CERTIFIED COPY

1 STATE OF CONNECTICUT
2 OFFICE OF HEALTH STRATEGY
3 HEALTH SYSTEMS PLANNING UNIT
4
5 PUBLIC HEARING
6
7 DOCKET NUMBER: 21-32425-CON
8 PREMIER BARIATRIC GROUP, PLLC
9 d/b/a NEW YORK BARIATRIC GROUP
10 ESTABLISHMENT OF AN OUTPATIENT SURGICAL FACILITY
11
12 HELD BEFORE:
13 JOANNE V. YANDOW, ESQ - HEARING OFFICER
14
15
16 DATE: DECEMBER 7, 2021
17 TIME: 10:02 a.m.
18 PLACE: HELD VIA ZOOM PLATFORM
19
20
21
22
23 Court Reporter: Theresa Bergstrand, CSR
24
25

1 **A P P E A R A N C E S**

2

ADMINISTRATIVE STAFF:

3

Brian Carney
4 **Jessica Rival**
Leslie Greer

5

REPRESENTING THE APPLICANT:
6 **Shipman & Goodwin, LLP**
One Constitution Plaza
7 **Hartford, CT 06103**
BY: Joan Feldman, Esq.

8

WITNESSES:

9

Dr. Shawn Garber
10 **Vijay Bachani**
Alan Benson

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1 (The hearing commenced at 10:02 a.m.)

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3 HEARING OFFICER YANDOW: Good morning. This is the

4 matter of a Certificate of Need Application, filed by

5 the Applicant, Premier Bariatric Group, PLLC. This is

6 with the Office of Health Strategy, Docket Number

7 21-32425 CON. The Applicant in this matter seeks to

8 establish an outpatient surgical facility under

9 Connecticut General Statute, Section 19(a)-638(a)(6).

10 In its application, Applicant Premier Bariatric

11 Group, PLLC, states it is doing business as New York

12 Bariatric Group, that it is a privately owned, single

13 specialty bariatric practice. Applicant gives a brief

14 description of its proposed, of its proposal stating it

15 seeks to establish a licensed single specialty

16 outpatient surgical facility in Stamford, Connecticut.

17 Applicant states the ambulatory surgery center will

18 primarily perform laparoscopic sleeve gastrectomy and

19 related tests and procedures in connection with the LSG.

20 The public hearing before the Office of Health

21 Strategies Health Systems Planning Unit is being held

22 today, December 7th, 2021. My name is Joanne V. Yandow,

23 Y-a-n-d-o-w. Victoria Veltri, the Executive Director of

24 the Office of Health Strategy has designated me to serve

25 as the Hearing Officer for this matter to rule on all

1 motions and recommend findings of fact, conclusions of
2 law upon completion of the hearing. Public act 21-2,
3 Section 149, effective July 1, 2021, authorizes an
4 agency to hold a public hearing by means of electronic
5 equipment. In accordance with the Public Act, any
6 person who participates orally in electronic
7 meeting, shall make a good faith effort to state your
8 name and title at the outset of each occasion that such
9 person participates orally during an uninterrupted
10 dialogue or series of questions and answers. We ask
11 that all members of the public mute the device that they
12 are using to access the hearings, to access this
13 hearing, and silence any additional devices that are
14 around them. The public hearing is held pursuant to
15 Connecticut General Statutes Section 19(a)-639(a), and
16 will be conducted under the provisions of Chapter 54 of
17 the Connecticut General Statutes.
18 Office of Health Strategy staff is here to assist
19 me in gathering facts related to this application and
20 will be asking the Applicant witnesses questions. I am
21 going to ask each staff person assisting with questions
22 today to identify themselves with their name, spelling
23 of their last name and their title. And I'll start with
24 Mr. Carney.
25 MR. CARNEY: Good morning. My name is Brian

1 Carney, B-r-i-a-n C-a-r-n-e-y. I am a Planning
2 Specialist and the Certificate of Needs Supervisor at
3 the Office of Health Strategy.
4 HEARING OFFICER YANDOW: Thank you. Ms. Rival.
5 MS. RIVAL: Hello, I am Jessica Rival. I am a
6 Health Care Analyst with the Office of Health Strategy.
7 And it's Rival, R-i-v, as in Victor -a-l.
8 HEARING OFFICER YANDOW: Thank you. The
9 Certificate of Need process is a regulatory process, and
10 as such the highest level of respect will be accorded to
11 the Applicant, members of the public and our staff. Our
12 priority is the integrity and transparency of this
13 process. Accordingly, decorum must be maintained by all
14 present during these proceedings. This hearing is being
15 recorded and will be transcribed. All documents related
16 to this hearing that have been or will be submitted to
17 the Office of Health Strategy are available for review
18 through our Certificate of Need portal, and the
19 Certificate of Need you will often here referenced as
20 CON. The CON portal is accessible on the Office of
21 Health Strategies CON web page.
22 In making my decision, I will consider and make
23 written findings in accordance with Section 19(a)-639 of
24 the Connecticut General Statutes. The CON portal
25 contains the table of record in this case. As of this

1 morning, exhibits were identified from A to Q, is that
2 correct, Ms. Rival, we go up through Q, I believe, is
3 the last one?
4 MS. RIVAL: No. O.
5 HEARING OFFICER YANDOW: O. Okay.
6 MS. RIVAL: This was a revision, so it is A through
7 O.
8 HEARING OFFICER YANDOW: Okay. Thank you.
9 MS. RIVAL: Sure.
10 HEARING OFFICER YANDOW: In accordance with
11 Connecticut General Statutes Section 4-178, the
12 Applicant is hereby noticed that I may take judicial
13 notice of the following documents: The Statewide
14 Healthcare Facility and Services Plan; Facility and
15 Services Inventory; OHS Acute Care Hospital Discharge
16 Database; Hospital Reporting System, also known as HRS,
17 Financial and Utilization Data; and all payer claims
18 database claims data. I may also take administrative
19 notice of prior OHS Final Decisions that may be relevant
20 to this matter.
21 Mr. Carney, are there any additional exhibits to
22 enter into the record at this time?
23 MR. CARNEY: No, Attorney Yandow, not that I am
24 aware of.
25 HEARING OFFICER YANDOW: Okay. Thank you. Counsel

1 for the Applicant, would you please identify yourself?
2 MS. FELDMAN: Good morning. My name is Joan
3 Feldman. I am a partner with the law firm of Shipman
4 and Goodwin, and I am counsel for Premier Bariatric
5 Group, PLLC.
6 HEARING OFFICER YANDOW: Okay. Thank you.
7 Attorney Feldman, are there any objections to the
8 exhibits in the Table of Record, or the Noticed
9 Documents.
10 MS. FELDMAN: No, there are not.
11 HEARING OFFICER YANDOW: Okay. All identified and
12 marked exhibits are entered as full exhibits. Attorney
13 Feldman, just to clarify, the full, the legal name of
14 the Applicant, just so we make sure we have it in the
15 record?
16 MS. FELDMAN: Premier Bariatric Group --
17 MR. GARBER: Premier Bariatric Surgery, LLC.
18 HEARING OFFICER YANDOW: Okay. All right, Dr.
19 Garber, I am going to ask -- okay. When your, I will,
20 you are a witness in the matter, so I know your attorney
21 is going to introduce you soon, and I appreciate your
22 assistance, but I just, at this point, want to, any kind
23 of legal question I will direct to counsel, Attorney
24 Feldman.
25 So Attorney Feldman, Premier Bariatric Group, PLLC?

1 MS. FELDMAN: That is correct. Doing business as
2 New York Bariatric Group.
3 HEARING OFFICER YANDOW: All right. Thank you. We
4 will proceed in the order established in the agenda for
5 today's hearing. The agenda can be found on the CON
6 portal. I would like to advise the Applicant that we
7 may ask questions related to your application that you
8 feel you have already addressed. We will do this for
9 the purpose of ensuring that the public has knowledge
10 about your proposal and for the purpose of
11 clarification. I want to reassure you that we have
12 reviewed your application, completeness responses and
13 prefiled testimony. As this hearing is being held
14 virtually, we ask that all participants to the extent
15 possible, to enable the use of their video cameras when
16 testifying or commenting during the proceedings. Anyone
17 who is not testifying or commenting shall mute their
18 electronic devises, including your telephones,
19 televisions and other devices not being used to access
20 the hearing. All participants shall mute their devices
21 and disable their cameras when we go off the record or
22 take the break. Please be advised that the hearing may
23 be recorded during breaks. It is our intention not to
24 record during breaks, but there is a possibility that
25 that could happen. So just want to advise you, if you

1 are recording, if the recording is on, any audio or
2 video not disabled during breaks, may be accessible or
3 will be accessible to all participants to this hearing.
4 So I will try to give reminders when we go on breaks,
5 but you will also want to try to remember that.
6 Public comments during the hearing will likely go
7 in the order established by OHS during the registration
8 process, however I may allow public officials to testify
9 out of order. I, or OHS staff, will call each
10 individual by name when it is his or her turn to speak.
11 Registration for public comment will take place at 2:00
12 o'clock, and is scheduled to start at 3:00. If the
13 technical portion of this hearing has not been completed
14 by 2:00 o'clock, public comment may be postponed until
15 the technical portion is complete. If the technical
16 portion is complete before 2:00 p.m., we will break
17 until 3:00. Applicant's witnesses must be available
18 after the public comment, as OHS may have follow-up
19 questions based on the public comment.
20 Mr. Carney, are there any other housekeeping
21 matters or procedural issues that we need to address
22 before we start?
23 MR. CARNEY: No Attorney Yandow, I think we are all
24 set.
25 HEARING OFFICER YANDOW: Okay. Thank you.

1 Attorney Feldman, are we all set? Yes? Okay. You are
2 on mute, so you just want to, do you have an opening
3 statement?
4 MS. FELDMAN: I have a few comments to make, and
5 thank you for that opportunity.
6 We are very happy to be here today. We have, as
7 you know, waited for some time. We patiently waited.
8 We are very excited about bringing this proposal to OHS
9 because we think it exemplifies all of the policy
10 directives that OHS has established with respect to
11 offering lower cost, accessible, ambulatory services.
12 As you probably know, the managed care companies, the
13 third-party payers are all shifting what was essentially
14 only inpatient care to ambulatory settings. This is the
15 first proposed ASC that will offer laparoscopic sleeve
16 gastrectomy in Connecticut. It is a minimally invasive
17 procedure. It takes approximately 35 to 40 minutes.
18 Dr. Garber will go into greater detail and be able to
19 answer all of your questions about the procedure, but it
20 has a very, very minimal complication rate. Patients
21 are on their way again 2 hours after the procedure is
22 completed. They don't have to navigate a hospital.
23 There is less exposure to infection. It's a lower cost
24 procedure format in an ASC by approximately 30 to 40
25 percent less expensive than an inpatient procedure.

1 About 80 percent of the patients will qualify to have
2 this procedure performed in the ASC. Basically having
3 been screened using standards for making those types of
4 determinations, and again, I don't want to steal Dr.
5 Garber's thunder, but it really is something that is
6 very much needed in the State of Connecticut. We, it is
7 already being performed at about 14 other states on an
8 ambulatory basis. Premier has just opened an ambulatory
9 center and will begin performing the procedure very
10 shortly in the next couple of days or weeks in New
11 Jersey. It has negotiated with national payers for this
12 lower rate, and has already begun to negotiate in the
13 State of Connecticut. The payers are very excited and
14 encouraged by this opportunity.
15 It is going to be located in Stamford, Connecticut,
16 which is in Fairfield county, where there is 27 percent
17 incidence of morbid obesity. It will be accessible to
18 Connecticut residents and Westchester County and New
19 York, other New York residents. The thing that is so
20 unique about this particular application, and as Brian
21 and Steve and other staff members know, I have been
22 before OHS many, many times, I am leading with the fact
23 that is a lower cost procedure and that we welcome
24 Medicaid parents. 25 percent of our patient population
25 is covered by Medicaid. Why is that of

1 interest, well, when you look at the statistics with
2 respect to morbid obesity, there is a higher incidence
3 of morbid obesity among lower socioeconomic groups,
4 individuals that are black and Latino. We also know
5 within the last two years that with the COVID-19
6 pandemic, that folks who are morbidly obese are at a
7 higher risk for death as a result of COVID. So it is
8 really an important procedure to perform. Dr. Garber
9 can address how it reduces complications, secondary
10 complications that are often associated with morbid
11 obesity, such as heart disease, diabetes, hypertension,
12 sleep apnea, arthritis, all of those very chronic and
13 disabling diseases.
14 More importantly, in addition to the successful
15 outcomes regarding weight loss, it really makes a very
16 beneficial change in the lives of the individuals that
17 undergo the surgery, in that they are able to become
18 more functional. They are able to go out into society,
19 work again, travel, et cetera.
20 So, we are very excited about this. This surgery
21 center that they are planning to locate was occupied by
22 a prior ambulatory surgery center. Actually that was
23 grandfathered in before there was a CON process for
24 ASC's, and it's of minimal expense. The only expense is
25 primarily associated with equipment to outfit the two

1 OR's, one that will be used initially, and the procedure
2 rooms. So I will finish, and if you will allow Dr.
3 Garber to provide his testimony, we can begin.
4 HEARING OFFICER YANDOW: Okay. So your witnesses
5 lined up today are Dr. Garber, anyone else lined up
6 today?
7 MS. FELDMAN: We don't have any other individuals
8 providing testimony, but we have with us the Chief
9 Operating Officer of Premier, which is Vijay Bachani,
10 and we have the CFO, which is Alan Benson, in the event
11 OHS has any specific questions that are within their
12 area of expertise.
13 HEARING OFFICER YANDOW: Okay. And before I
14 decide, you know, whether or not to call them, could you
15 tell me, Attorney Feldman, basically as far as the COO
16 and the CFO, what their knowledge base is? And if I
17 want more, I'll certainly swear them in and ask them
18 that, but do you, can you tell what it is that they
19 would have to offer?
20 MS. FELDMAN: Sure. So Mr. Bachani is the Chief
21 Operating Officer and he will have knowledge regarding
22 the establishment of the organization. He will have
23 knowledge about the reimbursement of the organization,
24 as will Dr. Garber, and staffing issues and just
25 operational issues and business issues. Mr. Benson will

1 be able to address any questions you have with respect
2 to the Financial Attachment B, regarding our projections
3 and things of that nature.
4 HEARING OFFICER YANDOW: Okay. Thank you. Okay.
5 And Dr. Shawn Garber is the only witness that filed
6 prefiled testimony, correct?
7 MS. FELDMAN: Correct.
8 HEARING OFFICER YANDOW: Okay. All right. Dr.
9 Garber, could you please raise your right hand.
10
11 (Whereupon Dr. Shawn Garber was duly sworn in by
12 Hearing Officer Yandow.)
13
14 HEARING OFFICER YANDOW: Okay. Could you state and
15 spell your name, please.
16 MR. GARBER: Shawn, S-h-a-w-n Garber, G-a-r-b, like
17 boy-e-r.
18 HEARING OFFICER YANDOW: Okay. And what is your
19 title regarding the Applicant?
20 MR. GARBER: I am the Founder and President of
21 Premier Bariatric Surgery, PLLC.
22 HEARING OFFICER YANDOW: Okay. So Dr. Garber, I
23 just want to make you aware, that Attorney Feldman gave
24 us a nice outline about what the evidence is going to
25 show, but your attorney's statements aren't evidence.

