers will move to the ambulatory surgery center and we will be left to care for the, the larger component of Medicare and Medicaid.

The information that I provided here, that, that's actual information for 2016. The individual who does care both at our facility and at the eye center, 95 percent of the cases he does in our facility are governmental payers, Medicare or Medicaid. That means 5 percent of his business in our institution is commercially insured, higher paid commercially insured. We expect the same thing to happen because it's in their best interests to take the higher paying of the cases at, as an ambulatory surgery center. Anybody would do that if they were, if that was them. The

difficulty is what's left for the hospital to be able to treat and be paid for.

MS. KUIPER: Do you know if the eye center accepts Medicaid at all?

MR. HICKEY: I believe they do, but I'm not positive.

MS. KUIPER: I just have one more question. I want to get a little more on your thoughts of -- am I correct in understanding that one of your arguments against the center is that it will take away from your revenue; is that fair?

MR. HICKEY: That's absolutely fair.

MS. KUIPER: So what's the, what's kind of the limit of that argument? You also mentioned that there isn't a fair playing field with them. So let's say there was a pharmaceutical remedy for something that's currently, that we currently provide surgery for and so a patient could take a pill and it would be much less burdensome to them than getting surgery. We obviously wouldn't say we won't let them have access to pills as, as a, as a remedy, even though there's a lot of arguments that a pharmaceutical company isn't on the same playing field or that might be better use of than giving money to pharmaceutical companies.

So what's the limit of the argument that decisions

should be made on the basis of making sure that the hospital keeps the revenue that they're used to getting?

MR. HICKEY: Well, again, I think that goes back to the issue of system and the importance of the system. As you move services that are more profitable -- and I don't think anybody would deny. We don't deny that the services that would be moved are more profitable -- that's going to siphon profit away from the organization. That's going to make it increasingly difficult for the organization to continue to provide the critical services to the community that may not be funded, that might not be appropriately funded. I mentioned some of them in my testimony just a few minutes ago.

The whole crisis right now that exists within mental health, pain and addiction, substance abuse is a perfect example of a, of something that's not necessarily appropriately funded in an even way across the state, but it would still be the expectation that an organization like the hospital would still have to continue to contend and other hospitals would have to contend with that.

You know, and it's not something that they would have to contend to because their scope is so narrow.

You know, it's, it's really an issue associated with -- yeah, and I think, from a capacity perspective, we clearly have, you know, the capacity to treat these patients. So it's important to maintain and to use that capacity, especially from a, from across the system, you know, make sure you use the capacity to its fullest extent.

MR. HUDSON: And I've been notified by Board members that there are some follow-up questions.

MR. HOGAN: Well, it's a clarification question.

MR. HICKEY: Oh, absolutely.

MR. HOGAN: How do you connect your testimony to what guides us, the law and HRAP?

MR. HICKEY: You know, I think the issue is -- and, you know, Jeff and Mike are probably better to talk to this than I am from VAHHS. I think they talk specifically about the seven criteria that you need to make and the fact that, you know, from their testimony's perspective, four of the criteria was not met. I think capacity was a significant component of that, you know, of that argument, and, you know, I think, you know, our issue comes back to -- I'm talking to you about impact on our organization and the potential impact on the system for the cost of

providing care.

MS. HOLMES: Just, sorry, one follow-up question. You mentioned the surgery center estimated it would, 53 percent of what they would collect of what you typically collect, and you were saying that your estimate would be closer to 80 percent?

MR. HICKEY: Correct.

MS. HOLMES: Can you just walk me through the assumptions behind that modeling?

MR. HICKEY: Yeah, absolutely. I mean, you know, it's, what I did is I took their, their calculations, because it's in their application, and, you know, don't hold me to the exact number, but I think their average reimbursement per case was $1,142 or similar to that. That's just simply taking their net patient revenue and dividing it by the cases that they, you know, are estimating that they would produce.

I went to our system, and I tried to take, you know, what we thought were similar cases and calculate a net revenue per, for those particular cases. In particular, I focused on the endoscopy cases, and ours came to $1,400 and change, a difference of -- and that qualified a difference.

Their calculations would have said that we would have gotten almost $2,200 per claim for those

particular, for similar cases, and, again, they were using national data. So I don't argue their 50 to 56 percent. They're using national data to come up with that calculation, and we all know the differences, you know, from a national perspective versus a state perspective could be significant.

MS. HOLMES: Okay, thank you.

MR. HICKEY: Sure.

MS. LUNGE: I'm still good.

MS. KUIPER: I think we're finished. Thank you.

MR. HUDSON: HCA is happy? Okay.

MR. HICKEY: Thanks for the opportunity.

MR. HUDSON: Next on the agenda we have Dr. Elizabeth Wennar Rosenberg on behalf of ACTD, the Surgery Center Applicant.

DR. ROSENBERG: I think that -- I think you're being handed out, because I originally submitted my testimony prior to coming, and, afterwards, I decided that, while I want to stick to some of that, that I realize that my original testimony was really focused on more of a health policy approach to this initiative, and I realized after the previous session that maybe a little bit more focus and some more factual, bulleted things that I could talk to you about

might be a little more helpful to you.

In addition to that, I, too, I heard that you're very data-driven and you like data. I come from a background where data is pretty much what you live and die by, and, while I like that, I'm going to tell you just, if I could very quickly, a very short story that a professor told me when I was leaving to make a point to me, because I was so focused on data, which is very important in making good decisions, but he said to me, Beth, this is a little bit like -- think of it this way.

