First, I'd like to thank you for inviting me to share my perspective with you today. My name is Greg McCormick. I'm an ophthalmologist practicing at Ophthalmic Consultants of VT in South Burlington. I also operate at and am one of the owners of The Eye Surgery Center in South Burlington, the only ambulatory surgery center currently operating in Vermont. My thoughts that I will share with you are formed by a variety of perspectives. First, having grown up in rural VT with a father who was a small business owner and a mother who was a career special educator, I was taught at a young age to live life with honesty and integrity. My dad used to tell me that a hand shake in VT is legally binding. I have no idea if that is literally true but that philosophy has guided me in life.

When I graduated from the University of Vermont Medical School, and stood with my classmates to take the Hippocratic Oath, I was blissfully ignorant of the politics of big medicine. Since that time, I've become less naïve. I'd like to start out by acknowledging many of the excellent comments made by the previous speaker, Dr. Elliott Fisher. In particular, Dr. Fisher stated that monopolies raise prices and that he remains shocked that hospitals are allowed to be reimbursed so much more for the same services provided at independent facilities such as Ambulatory Surgery Centers. Dr. Fisher did express concern that studies may suggest that nationally, in some regions, high numbers of Ambulatory Surgery Centers may correlate with higher procedure volumes. Dr. Fisher, did not, however, present any information to suggest that increased volumes would occur after a rigorous Certificate of Need process. In fact, Vermont has the most rigorous Certificate of Need process in the country with only one operational Ambulatory Surgery Center. The size of our facility, with only two operating rooms, was built to match the needs of our community as determined by our Certificate of Need. This is hardly comparable to the many states where there is little or no limitation on the number of Ambulatory Surgery Centers that can be built. I believe New Hampshire has approximately 50 such centers. Therefore, the concept of "Induced Demand" that may be valid in some locations, may have little relevance in the context of the well thought out resource allocation in Vermont, as validated by the Certificate of Need Process.

I also agree with Dr. Fisher on the critical importance of "shared decision making." Having attended UVM Medical School in the late 1990's, I can tell you that Vermont may be ahead of its time. UVM has been training doctors in the critical importance of shared decision making for years. "Shared decision making" relates to the critical process of informed consent. Doctors should educate patients to help them decide the best path, rather than simply instruct them what the doctor thinks they should do. This has been a change compared to historical traditions in medicine. At one time, the doctor was expected to make the choice, and the patient would do as instructed. This is not how we do it today, or at least, not how it should be done. In Dr. Fisher's opinion, if a patient is advised to have surgery that a well informed patient would not choose, then a surgeon is committing assault to do it. I couldn't agree more. In my practice, almost all procedures are optional rather than critically time sensitive. I consider it my job to educate patients about their choices, not to make the choice for them. As I understand it, Dr. Fisher was indicating that as long

as there is good informed consent and shared decision making between the doctor and the patient, that even if volumes of procedures increase in a community, it is appropriate. Therefore, it would be a gross oversimplification to conclude that increasing volumes of a particular procedure in Vermont, if that were to occur, would necessarily reflect anything other than good patient care.

As Dr. Fisher mentioned, hospital services are expensive. What if Vermont hospitals came to you and asked if you would allow them to cut their costs in half? What if they offered to give you objective proof of equal or superior outcomes, with accreditation from the Joint Commission and with outstanding quality scores from CMS through the Merit-Based Incentive Payment system, the system designed to pay physicians for value rather than volume with payment adjustment based on evidence-based and practice-specific quality data. Would you accept it?

Around the country, there are examples of hospitals that have been successful doing this. One thing we do know, however, is that hospitals can't do it alone. Hospitals are saddled with bureaucracy and standardized systems which for some services are absolutely essential. We need our hospitals, we need them and we allow them to be regulated monopolies because we need to protect them and ensure that they don't fail. But the key to understanding the success stories we see occurring around the country is in understanding that hospitals and health care are not synonymous. We need hospitals but we don't need them to provide *all* health care. We know hospitals have extremely high overhead, so why pay hospital prices for things that don't need to be done at a hospital?