1 Evidence has to come from witnesses and from documents.
2 So she set forth a path, hopefully on what kind of
3 information we are going to get today from the
4 witnesses. You know, your testimony is going to be
5 helpful, any kind of documentation, if it is already
6 been submitted, you know, please refer to that, anything
7 that will back up any kind of statement you have. Any
8 documents that you have that haven't been submitted, we
9 may seek late files, or if you believe there is
10 something there that we haven't identified, I mean,
11 certainly bring that to our attention. And we will
12 certainly take a break at, you know, some point, too,
13 and you can always, you know, come back to me during
14 this hearing today to tell me other documents that you
15 think might be relevant that we should consider, okay.
16 Now you did file a prefiled testimony, do you adopt
17 the written testimony that you submitted and that has
18 been filed on CON portal?
19 MR. GARBER: Yes, I do.
20 HEARING OFFICER YANDOW: And is, and is that
21 information true and accurate to the best of your
22 knowledge?
23 MR. GARBER: Yes, it is.
24 HEARING OFFICER YANDOW: Okay. So we have this, I
25 mean, we may also have some public viewing in to get

1 information. I mean, your document is on the portal.
2 It is now a full exhibit. You have taken an oath that
3 this is true, but so you can certainly tell me what is
4 in there. Certainly expand, if you need to. And again,
5 refer us to any other documents that are in the record
6 that you think that are helpful and support what you
7 have to state. So, I will turn it over to you, Dr.
8 Garber.
9 MR. GARBER: First I want to thank Attorney Yandow
10 and the rest of the staff for having me today and
11 looking at our application. Like Ms. Feldman said, we
12 are very enthusiastic about this and we think it is a
13 great opportunity for us to provide care to the
14 residents of Connecticut and increase access to care,
15 which has always been very, very important to myself and
16 our practice.
17 A little background about New York Bariatric Group,
18 we are the larger bariatric surgery practice in the
19 country. We have over 24 bariatric surgeons, now, more
20 than what we originally had in our application. We have
21 been growing since the application was submitted. We
22 have a comprehensive support structure in place in our
23 practice, which I think is very important for our
24 application to show that we do very comprehensive
25 workups and evaluation of all of our patients prior to

1 undergoing any kind of surgery.
2 So we employ our own cardiologists, pulmonologists,
3 nutritionists, psychologists, as well as
4 anesthesiologists. The bariatric patient population is
5 very unique in that they have a lot of comorbidities and
6 medical problems, like diabetes, sleep apnea,
7 hypertension. Anesthesiologists need to be specialty
8 trained to take care of bariatric patients and that is
9 why we employ our own. We do a very comprehensive
10 workup on all of our patients. All of our patients,
11 before undergoing any kind of surgery, will see all of
12 these different specialists of cardiology and pulmonary,
13 nutrition and psychology, and if they find anything out
14 of the ordinary in this patient population, then
15 obviously they would take care of it. If they do a
16 cardiac workup and they are having chest pain, we will
17 send them to have their heart checked prior to
18 undergoing surgery. If they have psychological issues
19 that we think they won't perform well after surgery, we
20 will undergo counseling and correct those issues prior
21 to surgery. So we do a very thorough evaluation of
22 everybody, and that has been what we have been doing
23 for, since I started my practice many years ago.
24 We also set up and run over seven MBSAQIP Center of
25 Excellence Programs at different hospitals throughout

1 New York, New Jersey and Connecticut.
2 HEARING OFFICER YANDOW: Dr. Garber, I am just
3 going to ask, I don't know if, so I am not a doctor and
4 I am not, some of the acronyms you use may, maybe
5 everybody but me knows what they mean. But I know,
6 like, Attorney Feldman was talking about ASC, ambulatory
7 surgery center, can we agree that ASC is an ambulatory
8 surgery center?
9 MR. GARBER: Yes. Yes. I will elaborate more on
10 those acronyms for you, I will --
11 HEARING OFFICER YANDOW: So just be mindful, you
12 know, those of us taking into consideration -- I mean,
13 my job as the hearing officer is to apply the law to the
14 facts. Okay. So I am not a medical person, so anything
15 you assume might be, you know, it will be helpful for me
16 when you use, at least the first time, tell me what it
17 means.
18 MR. GARBER: Sure. So MBSAQIP is a program to do
19 Centers of Excellence for bariatric surgery. It was set
20 up by the American College of Surgeons and the American
21 Society of Metabolic and Bariatric Surgeons. Together
22 they formed this MBSAQIP, which what they do is, is they
23 certify hospitals to be centers of excellence. And how
24 they do that is, is we have to have lots of special
25 procedures and policies in place at each hospital,

1 proper equipment, proper training of all the staff. We
2 have to have an independent data collector that goes
3 and, that enters data into a centralized database
4 nationally of all of our complication rates, procedures,
5 everything gets entered by an independent person. And
6 we get benchmarked against other programs around the
7 country. Every quarter we get a report from MBSAQIP.
8 So it is a Center of Excellent program that is
9 nationally recognized by the American College of
10 Surgeons and the American society of Metabolic and
11 Bariatric Surgeons. In all of the hospitals that we
12 work at, we have achieved that status. And we, me or
13 one of my surgeons, have set up and run each one of
14 those programs. Our goal here with this surgery center
15 that we are setting up, is they do MBSAQIP, the Center
16 of Excellence Program, does have defined criteria for
17 ambulatory surgery centers performing bariatric surgery.
18 So our plan is, number one, is to follow all of the
19 strict rules, policies and criteria when setting up our
20 program there, as well as achieving Center of Excellence
21 by that accreditation within the year of opening up the
22 center.
23 We participate with all the major insurance
24 companies. This is another important thing. So there
25 is a lot of bariatric surgeons I know in the northeast

1 that are out of network with insurance plans. We are a
2 fully, 100 percent in-network model and do participate
3 with every insurance, as well as we accept Medicare and
4 Medicaid patients. We, New York we do all the managed
5 medicaid plans, Connecticut there is only one Medicaid,
6 Husky, and in Connecticut it is a very large portion of
7 our patient population is the Husky Medicaid. So about
8 25 to 30 percent of our patients that we treat
9 currently, do take Medicaid. And we look at that as
10 charity caring, that our reimbursement is quite low and
11 that we pretty much lose money on every patient that we
12 take care of with Medicaid, we lose money. Second to
13 the reimbursement as compared to what we pay our
14 surgeons. But it is very important to us as
15 organization is to treat all patients and really help
16 the community. Because obesity, as everyone knows, is a
17 huge epidemic in the U.S. and growing every single day.
18 There is always news articles. It affects lots of
19 different medical problems that patients get, like
20 diabetes, high blood pressure, sleep apnea, joint
21 disease, a high degree of depression in morbidly obese
22 patients. And like my attorney mentioned earlier, it
23 disproportionally affects the lower socioeconomic
24 classes and black and Latino communities.
25 HEARING OFFICER YANDOW: I just want to just touch

1 base, and I don't mean to interrupt, but that was one of
2 the things that you stated, and I know that there was a
3 link in documents that you filed. So when I clicked on
4 that link, I didn't find the information about the black
5 community and the Hispanic community. So maybe,
6 Attorney Feldman, if you could check that link and I
7 just want to make sure that information is there based
8 on the population that you say it affects. I did go
9 through documents, I clicked on links, I clicked on the
10 footnote link. I know that the link in the prefiled
11 testimony, I couldn't get on those through the links,
12 but I could get on through the links through the
13 application.
14 So if, that was something I did want to follow-up
15 on. So maybe, Attorney Feldman, on a break or
16 something, can take a look to see where that information
17 is and refer us later. Okay. I am sorry, Dr. Garber,
18 go ahead.
19 MR. GARBER: No problem, at all.
20 I want give to you a little background of what is
21 laparoscopic sleeve gastrectomy, because like you said,
22 a lot of people, again, might not be aware of what that
23 is. It is the most commonly performed procedure right
24 now for weight loss in the United States. So over the
25 years there has been evolutions of different procedures.

1 Many years ago, many people might have heard or
2 something called gastric bypass surgery. Then there was
3 lap band surgery. Sleeve gastrectomy has been around
4 for quite some time, probably for over 15, 16 years, and
5 it is now the number one most common surgery being
6 performed in the United States for weight loss. What
7 laparoscopic sleeve gastrectomy is, it is a minimally
8 invasive procedure done laparoscopically through five
9 little tiny incisions about a quarter of an inch each.
10 We put a camera inside the abdomen and we watch what we
11 are doing on a TV screen. And then we staple and remove
12 about 70 percent of the patients stomach and pull it out
13 through the bellybutton. And we make the stomach into a
14 long thin lube like a sleeve. A lot of people think
15 that you put a sleeve in, it really what we do is we
16 change the shape of the stomach into looking like a
17 sleeve. So it becomes a long thin tube. And this has
18 been shown to be very effective in helping people lose a
19 large majority of their excess weight.
20 So the surgery is extremely successful. The
21 long-term success rate of sleeve gastrectomy is the
22 majority of patients will lose about 80 percent of their
23 excess weight within one to two years after surgery.
24 HEARING OFFICER YANDOW: And that is, so going
25 back, just to step back, when you are talking about what

1 the surgery entails, just give me a little more detail
2 as far as, you bring in an anesthesiologist, the patient
3 is -- I mean, I, you know, just, I need to be spoon fed,
4 you know, what is the procedure so.
5 MR. GARBER: No problem at all. So the patients
6 undergo their extensive workup in our office prior to
7 surgery where they see all these different specialists,
8 with I mentioned earlier. They come in, they get
9 preadmission testing. We do preop blood work on them.
10 They come in, they have, undergo extensive education
11 require to surgery. We document all the risks,
12 benefits, alternatives, obtain specific consents
13 specific for the procedure. They come in, they will
14 meet with an anesthesiologist that will evaluate the
15 patient. The patient would be brought into the
16 operating room. They will undergo general anesthesia,
17 so they do get a breathing tube inserted. The nice
18 thing about some of the newer technology in, many years
19 ago, 20 years ago when I first started doing bariatric
20 surgery, sometimes it would be difficult to put a
21 breathing tube in an obese patient because they have
22 very thick necks and it would be hard to get the
23 breathing tube in. Now there is great technology called
24 the Glide Scope, which is actually a camera where they
25 put in the back of the throat, and under direct

1 visualization they can easily put those tubes in
2 nowadays, and obviously we would have those at the
3 center. So really the risk of putting patients, obese
4 patients to sleep is very, very minimal nowadays with
5 the new technology that we have. Once they are asleep,
6 we prep and drape their abdomens, and then we make five
7 little tiny holes, like I said, a quarter to a half inch
8 each. We put little tubes inside the belly and we put
9 camera in the belly, and we have TV screens that we are
10 watching what we do. And then through those other four
11 tubes, we insert instruments where we staple and divide
12 the stomach. We have a special device that does three
13 rows of staples on each side of the stomach and then
14 cuts the middle. And we staple and divide the stomach
15 after placing a tube in the mouth, so we know it is the
16 proper size.
17 We then take that piece of stomach and we pull it
18 out through the bellybutton. And that is pretty much
19 the end of the procedure. And usually it takes, I have
20 done these in 20, 25 minutes. Some surgeons are 35, 40
21 minutes, but it is a relativity quick procedure. After
22 the procedure they are, the anesthesiologist wakes them
23 up, they take the breathing tube out, they go to the
24 recovery room. Usually within, within an hour we get
25 them out of bed, get them to start walking, and they

1 should be able to go home within about two hours, would
2 be the average length of stay of how long they would be
3 in the center. You are muted.
4 HEARING OFFICER YANDOW: Is it moderate or deep
5 sedation?
6 MR. GARBER: It is general anesthesia, so it is
7 deep sedation. It is general anesthesia, so it's deep,
8 it's completely general anesthesia, so that's as deep as
9 anesthesia can be.
10 HEARING OFFICER YANDOW: Okay. Thank you.
11 MR. GARBER: So why do we think that we should
12 approve laparoscopic sleeve gastrectomy in a surgery
13 center? We think it is a much more cost effective
14 option, as opposed to right now all of the surgeries
15 that we do in the State of Connecticut are done in the
16 hospital as an inpatient basis. The amount of
17 reimbursement that the hospital are getting paid by
18 payers is much higher than what we are going to be able
19 to do it for in the surgery center.
20 So like mentioned earlier, we have already
21 established a surgery center in New Jersey, in Paramus
22 New Jersey. We took ownership of it. It was an
23 existing ASC that we took over the license, and we took
24 over about four months ago. I have been aggressively
25 negotiating with all of the major payers in New Jersey.

1 And as of last week, we have completed 100 percent of
2 the payers. We do have agreements with, to perform
3 laparoscopic sleeve gastrectomy in the surgery center
4 and approximately a 30 to 40 percent reduction of what
5 they were paying the hospitals. So the insurance
6 companies are extremely excited about being able to move
7 the patients from the inpatient to the ASC setting.
8 I have begun discussions with, in Connecticut, with
9 Anthem Blue Cross Blue Shield. We have a meeting set up
10 next week to start discussing rates, being hopeful that
11 we get approval for ASC. The other payers are all
12 national payers, like United, Cigna, Aetna, which we
13 have agreements with, which also are big payers within
14 Connecticut, so we are pretty confident that we would
15 get the same exact agreements that we have in those,
16 with those major payers in Connecticut, as well.
17 As far as Medicaid, which I know is big part of the
18 application, so currently, CMS, which is Centers for, I
19 am not sure what CMS stands for, it is Medicare. So CMS
20 does not have a reimbursement rate for sleeve
21 gastrectomy in an ASC setting. Therefore Medicaid, and
22 specifically Husky Medicaid does not have any rates set
23 to perform sleeve gastrectomy in an ASC setting. So
24 right off the bat, we are not able to do Medicaid
25 patients in the surgery center. But I have reached out

1 to Bradley Richards many times. I have sent a lot of
2 documentation that we sent to your office, about the
3 benefits and safety of sleeve gastrectomy in the ASC,
4 and he is generally supportive of the concept, but he is
5 in the process of doing a fiscal analysis for that. So
6 I have had many communications with him on that, and the
7 hope is that they will approve it with the rate and will
8 start doing it in the ASC.
9 We also are committed to doing five percent charity
10 care for patients. So patients that have no insurance,
11 can't afford it, we are either going to do very reduced
12 rates based on financial need or even offer free surgery
13 to patients in the community, because we do believe that
14 this is an epidemic and there is many, most private
15 practices do not take Medicaid parents into their, into
16 their office. But we have, and we continue to.
17 We think that, like I said earlier, there is about
18 a 30 percent savings over inpatient. Another example of
19 why this is needed is self-pay rates. So we see a small
20 percentage of patients that self-pay for surgery. The
21 rates for the hospitals in Connecticut are higher than
22 New York and New Jersey. So most, currently most of our
23 patients that do self-pay, they end up having their
24 surgery done in New York or New Jersey because it is
25 lower self-pay rates. So the prices in Connecticut are

