

First, I'd like to thank you for inviting us to share our perspective with you today. My name is Katherine Lane. 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 today reflect my own perspectives as well as the general opinions of my partners at The Eye Surgery Center.

As you know, last year, similar legislation was presented in S.278. After significant discussion, it was determined that more information was needed. Then, H 912 called for the Agency of Human Services to pull together a workgroup to develop recommendations for the regulation of freestanding healthcare facilities and their role in a coordinated and cohesive health care delivery system. Two doctors from our center, Dr. Juli Larson and Dr. Greg McCormick, regularly took time away from patient care to participate in the workgroup along with our managers. The workgroup ended with a consensus about how best to move forward and we support the new licensing requirements as passed by the Senate in S.73 which accurately reflects the results of that collaborative effort. Many of the new provisions proposed to modify S.73 that we learned of on Friday are significantly different from the recommendations of the workgroup that our center participated in last fall. We do not feel these new provisions will serve the interest of Vermonters as they will not improve patient care or reduce costs.

First, I'd like to point out that doctors at The Eye Surgery Center all fully support the practice of "Shared decision making" as it 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 my practice, most procedures are elective rather than critically time sensitive. I consider it my job to educate patients about their choices, not to make the choice for them. While we don't object to a shared decision making policy as part of licensure, I'd point out that the center does not provide patients with informed consent as that is a process between a patient and their provider, not the facility. Similarly, when I perform surgery at UVMMC, I provide the informed consent for surgery to my patients and the hospital does not play a role. This is because there is a responsibility on the surgeon, a medicolegal liability that a facility is not in a position to assume. Hospitals and facilities could be sued much more easily and readily if it were determined that a facility were responsible for the informed consent process between a patient and an outlying doctor with admitting privileges.

Central to this discussion is whether or not the cost of additional regulatory oversight is needed in Ambulatory Surgery Centers. The short answer is that there is already a tremendous amount of regulatory oversight and that ASCs are not the same as hospitals. ASC's that are accredited by the Joint Commission and meet the

criteria for licensure as passed by the Senate in S.78 will achieve a high level of quality while offering lower costs. Part of the reason Ambulatory Surgery Centers are able to provide services at lower fees is because of lower administrative overhead. Converting our operations into a mirror of a hospital defeats the purpose of our role and inhibits our ability to maintain financial viability. For the purposes of our Center, our accreditation with the Joint Commission qualifies us for certification with the Centers for Medicare and Medicaid Services. We do not object to the New proposed license requirement, (a)5 “The applicant shall maintain certification from the Centers for Medicare and Medicaid Services and shall accept Medicare and Medicaid patients” as long as this language includes what we are currently doing. The majority of our patients fall into the umbrella of Medicare and Medicaid and we intend to keep serving them. However, we want to be assured that any method that satisfies the criteria as deemed status by CMS will meet the Vermont requirement.

Regarding quality of care, my practice, Ophthalmic Consultants of Vermont and TESC participate 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. This relates to New proposed licensing requirement (a)12. My practice has received high quality marks allowing us to be reimbursed by Medicare for quality not just quantity. This rating was based largely upon MIPS reporting of our cataract surgery outcomes performed at TESC. These outcome measures include visual acuity, surgical complications, and accuracy of target refractive outcomes. 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). At Ophthalmic Consultants of Vermont, we reported roughly one tenth the average complication rate reported according to the Preferred Practice Pattern for cataracts by the American Academy of Ophthalmology. 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. Our practice has performed thousands of cases at the Eye Surgery Center without a single infection. Having said all of the above, the requirement in the proposed language in (a)12 does not improve upon what we are already doing. “The applicant shall participate in any voluntary or compulsory quality reporting program offered by the Centers for Medicare and Medicaid Services. The applicant shall provide its performance results for each quality measure to the Department at least annually, or as otherwise directed by the Department, for posting on the Department’s website.” This language leaves us unable to make decisions about what measures best relate to our facility and it requires us to duplicate our efforts by informing the State that CMS has data publicly available. CMS already has financial incentives and penalties that sufficiently incentivize us to participate in these programs within various

requirements and our results are a matter of public record with CMS. We believe the State has every right to offer links to such information without our direct consent and, therefore, legislating this requirement is unnecessary and duplicates the efforts.

Ultimately, our tiny center is able to do good things. Our 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. As the majority of our patients have Medicare, the proof of our value is a matter of public record. Unlike hospitals, we pay income tax on any earnings from our center. A provider tax being added on top of the income tax would be an unfair double standard while allowing tens of millions of dollars in profits at UVMMC to go untaxed. Meanwhile, our physician leadership is unpaid while that is certainly not the case at UVMMC. We are doing our fair share in terms of value, quality and taxes. We urge you not to create a double standard and double tax the already vulnerable community of independent physicians that are already offering tremendous value in VT health care. We strongly oppose the potential Ambulatory Surgical Center provider tax that is being discussed at this hearing.