I'm sitting on this side, and I say to you, What do you mean, you don't believe in this? Okay? You understand you're going to go to hell because you don't believe in this? And you say back, Prove it to me. And then the other person says to you, Beth, there's no such thing as hell, and you say, Prove it to me. So I sort of feel like I'm sitting in the same position again of, Prove it to me, and I get that. I do get it.

So what I'm going to do today is walk you through some very factual things, but I'm going to start with a little bit for -- most of you don't know me. Many of you do. Mr. Hogan probably knows me. I think we've been around quite a while. We may be the historical whatever in this room, but I'd rather refer to us as

historians. But I have resided everywhere from St. Albans to Bennington, and I've worked as a, on the payer side. I've worked on the provider side. I've been a consumer. I have been a business owner. So I feel like I've worked my way down around 7 first.

I, I have a long background of trying to -- I really do try to do the right thing, and when I was asked to come here, I want you to understand I came here because I really am about good policy in Vermont. I recently moved to Saratoga Springs, New York. I still access all of my care in Vermont, predominantly in Chittenden County, although, I must be honest, I do occasionally meander down to that place in Hanover, New Hampshire.

But, having said that, I want to just see if I can walk you through, and I do appreciate some of the questions that are being asked, and I'm going to end. Because what I do today now is volunteer my time as an advocate to try and help people navigate through the system, because that's where we're at. I did provide Susan with my bullets, so I think you may have those in front of you. I have my clock, too, so I'm watching. You tell me if you want me, how you want me to amend my original testimony. Do you want me to amend it, have this stand alone? I can do whatever your pleasure is.

MS. HENKIN: Just, if you can move through it quickly, that would be good.

DR. ROSENBERG: Okay, all right. And I also brought some minor reading material which is everything from the loosest, which the header is about how much you save, to very academic literature here that supports specific kinds of things being done in ambulatory surgery centers. So, having said that, I'm nearsighted, so I'm going to take my glasses off so that I can go through this. I want to try and just -- because I've heard this for so many years. For 25 to 30 years, I've heard that Vermont is a nonprofit state. We all about nonprofit. That's who we are.

Now, my definition of nonprofit is 501(c)(3) just from a pure IRS standpoint. Used to be, in the State of Vermont, there was a status you could get that was called nonprofit taxable, and I don't believe that exists any longer. Didn't matter to the feds, though. You still paid taxes. So I just want to briefly talk about that, because the reality of the situation is that, when you're talking about physicians that are what we call independent, they're really self-employed. There are mental health providers throughout the state. There are dentists throughout the state. There are a broad variety of social workers and other health care

providers that all are independent and, therefore, by definition, are for-profit.

I would say we really need to stop talking about, We're closed for business. I understand what they're trying to say, but the reality of the situation is we are very dependent on many entities that could be classified as for-profit. So we need to stop saying we're not open for business, and if we don't want for-profit insurance companies in here that are publicly traded, that's fine, but to the last of my knowledge, I don't see many physicians in Vermont or mental health providers or dentists that are publicly traded. They are not. They aren't for-profit, okay?

Number 2, from a payer perspective -- and I, and I'm not representing any particular payer here. I have worked for two in the state. I worked -- I was the first VP administrator to come to Vermont and open MVP in Burlington and Upstate New York. I have some difficulty, to tell you the truth, because for years -- and I was very involved in the beginning where we were at risk and we had very significant risk with many of the payers throughout the state combined through PHO's at the time. Those have now gone by the wayside, and now we've moved on to something called ACO.

In the prospect of where you're dealing with

providers in the state, physicians are very well -- you negotiate based on -- the contracts are fee schedules, fee-for-service, or we may do occasionally some mini-caps or something historically.

But I yet, to date, have ever been successful at sitting in front of a hospital -- and I'm a fairly good negotiator -- and been able to negotiate with them anything except discount off charges. I, I've never been able to negotiate with any other type of provider as it relates to charges. They're irrelevant in this day and age for the most part, but not here.

So, you know, I understand where we're going, but we're not there yet, and I'm hearing a lot of people talk about where we're going to be. That remains to be seen, whether we're going to get there. I'd love to see us get to global budgets again, but we're not there yet. So we're still, from a payer perspective, if I were still sitting at the table, I would still have to be negotiating discount off charges.

The other thing that, that I wanted to talk to you was about Medicaid participation. I heard a question posed about, Was this center going to require all of their physicians to accept Medicaid? I agree that's very important, but I've been very involved with many medical staffs throughout the state, and I have never

seen any hospital require that, in order to be on the medical staff, that you will participate in Medicaid.

Having said that, the PHO's in many cases used to do that. As Physician-Hospital Organizations, they would say to their participating providers, If you want to participate, you will accept all, and so PHO's did do that in some instances, but I have, to date, I have no knowledge of any hospital that requires, in order to be on their medical staff, that you must accept Medicaid. I think, I think that's a -- I think it's a very important thing, and it should probably be asked that anybody on a medical staff should accept Medicaid. They should accept everybody with the exception, I'm going to have to say, of pediatrics, because you have to be very sensitive to them in terms of accepting Medicaid too much.

Now I'm going to get to something that's probably a little close to my heart. I'm hoping that I don't, because I did spend a lot of years there and have been very committed to this particular organization, but I have to talk about Franklin County and about Northwestern. I have always found in all the years that I was there that the physicians were extremely loyal to that facility, very loyal. There is very rare would you hear of any physician thinking about leaving

that hospital, at least in my history there, and going to Chittenden County to provide services.