1 much higher. And by offering an ASC where we control
2 the rates, we are going to able to offer a much more
3 affordable solution for patients without insurance to be
4 able to have the procedure done.
5 There was an article that we submitted with our
6 application of in SOARD, which is the Surgery for
7 Obesity And Related Diseases, that was published in
8 2018, where they looked at 3,162 patients from nine
9 different ambulatory surgery centers and they showed
10 that laparoscopic sleeve gastrectomy in an ASC setting
11 is safe with low complication rates. When thinking
12 about what is this equivalent to, to proceed as you
13 already approve in a surgery center, it is very similar
14 to approval for a gallbladder. So laparoscopic
15 cholecystectomy, or removal of a gallbladder, which is
16 the organ attached to the liver, is now routinely being
17 done at ambulatory surgery centers. And the risk of
18 that is very similar to the risk of the sleeve
19 gastrectomy. So we don't think there is any really
20 added risk.
21 We think we can bring 80 percent of our patients
22 that currently are done in the hospital to the
23 ambulatory surgery center. There will still be about 20
24 percent of the patients that would be too high risk with
25 severe sleep apnea or heart disease, that will still

1 need to be done in the hospital setting. So we are not
2 going to be moving 100 percent of our cases to the
3 ambulatory surgery center, but we are estimating, and it
4 is a little bit of a guess, but looking at our data we
5 think it's pretty accurate, about 80 percent of our
6 patients into the surgery center.
7 So like I had mentioned earlier, and one of our
8 other exhibits is the MBSAQIP, which we mentioned
9 earlier, which is the organization for the American
10 College of Surgeons and American Society of Metabolic
11 and Bariatric Surgeons, they do have a set criteria
12 which we have submitted with our application, the
13 MBSAQIP criteria to achieve Center of Excellence. And
14 there is a Section 1.2, which talks about low acuity
15 patient and procedure selection. So in there has very
16 specific defined criteria of which patients should be
17 done safely, that can be done safely in a surgery
18 center, and it is based on BMI. BMI is body mass index.
19 It is your ratio of height to weight. So if you are
20 taller, you need to weigh more to have a higher BMI. So
21 the criteria we use in general for surgery, is a body
22 mass index of 35, which is, or with any medical problem
23 related to obesity, like diabetes, hypertension or sleep
24 apnea, or a BMI, or body mass index of 40 or greater
25 with no medical problems qualifies for surgery. And

1 those are the criteria that has been around forever.
2 That is the criteria that all the insurance companies
3 use to approve bariatric surgery, and those are the
4 criteria that we follow, as well.
5 The MBSAQIP 1.2 low acuity patient procedure
6 selection does limit the BMI's and age criteria of who
7 can be done safely in the surgery center, and they
8 recommend ages of eight to 65, males with a BMI less
9 than 55 and females with a BMI less than 60. And the
10 reason the difference between males and females are, a
11 lot of people probably aren't aware, but males and
12 females carry their fat very differently. Males
13 typically carry most of their fat in the central part of
14 their abdomen and body. Men are more typically have
15 more medical problems like diabetes. It is a much more
16 unhealthy way to carry weight. Where females, we call
17 them as pear shaped, more often carry a lot of the fat
18 and weight in their buttocks and thighs and lower body.
19 And their abdomens are smaller. They usually have less
20 medical problems and easier to do the surgery on a
21 female, than a male because there is less fat around the
22 organs, believe it not. So the BMI criteria is
23 definitely a little bit higher for females versus males.
24 And then they can't have any organ failure, they can't
25 have an organ transplant and no significant cardiac or

1 pulmonary disease. And like I said, all of our patients
2 are undergoing cardiac and pulmonary workups prior to
3 surgery. So we plan on following this criteria exactly
4 because we want, we want to apply to achieve MBSAQIP
5 Center of Excellence at our center.
6 There is a section that, I think it is page, I'll
7 tell you what section, Section 8.1 in the MBSAQIP is
8 where they -- sorry, I think it is actually 8.2, is
9 where they define the criteria for performing bariatric
10 surgery, specifically staple procedures, which is
11 laparoscopic sleeve gastrectomy, in an ambulatory
12 surgery center. So you can reference that for these
13 criteria. And like I said, these criteria are set up by
14 the American College of Surgeons and the American
15 Society of Metabolic and Bariatric Surgeons.
16 HEARING OFFICER YANDOW: And what document was that
17 again, please?
18 MR. GARBER: It is the MBSAQIP Centers -- it is
19 MBSAQIP Criteria Handbook.
20 HEARING OFFICER YANDOW: Is that --
21 MR. GARBER: Is the --
22 HEARING OFFICER YANDOW: Is that attached to the
23 application, or is that --
24 MR. GARBER: It is within the application. It
25 might have been submitted in one of the follow-up

1 questionnaires, but it definitely was submitted to you.
2 And if not, we can get you another copy of it. But I am
3 pretty confident that you have a copy of that somewhere.
4 HEARING OFFICER YANDOW: Okay. We will certainly
5 look at the whole record.
6 MR. GARBER: Okay. So like, like earlier was, it
7 was said, laparoscopic sleeve gastrectomy is currently
8 in 14 different states in the U.S. It is in Ohio,
9 Nevada, California, Texas, Georgia, Washington State,
10 Arizona, Kansas, Indiana, Illinois, Delaware, Oregon, as
11 well as New Jersey. The New Jersey ASC we plan on
12 starting January 1st, if we are going to start doing
13 first sleeve gastrectomy in the ASC. We have not done
14 it yet and we have been waiting to negotiate the payer
15 contracts, which took a little long than expected. But
16 like I said, they are all completed and we are starting
17 January 1.
18 So a little bit about the target population, which
19 was mentioned earlier. Obesity is on the rise. It is a
20 major epidemic in the U.S. In Connecticut 29 percent of
21 the population is obese, and in Fairfield County 27
22 percent are obese. Another point, which we think is
23 important, which everyone, has been on everyone's radars
24 lately is COVID. There is a much higher risk of death
25 from COVID and being hospitalized for the morbidly obese

1 patients. We saw it on the news when COVID epidemic
2 hit. There was good data published by NYU that a good
3 percentage of the patients that get hospitalized are
4 morbidly obese and there is much higher risk. So, we
5 think that bringing patients to a lower acuity place,
6 like an ASC, patients will feel a lot more comfortable.
7 So we got a lot of pushback after, once COVID hit, we
8 were all shutdown for a couple months. Havoc
9 everywhere. I am sure you guys had plenty of havoc
10 yourselves. And we, since then, we have patients that
11 sometimes are scared, they don't want to go to the
12 hospital for surgery. They're like, there is COVID
13 there, I don't want to go there. And we know that has
14 affected lots of different things. People with cancer
15 are dying. We are seeing epidemics everywhere in all
16 different types of medicine, that people aren't going
17 for their routine colonoscopies and breast imaging. So
18 we know that because of COVID, everyone put their health
19 on hold, and we think that offering this lower acuity
20 place, where patients can come and not be part of a
21 hospital, they will be much more apt to have surgery.
22 Right now in the United States, we only operate on one
23 percent of the patient population that qualify for
24 bariatric surgery. So a lot of it is awareness. A lot
25 of people are scared of surgery, but we at the New York

1 Bariatric Group do a really good job on educating
2 patients. We do offer free seminars to patient's
3 regularly at all different hospitals. We do online
4 seminars, now, like we are doing right here. So we
5 really believe in educating the community about this.
6 Obesity leads to all these medical problems and
7 costs the government and insurance companies hundreds of
8 millions of dollars a year related to all the
9 comorbidities. Type two diabetes, which is adult onset
10 diabetes, is almost always related to obesity. Sleep
11 apnea, almost always related to obesity. Those medical
12 problems go away when we do surgery on these patients.
13 So we cure that Type 2 Diabetes, we cure sleep apnea.
14 We cure high blood pressure. We cure all these
15 different medical problems by doing this procedure. So
16 it really is a life changing procedures for patients to
17 reduce their comorbidities and increase their life
18 spans. We know that morbidly obese patients die maybe
19 seven, eight years earlier than non-morbidly obese
20 patients.
21 As far as cost savings, like I said, from the rates
22 that we have negotiated from what, we don't know
23 definitively what hospitals get. I kind of have a
24 general understanding of what hospitals get from the
25 facility fees, that our rates are about 30 to 40 percent

1 less than what the hospitals are getting paid.
2 In conclusion, I would like to say, I thank you all
3 for considering the application. We really think that
4 this is a great service that we can provide to the
5 community for patients in need that can't attain this
6 necessary surgery that is life changing, decreases
7 medical issues, decrease the general cost of medical
8 care overall to the State, as well as to the insurance
9 companies. And we think that by offering this lower
10 cost alternative, we will increase access to care and we
11 will just help make the community healthier.
12 HEARING OFFICER YANDOW: Thank you. I know OHS
13 staff has some questions for you, but I have some first.
14 And you will, I may chime in with some of their
15 questions. But sort of on the top of my head, and I
16 think you have gone through the 19(a)-639 criteria,
17 because I see in your written testimony here you, sort
18 of, tried to break it down in some of the pieces. And
19 one of the the parts of the law that we have to look at
20 is whether there is a clear public need for the health
21 care facility or service processed by the Applicant. So
22 I know you have given me a lot of general information,
23 so I would like to focus it on Connecticut. I mean,
24 how, and I'll follow-up with some questions, but let me
25 just, sort of, put this out and let me -- I am

1 interested, how many Connecticut patients do you work,
2 do you deal with, now? Why do you think if you do this
3 you are going to get some patients in the, in this
4 center? I know you talked about the COVID and, but I
5 don't know what kind of numbers we are talking about. I
6 mean, how many patients do you now do this procedure on
7 in hospitals? What hospitals do you do them in? Why
8 doing this, why can't, is the change just about saving
9 money or is, can you not get to all your patients
10 because you can't get, you know, time in the hospitals?
11 I don't know. I don't know what the need is specific to
12 Connecticut. So if you could, sort of, explain a little
13 bit more about how, what the clear need is in
14 Connecticut and the area that you are looking to, you
15 know, to start this facility.
16 MR. GARBER: So currently we perform all of our
17 surgeries at Saint Vincent's Hospital in Bridgeport, as
18 well as Saint Francis Hospital in Hartford, are the two
19 hospitals where we perform all of our surgeries. In
20 2020, we took care of 439 Connecticut Medicaid patients.
21 Overall in the practice, we are doing approximately
22 about 4,500 bariatric surgeries a year. In Connecticut,
23 separately, we have to, I have to get that data, I don't
24 have that offhand, to be honest with you.
25 HEARING OFFICER YANDOW: Okay. Those are numbers

1 we are going to need. We are going to need a breakdown.
2 So if we could have a late filed exhibit, and I'll
3 certainly let Jessica or Brian certainly with their --
4 MS. FELDMAN: I just want to -- they are all in the
5 application, those numbers.
6 HEARING OFFICER YANDOW: Those numbers, the
7 breakdown by state?
8 MS. FELDMAN: In the State of Connecticut with
9 respect to the need and Fairfield County, all of that
10 information is in the application. We did not provide
11 data on other states.
12 MR. GARBER: So somewhere, if I could read a little
13 bit from the application. In, based, this is based on
14 2019 data as far as what qualifies. In Fairfield County
15 alone, there is about 198,000 patients that are obese,
16 about 27 percent of the population. Of those, one
17 percent will choose bariatric surgery, which is about
18 1,982 patients. So we estimated in, about 2,542
19 prospective patients. That is what is in our
20 application. In that area.
21 As far as what we are currently doing, Vijay or
22 Alan, if you don't mind, if you can pull up quickly that
23 number of patients in Connecticut, we can get you the
24 actual number of cases that we have done. But we are
25 doing, probably, I am averaging, I am guessing -- we

1 will go back to the actual data, we will get you right
2 now. About -- Alan or Vijay, do you have that?
3 Probably about 40 cases a month.
4 HEARING OFFICER YANDOW: And I am going, is it Mr.
5 Bachani -- am I pronouncing it correctly? Is it
6 Bachani, Bachani.
7 MR. BACHANI: Yes, correct. My name is Vijay
8 Bachani. I am the Chief Operating Officer at Premier.
9 HEARING OFFICER YANDOW: Okay. Mr. Bachani, could
10 I have you raise your right hand, please.
11
12 (Whereupon Mr. Vijay Bachani was duly sworn in by
13 Hearing Officer Yandow.)
14
15 HEARING OFFICER YANDOW: Okay. And please state
16 and spell your name for the record. And if you could
17 also state your title.
18 MR. BACHANI: First name is Vijay, V-i-j-a-y last
19 name is Bachani, B-a-c-h-a-n-i. And my title is Chief
20 Operating Officer.
21 HEARING OFFICER YANDOW: Okay. So do you have any
22 information that Dr. Garber was just addressing?
23 MR. BACHANI: Yes, if you give me a minute, I am
24 actually looking it up right now.
25 HEARING OFFICER YANDOW: And while you are doing

1 that, Mr. Benson, could I have you unmute yourself for a
2 second. Thank you.
3 MR. BENSON: Sure.
4 HEARING OFFICER YANDOW: Mr. Benson, can you raise
5 your right hand, please.
6
7 (Whereupon Mr. Alan Bachani was duly sworn by
8 Hearing Officer Yandow.)
9
10 HEARING OFFICER YANDOW: Okay. Thank you. Could
11 you please spell your name and give your title for the
12 record, please.
13 MR. BENSON: Sure. My name is Alan Benson, that is
14 A-l-a-n B, as in boy-e-n-s-o-n. I am the Chief
15 Financial Officer.
16 HEARING OFFICER YANDOW: Okay. Thank you. So
17 there is no pending question to you right now, Mr.
18 Benson, but just in case one comes, I just thought we
19 would get that out of the way.
20 MR. BENSON: Sure.
21 MR. GARBER: In the meantime I could talk about as
22 far as what I think the advantages of why moving it to
23 the ASC -- I think that, a couple of things, I think one
24 is, I think patients will be more apt to have surgery
25 based that they can go home the same day and have it

1 done in the surgery center.
2 HEARING OFFICER YANDOW: I just, I have a question.
3 I am sorry. Leslie, am I the only one, somehow Mr.
4 Garber's testimony sometimes gets a little static --
5 MR. GARBER: I think it is Ms. Feldman's, when she
6 is off mute is when it happens.
7 MS. GREER: Yes, that is correct.
8 HEARING OFFICER YANDOW: Okay. I just didn't know
9 if it is my speaker or if it is, so that is okay. So
10 you are getting that also. So Dr. Garber, we will
11 certainly stop you if your testimony isn't clear. I
12 just didn't know if that was on my end or your end.
13 MR. GARBER: Sure. So a few things is, one is I
14 think that by offering an alternative setting versus the
15 hospital, I think number one, a lot of patients are
16 scared to be in the hospital. They are scared to spend
17 a night in the hospital. They increasingly scared
18 because of COVID, of what is going on in the world right
19 now. So I think those are reasons why patients will
20 prefer and probably be more apt to have surgery in an
21 ambulatory setting. Patients didn't like to spend the
22 night in the hospital. Patients are scared of
23 hospitals. We know that in general.
24 Second is, I think that the lower cost alternative
25 is a big part of it. So right now, if it is done in a