On a different note, we have been advised that there are some who advocate that all surgeons with privileges at an Ambulatory Surgery Center have admitting privileges at a local hospital. This sounds simple enough but in truth it is not. For starters, let's make it clear that it is neither necessary nor helpful for all ophthalmologists to admit patients to a hospital. For comparison, should we start making all dentists have hospital privileges even though most of them don't ever have any reason to admit patients to the hospital? Having said that, I recently completed 7 days of continuous level 1 trauma call for UVM. My partners at Ophthalmic Consultants of Vermont and I all volunteer for the UVM call system even though we do not all operate at UVM. Some of my partners keep admitting privileges at UVMMC specifically for the purpose of supporting the community by volunteering for the Level 1 Trauma call system. Ophthalmologists with admitting privileges at UVM are required to take Level 1 Trauma Call. In a typical year, we provide roughly 1000 hours of unpaid call for the UVM level 1 trauma system. This is not a necessary part of our regular practice and, while so far we feel we 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 such legislation is passed, it would require us, by state law, to provide approximately 1000 hours of unpaid service to the UVM level 1 trauma system. For now we will continue to offer this free service as volunteers but we 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.

Overall, the proposed legislation appears to lump Ambulatory Surgery Centers into the same general category as hospitals and in some cases seeks to provide even more strict

standards for an ASC than a hospital. 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. Of note, several requirements are significantly beyond what hospitals provide:

(a)8) "The applicant shall post on its website the commercial, self-pay, and Medicare prices for each of the 25 most frequently performed procedures and surgeries, or the commercial, self-pay, and Medicare practices for each of the procedures and surgeries that comprise at least 75 percent of the applicant's overall volume, whichever results in disclosure of a greater number of prices. The applicant shall update and post the information at least quarterly, regardless of whether the prices have changed."

First, we strongly support price transparency but object to the language listed above. Hospitals and insurance companies do not do this. We simply feel that the intent here is being misplaced on our center. The problem here lies with insurance companies and hospitals. Neither are advocates of true transparency. As you know, billed amounts are a formality. It is the allowed amounts that insurance companies (or patients with high deductible plans) pay. But these allowed amounts can be difficult to obtain. For example, at Ophthalmic Consultants of Vermont we literally spent nearly two years asking Cigna for our existing fee schedule and eventually gave up. They literally wouldn't tell us what we were due to be paid by code and wouldn't give us a copy of our current contract. On the other hand, on a per patient basis, they would give us detailed information about costs. When we schedule surgeries at the hospital it can be as much or more difficult if not impossible to get accurate answers for our patients about costs. But, on a practical level, it represents a lot of work for our staff every time a patient asks these questions because getting useful information out of hospitals and insurance companies is laborious. I'm proud to say that we have a different philosophy, a personalized approach. We are willing to do the work with each and every patient but it is impractical if not impossible for us to meet the requirements of (a)8 particularly when insurance companies may refuse to give us a fee schedule and when price changes from the insurance company may happen without our knowledge. Furthermore, I believe our contracts forbid us from disclosing our low prices because the insurance companies evidently oppose price transparency and, together with hospitals, consider prices proprietary. Nothing would help patients, independent doctors and ASCs more than price transparency but it needs to be universal and would best be administered by insurance companies or a State website. Lastly, we believe we are already exceeding the requirement of (a)8 by helping individual patients as needed navigate the significant challenges of working with hospital, facility and insurance billing.

Regarding (a)10) "The applicant shall provide each patient with an itemized, detailed, and understandable explanation of charges, regardless of the source of payment, and provide patients with information about the applicant's: (A) health care prices; (B) financial assistance; and (C) billing and collections practices."

This proposed New section, (a)10 is well intended and we already meet every element of its intent. As described above, it is complicated to provide this information and,

therefore, we do it upon request. We believe in transparency but, for several reasons, we do not feel that the administrative burden of providing all of this is advisable in advance when patients have not requested the information. First, it is a lot of work that may not be needed as an expense in the system. Secondly, it introduces the potential for errors or misunderstandings. This gets complicated because sometimes real time data from insurance companies can be inaccurate, for example, deductibles a patient might owe may not be the same when queried as when the actual date of service for a procedure occurs. Also, sometimes medically necessary procedures may be determined at the time of service, after administration of anesthesia, without ability to review costs in advance. In the end, we fully practice price transparency as a part of our regular care and we believe we do so much better than our hospital counterparts. Efforts at improving price transparency are important and should be more centralized with an emphasis on hospitals and insurance companies. We strongly support the concept and will not object to policies for disclosing true prices (not billed amounts) that hospitals and insurance companies will make publicly available as well. If such legislation exists, we will support it. However, isolating it in ASC legislation would only further burden the ASC without allowing patients any better ability to price compare. We believe that the assistance we give our patients now is the best we can do until true price transparency (for allowable rather than billed amounts) is available to Vermonters across the board.