This is a critical question I've asked myself. How do I best use my training to bring high quality, affordable health care to Vermonters. A number of years ago, my practice, Ophthalmic Consultants of VT was struggling to meet the needs of our patients due to limited operating room access. Around that time, the Chair of the Department of Surgery at UVM Medical Center offered me the position as Chief of Ophthalmology at UVM. I was open to a conversation. Maybe it was time to join UVM. At least as Chief of Ophthalmology, theoretically, I'd have the power and influence to make sure that we could continue the good work at UVM just like we were already doing in private practice, when private practice seemed it may be doomed to fail in Vermont. So, I asked the hospital the same question that I posed to you. Would you be willing to treat patients with the highest quality of care, in an environment that would cut the cost in half? I explained to the hospital that nationally, eye surgery has transitioned out of hospitals into highly focused, high quality, low cost ambulatory surgical facilities. I showed them information from consultants and even shared specific plans. If the hospital would agree, together we could address the long waits patients were experiencing for hospital based eye surgery while cutting costs by millions of dollars per year. Unfortunately, the hospital wasn't interested. They claimed it wasn't practical for them to participate in ownership of an Ambulatory Surgery Center. Other surgeons, they argued, would complain and expect to have access to the same type of facility.

While considering this possibility, I discovered that transitioning our practice to UVM would not simply change the sign over the door from Ophthalmic Consultants of Vermont to UVM Ophthalmology. Despite having the same office, the same staff, the same doctors and the same equipment, suddenly we would be billed as a "hospital." Prices would go up without tangible benefit to patient care. Why charge hospital prices for things that don't need to be done at a hospital?

During my conversations with the hospital, it was my impression that ophthalmology was not profitable for the hospital, despite the high charges. I had hoped that if we became a part of UVM, that all the extra charges would be profit that could be used for some good purpose. But it seemed that the extra charges would be burned up by inefficiency. Supporting this notion, in the Certificate of Need decision granting a Certificate of Need for The Eye Surgery Center, the Commissioner stated that "FAHC argued before the Commission that their financial condition would suffer if the applicant's project were to be granted… No credible evidence, as opposed to unsubstantiated assertions or concerns, was offered that a net revenue loss would in fact occur." Indeed, UVM, flush with tens of times in millions of profit more then the entire operating budget for The Eye Surgery Center, has seen astounding profits since The Eye Surgery Center opened its doors. When I told the hospital that I would consider the position as chief of ophthalmology if they would work together to utilize an Ambulatory Surgery Center, they told me their answer was "no".

I gave the concept long and hard consideration. But in the end, I did not feel it was in my patient's best interest to convert my practice into a high cost "hospital" when there appeared to be no benefit to my patients. While UVM had declined to engage in creation of an ambulatory surgery center with me and my partners, I was fortunate that other ophthalmology colleagues were willing to work together. Since joining together at The Eye Surgery Center, I've done thousands of eye surgeries there. I can tell you that the center is terrific but not just because it is about half the cost of hospital based care. The center also has unsurpassed quality and remarkable patient satisfaction outcomes.

The Eye Surgery Center has accreditation from the Joint Commission providing rigorous quality oversight and the majority of our patients have Medicare. My practice participates in CMS' MIPS – Merit-Based Incentive Payment system, the system designed to pay physicians for value rather than volume with payment adjustment based on evidence-based and practice-specific quality. Preliminary reports, which I am happy to share with you, show that my practice has received the highest quality rating possible (60/60 points according to the IRIS Registry). This rating was based primarily upon MIPS reporting of our cataract surgery outcomes, including visual acuity, surgical complications, and accuracy of target refractive outcomes. This highest of rankings from the CMS quality reporting program is consistent with my own experience. One of the metrics for cataract surgery has to do with intraoperative complications. The most common metric is that of unplanned vitrectomy surgery, which is an indicator of technical complications

during cataract surgery. Published reports tend to show between 10-20 unplanned vitrectomies per 1000 cases, which significantly increases the risk of postoperative complications and vision loss after surgery (www.aao.org/preferred-practice-pattern/cataract-in-adult-eye-ppp-2016). In my last 1000 cataract surgeries at The Eye Surgery Center I've had no unplanned vitrectomies, consistent with the highest ranking by MIPS criteria. Similarly, studies have shown infection rates are lower at ambulatory surgery centers than at hospitals. Typical reports of infection after cataract surgery range from one in 300 to one in 1500 cases. I've done thousands of cases at the Eye Surgery Center without a single infection. I've done a smaller number of cases at the hospital, with one infection, consistent with the published literature.