One, it's inefficient to travel 30 or 28 miles one way and 30 or 28 miles back. Two, it just is disloyal to come into the community, be on the medical staff, and then say you're going to take your patients to Burlington, and the patients tend to follow the physician. They don't go searching in Burlington if they've got a physician on the medical staff that they're happy with in Franklin County at Northwestern. They stay there, and I would say that my sense would be, my opinion is they will stay there. Those physicians are not going to be doing their cases at this ambulatory surgery center.

Then I heard -- and this is just brief -- I heard something about nurses the other day at -- I'm still saying Fletcher Allen. Excuse me. I know it's University of Vermont Medical Center. But I heard something about nurses and high satisfaction, and that's probably true for the most part, but I've had ample opportunity, having been a nurse and speaking with nurses there, that they've told me that there is no other choice for them if they want to be in an acute care setting, that there's no place else for them to go.

Their homes are in Chittenden County, their children are in school there, and if they want to practice in a hospital in an acute care setting, whether it's surgery or whether it's in the ER or whatever, that's where they've got to practice. They have no choice.

Now I'm going to get to the issue that has to do with refining. I'm going to ask you just to open your mind a little bit, because this is really about -- you're calling it Certificate of Need. I come from a background where we sort of changed it to Determination of Need, which is really the same thing, essentially.

Capacity is an interesting thing, because I would -- I'm going to provide you with some examples. I have permission to do this, and I can provide you with the documentation of the permission. But think of capacity in this way. This is an academic medical center with, with interns, residents, students. They're learning, okay? I admit they need to learn on someone, but this is -- I'm going to give you an actual couple of cases in hospital outpatient that occurred there, and I was there as a patient advocate with the individuals, and I have permission from them.

One individual was brought in premedicated, in the holding bay, had signed -- there is an authorization

with very small type in it in any academic medical center you go into that, somewhere buried down in there, it says you've just entered into a teaching facility and some of your care may be provided by interns, residents, or whatever.

A large share of people have no idea that that's the case. Yes, they know it's a teaching, but they don't think of that because the doctor they've been seeing is not that resident or that intern that walks in and says, Hello, I'm Dr. So-and-so, okay?

MS. HENKIN: I'm just asking you to get to the point that you have relevant to this case.

DR. ROSENBERG: I'm going to get to it. So this is what happens, okay? The patient was premedicated, had signed and had initialed saying, No, I do not want a resident or intern doing my surgery; I am willing to have them observe, and initialed that and struck it out. About 45 minutes into after being medicated, the physician comes tearing into the room and says, What is this? And the patient says, What is what?

And I said, Let me read it, because he's been medicated, so let me just read it to him. I said, Oh, he's saying no. He's saying it's okay for residents, interns to observe but not to perform his surgery. And

she backed up and she said, Absolutely not. You are in a teaching hospital. They are going to be doing your surgery with me.

And his point was, Well, wait, I don't want -- I want you. I've been seeing you, and I want you to perform the surgery. And her point was, No, part of my team, you came into this teaching hospital. This is how it occurs. So the patient said, I don't feel like I have a choice at this point. So the surgery did take place, and when it was over, my recommendation was -- I do not believe in litigating, okay? I understand we have some attorneys in the room, but I believe in learning, and so I went down to the patient advocate's office, and they were very gracious and they were very helpful, and it became documented, and they worked with us on it, and we used it as a learning experience in terms of things. So that was it.

The second one was a very similar situation, but it was for a colonoscopy, okay? I just need for you --

MR. HUDSON: I think we probably don't need to duplicate that story.

DR. ROSENBERG: I don't need to duplicate it, but what I'm trying to tell you is that, from the standpoint of capacity, you need to understand there is a difference between going into a teaching facility and

the expectations, and you have no other option in Chittenden County but to go into the teaching facility whether you know it or not. It's not a community hospital.

MR. HOGAN: You know --

MR. HUDSON: At this point, let's open it up to questions from the Board.

MR. HOGAN: I personally went through a pile of surgeries in the last few years, and I always was presented with a form, and I always crossed off Number 4 on that form which was, I do not want a resident covering my surgery. I don't know what the problem was. It's very clear. It's in black and white. They give it to you. I just don't know what the problem is that you're trying to describe here.

DR. ROSENBERG: The problem is --

MR. HOGAN: Now, there may be a problem with the physician, but then you dealt with that, and that's the way to deal with it.

DR. ROSENBERG: But you shouldn't have to find that out -- I'm going to say to you, You should not have to find that out after you are in a bay waiting.

MR. HOGAN: I agree.

DR. ROSENBERG: You should not have to find

that out, and, if that's the case, then it should be posted over the door when anybody walks in that, when you walk through this door --

MR. HUDSON: Okay. The refinement of these procedures is not relevant to the hearing.

DR. ROSENBERG: It's not relevant that you don't have a choice? Are you telling me it's not relevant?

MS. HENKIN: If your opinion is that you don't have a choice, that's fine, and the Board can take that for what it's worth, obviously.

DR. ROSENBERG: Well, one person did say, I will make a choice; I'll drive someplace else next time. The other person said, I can't drive, so I have no choice. So I'm just trying to tell you that it's a different kind of capacity.

MS. HENKIN: I understand anecdotal stories are important, but, as far as keeping this concise and related to what the Board is reviewing, that would be helpful.

DR. ROSENBERG: I respect that. I guess the thing is that, if we're going to -- I would like to finish on the policy piece real quickly. If we are going to move for, in terms of policy and savings and efficiencies, there are two things that are pretty well

proven out there, and there's enough literature to support that.