Regarding ASC budgets, the current budget for ASCs in VT, with only The Eye Surgery Center in operation, is tiny. With a yearly budget of roughly 4 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. 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 to have our budget approved by the GMCB 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. Our insignificant budget is hardly worth the time and energy of the Green Mountain Care Board to regulate. Nor is it fair to our physician owners, who are solely responsible for paying our bills, to require approval from the GMCB in our own dynamic budgeting process. With our tiny budget, a single surgeon may represent as much as a quarter of our volume. Should a surgeon join the ASC, or retire, or move out of state, our budget may take fairly wild swings, all at no cost to the healthcare system. Unlike a hospital, we aren't open 24 hours a day, 365 days a year. If we do more cases, our budget is higher and so is our revenue. If we do fewer cases, the opposite is true. It would not serve a useful purpose to go back and forth with the GMCB to approve such fluctuations. We don't have the financial padding to hire additional executives, accountants and lawyers to manage a regulated budget process. Furthermore, as noted above, 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, our homes as collateral to underwrite the loans, the long term lease, and the 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 the good of Vermont.

On a related note, participation in Vermont's systemwide payment and delivery system reform initiatives, as proposed in (a)6 is something we'd like to be included in doing. To be honest, we don't have the clear impression that all parties truly welcome us to the table. Having said that, requiring our participation without defining our voice puts us in poor position to advocate for our perspective. As noted already, we come from the position of wanting to offer high quality care at the lowest price. We've been doing that for about a decade. We can prove it. We'd like to be an example of how things can be done better and we'll happily volunteer to participate. We are opposed to mandatory participation that reduces the strength of our voice at the table, poses the risk of eroding our operational efficiency and reduces the value and quality that we are already bringing to Vermonters.

Lastly, we have concerns about the proposed revision (a) (13) (FOR FURTHER DISCUSSION) "The ambulatory surgical center facilities, including the buildings and grounds, shall be subject to inspection by the Department, its designees, and other authorized entities at all times."

We are unsure about the purpose of this. We are subject to inspection by the Joint Commission unannounced. We also have supported sections (a)2 and (a)4. "(a)(2) The applicant shall demonstrate that its facilities comply fully with standards for health, safety, and sanitation as required by State law, including standards set forth by the State Fire Marshal and the Department of Health, and municipal ordinance. (a)(4) The applicant shall participate in the Patient Safety Surveillance and Improvement System established pursuant to chapter 43A of this title." We would like to know what additional requirements would be subject to unannounced inspection beyond those safety concerns already addressed by the Joint Commission and sections (a)2 and (a)4. Preparing for unannounced inspections is a major undertaking for any institution and we oppose duplicating this process unnecessarily.

To be clear, we do not oppose certain new principles set forth in S.78.

1. Regarding (a)(9) “(FOR FURTHER DISCUSSION) The applicant shall maintain a policy to provide charity care to patients that is comparable to those of the hospitals in the geographic region in which the ambulatory surgical center is located.”

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. Our policy is quite simple. There is tremendous complexity to the UVMHC guidelines. While the philosophy between both policies is similar, the complexity is not. We want to be sure that (a)(9) as drafted, will allow for these substantial differences, allowing that an ASC can reasonably use a simple policy that won't require us or our patients to hire an accountant to understand. We are pleased to offer charity care and will continue to do so but hope that we will not be burdened with a complex and onerous system that mirrors UVMHC to the detail, confuses our staff and our patients. We would propose that the language be modified to state that we agree, as a part of our license, to file our Charity Care policy with the state. We believe this transparency will allow the State assurance of our intentions without adding undue complexity for our center or confusion about our legislative mandate. Unlike a hospital, which can have bills of hundreds of thousands of dollars, an average bill from our center is about \$1000 and I am not aware of any surgery that we have ever been paid more than \$5,000 other than rare corneal transplant surgery which has a human tissue pass through cost of around \$5,000. A simple policy is most appropriate for the magnitude of the bills from our center. We support legislation that will allow for our current, and we feel appropriate, charity care policy. We are happy to provide you with a copy if you wish.

2. (a)(5) (NEW) “The applicant shall maintain certification from the Centers for Medicare and Medicaid Services and shall accept Medicare and Medicaid patients.”

As stated earlier, we support this condition as long as “deemed” status by the Joint Commission combined with accepting Medicare and Medicaid satisfies the requirement.

3. (a)(7) (FOR FURTHER DISCUSSION) “The applicant shall have a transport agreement with at least one emergency medical services provider for emergency patient transportation.”

We support this condition as written.

We all know that most independent doctors have already been forced out of private practice in Vermont. Fortunately, we have felt that in our specialty, with the efficiency we bring to patient care in our offices and at the Eye Surgery Center, that we can make the choice that allows us 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 the proposed modifications to S.73, with the specific exceptions we’ve outlined above.

On a final note, we would like to express our 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.