Ultimately, our tiny center is able to do good things. Our entire tiny budget of several million dollars is sufficient to allow us to restore vision to thousands of eyes each year while saving the health care system in Vermont several million dollars per year by virtue of the fact that we are able to deliver care at roughly half the price. So I ask again, why pay hospital prices for things that don't need to be done at a hospital?

This bill not only impedes competition, it has many, perhaps unintended, consequences. For example, this bill calls for all surgeons with privileges at an Ambulatory Surgery Center to have admitting privileges at a local hospital. This sounds simple enough but in truth is a hidden bomb. For starters, lets make it clear that it is neither necessary nor helpful for me to admit patients with eye problems that I manage to the hospital. All of the eye problems I treat are best managed using the high tech equipment I have available to me in the out patient setting, not by admitting them to the hospital. For comparison, should we start making all dentists have hospital privileges even though, like me, most of them don't ever have any reason to admit patients to the hospital? If a patient has major cardiac, neurologic or other ailments requiring hospitalization, then I would not manage those conditions, I would defer to other specialists. Therefore, state law that mandates that I have admitting privileges at UVM would be bizarre and not helpful for my patients. Having said that, for the last 7 days I have been on continuous level 1 trauma call for UVM. Given that I do not have operating room time or a need to admit patients at UVM Medical Center, the reason why I keep admitting privileges at the hospital is to volunteer for the Level 1 Trauma call system. UVM requires some doctors with admitting privileges to take unpaid call, in addition to the UVM employees. As it turns out, ophthalmologists with admitting privileges at UVM are required to take Level 1 Trauma Call. In the past year, I've taken approximately 1000 hours of unpaid call for the UVM level 1 trauma system. While I have received no pay to participate in the on-call system, I've done so voluntarily because I have felt qualified and willing to help support the needs of my community. But lets face it, this is not a necessary part of my regular practice and, while so far I feel I can help, if a doctor in our community does not feel qualified or willing to engage in Level 1 Trauma services, we shouldn't be forcing them. If this legislation is passed, it would require me, by state law, to provide approximately 1000 hours of unpaid

service to the UVM level 1 trauma system. For now I will continue to offer this free service as a volunteer but I do not feel any citizen should be subjected to unpaid labor that is mandated by the state, particularly, when the expertise required and the liability associated with offering such services is so great, and no doctor should be forced into a position where they are not comfortable providing services.

Along a similar vein, this legislation proposes a seemingly reasonable but in actuality totally unfair and destructive mandate on ASC's and affiliated, essentially taking away their ability to negotiate fair compensation with insurance companies. "The ambulatory surgical center shall require each physician performing procedures or surgeries, or both, at the ambulatory surgical center to certify that he or she will accept patients without regard to payer type, insurance status, or ability to pay for services." First, I want to point out that our ASC has a Charity Care policy and we provide free care for qualified patients at or below the Health and Human Services Poverty Guidelines. We also provide care at half of our already low price for patients earning up to 200% of the HSS Guidelines. The majority of our patients have Medicare. We also accept Medicaid. We do so voluntarily but we oppose legislation that requires every doctor operating at the ASC to be willing to accept *any* insurance. Amazingly, not even hospitals are required to accept *all* insurances. They are allowed to negotiate insurance contracts with fee schedules that vary from payor to payor. Furthermore, hospital fee schedules are not offered to independent doctors. It is a well proven fact that private insurance companies typically offer much lower fee schedules to independent doctors who have very little leverage in negotiations. If independent doctors are required by law to accept all insurance plans accepted by regional hospitals then independent doctors would have no negotiating power allowing them to obtain fair compensation. If mandatory fee schedules are going to be imposed on independent doctors then we must be offered the same fee schedule as the hospital if there is anything fair or just about such a mandate. Similarly, if this legislation will require ASC's to require all doctors to accept all insurance plans, why don't hospital privileges require that a physician with hospital privileges accept all insurances? At this time, a provider who does not accept Medicaid can still have privileges at a hospital, why not at an ASC? This legislation imposes unfair requirements of ASC's and associated independent doctors, while leaving a different standard for hospitals, and will further perpetuate the trend that the health care system is putting independent doctors out of business.