Two is there are many people that do not belong in emergency rooms because it's inefficient. It's not just from a cost perspective. It is both. It's cost. It's that you do not belong in an emergency room with certain types of things. There are other places you should be, and those places do exist. They're urgent care centers. They're out there. People have allowed them to exist, and you get much better care in terms of it's faster, it's quicker, and it costs less, okay?

So the same thing is holding true in the rest of the country when it comes to ambulatory surgery centers. Look at the payers. They have videos posted educating consumers right now about how to be more efficient in getting their care and the cost of their care, money out of their pocket. Go to the ambulatory surgery centers. We have a, we have agreements and contracts with them.

So all I'm saying is that I think, if you could just think of capacity -- and I do hear what you're saying, but you're very -- you are a very well-informed individual. That is not the general population, okay, out there of covered lives. And so the, I want to thank -- these are not the advocates, but the advocates

from the hospital were extremely helpful, and I do think it was a learning experience, but it didn't happen just once.

MR. HUDSON: And, speaking of the Health Care Advocate, do you have any questions?

MS. KUIPER: I don't believe so. Thank you.

MR. HOGAN: I just want to fill in a little piece for you. 47 percent of Vermont's health care is for-profit, 47 percent. So it's not this, okay?

DR. ROSENBERG: That's good to know. But, I mean, you got the sense the other day that we really were all about being nonprofit, and I think that's wonderful, but, you know, the nuns used to say, No margin, no mission. So I will leave you on that with the nuns, but I'd just encourage you to really think about capacity in Chittenden County -- I'm not talking about the rest of the state -- but in Chittenden County in terms of capacity.

And, as far as the global budgets go, I would like to address one thing, one last thing. If you do have a global budget and you are at risk, I can tell you right now those parties that are contracted for are assuming risk because they will participate in the risk through their contract. They have to, or else they'd be cut out. So, if they have a contract and they're in the

global budget, they will be at risk. Their withholds apply to that and performance measures.

MR. HUDSON: Thank you, Dr. Rosenberg. And, at this point, I'd like to call to the stand Ms. Amy Cooper of ACTD.

MS. COOPER: Hello. Thank you for having me back. Can you hear me? Hello. Hi. So there have been a lot of issues swirling around this application. I did take a lot of time over the past couple days to try and organize my thoughts here so that I can present a succinct summary to you of where I think we stand now.

We have heard a lot about the community over this application, and I'm going to take a few minutes to tell you about the independent physician community here in Vermont that I've had the privilege of being a part of for the last four years. Then I'm going to respond to some of the allegations made by the opposing parties at the hearing last week and then, finally, directly to some of the Board's questions that were raised at the hearing last week.

Independent physicians in Vermont are innovators. The first meaningful use certified EHR in Vermont was installed in an independent practice down in Middlebury. One of the first two blueprint practice

sites in 2007 was Gene Moore's practice in Burlington, Vermont, an independent practice and member of Healthfirst. Independent physicians here have dutifully and enthusiastically participated in all the state health reform programs.

Healthfirst started the first ACO in the state Medicare certified in 2012. The hospitals followed in 2013 with OneCare, and other providers followed. One-third of the physicians participating in the current Medicaid Next Gen ACO program pilot are independent physicians, and 9,000 out of the 30,000 patients have independent primary care docs in that Medicaid program.

There is absolutely no reason for the Board or anyone else to assume that independent physicians in the Green Mountain Surgery Center will not continue to participate in state health reform programs in the future. I have said that we will contract with the ACO's, and, as Beth Wennar mentioned, when we contract, if there are global budget and withhold and risk elements, we will participate in all of those elements.

MR. HOGAN: Does that include budget review?

MS. COOPER: If the ACO budget is being reviewed and the surgery center's budget is part of that budget, then yes.

MR. HOGAN: Okay.

MS. COOPER: The physician investors that were persistently accused of being profit mongers during the hearing last week are the same ones who have been serving this community for many years and have taken all payments including substandard Medicaid rates with no ability to cost shift in their budgets to compensate for this and no extra support payments from the state or federal government for seeing uninsured or underinsured patients. It is done purely out of a sense of community.

I think that independent physicians in Vermont have shown historically that they are primarily community driven rather than primarily profit driven. They dedicate the majority of their lives to serving others, and I think a little more consideration of that fact would be appropriate.

In sharp contrast to this history of participation, it may surprise you to learn that our state's largest hospital, the $1.1 billion UVM Medical Center in Burlington, has opted for the past eight years not to pay into the blueprint program to support the primary care medical home services for all of their employees. Despite this fact, these services are being provided anyway to the UVM Medical Center employees by

small, independent practices and their staffs.

Moving on to some of the allegations that have been made by opposing parties in this hearing, there were numerous misleading or even false statements that the Green Mountain Surgery Center will be unregulated. On the contrary, it will be regulated by CMS. It will be accredited by the Joint Commission just as hospitals are. It will report on quality measures annually to Medicare, and it will be subject to CON requirements from the Green Mountain Care Board if this application is approved.

The Green Mountain Surgery Center will also pay income tax and property tax. We will not, as far as I know, be subject to the provider tax, but we will also not receive DSH payments back in return for being subject to the provider tax which is how that tax operates, as I'm sure you know.

The opposing parties also put emphasis on the Green Mountain Surgery Center being a for-profit entity. That's been covered already in this conversation, so I won't spend too much time here except to say that this emphasis is intentionally misleading. Nonprofit institutions also earn profits and have a profit motive. The Green Mountain Surgery Center will contribute to the community by paying

taxes, has voluntarily adopted a charity care policy that complies with the rules that apply to 501(c)(3) nonprofit hospitals, and would accept a CON condition regarding the percentage of Medicaid patients to be seen as I mentioned during the last hearing.