1 hospital setting, the costs are much, much higher. So
2 if they have co-pays and coinsurances and have to pay a
3 portion of that bill, it might be unaffordable for
4 patients, then. By bringing it to a lower cost setting,
5 they will have lower coinsurances, lower deductibles. I
6 think also, the fact that we are going to offer five
7 percent charity care. So there is no hospital, I can
8 bring, if someone has no insurance and that were to be
9 done at any of these hospitals that I work at, they are
10 not letting me do it for free. But we are willing to do
11 that to serve the community.
12 So I think a combination of those factors will
13 increase the availability that more patients will choose
14 to have surgery because of the more cost effective, as
15 well as they feel more comfortable being in an
16 ambulatory center, with less infection, less risk for
17 COVID, as well as not being in a hospital.
18 HEARING OFFICER YANDOW: Mr. Bachani, you look like
19 have some information.
20 MR. BACHANI: Yes, I have some updated numbers for
21 you. So in the State of Connecticut, in the trailing
22 12 months, we did, with the two hospitals of Saint
23 Francis and Saint Vincent's, I have 540 bariatric
24 surgeries that we did.
25 MR. GARBER: And of note is out volume has been

1 growing by approximately 20 to 30 percent year over
2 year. We have just hired a fourth full-time bariatric
3 surgeon for the State of Connecticut, so we had three.
4 We have a fourth one that is going to be starting very
5 shortly. So we are growing by 20 to 30 percent year
6 over year.
7 HEARING OFFICER YANDOW: Okay. And as I said, I
8 will have more questions as we go along, but I know that
9 OHS staff has some prepared questions for you. So Mr.
10 Carney, do you want to go ahead and start?
11 MR. CARNEY: Sure, Attorney Yandow. Let me just
12 pull up my questions.
13 HEARING OFFICER YANDOW: Okay.
14 MR. CARNEY: Brian Carney from OHS. So first
15 couple of questions sort of relate to, sort of,
16 generally clear public need and volumes. So I am
17 looking at page 21 of the prefiled, and it provides a
18 volumes broken down by service type. In addition to
19 bariatric LSG, there will be general surgery,
20 endoscopies and plastic surgery. Can you please discuss
21 these other services that you plan to provide and how
22 they relate to the bariatric LSG, are they directly
23 related or --
24 MR. GARBER: Sure. So as far as endoscopies, so
25 all of our patients are required to have a preoperative

1 endoscopy prior to undergoing a sleeve gastrectomy. The
2 reason being is we need to know their stomach anatomy so
3 we can see if they have a hiatal hernia where the
4 stomach has slid up into the chest, if they have any
5 tumors in the stomach, any ulcers in the stomach. So we
6 do a full evaluation of everyone with a preoperative
7 endoscopy.
8 Also intraoperatively, so at the end of the sleeve
9 gastrectomy, during the actual surgery, we always do an
10 endoscopy at the end of the surgery, where we put a
11 scope down, we look inside the sleeve. We make sure it
12 looks good, as well as we inflate air and we put water
13 around the stomach, we look for air bubbles, kind of
14 like a tire leak, to make sure everything looks good
15 before we leave the operating room.
16 And the postoperatively some patients
17 postoperatively might get reflux or they might have
18 issues, and we might do a postoperative endoscopy on the
19 patient. So we do a very large number of endoscopies.
20 I think Vijay can maybe pull up some data on how many
21 endoscopies we do a year, but we do thousands and
22 thousands of endoscopies every year.
23 As far as general surgery, so there will be patient
24 population postoperatively they could develop
25 gallbladder issues. So there is a connection with rapid

1 weight loss to develop gallstones, and some of those
2 patients might need their gallbladder removed
3 laparoscopically. So laparoscopic cholecystectomy would
4 be one of the most common general surgery cases we might
5 do, as well as hernia repairs. So people that are
6 morbidly obese, we make these little wounds, there is a
7 lot more tension on those wounds, and the risk for
8 developing a postoperative hernia on one of those wounds
9 is higher than the general population that is not obese.
10 So we will also probably be doing hernia operations.
11 Those are probably the two most common type of
12 general surgery cases, which are commonly done in ASC's
13 now, that we would be doing in our current patient
14 population.
15 As far as plastic surgery. We had one plastic
16 surgeon. We just hired three more plastic surgeons.
17 One that is full time for Connecticut that just started
18 recently. So patients that lose a large amount of
19 excess weight commonly develop intertrigo, which is a
20 rash underneath the hanging skin folds of the abdomen.
21 And insurance companies, believe it or not, they do
22 approve it as a medically necessary procedure, a
23 panniculectomy, which is removing the excess skin of the
24 abdomen. So that is very commonly done in our patient
25 population. As well as patients want cosmetic things,

1 patients will have droopy breasts and want breast lifts.
2 Patients will want arms, they have hanging skin of the
3 arms, or they want thigh lifts. So these are, it is
4 very, very common that our patient population will end
5 up with plastic surgery, probably a minimum of 50
6 percent of our patient population after rapid weight
7 loss will want some kind of plastic surgery to remove
8 their excess skin. Some of those procedures are
9 medically necessary procedures that are covered by
10 insurance, like the panniculectomy, and that is the
11 plastic surgery portion that we are talking about. So
12 these are all related to the same patient population we
13 are talking about.
14 MR. CARNEY: Okay. Thank you Dr. Garber. Moving
15 on. Page 21 of the prefiled states that the projected
16 outpatient volume is based on the Applicant's actual
17 inpatient LSG volumes within the state, within the
18 target service area, appropriate for shifting to an ASC
19 setting. I think it mentioned something like 17
20 percent. So I believe you said that the hospitals, you
21 only right now are currently performing bariatric
22 surgery at two hospitals, would be at Saint Vincent's
23 and Saint Francis?
24 MR. GARBER: Yes.
25 MR. CARNEY: Okay. All right. Which hospital was

1 **used to determine the outpatient volume at the proposed**
2 **ASC in Stamford?**
3 **MR. GARBER: I think we used both hospitals volumes**
4 **combined to determine that, the volume. So we took the**
5 **total volume we are currently doing, and we are assuming**
6 **about 80 percent of it could be done in an ASC setting**
7 **and 20 percent would stay in the hospitals.**
8 **MR. CARNEY: All right. So basically, 80 percent,**
9 **you are calculating 80 percent of the volume at Saint**
10 **Vincent's and Saint Francis could be performed at the**
11 **proposed ASC. Okay.**
12 **MR. GARBER: Correct.**
13 **MR. CARNEY: What is the 17 percent you were**
14 **talking about, how did you determine that 17 threshold**
15 **for inclusion? Is that based on, of the population --**
16 **you mentioned, the 17 percent.**
17 **MR. GARBER: 27 percent of the patient population**
18 **are in Fairfield is considered obese. I don't know if**
19 **that is what you are referring to, the 27 percent.**
20 **MR. CARNEY: I think -- it is on page 21 of the**
21 **prefiled. Page 21 on the prefiled says, outpatient**
22 **volume is based on actual inpatient LSG volumes within**
23 **the target service area, appropriate for shifting to an**
24 **ASC. Approximately 17 percent of the population of the**
25 **target service area eligible for LSG, plus anticipated**

1 growth of 20 percent. So two paragraphs below your
2 volume table on page 21.
3 MS. FELDMAN: Brian, would you please let us know
4 what the table is that you are referring to?
5 MR. CARNEY: Yeah, the 17 percent comes from a
6 paragraph below the table. The table is the utilization
7 projections.
8 MR. GARBER: I found it.
9 MR. CARNEY: Page 21. It is in the issues.
10 MR. GARBER: So 17 percent of the primary service
11 area, so we are saying that the 2,542 prospective
12 patients in Westchester and Fairfield?
13 MR. CARNEY: Yes.
14 MR. GARBER: And if we operated on 17 percent of
15 them, it is 425 cases, is how we did that calculation.
16 MR. CARNEY: Okay. And what does, what does the 17
17 percent represent, Doctor? How did you determine, like
18 17 percent of the population would be eligible, I guess?
19 MR. GARBER: Well, I think we used, we took what
20 we, at the time when we did the application, I think we
21 were doing about 425 cases a year. So we took 425 cases
22 a year and divided by the 2,542 to get the 17 percent.
23 So now it is actually probably higher because as Vijay
24 said, in our trailing 12 months, we have been like 580
25 something cases. So the numbers are actually higher

1 than what the application was. This was a year ago.
2 MR. CARNEY: Okay. Still looking at that table, so
3 the volumes in the table appear to bill surgical cases
4 and procedures, and it appears that individual patients,
5 you know, would receive, like, the bariatric surgery,
6 plus they would receive at least two endoscopies.
7 Multiple services. So what I am looking for is, what,
8 what would be the projection of unduplicated patients in
9 that table. So you have totals of 2016, 2419, 2903,
10 same page, what are we talking about as far as actual
11 patient, unduplicated patient volume?
12 MR. GARBER: Well I would say, not looking at that
13 number, just based on current numbers. I would say 80
14 percent of the, figure we are close to 600 cases, 80
15 percent of that, about 480 unique patients, I would
16 estimate. 80 percent of what our current volume is in
17 the trailing 12 months.
18 MR. CARNEY: Okay. I would like to ask for a late
19 file related to that, Attorney Feldman. I would like to
20 have those projections presented by unduplicated
21 patients. And sort of a description to, as to how they
22 were arrived at.
23 HEARING OFFICER YANDOW: There will probably be
24 several late filed exhibits, and we will go over them at
25 the end of the hearing. Attorney Feldman, you will

1 probably want to keep an ongoing list. I know Ms. Rival
2 will be keeping an ongoing list, and I will issue an
3 order at the end of the hearing about when these are
4 due. So I will ask you, and I am sure on a break you
5 can consult with your client, regarding how long it
6 would take to come up with this information.
7 MS. FELDMAN: May I just ask for clarification for
8 Mr. Carney, right now?
9 HEARING OFFICER YANDOW: Yes.
10 MS. FELDMAN: Okay. So Mr. Carney, in the
11 application itself, we projected very conservatively the
12 volume of cases that we would see in Fairfield County
13 based on the statistics of individuals with obesity in
14 Fairfield County, okay. And then in follow-up, I
15 believe there completeness questions, correct, where we
16 are referring to that chart regarding the 17 percent. I
17 believe that was raised in a completeness request -- oh,
18 no, it was in the prehearing. I am sorry. It was in
19 the prehearing issues. Again, that number was a
20 conservative low number. So you're asking for us to
21 determine the volume of unduplicated procedures. We
22 have the number of patients that are going to have LSG.
23 All those other procedures are associated with those
24 patients. You are asking us to clarify, what? I am a
25 little confused.

1 MR. CARNEY: So, you have a volume projected volume
2 table, but the total of 2016, 2419, 2903.
3 MS. FELDMAN: Right.
4 MR. CARNEY: Is that the number of patients that
5 will correspond to just bariatric LSG --
6 MS. FELDMAN: Right. Those are unique patients.
7 And the other procedures are associated with those 425
8 patients. There might be some people, perhaps, Dr.
9 Garber, who are, you know, maybe have endoscopies and
10 you decide not to do the surgery on them. But for the
11 most part, those procedures that follow, these are not
12 people that are coming in off the street for plastic
13 surgery. These are not people that are coming in to
14 have an upper GI. These are people that are having
15 procedures performed at the surgery center in connection
16 with the LSG procedure that, it is usually postop, post
17 LSG.
18 MR. CARNEY: Right. So but that, that is really
19 still not getting the answer. I really want you to give
20 me the unduplicated number of patients, because the 425
21 is for bariatric, but then you are saying you are doing
22 additional procedures for plastic surgery, which may
23 come after the initial bariatric LSG. That still would
24 be a legitimate unduplicated patient. So I would like
25 to see a better, a better estimate with a total of

1 unduplicated patients for those three years, and also
2 for you to revise the payer mix to reflect that same
3 total of unduplicated patients.
4 HEARING OFFICER YANDOW: Because my question with
5 that chart, if I am looking at it, so if it's, as Dr.
6 Garber, and my question goes to Dr. Garber, 420 LSG's,
7 but there is 1,273 endoscopies. So are you saying there
8 is like, you know, 800 -- whatever the math is -- of
9 people that you say, we are not going to do it, is that
10 what you are --
11 MR. GARBER: No. No. So there's patients that get
12 multiple endoscopies. There are, there is going to be
13 patients that we operated on three years ago that,
14 before we even had an ASC, they are going to come in for
15 endoscopies just having issues postoperatively. Some
16 people have bariatric endoscopies, we have -- so there
17 is medical reasons why people might need to receive
18 endoscopies yearly after surgery and it could be
19 patients that were never operated on in ASC. We based
20 our endoscopy numbers off, based on the current
21 endoscopy volume that we are doing currently. And being
22 able to move all of that, 100 percent of that to the
23 ASC. There is no reason, 100 percent of our endoscopy
24 volume can be moved to the ASC. So the endoscopy
25 estimates are based on what are we currently doing. We

1 are looking at 20, 30 percent growth, and that is how we
2 calculated our projected endoscopies. As far as the, if
3 you look at Table E, we estimated that in 2022, we are
4 going to do 743 bariatric cases and in 2023 we are going
5 to do about 900 and, no, 800 -- a little over 900 cases.
6 And in 2024, do a little bit over 1,000 bariatric cases.
7 And that is by taking our current volume and then, and
8 then adding the 20 to 30 percent volume. And you can
9 see based on the way our volume has grown from the
10 initial application to now, we should be able to achieve
11 that 743 by 2022, would be my guess we would probably do
12 that.
13 So I think, our numbers were based on historical
14 volumes that we were doing, and estimating with our 20,
15 30 percent growth, which we have historically done over
16 the past five years that we looked at, and that is how
17 we got our numbers.
18 HEARING OFFICER YANDOW: So in 2021, the current
19 year, and I know we are a couple weeks away from the
20 end, but how many endoscopies in Connecticut? Just give
21 me a ballpark. I don't know if it is in there, because
22 I have a question --
23 MR. GARBER: Yeah, they would have to -- I wouldn't
24 know that offhand, but Vijay could probably pull that
25 out.

1 HEARING OFFICER YANDOW: Okay. So let's just say,
2 you know, I am just making a hypothetical here. Let's
3 say you do 1,000, you did 1,000 endoscopies, were those
4 all done in either Saint Vincent's or Saint Francis?
5 MR. GARBER: Yes. Or done in our endoscopy, we
6 have an endoscopy suite in Westchester, as well.
7 HEARING OFFICER YANDOW: In New York?
8 MR. GARBER: Yes.
9 MR. BENSON: Since July, we have done 313
10 endoscopies in Connecticut.
11 HEARING OFFICER YANDOW: 313 in Connecticut.
12 MR. GARBER: Since July. So that is just, this
13 July?
14 MR. BENSON: Yes, July '21.
15 HEARING OFFICER YANDOW: So say, say that you
16 double it. Let's just do the ballpark of 600, I am not
17 saying that is the number, but say you did 600 in
18 Connecticut. How do you get to doubling that for 2022?
19 MR. GARBER: I think, because as our patient volume
20 grows by 20, 30 percent, the endoscopy business is going
21 to grow higher than the surgery volume, because every
22 patient needs, every patient is guaranteed to need two
23 endoscopies. They need a preop endoscopy and they need
24 one during the sleeve gastrectomy. And then there is a
25 ceratin percentage that will need postop endoscopies.