Overall, the proposed legislation seeks to lump Ambulatory Surgery Centers into the same general category as hospitals. However, with operational focus and services provided at roughly half the cost for the same service, and with tiny budgets, ASC's are very different from hospitals. The current budget for ASCs in VT, with only The Eye Surgery Center in operation, is tiny. With a yearly budget of roughly 3 million dollars per year, we operate at a small fraction of one percent of the combined hospital budgets in Vermont. Even when the second ASC opens, our overall expenditures will remain miniscule in the state budget. As previously asked, why pay hospital prices for things that don't need to be done in a hospital? Procedures performed at our center should not be shifted back into the hospital environment, driving up health care costs by millions, nor should there be any efforts to convert us to an inefficient hospital-like environment. The proposed legislation will kill our operational efficiency through a variety of means

that will serve no benefit to our patients. There are many onerous reporting requirements that we are not staffed to meet. We have no need for public hearings to determine our strategic plan. We have a very limited Certificate of Need approval, restricted to eye surgery. Public hearings calling for us to provide other services would be irrelevant. This makes sense for a hospital with a broader mission, but we are focused in our service. Treating us like a hospital, like this legislation proposes, doesn't help us care for patients, but it does introduce waste.

Similarly, the proposed legislation seeks to lump our facility's budget into the same type of approval process as a hospital. Our insignificant budget is hardly worth the time and energy of the Green Mountain Care Board to regulate. With our tiny budget, we don't have the financial padding to hire additional executives, accountants and lawyers to manage a regulated budget process. Furthermore, our budget is personally guaranteed by our doctors. As you can see from our implementation reports that were filed for many years, our finances are not without risk. However, any shortfalls in our budget, when they occur, come at no risk to tax payers because we, as owners, have offered our personal assets, our savings, as collateral to underwrite the loans, our long term lease and financial operations of our health care facility. Our Certificate of Need was approved based upon financial projections meeting all criteria of Vermont law. Our doctors have trusted the process and made long term financial commitments based upon the CON requirements. These new financial burdens that were not disclosed in the CON process threaten the viability of our organization and are an unfair burden on a small group of doctors who are doing really good things for Vermont. We trusted the state and the CON process, please don't change the rules, jeopardizing our ability to continue our good work, and threatening our personal assets that have been leveraged as collateral for our facility.

I hope you understand now why I chose my path. I realize it would have been easier to accept the job as chief of ophthalmology at UVM, forget about health care costs and policy, and take the path that was safest for my own career and finances. We all know that most independent doctors have already been forced out of private practice. Fortunately, I felt that in my specialty, with the efficiency I could bring to patient care in my office and at the Eye Surgery Center, that I could make the choice that would allow me to best serve Vermonters and still remain viable. In the end, my partners and I decided that if we offer the best care at the best price we should be able to trust that the government will value our services to Vermonters, rather than undermine our good work. At some point in life, we all need to have faith. We've put our faith in you, that you will not threaten the viability of one of the greatest examples of success in Vermont health care. The Eye Surgery Center – with unsurpassed outcomes at a savings of approximately 50% to the health care system – improving vision in thousands in a safe and comfortable environment. This proposed late-in-the-game change in rules is unfair to our doctors, who have taken personal financial risk and who may be significantly harmed by this legislation despite the wonderful outcomes our center is providing Vermonters. Please help us continue the good work we are doing by saying "no" to this Bill.

On a final note, I'd like to express my genuine desire to continue to promote high quality, low cost, accessible care for Vermonters. As you know, The Eye Surgery Center is a rare example of health care at its best. I would welcome any of you to visit our center so that you can better understand how one little place can help so many people at substantial savings with outstanding outcomes. We're proud of what we have accomplished and would welcome you any time.