It is also relevant, I think, to point out here that UVM Medical Center, the state's largest nonprofit corporation, notes on Page 12 of its 2016 financial report that UVMMC runs some for-profit corporations without offering definitions as to what they do. One is call UVM Medical Center Executive Services, another 116 Realty. Another is called UVM Health Ventures. There is also an entity called UVM CIC which is exempted from taxes by the government of Bermuda until 2035. They also state in their financials that some of these entities are not accounted for in their statements because they have uncertain tax positions.

The next allegation that I would like to take on is the statement made by UVMMC during the hearing where they represented that they have ample capacity available in their OR's and PR's, procedure rooms. In fact, the truth is that there are not enough intake rooms in the endoscopy center to support keeping all of the procedure rooms full at all times. That is why there are available hours and empty rooms in their

utilization calculations, but that does not mean that they can realistically be used to that capacity.

If all the rooms were to have a full day, then there would be 96 procedures done, 8 rooms, 12 per room. In actual fact, a very busy day there is in the 70's in terms of the amount of procedures, and one can be certain that on those days patients will not be ready on time and there will be delays in the schedule. Given the realities of this situation, in effect, 70 to 74 percent utilization is, in fact, full capacity at UVMMC, and that's information that I have received from physicians who do operations and endoscopies at UVMMC.

Moving finally to the most important piece that I want to address today, the questions that you raised as the Board during the hearing. The first regards the determination of need and what is the definition of need. We have focused a lot on affordability in this application, but I also think it's important to point out that we have defined need more broadly than that as a need to reduce the wait times for procedures in Chittenden County; a need to improve the patient experience by offering a smaller, more convenient, less intimidating environment for patients; a need to provide choices for where and how to receive care in Chittenden County; and a need to retain and recruit

physicians. All of these are part of the need that we have identified in our application.

You also asked about our prices at the hearing, and I want to clarify some of the good questions that were brought up in regards to those. You had suggested that a list of common CPT codes with the Medicare prices paid to ASC's versus the Medicare prices paid to hospitals would be helpful, so I went back to our original application, and I found that we did provide a list of price comparisons by code.

On Page 25 we showed the five high-volume procedures with codes comparing ASC and hospital Medicare prices. As an example, one was a hysteroscopy, Code 58558, which costs Medicare $961 in an ASC and costs Medicare $1,717 when performed in a hospital, which is that 56 percent ratio that we referenced several times throughout our application.

In our response submitted on December 3rd 2015, December 23rd 2015, we also provided current commercial reimbursement rates for three common outpatient CPT codes currently at UVM Medical Center, the other option in Chittenden County. We compared those rates to the average prices in the northeastern states for a colonoscopy using a price transparency website called New Choice Health. That data showed, as we mentioned

in the footnote, that UVMMC is reimbursed by commercial payers between $2,000 to $4,000 for a colonoscopy and that the ASC's in neighboring states are reimbursed by commercial payers not more than $1,250 for performing a colonoscopy.

You also asked about Medicare's new site neutrality policy at the hearing, which I think is an important question in this changing environment. The way it stands now, I want to be clear that the site-neutral payment provisions passed in 2015 won't affect the amount of Medicare savings, approximately $2 million per year that we estimated in our application. The site neutrality payment provisions only apply to hospital-owned sites of care built or acquired after October 1st of 2015. Therefore, the Medicare savings we show versus procedures currently performed in existing UVMMC hospital buildings are still entirely valid and will be for the foreseeable future.

Finally, you pointed out that, you pointed out the part of the CON law that states that we, as the Applicant, have the burden to prove that the Green Mountain Surgery Center won't -- and I'm quoting from the law now -- "Result in an undue increase in the costs of medical care in light of factors including the

financial impact on hospital services, expenditures, and charges and whether the public benefit of the project outweighs these impacts."

I think we've proven that Green Mountain Surgery Center will reduce the cost of services to patients and payers and otherwise provide substantial public benefit. In fact, the public has weighed in heavily on this application. The public clearly sees the benefit, and members of the state's largest consumer groups including AARP, representing 140,000 Vermont seniors; the state's largest unions, including the State Employees Union representing 24,000 Vermonters; members of the State Teachers Union and representatives of their health plan representing 43,000 Vermonters have weighed in in support of this application.

Some of the largest and smallest self-insured businesses in the state have weighed in. Individual patients, physicians, all three of the major commercial health insurers have taken the time to review this application and have come out strongly in favor of it. I am not sure that I'm aware of a better standard for the Board to use to weigh the public benefit than to hear an accounting of the benefits from all of these types of members of the public themselves.

We've also shown as part of our application that

the impact on UVMMC and NMC in lost volume will be very small relative to the overall size of either institution. Though Mr. Hickey did say that he believes GMC will have an exponentially greater impact on NMC than the eye surgery center did, there has been no evidence provided.

We, in our application, estimated that, based on the physician interest that we have received in the center, only about 160 to 200 cases per year would have a chance of moving down from Northwestern into the Green Mountain Surgery Center, and they have not shown any data that disputes what we have presented. Because the impact on UVMMC and NMC in lost volume will be small relative to the overall size of either institution, it follows that any impact on their services, expenditures, and charges would also be small and not undue in light of the benefits of the Green Mountain Surgery Center to patients. It's important to point out here that both hospitals in opposition have enjoyed overages in their budgets of tens of millions of dollars over the past two years.