1 If everything is straightforward, they have no history
2 of any issues, we usually have one year postop, we
3 recommend an endoscopy to check the sleeve and see how
4 everything is. So that's three endoscopies on the
5 average patient.
6 Then you have patients that have real issues that
7 might need it more often. People get a stricture and
8 might need to have it, have endoscopies to check it
9 every month for three months in a row. People might get
10 an ulcer and they might need repeat endoscopies, so, but
11 on the average patient we will probably get about three
12 endoscopies within the year of the surgery. So they
13 will get one preop, they will get one intraop and then a
14 year postop we do a screening endoscopy on all patients.
15 So each patient gets about three endoscopies.
16 HEARING OFFICER YANDOW: The ones that go to
17 Westchester, are they the Bridgeport patients? I mean,
18 just going to Saint Francis from Westchester is quite a
19 distance.
20 MR. GARBER: Yeah, so currently we do a one-day
21 workup process where the patient comes in one day, they
22 see cardiology, pulmonary, nutrition, psychology and
23 have an endoscopy all in one day. So we make the workup
24 process very easy. We currently do not do that and
25 offer that in Connecticut at the moment. So patients

1 are willing to drive to our Westchester location to do a
2 workup of one day because the convenience of taking one
3 day off from work, and they have the whole workup
4 completed, as opposed to, in Connecticut, having to go
5 to six different doctors on six different days. We do
6 plan on, at the, adjacent to the surgery center in
7 Stamford, we have adjoining office space that we have a
8 lease signed on, we are planning on moving that one-day
9 workup to Stamford right next to the ASC. So they are
10 going to come in one day, do the cardiology, pulmonary,
11 nutrition, psych and then they are going to go in the
12 ASC and have an endoscopy. So all those patients
13 currently going to Westchester, are going to be done in
14 Stamford once we get the ASC.
15 HEARING OFFICER YANDOW: Okay. Brian, I don't know
16 if my questions were helpful or not, or they just, but I
17 am sorry, you can go ahead.
18 MR. CARNEY: Yes, no, they are fine. And I am not
19 saying, like, these numbers aren't valid, but I really
20 want to take a look at actual patients being served.
21 And I see endoscopy a little bit different of a
22 procedure compared to the surgeries. It is a little bit
23 more entailed, and I would like to, like to have a look
24 at, tightened up the projections based on unduplicated
25 patients.

1 MR. GARBER: Yeah, I think we can definitely do
2 that for you. I don't think it will be a problem. We
3 can look at the number of surgeries we did, which are
4 all unique bariatric surgeries, and then we can look at
5 how many patients we estimate will have other procedures
6 that didn't have the bariatric and add those on to get
7 the number of unique patients. I think we can figure
8 that out for you and we will submit something.
9 MR. CARNEY: Okay. That would be great. And then
10 something related which, you know, you talked about your
11 procedure is done inpatient basis at the two
12 hospitals, and I don't think you probably, well, I would
13 like it in writing anyway, give me a number, but I would
14 like to have you provide the three historical years of
15 volume for each hospital, Saint Vincent's and Saint
16 Francis, where you're performing bariatric surgery on an
17 inpatient basis. So I would, you know, I would give us,
18 you know, the different categories, service categories
19 that you have included there, as well, just so we have
20 idea of volumes, because that is where, you know, we are
21 basing your projected volumes at your proposed facility.
22 MR. GARBER: Yes. So, sorry to interrupt. But the
23 projected volume is that, plus right now all of our
24 Westchester patients are being done in Westchester, and
25 we think, and being done as inpatient at New York

1 Presbyterian Hudson Valley Hospital in Westchester. We
2 think it, Stamford is pretty close to Westchester, and
3 we think a good percentage of those patients are going
4 to be wanting to come to the ambulatory surgery center
5 in Stamford. So it is also we are going to be moving a
6 volume of that patient, so we can, if you want, we can
7 give you the volume that we are doing in Westchester, as
8 well. And then I think there will be a small volume
9 from Manhattan also that might come. But that will
10 probably be a small volume that we predict.
11 MR. CARNEY: So, absolutely, Doctor, yes. So
12 anything used in coming up with your projection that you
13 can provide, you know, as evidence as to where that
14 volume would be coming from, that would be gratefully,
15 helpful, you know, regardless of, you know, the state,
16 the volume is based on, as you said, you know, volume
17 from New York, as well.
18 HEARING OFFICER YANDOW: Yes. So Dr. Garber, so
19 anything, anything we are asking for, I mean, the burden
20 is yours, you bring the application, so we only have
21 what you give us. So, you know, these are analysts
22 that, you know, work on these numbers. And, you know,
23 need to look at, in projecting, you have to fill the
24 criteria in 19(a)-639. So any information you can give
25 us is certainly going to be to your benefit when we are

1 analyzing the application. If these questions are being
2 asked, it is because there are questions about the
3 numbers. So will these follow-ups. So, but again, you
4 know, the burden is yours. We are not digging up the
5 information, you are giving us the information.
6 MR. GARBER: No problem, at all. I think that is
7 very easy data for us to provide. But that is how we
8 got to our number, is basically a certain percentage of
9 Westchester we think that will come there, a certain
10 percentage of Manhattan, a lower percentage, that will
11 come there, we looked at 80 percent of being able to
12 move to outpatient and then, and we factored those
13 numbers, is where we got our numbers. So we will give
14 you the breakdown exactly how we calculated those
15 numbers with actual numbers from each of those
16 hospitals.
17 HEARING OFFICER YANDOW: Yeah, so you want to do
18 that and you want to back it up with any kind of
19 information. I mean, because with a, you know, it's, we
20 can't just have a, I'll build it and they will come,
21 kind of, you know, that doesn't fit the criteria. We
22 need the evidence, the numbers, the information that is
23 going to support any kind of finding that is going to be
24 recommended to the Executive Director. Okay. So that
25 is why we are asking. So it is not just bringing up the

1 numbers. How did you get there? What information do
2 you have that got you to those numbers, that is what is
3 helpful for us.
4 MS. FELDMAN: Hearing Officer Yandow, I just want
5 to reemphasize, and I know this is not testimony, but in
6 my role as healthcare counsel for many of the health
7 systems in the state, negotiating managed care
8 agreements and the managed care payers do not want
9 procedures performed on an inpatient basis. So what we
10 presented in this application, that theme is running on
11 a parallel track. Our projections are very conservative
12 projections. And you will see, even in our financial
13 pro forma, we did not include Medicare and Medicaid. We
14 believe that Medicare will, by 2023 or 2024 the
15 latest, remove this procedure from inpatient only and
16 recommend that it be performed on an ambulatory basis.
17 We know that that is the direction that the Department
18 of Social Services is considering right now with
19 respect, with respect to its population because it will
20 save them a lot of money. None of that was included in
21 our, in our projections, because it won't be paid for
22 right now. But that is volume that we will have.
23 What we did was look at the statistics and there
24 are citations to all of this data in the application,
25 including earlier you had mentioned you could not find

1 the data support for the impact on the minority
2 population. There are three cites in the application
3 that have that. Two in the Executive Summary. It is
4 the CDC cite and the NHI cite. And also, there's a
5 chart in the application itself. It looks like this,
6 and it is from the Connecticut Data Even. And that
7 chart specifically talks about the impact on black and
8 Latino population in Connecticut. So I just wanted to,
9 sort of, I understand that you, I expect these numbers
10 to be much higher. So when we go back and we shift the
11 volumes from the hospital and we shift the volumes from
12 Westchester and I think the other thing about New York
13 bariatric group, so that you can understand, is that
14 they, they are premier. They are it in Fairfield County
15 in terms of doing, they're the go-to surgeons for this
16 type of procedure. They also have a very aggressive
17 marketing arm and they do have, most of their business
18 comes from self-referral. Patients bring themselves to
19 the practice and get evaluated for the procedure. I'll
20 shut up now, but I just wanted to --
21 HEARING OFFICER YANDOW: No, I mean, Attorney
22 Feldman, I appreciate your advocacy. You know, I see
23 you are working hard for your client. But my job as the
24 Hearing Officer is to make sure any kind of proposed
25 finding I make is supported by the facts. So, and I

1 appreciate all you have to say, but my instructions to
2 the analysts, and the way I'll look at it, is anything
3 the attorney says is not evidence. So it is going to
4 have to be supported by the evidence. I certainly take
5 your argument, and I certainly respect that you are
6 giving the lead, you know, I want you to certainly tell
7 your witnesses where they should be going and Dr. Garber
8 is doing a fine job, you know, letting us know the
9 information here, but that is where I want to get my
10 evidence. And I appreciate that you have done this for
11 many years, you and I have, I have not, but my job is to
12 look at the evidence. So that is, that is what I am
13 doing.
14 MS. FELDMAN: I understand that, absolutely. And
15 nothing I said today is not already in the application.
16 So --
17 HEARING OFFICER YANDOW: And I appreciate that.
18 MR. GARBER: Just one other piece of data that I
19 just got is that, so in Westchester, we, trailing
20 12 months, target almost 450 bariatric cases there. So
21 you combine that with the 588 that we did in
22 Connecticut, you have over 1,000 cases. And if we did
23 80 percent of it, it was about 800 is what I would
24 estimate right now based on the trailing 12-month data.
25 As far as endoscopies, in Westchester our

1 endoscopies suite there, we do, we are probably going to
2 do about 1,200 endoscopies in that endoscopy suite in
3 the trailing 12 months. So we have that data, plus we
4 have the endoscopies in Connecticut. We will get
5 everything more formally, like you wanted. We will get
6 you the actual hard numbers from each hospital and what
7 percentage we estimate are going to come there of unique
8 patients, like you want. We will get that to you.
9 MR. CARNEY: Okay. Yes. One further thing with
10 that, too, with the inpatient volumes, I would like to
11 also see those volumes broken up by gender, age group,
12 race, ethnicity.
13 MR. GARBER: Gender.
14 MR. CARNEY: Gender, age group, race and ethnicity.
15 MR. GARBER: I assume we have race and ethnicity in
16 our DMR record, but we are going to double check if we
17 have, there is a chance we might not have accurate data
18 on that because I don't know if every patient reports
19 that. But we can do our best to report that the best
20 that we have in our database.
21 MR. CARNEY: Great. Thank you. All right. Moving
22 onto access to services. Page 20 of the prefiled
23 testimony states that there is strong interest, this is
24 a quote, Connecticut Medicaid to cover LSG in am
25 ambulatory outpatient setting. Prior, or after I

1 reviewed this letter, Dr. Richards of DSS provided, he
2 states that it is only the initial step of the process,
3 that he cannot predict whether the proposal will
4 ultimately be implemented, that the letter does not
5 constitute the agencies endorsement or support of this
6 proposal. So given the letter's full response, how do
7 you characterize that there is strong interest from
8 Connecticut Medicaid to cover LSG in an outpatient
9 setting?
10 MR. GARBER: So I have e-mail correspondence from
11 him saying that he, quote unquote, he is generally
12 supportive of the concept, but he needs to do a full
13 fiscal analysis. So I am, we have had multiple
14 correspondences back and forth with me presenting data
15 to him, and he has been very receptive to it and
16 graciously responding right away to all of my e-mail
17 correspondence with him. So that was our perception
18 based on the terminology he used, that he is generally
19 supportive of the concept. We found that as optimistic,
20 but obviously it means nothing unless they do a fiscal
21 analysis of what it means financially to them. So it is
22 an unknown, and we don't know. And like my attorney
23 said, we did not include any Medicaid patients in our
24 projections. We assume, we did very conservative, all
25 of the numbers we forecast was based on non-Medicaid and

1 non-Medicare parents.
2 MR. CARNEY: Okay. Dr. Garber, did DSS provide you
3 with any additional insight on the timing of their
4 review and completing it?
5 MR. GARBER: They have not. They did say that they
6 planned on reviewing it at their next meeting, but I am
7 not sure when that is.
8 MR. CARNEY: Okay. And finally on this topic, Dr.
9 Garber, do you know of any other states where Medicaid
10 covers outpatient bariatric surgery?
11 MR. GARBER: I do not know, offhand, to be honest
12 with you. I think in general, I think, the majority of
13 ASC's around the country are, do not have no interest in
14 even doing Medicaid, so I don't think they even tried
15 to. They are very, they are for-profit, a lot of them
16 are out-of-network businesses. We are a different
17 business model. So I am not, I am not sure offhand to
18 be honest with you.
19 MR. CARNEY: Okay. All right. Moving onto the
20 subject of, related to quality. So the question was,
21 are you currently performing outpatient bariatric
22 surgery at any outpatient facility. And I guess my
23 understanding from your earlier statements was that you
24 have one in New Jersey, it is close, but you haven't
25 done any yet, is that the case?

1 MR. GARBER: That is correct. We plan on starting
2 right after the new year. We are gearing up to start.
3 We just completed all the insurance payer contracts.
4 That was holding it up.
5 MR. CARNEY: Okay. So, so you start the beginning
6 of the year, you are saying, January, you think?
7 MR. GARBER: Some time in January we are hoping to
8 start, yes.
9 MR. CARNEY: Okay. All right. So there would be
10 no data or anything to provide from that facility at
11 this point in time. Okay.
12 MR. GARBER: No.
13 MR. CARNEY: Okay. All right. On page five of the
14 prefiled testimony, Dr. Garber, you state that the
15 literature is replete with peer-reviewed articles that
16 conclude that ambulatory surgery centers present minimal
17 risk of complications and mortality when performing LSG
18 on appropriately screened candidates. Please elaborate
19 on who, who basically, of your patient population, would
20 be eligible for LSG on an outpatient basis.
21 MR. GARBER: So we think 80 percent, we estimate 80
22 percent of our patient population, based on using, like
23 I mentioned earlier, the MBSAQIP Section 1.2 criteria of
24 who should be done in an ASC setting. So we plan on
25 following those criteria exactly, which is age greater

1 than 18 --
2 MR. CARNEY: Okay.
3 MR. GARBER: -- less than 65, we are estimating
4 about 80 percent of our patients fall into that category
5 that would qualify.
6 MR. CARNEY: And what other comorbid conditions
7 specifically require inpatient care?
8 MR. GARBER: Sure. So severe sleep apnea would
9 probably be one that we would do in the hospital. Any
10 history of organ failure, patient has kidney failure.
11 Significant cardiac disease, significant pulmonary
12 disease, and then the higher BMI. So a male BMI greater
13 than 55, a female BMI greater than 60. We are not going
14 to do anyone under 18, and anyone has to be less than
15 65-years-old. So those are pretty much the reasons why
16 we would exclude patients, based on those criteria I
17 just mentioned. Of if anything came up during the
18 workup process.
19 MR. CARNEY: Okay. So you spoke already about the
20 screening process pretty thoroughly, and typically how
21 you would exclude certain patients. Can you quantify
22 the current complication and mortality rates linked to
23 performing LSG in an outpatient setting? Is there, I
24 think you gave us one study --
25 MR. GARBER: Yeah, but the larger study was in

1 surgery for obesity and related diseases, from 2018
2 where they studied 3,162 outpatient sleeve gastrectomies
3 at nine different centers. And they had, I'll tell you
4 the exact numbers, they had a zero percent mortality,
5 which is what we have on an inpatient basis, as well.
6 And the short-term complication rate was 2.5 percent.
7 MR. CARNEY: And that would include certain things
8 like infection, or --
9 MR. GARBER: Yes. So the, the different
10 complications that we look for in this patient
11 population would be, they can develop a leak after a
12 sleeve, where that staple line leaks. That is probably
13 one of the more serious things that we worry about, but
14 they are usually easily treated if identified promptly.
15 Of note, most leaks don't happen when they are even in
16 the hospital as the inpatient. They usually happen,
17 three, four, seven days later anyway. So whether it is
18 inpatient or outpatient, it is not going to change how
19 the leak gets handled, at all. Bleeding is probably one
20 of the more immediate things that we worry about, and we
21 do plan on doing hemoglobin hematocrit levels at the
22 center prior to sending them home to make sure there is
23 no bleeding, and obviously follow their vital signs.
24 And then longer term things we worry about, wound
25 infections, wound hernias, things like that. And then

1 you worry about the general issues with any surgery, a
2 patient could die from any surgery, they could have a
3 heart attack, they can have pulmonary problems, and that
4 is where we are going to thoroughly screen all of our
5 patients preoperatively which we do now even on an
6 inpatient basis.
7 MR. CARNEY: Okay. Thank you, Doctor. Please
8 discuss any adverse events experienced performing
9 bariatric surgery in any of the Connecticut hospitals
10 that you are, or at your other bariatric surgical
11 centers. And further, like, have you had any
12 disciplinary actions imposed from any regulatory bodies,
13 you know, related to your surgeries?
14 MR. GARBER: We have not had any disciplinary
15 actions. We have had complications. If you do 4,500
16 bariatric cases a year, you are going to see
17 complications. Like I said, the most common things
18 would be, a leak would be the most common thing, but it
19 is still pretty rare. It happens in less than one
20 percent of patients, and most of those are even treated
21 nonoperatively. We have a GI, interventional GI doctor
22 that sometimes just put a stent in, where they bypass
23 the leak with, like, a tube, so it heals by itself. So
24 sometimes it doesn't require operations.
25 MR. CARNEY: So, Doctor, do you track those type of

1 things?