Instead of increasing prices in response to the opening of the surgery center, hospitals may respond by increasing efficiencies, reducing overhead, or repurposing space. We shouldn't assume that hospitals

need to do exactly what they do now into the future. The Certificate of Need law does not require the eternal preservation of the status quo.

I believe the hospitals are ready to adjust their strategies to the slightly new state of affairs once the Green Mountain Surgery Center is up and running. In fact, I know the hospitals are already getting ready to do this. You probably have all already been invited to the Vermont Hospital Association's annual meeting this year on September 20th. The theme of the meeting is "Positive Disruptions and Opportunities Ahead".

What follows on the invitation to the annual meeting is a quote from Melinda Gates. She says, "Disruption is usually unwelcome. It represents conflict, chaos, and potential danger. We discourage disruptive behavior in our homes, in our societies, often favoring passivity and compliance instead, but disruption can be a positive, sometimes vital, catalyst for change. It can challenge old assumptions, ignite conversations, activate authorities, and expose new possibilities. To solve the most intractable challenges in health, we need positive disruption".

Allow me to leave you with this final thought, that our small ASC project is just the kind of positive disruption that's needed in Vermont health care, and it

will be a disruption that our hospitals are ready for, are preparing for, and are capable of reacting to in the best interests of the patients, the payers, and the community at large. Thank you.

MR. HUDSON: Thank you, Ms. Cooper. At this point in the hearing, we will return -- we have follow-up questions? Okay. Sounds like we have some follow-up questions.

MS. LUNGE: Thank you. And thank you, Amy, for circling back on the questions that I asked last time. I appreciate that. What I was -- I did see your list of five codes on Page 25, and what I was looking for help with is connecting that both to the data that you provided on colonoscopies which is on Page 10 of -- hold on. I'll get you the date -- the date that you provided on March 31st 2016 as well as the revenue assumptions.

Because I wasn't necessarily going to make an assumption just on five codes when I know that that doesn't, those five codes don't necessarily match up to the greatest volume of what you propose, for example, in the colonoscopies, and I don't want to put you on the spot and ask for an answer right now, but I think if, if -- I think we can ask for supplemental information. So, if that's something you'd like to

provide, I'd welcome that, so --

MS. HENKIN: Can we set a deadline on that? Because we're going to be having -- if you have something to provide afterwards on that, can you do it by the beginning of next week?

MR. HUDSON: There are a couple of deadlines we should talk about, and now is as good a time as any to request a brief conference after the close of the hearing with all the attorneys to discuss deadlines.

MS. HENKIN: Okay.

MS. LUNGE: Yeah. So you guys can figure out the deadline.

MR. HUDSON: We can figure out the deadline.

MS. LUNGE: And it's totally your choice, but that would be helpful, and I appreciate you making the clarification today.

In terms of the Medicare site neutrality, am I remembering incorrectly that there's some movement to apply that to existing facilities over time?

MS. COOPER: There is a movement to apply that to existing facilities which is being strongly opposed by the American Hospital Association. So, with politics in DC, it's anyone's guess what will happen, but, yes, you're right. There is a movement.

MS. LUNGE: All right. Thank you. I think

that's what I have right this minute. I'll pass to you.

MS. HOLMES: Great. So, Amy, can you just -- I just want make sure that I have a firm understanding of how the pricing works. So can you just break down for me? There's a facility fee, and there is a professional services fee, and the professional services fee will be the same whether that provider is in a hospital or at the ambulatory surgical center by payer, right? So, really, the differential is in the facility fee that's charged for the service?

MS. HENKIN: Can you just speak, because we have a transcript?

MS. COOPER: Oh, sure. Yes, that is all correct.

MS. HOLMES: Okay. So far, so good. So the real differential is in the facility fee that is applied to the procedure, and your testimony is that, on average, it's 53 percent of what, in the ambulatory surgical center, 53 percent of what would otherwise be charged as a facility fee in a hospital?

MS. COOPER: Yes. We have said that it's 50 percent on average for commercial payers and 56 percent on average for Medicare.

MS. HOLMES: Okay. And so but that's

literally just the facility fee?

MS. COOPER: Yes.

MS. HOLMES: The assumption is the professional service fee will not make a difference no matter where the site of the service is?

MS. COOPER: Yes.

MS. HOLMES: Okay, thank you. And I also wanted to echo Robin's appreciation for your answering some of the questions. One of the questions that I did ask that I didn't hear an answer to but I'm still curious about is, Are there procedures that are currently done in offices that, when moved to the ambulatory surgical center, will generate a higher reimbursement because of that site in the facility? You know, is there no facility fee, for example, in an office procedure but now, because it's in an ambulatory surgical center, it has a facility fee attached to it? So, again, I'm thinking about procedures that are currently done in offices that now will be done in --

MS. COOPER: So I can answer and tell you that there's -- none of the codes that were submitted by the physicians that we surveyed asking them, Which procedures do you think you'd do here most often -- again, we did not ask for an exhaustive list from each physician, but we said, Which procedures do you think

you would do most often? From the pain management physicians that submitted answers, none of those codes are currently done in the office that would move into the ASC.

Now, this application has been live for three years since we surveyed the physicians. I know that there's been a change in both the regulations, as Joan mentioned, in terms of what's allowed to be done in an office specifically for pain management versus in a surgery center, and I have not gone back to see how those regulations affect our plan volume.

There's also been a change in the practice pattern of a couple of the pain management physicians who gave us estimates. They combined their practices into one joint practice now. They used to be doing both solo practitioners. Their mix may have changed since then as well, and I don't know. I haven't checked back with them.