2 MR. GARBER: We do.

3 MR. CARNEY: Is that something you can report on,
4 could you provide us with some information that would
5 show that it's one percent of your patients, something
6 to that effect?

7 MR. GARBER: So we have, so each hospital, we have
8 data from each hospital separately.

9 MR. CARNEY: Okay.

10 MR. GARBER: So, so like I said, we are part of
11 MBSAQIP, so there is an independent data collector that
12 collects all complication data, submits it to the
13 database and then they report off of that, and they
14 benchmark our hospital against other hospitals in the
15 country every quarter. More than happy to get you
16 copies of those reports from the Connecticut hospitals
17 of, it is called a SARS report, S-A-R-S. I am not sure
18 what that stands for, but we can definitely provide, we
19 can get access to that from the Connecticut hospitals,
20 assuming that they will be willing to provide it to us
21 and give you a copy of our SASS reports.

22 Of note, there are a couple of other surgeons not
23 related to us that do work at those hospitals, so their
24 data would be part of the report. It is not unique to
25 our practice, but we do the vast majority of the cases

1 at both of those hospitals. So it will would be
2 relatively accurate reflecting our specific complication
3 rates.
4 MR. CARNEY: All right. Thank you, Doctor. Yes,
5 that would be very appreciated, if you could provide
6 that information for us. And that is the last of my
7 questions. I am going to past it along to my colleague,
8 Ms. Rival.
9 HEARING OFFICER YANDOW: Okay. I think we are
10 going to take a 10-minute break. So it is 11:37, so if
11 we could come back at, let's say, at 11:50. So if
12 everyone could mute themselves during this and we will
13 all come back on at 11:50. All right. Thank you. We
14 will see you then.
15
16 (Whereupon a short recess was taken.)
17
18 HEARING OFFICER YANDOW: Brian, you just had a few
19 follow-ups?
20 MR. CARNEY: Yes, thank you, Attorney Yandow.
21 Yeah, just a couple of follow-up questions. First one
22 is for Dr. Garber. You talked about maybe opening the
23 surgery center in New Jersey in January. Doctor, do you
24 any, like, patients already scheduled for those January
25 procedures yet, or is it too soon for that, even?

1 MR. GARBER: It is too soon. We actually had a
2 meeting with my New Jersey surgeons, actually, last
3 evening to start putting in place all the proper
4 procedures and protocols, and they asked me that same
5 exact question, they want to book them. But we need to
6 get equipment and, you know, supply chain issues right
7 now. So I said before we book, let's make sure we are
8 going to have all the equipment in time. So we are
9 trying to get all the equipment ordered in the next
10 week. So I said, let me see if we get all the equipment
11 on time. If we can, then we are ready. As for as
12 insurance companies, that we are good for by January.
13 It is at matter of, we are not sure about the equipment
14 yet that is going to be in place. We are waiting to
15 hear back from all the manufacturers.
16 MR. CARNEY: Okay. Thank you. Thank you. And the
17 second question is, just a little bit of curiosity, but
18 you guys have a lot of volume in New York, New York
19 State, did you consider, have you tried or considered
20 establishing an outpatient surgical facility in New
21 York, as, you know, why, I guess why Connecticut not New
22 York, per se?
23 MR. GARBER: So, New York we definitely are
24 interested and we are exploring opportunities in New
25 York. Connecticut, we found this ASC that was fully

1 built out. The most beautiful ASC you will ever see.
2 So it was just an opportunity that came upon us that we
3 wanted to take advantage of. And that is why that
4 happened quicker than New York. But we do plan on
5 looking to get one in New York, and Long Island
6 specifically, which is our, where I originally started,
7 which would be home base. We plan on hopefully doing
8 something in the future.
9 MR. CARNEY: All right. All right. Thank you very
10 much, Dr. Garber. I am going to pass it along to Ms.
11 Rival, so we can continue along with the questions.
12 Thank you very much.
13 MS. RIVAL: Hello. This is Jessica Rival. Page 21
14 of the prefiled states that you will seek Metabolic and
15 Bariatric Surgery Accreditation Quality Program Center
16 Distinction Status within the first year of opening.
17 How does the accreditation process work?
18 MR. GARBER: Sure. So one of the good things is
19 one of my partners, Dr. Angstadt is a surveyor for
20 MBSAQIP, so he is one of the guys that does the surveys.
21 So we have our in-house expert. But we have done it
22 already at seven different institutions. So you need to
23 set specific procedures and policies that they require
24 must be in place at the center. We need to have the
25 proper equipment and proper training of all the staff,

1 as well. And then we need to do a certain number of
2 volume of cases. I think for the low acuity, which is
3 what this is, I think you need 25 stapled cases, which
4 is sleeve gastrectomy. You have to do a minimum of 25
5 cases before we apply. Once you apply, they will give
6 you a provisional approval based on the application, and
7 then at that point you need to start submitting data.
8 So that is when we have to hire an independent data
9 person to collect data and the data is collected from
10 actual surgery center, as well as the follow-up care
11 they actually track with that data, as well, so they
12 have full access to our EMR, Electronic Medical Record.
13 And they then will come to do an onsite survey. I think
14 temporarily, right now, they might be doing virtual
15 surveys, like this, but traditionally they would do an
16 onsite survey where they would walk around the facility,
17 they would ask questions of the staff to make sure they
18 are trained to know how to take care of all the obese
19 patients, as well as make sure we have the proper
20 equipment, that all the beds and the stretchers,
21 everything is rated for the proper weights, our toilets
22 have the proper toilet supports. You can't have a
23 wall-mounted toilet because there is a danger of that
24 breaking off the wall. So we have to make sure that
25 they have all the proper facilities and all the proper

1 protocols and procedures need to be all be documented.

2 MS. RIVAL: Okay. Are you currently accredited at

3 the New Jersey outpatient facility?

4 MR. GARBER: Not yet, because we haven't started

5 doing any surgery there yet. So we need to do at least

6 25 cases, but we do plan on applying for that one, as

7 well, as soon as we have the proper volume in place.

8 MS. RIVAL: Okay. Now after you do the 25 cases

9 necessary to apply, is there a yearly minimum that you

10 need to achieve as far as volume requirements for safety

11 and quality?

12 MR. GARBER: Yes.

13 MS. RIVAL: And what is that.

14 MR. GARBER: I think it is a minimum number. For

15 the hospitals, I think, I am not, the reaccreditation is

16 every three years.

17 MS. RIVAL: Okay.

18 MR. GARBER: And the volume, I think is, for the

19 hospitals, I know it is 50 cases per year. But for the

20 ASC's it might be 25 cases per year. I am not sure

21 exactly of that required number. But we should fare

22 exceed either one of those numbers. I am not worried,

23 we will exceed those numbers anyway.

24 MS. RIVAL: Okay. And the guidelines that you

25 included with the application, I believe they were to

1 **the 2016 standards manual. Are those the current**
2 **guidelines?**
3 **MR. GARBER: Those were, at the time of when we**
4 **submitted our application, those were the most updated**
5 **guidelines they that had available on their website.**
6 **But they do, every so often, will add certain, certain**
7 **things and remove different guidelines. But as of the**
8 **time of the application, we, I can look and see if**
9 **anything has changed since then, but when the**
10 **application was submitted this was the most updated**
11 **guideline that we pulled right from their website.**
12 **MS. RIVAL: Okay. Attorney Yandow, I would like to**
13 **ask for that as a late file. If there are updates to**
14 **the standards, that we receive a copy.**
15 **HEARING OFFICER YANDOW: We will add that to the**
16 **list. Dr. Garber, do you need any more specifics on**
17 **that request?**
18 **MR. GARBER: No, not a problem. I will go on the**
19 **website and see if anything has changed since this**
20 **addition of it. And if they are, we will print them out**
21 **and submit them. That is not a problem.**
22 **MS. RIVAL: Great. Thank you. Have you had any**
23 **preliminary discussions with the Department of Public**
24 **Health regarding performing LSG in an outpatient**
25 **surgical facility in Connecticut?**

1 MR. GARBER: We have not.
2 MS. RIVAL: Okay. And it appears that you have
3 reached out to Greenwich Hospital to establish a
4 transfer agreement for an emergency. Why was this
5 hospital chosen, given that there are other hospitals
6 that are closer in proximity?
7 MR. GARBER: Our lawyer had a relationship with
8 somebody that is there. We knew somebody to get the
9 agreement. But we are open to other transfer
10 agreements, as well. That shouldn't be a problem.
11 MR. BACHANI: Can I add to that?
12 MS. RIVAL: Please.
13 MR. BACHANI: So the previous owner had a transfer
14 agreement with Greenwich Hospital, and so it was very
15 easy to, you know, just continue that, to have that
16 transfer agreement with Greenwich Hospital.
17 HEARING OFFICER YANDOW: Is it in the application
18 how many miles from where this, the proposed center is,
19 to each hospital, is that in the application? Can you
20 tell me, Mr. Bachani or Dr. Garber, how far is it. I
21 think what I would like to know, my concern is, if there
22 is an emergency -- so let me start with this first.
23 Have you had occasions, well, I guess you haven't done
24 these in an outpatient, right? This has always be in
25 the hospital, so --

1 **MR. GARBER: Yes, so we, so as far as immediate**
2 **emergencies in that immediate postoperative period, we**
3 **probably have seen about a handful over the years of**
4 **doing over 4,000 cases a year, but it is not**
5 **significant, no significant numbers. Most of the**
6 **complications are something like the, probably the most**
7 **you urgent complication we would see that would need to**
8 **be addressed immediately would be bleeding**
9 **postoperatively. And that we would probably bring them**
10 **right back to our own operating room because we wouldn't**
11 **want to wait time to transfer them, so we would bring**
12 **them right back in our own operating room and address**
13 **it. Other things that were, I mean, if they had some**
14 **cardiac or pulmonary issues postoperatively and we**
15 **thought they needed to go to the hospital, but there is**
16 **nothing I can think of offhand, other than bleeding,**
17 **that would be, like, immediate transfer right away, and**
18 **that would most likely be handled at our own facility,**
19 **just because you wouldn't want to wait with someone**
20 **bleeding, we would have all the equipment at our own**
21 **facility in case of an emergency bleeding to address.**
22 **HEARING OFFICER YANDOW: Okay. If you could just,**
23 **because I know you have an agreement there, if you could**
24 **as a late file, I don't know, if the printouts from**
25 **Mapquest, I don't know if anyone uses Mapquest, or any**

1 kind of information that would show where your, how many
2 miles and travel time from the facility to each of the
3 surrounding hospitals, which I guess you have the
4 agreement with Greenwich, is that right?
5 MR. GARBER: Yes.
6 HEARING OFFICER YANDOW: Greenwich. You have
7 Stamford is nearby. What other hospitals are -- is
8 Danbury nearby there?
9 MR. GARBER: I am not, I am not from Connecticut.
10 I am from New York, but definitely Stamford Hospital is
11 nearby, Greenwich is nearby. I think those are probably
12 the two closest. But we will, we can get you the
13 mileage on that. It is not a problem.
14 HEARING OFFICER YANDOW: Okay. And maybe, Jessica
15 and Brian, you know the hospitals better than I do, as
16 far as, are there any other hospitals in that area?
17 MS. RIVAL: Not that I can think of.
18 MR. CARNEY: No, not that I am aware of. Saint
19 Vincent's is probably somewhere around there, but not
20 that close, I don't think.
21 HEARING OFFICER YANDOW: What about Norwalk? Is
22 Norwalk nearby there? I don't have a Connecticut map in
23 front of me. I am just, I don't get down to that, down
24 that way very often. But, so if you can just, if you
25 could just include the, any hospitals within, say, a 30

1 mile radius. I don't, I think Norwalk would probably be
2 within that.
3 MR. CARNEY: Yes, probably Norwalk.
4 HEARING OFFICER YANDOW: Stamford.
5 MR. CARNEY: Greenwich, Stamford.
6 HEARING OFFICER YANDOW: And Saint Vincent's is in
7 Bridgeport?
8 MR. CARNEY: Yeah, that's a little farther away.
9 HEARING OFFICER YANDOW: Okay. So I just, I think
10 we just need to know if there were an emergency what are
11 we are talking about travel time and distance wise, you
12 know, on the, with an ambulance.
13 MR. GARBER: Sure. I think Stamford Hospital is
14 super close, is my guess. But I'll check. And we have
15 privileges, our doctors have privileges at Stamford
16 Hospital, as well. We don't do any volume there, but we
17 have privileges there.
18 HEARING OFFICER YANDOW: Okay. And you may or may
19 not know this, I mean, do you know whether or not the
20 ambulance services around there have bariatric
21 ambulances?
22 MR. GARBER: I do not know, but I will say that it
23 is probably not necessary. Our average patients, so
24 everything thinks morbid obesity you are going to see
25 like a 600-Pound Life you see on TV, our average patient

1 is a 5'4" female that weighs 250, 260 pounds. Which the
2 ambulance are taking these type of patients all the
3 time. So we are not going to be operating on 500, 600
4 pound patients. We probably never operate on them in
5 general, and if we did, we would, definitely wouldn't
6 operate on them in the ASC. Those would be done in a
7 hospital anyway. So I think the patient population we
8 would be operating on in the ASC, in general, would fit
9 into any ambulance. I don't think you need any
10 specialized ambulance for the patient population.
11 HEARING OFFICER YANDOW: Thank you.
12 MS. RIVAL: The next question I have is in regards
13 to cost to the patient. Page six of the prefiled, Dr.
14 Garber states that Premier, dot, dot, dot, believes that
15 providing LSG in an outpatient setting will be 30
16 percent less expensive than if performed in an inpatient
17 setting. How did you determine that the cost would be
18 30 percent less expensive?
19 MR. GARBER: Sure. So those, 30 percent is, I
20 determined as the facility fee cost savings, not a
21 patient cost savings. So I know, approximately, I don't
22 know accurate numbers, because obviously it is all
23 confidential, it is, hospitals don't share those
24 numbers, but through the grapevine I have a general idea
25 of what hospitals get reimbursed and what I have