MS. HOLMES: Okay. And, really, it would be restricted to the pain management? None of the other practices would have this concern?

MS. COOPER: No.

MS. HOLMES: Okay. Thank you very much.

MR. HOGAN: I'm all set.

MR. HUDSON: Hearing no further questions

from the Board, are there any from the HCA?

MS. SHAW: No. We're all set. Thank you.

MR. HUDSON: Okay. Then it sounds like we're ready to move on to the public comments section.

MS. COOPER: Thank you.

MR. HUDSON: Thank you.

MS. HENKIN: Is there anyone here who didn't sign up who was intending to speak?

MR. HUDSON: I will start calling names. Is Justin Worthley here?

MR. WORTHLEY: Hi. My name is Justin Worthley. I'm the head of Human Resources at Burton Snowboards in Burlington, Vermont. In June 2015 we wrote a strong letter of support regarding the Certificate of Need application, and I wanted to reiterate we remain strong proponents of the proposal really based on two factors. The first is that we operate a self-insured health plan for our 500-plus US-based employees including over 350 here in Vermont. Therefore, we're pretty invested in high-quality, affordable health care for all of our employees.

Second, for that group of employees who are not in Vermont, about 150, they already have regular access to these centers, and we have a lot of data to support what we understand will happen here in Vermont with

this center is that the costs will go way down for procedures that happen in the center.

And that, you know, created a bit of a curiosity for me, because this has been seemingly so contentious here in Vermont. So I did some research looking into these centers in other states, and I learned that they really just are not controversial. In fact, they're very common. I learned that Vermont is the only state that has fewer than three of these facilities, and I guess we're a small state. We probably don't need a lot of them.

So I looked deeper at states that had the lowest population. They are -- Wyoming is the lowest -- counting backwards, Vermont, Alaska, North Dakota, and South Dakota, and those other four states each have a minimum of thirteen of these outpatient centers. Then I looked at states with the smallest geographic size. There's only five of them that have less land area than Vermont. They're New Hampshire, New Jersey, Connecticut, Delaware, Rhode Island. For each of these five states, each has a minimum of eleven of these centers.

So, you know, I looked at that, and I guess that helps me understand why there's so much opposition from the hospital associations here in Vermont, because

Vermont's the only place to fight this fight. They are common in all other places and part of the normal health care delivery system. Doesn't seem to make sense that Vermont is sort of left out of that.

So some points I'll emphasize in addition from our perspective. There's a lot of data proving that these centers are much more efficient in the delivery of quality outpatient surgical procedures compared to hospital systems. The proposals coming from a group that's very invested in health care in Vermont with a strong reputation around primary care, they're a group that we work with closely to connect our employees to their primary care physicians. They are invested in the state. We've been talking to the insurance companies. We know all three major insurers in the state have provided written support for this proposal.

Due to these reasons, we're sort of perplexed why we're still having this conversation and why there would be further delay. So I just want to reiterate, on behalf of Burton Snowboards, our owners Jake and Donna Carpenter, our 350 Vermont-based employees, we're really urging you to take swift action, not only to move forward with this Certificate of Need, but also continue to challenge Vermont's entire health care delivery system to accelerate the implementation of

proven models like this which will make the delivery of care better and more affordable for all of us. Thanks.

MR. HUDSON: Thank you, Mr. Worthley. Is Rick Dooley here?

MR. DOOLEY: I'd like to thank the Green Mountain Care Board for the opportunity to speak in support of the Green Mountain Surgery Center today. My name is Rick Dooley, and I've been a family practice physician assistant at Thomas Chittenden Health Center in Williston for the past 18 years, and I've been a PA now for about 22.

I've watched over the years as UVMMC has expanded its footprint to Chittenden County and beyond, and I've seen many signs of my previous colleagues that have been replaced with the UVMMC logo. I routinely hear, as an independent practitioner, I routinely hear from my patients that they would prefer to go to a non-UVMMC provider for lots of various reasons. Sometimes it's because of excessively high costs with hospital-affiliated services. Sometimes it's because they don't like the big institution on the hill. They don't like the parking garage, which, if you've ever been in it is terribly confusing.

There are various reasons, but they would like an alternative to UVMMC, and, unfortunately, we don't have

one. Currently, for a lot of my orthopedic patients, they actually prefer to drive over an hour to go to Copley Hospital to avoid UVMMC.

From a personal perspective, I had the good fortune or the misfortune to require a colonoscopy last year, and despite working in the health care field, I, like many Vermonters, have a high-deductible health insurance plan. I chose to go to an independent gastroenterologist, but the procedure had to be performed at UVMMC because there's no other facility to perform it there. The professional fee for the physician who did the colonoscopy was $650. The fee paid to UVMMC for the 30-minute procedure was $3,184 for a total cost of almost $4,000 of my $5,000 deductible.

Now, if I had wanted to drive a couple hours to the Salem Surgery Center in New Hampshire, an outpatient surgical center -- which I wouldn't recommend doing if you're prepping for a colonoscopy, but, if I could, I would have -- the total cost for the procedure including the physician fee would have been $2,100. The physician fee would have been about the same, about $700, but the $2,000 difference would have been in the facility fee. I paid almost double what I could have because of a lack of alternative facility in

Vermont.

Essentially, if I'm to understand the arguments that I've heard from NMC and UVMMC and VAHHS, I was required to give a $2,000 donation to the hospital so that they could then turn around and provide the services that they do for the community. Now, I'm a very charitable person. I may have donated that $2,000. I probably would not have donated it to UVMMC, but I might have donated it to other organizations.