1 negotiated with the payers already, and it is about a 30
2 percent savings. So obviously none of these payers in
3 New Jersey would have made a contract with me, paying me
4 what they are paying the hospital. They are going to
5 want a savings, and that is why they did the deal. So
6 it is about a 30 percent savings. Some cases it might
7 even be a 40 percent savings over what they are paying
8 the hospitals on the facility side. And then that can
9 trickle down as far as coinsurances, obviously. If it
10 is 30 percent more, their coinsurance would probably be
11 about 30 percent higher, but it depends on the maximum
12 out-of-pocket and stuff.
13 MS. RIVAL: Okay. Do you have any evidence to
14 support this?
15 MR. GARBER: I have evidence of what my agreements
16 I have negotiated in New Jersey, which I am confident I
17 can get, but we cannot disclose that, because they are,
18 all insurance contracts are confidential. We are not
19 allowed to share that as numbers. So I couldn't, I
20 don't think I can hand those over to you, my contract.
21 But we do have contracts with the payers. On the
22 hospital side, I do not have any direct evidence. All I
23 have is conversations with different administers of
24 hospitals of what they get paid.
25 MR. CARNEY: Doctor, just to follow-up, this is

1 **Brian Carney, could you give us some kind of a blended**
2 **rate, as opposed to, like, an average of the commercial**
3 **payers, as opposed to --**
4 **MR. GARBER: Sure. Yes. So I would say the**
5 **hospitals, on average, are getting between $15,000 and**
6 **$25,000 for the facility fee. I think majority of the**
7 **pay is between, pay between $18,000 and $20,000. And**
8 **our negotiated contracts on average is probably around**
9 **$12,000 is what we negotiated.**
10 **MR. CARNEY: So, Doctor, could you provide that to**
11 **us in writing, something similar to what you said?**
12 **MR. GARBER: Sure. I have no problem, but remember**
13 **the hospital portion is, I don't want to testify to**
14 **something that is 100 percent accurate. This is all**
15 **hearsay from other people. So to put it in writing,**
16 **I'll make it clear from my understanding that is what**
17 **the rates are, but I don't have any factual data on that**
18 **part. On our side of what we negotiated in New Jersey,**
19 **those are facts. And I have no problem to attesting to**
20 **those numbers.**
21 **MR. CARNEY: That is great. Maybe we can use the**
22 **claims database to support the other side of it**
23 **potentially, but from our perspective, you know, it is**
24 **great, you are obviously, you know, you know your stuff,**
25 **however we need to sort of have some kind of evidence**

1 that the 30 percent is actual, you know, a factual kind
2 of thing, so. Give us what you can provide, that would
3 be great.
4 MR. GARBER: Okay. Sure. No problem. I mean,
5 just the fact that they negotiated rates with me, you
6 know they are definitely paying us less than they are
7 paying a hospital. They wouldn't do it otherwise.
8 MS. RIVAL: Okay. Pages six and seven of the
9 prefiled testimony of Dr. Garber states, some
10 third-party payers have already begun to require that
11 LSG be performed in an outpatient surgical facility -- I
12 am sorry?
13 MR. GARBER: Yes -- I am sorry, that is just --
14 MS. RIVAL: Oh, I thought there was a question.
15 Have already begun to require that LSG be performed in
16 an outpatient surgical facility because it is
17 significantly less expensive, unless there are
18 documented medical reasons as to why the procedure must
19 be performed in an inpatient setting. Can you identify
20 these payers?
21 MR. GARBER: So I have one payer that is
22 definitive, High Mark Blue Cross Blue Shield. They are
23 based in Pennsylvania, but they, we do get plenty of
24 patients we see up here in the Tri-state area that have
25 High Mark Blue Cross Blue Shield. So they have an

1 official policy. It is on their website. I think my
2 counsel maybe provided it with my prefiled testimony
3 from their website showing that they do require all
4 sleeve gastrectomies are only approved as an outpatient
5 basis. And I have called, I have spoken to them, and
6 they are pretty absolute, they will not, unless there is
7 a medical issue that requires them to stay
8 overnight, they want all of them to be done as
9 outpatients. And we are stating to see some other
10 insurance companies, occasional self-funded plans saying
11 that on occasion. But High Mark is one that is official
12 across all High Mark patients only being approved as
13 outpatients, now. And we think that is the trend that
14 is going to move forward probably nationally in the near
15 future. So part of this is staying ahead of that curve
16 to offer that option.
17 MS. RIVAL: Great. What commercial payers will you
18 establish contracts with at your proposed Connecticut
19 outpatient surgical facility?
20 MR. GARBER: So like I mentioned earlier, so United
21 Healthcare, Aetna, Cigna, those are, all three of those
22 I already have negotiated rates for New Jersey and most
23 of them deal with, on a state-by-state basis, different
24 people you negotiate the contract with, but actually
25 United just moved their negotiations nationally, so I am

1 guaranteed that whatever rate I have in New Jersey, will
2 be in Connecticut because it is a national contract for
3 the ASC's. The other ones are local, so I do have to
4 deal with my local Cigna rep and my local Aetna rep, and
5 I am pretty confident I'll get at least what I got in
6 New Jersey. It is hard to get anything less. And then
7 in Connecticut, Anthem Blue Cross Blue Shield, which I
8 think I said earlier, I have a, we have a meeting set up
9 next week with their ASC negotiating team to start those
10 negotiations. And those are pretty much all the payers
11 that we really see, besides Husky Medicaid, which we are
12 hopeful that they will approve that eventually in the
13 nearby future.
14 MS. RIVAL: Great. And it is my understanding in
15 the testimony that you gave previously, that these will
16 all be in-network providers?
17 MR. GARBER: Yes. So we are a 100 percent
18 in-network model, correct. Which is unique to most
19 bariatric surgeons, definitely in New York, the majority
20 the private practice bariatric surgeons are all out of
21 network. So we are one of the few practices that, we
22 believe in a 100 percent in-network model.
23 MS. RIVAL: Great. On page 23 of the prefiled, it
24 states that you expect Medicare to cover LSG in an ASC
25 by 2024. Can you just give us a reason why that date

1 was selected?
2 MR. GARBER: So there, CMS has plans to slowly,
3 over the next couple of years, to move patients, move
4 different CPT codes, which are the codes that we use for
5 billing, from inpatient to outpatient, and it is a
6 guess. We don't know that for sure. So we are guessing
7 that by then that would happen. But it is kind of
8 irrelevant, because our patient population really don't
9 have Medicare anyway. So we are not operating on people
10 over 65 in our ASC. So it is really not relevant to our
11 application that Medicare population, it is more the
12 Medicaid population that is relevant.
13 MS. RIVAL: All right. And could you identify what
14 other states LSG in an ASC is covered by Medicaid?
15 MR. GARBER: That was asked earlier, and I was not
16 aware of that data, at all. So I am not sure of that,
17 if it is or it isn't on any of those states.
18 MS. RIVAL: Is there any way you could obtain that
19 information?
20 MS. FELDMAN: I believe it is in the application.
21 I will find the page.
22 MR. GARBER: No, we have in the application which
23 states perform bariatric surgery in an ASC, but we don't
24 know which ones actually do it on the Medicaid patients.
25 So I can try, but I couldn't promise. Every state has

1 different insurance companies, different managed
2 Medicaid, and I know, I know New York, New Jersey and
3 Connecticut climate pretty well, actually, I, we are
4 going to start talks now with NJ health, which is in New
5 Jersey. So they are part of Horizon Blue Cross Blue
6 Shield, which we developed a bundled rate with. So
7 Horizon Blue Cross Blue shield is paying us one set fee,
8 includes all the postoperative care, nutrition care and
9 the surgery anesthesia, we did a bundle. So they are
10 going to be introducing me now to their NJ Health team
11 to look to negotiate. So they are open to it,
12 definitely, in New Jersey, I know for a fact. But other
13 states, I don't, it will be hard for me really to know
14 because I am not even sure -- every state is very
15 different with Medicaid. Like Connecticut only has
16 Husky. New York we have 10 different Medicaid plans.
17 And New York obviously, no one has tried to do it
18 because no one is doing bariatric surgery in an ASC in
19 New York right now.
20 MS. RIVAL: Okay. Thank you. And my final
21 question has to do with the demonstration of financial
22 feasibility for the proposal. Could you please discuss
23 the overall financial feasibility of the proposal?
24 MR. GARBER: Yes. So I'll talk briefly on it, and
25 then Alan, our CFO can maybe jump in.

1 But we used very conservative numbers when we did
2 our estimates, based on what our costs are, our staffing
3 needs are going to be, as well as what the
4 reimbursement. And then the interesting thing in the
5 model we built, I think we put 12,000 as our estimate,
6 and that was a total guess before we had any contracts,
7 and I achieved that as probably our average, between
8 12,000, 12,500, is going to be, is what our
9 reimbursement is in New Jersey. So, I think that the
10 financial model we built, is probably super accurate,
11 now, I can say, based on the fact that we negotiated
12 those contracted rates in New Jersey, and I am confident
13 that we should be able to do that same in Connecticut.
14 I don't know if Alan wanted to add anything to
15 that?
16 MR. BENSON: Yeah, just from the expense side of
17 things, Dr. Garber mentioned the revenue side should be
18 pretty accurate to slightly conservative. Volumes being
19 the driver there from expense side of things. You know,
20 we know what the rent is, because we have, you know,
21 obviously looked at the space. Other big line items are
22 payroll, which we know because, you know, we have been
23 in business for 20-plus years. Benefits, same sort of
24 thing. Consumables, pretty straightforward. So there
25 is, there aren't any kind of big line items that, you

1 know, those are the big line items. Other than that, we
2 were kind of very thorough in mimicking, kind of, our
3 experience, you know, running our practice for 20 years.
4 MR. GARBER: And when those numbers were, a year
5 ago we did the application, we really didn't have hard
6 data. Now we own an ASC, now we have contracts, so we
7 can say with confidence that those are pretty accurate
8 financial models that Alan built.
9 MS. RIVAL: Great. That concludes my questions.
10 HEARING OFFICER YANDOW: Attorney Feldman, do you
11 have some follow-up questions on, of any of the
12 witnesses based on what our questions were?
13 MS. FELDMAN: No, I do not.
14 HEARING OFFICER YANDOW: Okay. What I would like
15 to do now then is I would like to take another break,
16 and then what we will probably going to have to do is
17 take a larger break, because the sign-up, and this was
18 based on what we, our hearings have mostly been going
19 until 2:00, and then we have continued them before we
20 could do public comment. So that is how this agenda was
21 set up. We can't do the public sign-up before 2:00
22 because we noticed the public that it would be at 2:00.
23 But what I would like to do right now is take another
24 break, come back at 12:30 to see if we have any other
25 follow-up questions. Maybe in that time, Attorney

1 Feldman, talk to Dr. Garber and maybe you will be able
2 to come up with some dates. I won't do the order until
3 the end of the hearing, but, for how long you think it
4 will take to get the late files, because I basically
5 will give you what you need. But I will put that in an
6 order at the end of the hearing. So let's take a break
7 and come back at 12:30.
8
9 (Whereupon a short recess was taken.)
10
11 HEARING OFFICER YANDOW: I just have one question.
12 Dr. Garber, in this, you know, the service area, where
13 else can you get this procedure done, now?
14 MR. GARBER: Only in hospitals.
15 HEARING OFFICER YANDOW: So do all hospitals do it?
16 I don't, it is --
17 MR. GARBER: Not all hospitals. Most hospitals do
18 offer it. But we really, pretty much, control most of
19 the market in the Fairfield area. We do extensive
20 advertising, I am sure you might have seen my billboards
21 on 95, and we are the premier practice, the largest
22 practice probably in the, in the state, definitely.
23 So, we get patients from everywhere, but there are many
24 other hospitals that do offer the surgery, as well, yes.
25 HEARING OFFICER YANDOW: Okay.

1 MR. GARBER: If you don't mind, I have some
2 follow-up to the, some of the questions earlier.
3 HEARING OFFICER YANDOW: Yes. No, please do.
4 MR. GARBER: So as far as the distance we looked
5 up, so Greenwich Hospital 6.2 miles away from the center
6 and 16 minute drive by regular car, not ambulance.
7 Stamford Hospital is 1.4 miles, and six minutes. And
8 Saint Vincent's is 26.3 miles and 34 minutes.
9 HEARING OFFICER YANDOW: Okay. So if you wouldn't
10 mind, in your late files, just put where you got this
11 information, just so we can put it as evidence, you
12 know, so we can cite to it, about the distance and the
13 travel. So that would be helpful. Just tell me where
14 you got the information and cite it so we can mark it.
15 MR. GARBER: No problem. It is right from Google
16 Maps, but we will document that.
17 And then one other thing that is follow-up as far
18 as the question as far as, how do you know you are
19 cheaper than the hospitals. So I have in front of me an
20 article from the Ambulatory Surgery Center Association,
21 which I think we may have submitted as an exhibit, but
22 if not we can, where they document that currently
23 Medicare pays ASC's 58 percent of the amount paid of the
24 hospitals outpatient department for performing the same
25 services. For example, Medicare pays hospitals $16,074

1 for performing outpatient cataract, while paying ASC's
2 only $964. So this article documents that CMS, in
3 general, pays 58 percent of what they would pay a
4 hospital for the same procedure. And in general, I
5 think we all know that, maybe we don't know, most
6 commercial payers follow CMS, basically, when they
7 determine rates for most procedures of how they
8 reimburse. So I think that is good documentation to
9 support. I mean, we are saying 30 percent, but it is
10 probably more savings based on this article that I have
11 here that, if you don't have, I would be more than happy
12 to supply.
13 And then the last thing, as far as the MBSAQIP
14 updated handbook that was requested, there is 2019
15 version, which I submitted to my attorney, that she will
16 send you in follow-up. And there is a Section 2.3 that
17 now is specifically labeled, ambulatory surgery center
18 patient and procedure selections. The criteria has not
19 changed from 2016, they are the same, but it is even
20 more clearly labelled that this is for ASC. It used to
21 say, low acuity. So we will submit that, as well.
22 And then in an earlier question as for as adverse
23 events, I think I maybe misunderstood the question a
24 little bit. We really haven't had any adverse events
25 that were reported to the state, reported, any major

1 thing that got reported or anything like that.
2 HEARING OFFICER YANDOW: And how about outside of
3 Connecticut?
4 MR. GARBER: Nowhere have we had any kind of
5 adverse affects that get reported to the State or
6 anything like that, no.
7 HEARING OFFICER YANDOW: And you are in New York,
8 New Jersey and Connecticut, correct?
9 MR. GARBER: Correct.
10 HEARING OFFICER YANDOW: Okay. Jessica and Brian,
11 any follow-up with that?
12 MR. CARNEY: No, Attorney Yandow. I don't have
13 anything further.
14 MS. RIVAL: Neither do I.
15 HEARING OFFICER YANDOW: Okay. Mr. Benson, I just
16 want to ask you, you have been, you know, through here,
17 listening to all the testimony and I, do you have
18 anything you want to add in support to the application.
19 MR. BENSON: No, I don't think so.
20 HEARING OFFICER YANDOW: Okay. Mr. Bachani?
21 MR. BACHANI: No, I do not. Thank you.
22 MR. GARBER: If I could add one more sentence?
23 HEARING OFFICER YANDOW: Sure.
24 MR. GARBER: Yes. Thanks. I just think, in
25 overall when you consider the application, I think you