In addition, you know, UVMMC has all this open space. I know Amy had just talked about this. I would argue that, rather than filling their open OR's and procedure rooms with procedures that could be more appropriately done in an outpatient surgery center, and certainly more conveniently for our patients, perhaps they should look at repurposing the rooms for the additional ICU capacity that someone suggested last week or perhaps improving their inpatient mental health capacity, just looking at different models that they could use.

It's my strong feeling that, if the Board is truly interested in working for Vermonters and lowering the cost of health care in Vermont, rather than supporting a high-cost, hospital-centric model, they should grant the Certificate of Need for the Green Mountain Surgery

Center. Vermonters and my patients want and deserve choice and competition.

I would also encourage the Board to look at cost transparency tools. New Hampshire has one that's already built. I put the website on here that I'll give to you guys that perhaps is a model where they can look at different costs associated with different care and really drive down the costs of health care in the state. Thank you.

MR. HUDSON: All right. And Dr. Jennifer Brown.

DR. BROWN: Hello. Hi. I'm Jennifer Brown. I'm an independent gynecologic and fertility physician in Vermont, and I'm here and I was here last week because I'm very passionate about health care in our state. I, I plan to be in the state a long time, and I'm invested in the vibrancy of our health care community. I have a husband who is a sugar maker. His family runs a small nonprofit ski area. We have three kids, and we have close ties to UVMMC as well. We -- I trained there. I did my subspecialty training at UVMMC. I had my first son there. I -- my aunt is currently receiving breast cancer treatment there. And I'm invested in UVMMC being an integral part of our health care community. I do think that there are some

things that they cannot do or should not be asked to do, and that's part of being in a community where all providers contributing our strengths to our overall health care community.

I have three points today in argument of the surgery center. One is I'll demonstrate need; two is I think competition drives improvement and efficiency in our system; and, three, I want to ensure that we continue to build a system that will allow us to attract future MD's to our state.

So, one, in terms of need, there are a number, as we've heard, of procedures that are not well-suited for a large hospital environment. In some cases it adds cost. In some cases it adds unwarranted stress. In some cases a layer of complexity that's not needed. As an example, I perform a number of hysteroscopic polypectomies. This is a very simple procedure that takes 30 minutes. When I practiced in Colorado, I'd routinely turn these over in 30-minute intervals. When I practice here, I block out an hour and a half of time to perform them at UVM, and, if I do more than one, I block out a half a day because of unpredictable start times or turnover times, and that's all in addition to the travel time.

So I do think that patients want, you know, a more

focused and accessible and efficient place as well to have these simple procedures done. They don't need to be in a large hospital with the layers of complexity involved there, and we all want efficiency.

Two, I think that, you know, we've heard a lot about capacity, and today we have heard a lot that maybe there is capacity but it's not meeting the needs, and, to me, that indicates that potentially this capacity hasn't adapted to the needs of the providers or the patients because it's not accessible to me, this capacity that I've been hearing about that's so easily available, and I would argue that it's possible that there's no incentive for there to be change around that capacity to allow it to meet the changing needs of our patients and our providers. I, my concern is that there is not a lot of incentive for the hospital system to improve efficiency or improve the costs for these outpatient procedures and make it work in the way that we know that it has the potential to work.

Three, my third point is that we do seem to have a shortage of physicians in Vermont, and what do graduating physicians want to do? I asked myself this question when I graduated. You want to provide care, You want patients to have access to your care, and you want to do it in an efficient way. You don't want to

be bogged down in a big system.

So, initially, when I completed my specialty training here, I actually moved to Colorado in order to do that, in order to be able to very directly provide care to my patients, and I was fortunate enough after we had our children that there became a practice opportunity in Vermont and that we were able to return here. Clearly, we have family roots here. And I think that, for future graduates in medicine, we want to provide that same optimistic, efficient, and cost-effective -- it's every physician's dream. We want to practice medicine.

So, yeah, in an answer to a previous question, you know, none of my office procedures -- I don't think other specialties -- I believe it was your question. Yeah, it was your question. I don't think any office procedures would move to a more complicated surgery center. Office procedures are designed for the office. So, with the pain specialty which I don't have much experience aside, other, other specialties are not going to move an office procedure to a more complicated setting. So, with that, I'd just ask that we all embrace this exciting change and continue to move forward.

MR. HUDSON: Thank you.

MR. HOGAN: Thank you very much.

MR. HUDSON: Are there any members of the public present who wish to comment who did not manage to sign up? It sounds like no. In that case, the public comment period will continue past this hearing for the next ten days. The next ten days lands on a weekend, so the deadline for public comment in this matter is going to be May 1st 2016. We will accept public comments by email, telephone, the Board's website portal for public comment, as well as US mail.

At this point, I think it's safe to conclude the hearing and turn this back over to the Board for their regularly scheduled board meeting.

MS. HENKIN: Can I ask something? Can we at least put the deadline on when we'll get that additional information that was going to come in from Ms. Cooper and just settle that right now? Is that possible? I don't think we need a separate meeting for that.

MR. HUDSON: We can, but there are a couple of documentary issues I need to settle with the attorneys, so I'll need to have that conference with them anyway. If we want to just settle the deadlines right now, the deadline for post-hearing memorandum is, per ACTD's request, May 2nd 2017, and all supplemental

information as requested by the Board, if you could have that to us by close of business on Monday. And, at this point, we can adjourn the hearing.

(Whereupon at 2:16 p.m. the hearing was adjourned.)

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 Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on April 19, 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 61 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 25th day of April, 2017.

// Sunnie E. Donath