1 really need to consider the way medicine is moving
2 nationally, and there is a big push nationally from CMS,
3 from the commercial payer to move cases from hospitals
4 inpatient setting to ASC's for cost savings. And that
5 is the bottom line is all the costs, you know insurance
6 companies, everyone want to save money. We know that
7 total joints, which was only done in hospitals forever,
8 recently has had a big push, and I think in Connecticut,
9 I think you guys are doing that in ASC's now, as well.
10 And I think that's just the way medicine is moving. I
11 think it is important when considering the application
12 that that is the way medicine is going and I think
13 Connecticut should try to stay on the top of that curve
14 of the way things are moving. And I think that we
15 really appreciate everyone's time. And we really
16 appreciate the consideration of our application.
17 HEARING OFFICER YANDOW: Attorney Feldman, do you
18 have any questions of the witnesses? No? I am sorry, I
19 think you on mute.
20 MS. FELDMAN: No, I don't. I do not.
21 HEARING OFFICER YANDOW: Okay. So I am going to,
22 you know, ask you for a closing statement. I don't know
23 if you prefer to do that now or after public comment.
24 I'll let you pick when you want to do that. I mean, we
25 have the time, now or --

1 MS. FELDMAN: Okay, if it would preferable that I
2 do it now, I think I am just going to echo what Dr.
3 Garber has stated, and I can't tell you enough, I am
4 sure you are forming your own impression, I have been
5 nothing but impressed with Dr. Garber and his team. How
6 knowledgeable he is and how interested in providing a
7 low-cost, high-quality service in the state. It has
8 absolutely been refreshing to work with him and hit all
9 the policy points that I believe this office has held
10 out and emphasized to providers when they have been
11 submitting their CON applications.
12 Most importantly, this is going to be accessible to
13 all patients, not just those that are commercially
14 insured. As was stated in our application, Dr. Garber's
15 group will be connecting with the federally qualified
16 health centers, which provide primarily primary care for
17 Medicaid parents and uninsured parents. And they have a
18 very difficulty time getting specialists to see their
19 patients. This is, to me, a very indicative of their
20 true commitment and their service model that works,
21 because they are obviously a profitable organization. I
22 think ultimately they are going to add a lot of value
23 and enhance the health of the community that it serves.
24 They are currently providing inpatient surgery.
25 They are not new to the state. They are at Trinity,

1 Saint Francis Medical Center. They are at Saint
2 Vincent's. Neither one of those hospitals has chosen to
3 intervene. They are very supportive of this group and
4 they are very appreciative of the high-quality work that
5 they provide.
6 I do think that this application is advancing
7 exactly what OHS is looking for by introducing these
8 high-quality services and they will be accredited by all
9 the applicable accrediting bodies. The fact that many
10 of the surgeons that work for premier are surveyors for
11 these accrediting bodies demonstrates that it is, you
12 know, integral to their culture, their values and how
13 they perform their surgery. It is a public health
14 problem. It is a good solution. And I think that it
15 will not only be cheaper for Medicaid, from the
16 procedural standpoint, but our hope is that the other
17 healthcare associated costs that result from chronic
18 morbid obesity will also be reduced. So I think the
19 state will, in fact, benefit from having this procedure
20 available to the patients.
21 So in closing, I just, you know, I can't
22 reemphasize enough that being willing and able, and we
23 are very confident, we cannot represent to you that DSS
24 has said, we are definitely going to do this, but to
25 me, as a healthcare attorney, it is a no-brainer. I

1 can't understand or, you know, don't expect that DSS
2 won't see this as a very safe option for their, for the
3 beneficiaries. So with that, I thank, I also thank you
4 for your time and we will see you again at 3:00 o'clock.
5 HEARING OFFICER YANDOW: Just to follow-up,
6 Attorney Feldman, and this may be in the record, so let
7 me know. You said how the hospitals support this. Are
8 there letters of support in the application?
9 MS. FELDMAN: There is. There is.
10 HEARING OFFICER YANDOW: From the hospital?
11 MS. FELDMAN: From Saint Francis Hospital and
12 Medical Center.
13 HEARING OFFICER YANDOW: Okay.
14 MS. FELDMAN: If you would like one from Saint V's,
15 we are happy to get one. We just didn't think it was
16 necessary. But they are very, they know exactly, and we
17 are happy to produce it, but they know exactly what we
18 are doing and they are very supportive of Dr. Garber and
19 his group.
20 HEARING OFFICER YANDOW: Okay. I mean, I'll leave
21 that up to you. I won't order that you do, but you
22 certainly would be able to do that. It may factor in, I
23 don't know, we are going to have to take it all in. But
24 I am certainly going to want to take a look at the Saint
25 Francis letter.

1 MS. FELDMAN: Sure.

2 HEARING OFFICER YANDOW: Jessica and Brian, any
3 follow-up with any of the statements or with what
4 Attorney Feldman said?

5 MS. RIVAL: No.

6 MR. CARNEY: No.

7 HEARING OFFICER YANDOW: Okay. So again, it's, you
8 know, we are not going to be back on until 3:00, and I,
9 you know, I know that is a long way. So we don't have a
10 crystal ball, we never know how long these hearings are
11 going to last. Our last several hearings have gone
12 until 2:00, and we based it on that. So, what we,
13 everyone needs to do -- and I'll just let you know, no
14 one at this point has signed up for public comment. So
15 there may not be anyone, which means we will just be
16 closing it shortly thereafter 3:00. But so we can close
17 or certainly break this technical piece right now, and
18 there may not be any other evidence we need to ask for.
19 And we will see you all at 3:00 o'clock.

20 MS. FELDMAN: Thank you.

21 HEARING OFFICER YANDOW: Thank you.

22

23 (Whereupon a recess was taken.)

24

25 HEARING OFFICER YANDOW: Well, good afternoon

1 everyone. It is 3:00 o'clock, now. Okay. We are back
2 from our break. We had public sign-ups from 2:00 to
3 3:00. This is for those who just are new tuning in.
4 This is the Certificate of Need public hearing in the
5 matter of Premier Bariatric Group, PLLC. This is Docket
6 Number 21-32425-CON, with the Applicant looking to
7 establish an outpatient surgical facility in Stamford.
8 So we do have one person that has signed up for
9 public comment. For anyone else that is on on this
10 meeting, we will call the names of the people signed up
11 for public comment, which is, at this point, just the
12 one. And if anybody wants to speak after that, we will
13 certainly give you the opportunity. Speaking time, I am
14 limiting it to five minutes. We usually do three, but
15 there does not seem to be a lot of people signed up to
16 talk. So if we could limit the time to five minutes.
17 You may get stopped at the end of five minutes, and we
18 strongly encourage anyone, anyone who speaks or anyone
19 who doesn't want to speak, they can submit further
20 written comment to the Office of Health Strategy by
21 e-mail or mail no later than one week from today. So we
22 will keep the record open for public comment for one
23 more week, and again, that can be by e-mail or mail.
24 Our contact information is on our website.
25 So we can go ahead and continue. The one person

1 who was signed up for public comment, we have Mariana
2 Morales.
3 MS. MORALES: Yes. Good afternoon guys.
4 HEARING OFFICER YANDOW: Hi. Can you put your
5 camera on.
6 MS. MORALES: Yes. I am doing the Zoom through my
7 phone, so it is a little bit awkward because our
8 computer doesn't have a camera, but I will.
9 HEARING OFFICER YANDOW: If you can do it through
10 your phone, that would be great. We usually, you know,
11 we like everyone who can, who is speaking, to show their
12 face. So you said you are able to do that through your
13 phone.
14 MS. MORALES: Yes, I believe so.
15 HEARING OFFICER YANDOW: Oh, there you are. In and
16 out. There you are. Hello.
17 MS. MORALES: Hello.
18 HEARING OFFICER YANDOW: So you heard my
19 instructions.
20 MS. MORALES: Yes.
21 HEARING OFFICER YANDOW: So if you can limit it to
22 five minutes. I'll let you know when you are about five
23 minutes. But, you know, please go ahead whenever you
24 are ready.
25 MS. MORALES: All right. I wrote it down only

1 because I tend to lose my train of thought, so I am
2 going to be reading it off my paper.
3 So hi. My name is Mariana. I am a patient of New
4 York Bariatric and wanted to share my experience so far.
5 I am a 21-year-old mother of a two-year-old. My son was
6 the biggest reasoning for undergoing the surgery. At my
7 heaviest, I wasn't able to keep up with my mommy duties,
8 such as playing with my son or chasing him around.
9 Something so simple as changing his diaper became a task
10 because of how out of breath I would get just having to
11 bed down to grab wipes and a diaper. My son needed more
12 of me, and I needed better for myself.
13 I was 21 with chest tightness, chest pains and
14 unbearable joint pain. I wasn't living how I was
15 supposed to. I finally made a decision towards a
16 healthy lifestyle. Although I was going to the gym
17 prior, that wasn't enough. It was a constant battle
18 between my mind and my mouth. That is when I found out
19 I was a candidate for the gastric sleeve through New
20 York Bariatric. I was having issues with other
21 facilities due to my insurance being Medicaid. Once you
22 turn 21 on Medicaid, finding a doctor becomes
23 impossible, and I am speaking from experience on that.
24 I took a leap of faith and started the process
25 towards the surgery. It was an eight-month process for

1 **me at the time, but it was the best decision I have made**
2 **so far. The process was tedious, but worth it. The**
3 **surgery itself was done in a hospital. It was a quick,**
4 **it was quick and bearable. In fact, I felt so good**
5 **afterward that I was, that I wish I could have gone home**
6 **the same day. I went home and had no complications**
7 **after surgery. I am currently five months out from my**
8 **surgery, from my surgery date and feeling better than**
9 **ever. I am down 70 pounds, 60 of those pounds which I**
10 **lost within the first three and a half months. I am**
11 **super excited to say that my joint pain is completely**
12 **gone and I haven't had chest pain or any chest tightness**
13 **since surgery. Because of Medicaid, my doctor and New**
14 **York Bariatrics, I was able to take my life back and**
15 **give my son the life he deserves. I am now able to run**
16 **after him, take him to the park and spend more time with**
17 **him, as opposed to being glued to my bed, and for that I**
18 **am grateful and decided to become a part of New York**
19 **Bariatric to help everyone undergo this life changing**
20 **surgery. And that is all I have for you guys today.**
21 **HEARING OFFICER YANDOW: Well, I appreciate your**
22 **comments. Thank you very much. I will certainly give**
23 **them serious consideration when looking at the record.**
24 **I appreciate it. And if there is any more comments, any**
25 **other comments you want to add, you can certainly put**

1 them in writing and send them to us.
2 MS. MORALES: Okay. Sounds good.
3 HEARING OFFICER YANDOW: All right. Thank you.
4 You can stay on, or you can sign off, whatever you want
5 to do.
6 MS. MORALES: Okay. Perfect. Thank you so much
7 for your time.
8 HEARING OFFICER YANDOW: Thank you. Okay. Leslie,
9 was there anybody else?
10 MS. GREER: No, we did not have anyone else signed
11 up.
12 HEARING OFFICER YANDOW: Okay. All right.
13 Attorney Feldman, anything else?
14 MS. FELDMAN: Nothing. No further comments.
15 HEARING OFFICER YANDOW: Okay. Great. Thank you.
16 And let me just check, Brian and Jess, was there
17 anything else that you wanted to ask or add?
18 MS. RIVAL: No.
19 MR. CARNEY: No, I don't have any additional
20 questions. Just the late file, that is it.
21 HEARING OFFICER YANDOW: Okay. Well I appreciate
22 everyone's time today, and we will certainly take
23 everything, you know, under consideration. The record
24 is going to stay open -- oh, the late files, Jess. Do
25 you have a list of those?

1 MS. RIVAL: Yes.

2 HEARING OFFICER YANDOW: Do you want to make, could

3 you read us what the list is, please?

4 MS. RIVAL: Sure. The first late file was to

5 review the projected volume tables and the payer mixed

6 table to reflect unduplicated patients. Additionally --

7 HEARING OFFICER YANDOW: I think, Jess, you just

8 went on mute, Jess. So, but I think if everybody even

9 else could just make sure they are on mute, because I

10 think there was a little bit of feedback. Okay. You

11 are back on, Jess, go ahead.

12 MS. RIVAL: I am sorry, how far were you able to

13 hear, or do you want me to just start from the

14 beginning?

15 HEARING OFFICER YANDOW: I think you can start from

16 the beginning. Projected volumes, and then you, sort

17 of, cutoff when you were sort of breaking that down, but

18 go ahead.

19 MS. RIVAL: I apologize. Okay. A revision of the

20 projected volume table and payer mix table to reflect

21 unduplicated patients.

22 Three-year historical year volumes for each

23 hospital where bariatric surgery performed on an

24 inpatient basis. We would also like the volumes by

25 gender, age group, race and ethnicity.

1 MR. CARNEY: And payer type, please.
2 MS. RIVAL: Oh, I am sorry. And payer type.
3 MR. CARNEY: That is okay. I missed that before.
4 Thank you.
5 MS. RIVAL: Sure. The volume and demographics and
6 payer type related to safety and complications in
7 adverse events, excuse me.
8 MS. FELDMAN: Can you restate that, please, Ms.
9 Rival?
10 MS. RIVAL: Sure. Of course. The information on
11 the volume and demographics for the payer type safety
12 complications, adverse events.
13 MR. GARBER: So that, just to be clear, I think is
14 that the SARS reports from the hospital, is what you are
15 looking for, that we get from the third party that
16 benchmarks the hospital against other payers?
17 MR. CARNEY: Sorry. I can clarify. Jess, that one
18 was for the outpatient bariatric surgery facility in New
19 Jersey.
20 MS. RIVAL: I am sorry, I am not able to hear you,
21 Brian.
22 HEARING OFFICER YANDOW: I think could everyone
23 else, while other than Brian and Jess, just mute their
24 mics, because I think we get feedback. Yes. Thank you.
25 MR. CARNEY: Yeah. Sorry. Jess, that was, that

1 was intended for their outpatient surgical facility in
2 New Jersey, which is not operational yet. So we will
3 skip that one.
4 MS. RIVAL: Okay. The updated standards manual.
5 Both the distance and the time from the proposed
6 ASC to local hospitals.
7 The blended cost of LSG at the ASC.
8 MR. BENSON: What do you mean by blended cost?
9 MS. RIVAL: Not specific to one payer, but, excuse
10 me, a blending of, you know, what someone would pay
11 out-of-pocket, in addition to, you know, an average
12 amount of payers, et cetera.
13 MS. FELDMAN: If I may, Ms. Rival, I think Dr.
14 Garber had offered to provide this sort of a general
15 range of a number.
16 MS. RIVAL: Yes. We also discussed a late file on
17 the complications and the SARS report from the
18 hospitals.
19 MR. GARBER: Just on that, we, in the break we did
20 check with the hospitals. We do have Saint Vincent's
21 SARS report. Saint Francis, we are relatively new
22 working there, the SARS report for Saint Vincent's is
23 for the year of 2020, which we have. We do not have a
24 SARS report available for Saint Francis, because we just
25 started there within 2021. So that is, we can only

1 produce the Saint Vincent's one.

2 MS. FELDMAN: Is that all right that we are just

3 able to produce Saint V's? It is not available at Saint

4 Francis.

5 HEARING OFFICER YANDOW: I think if it is not

6 available and you can't get it. But, I mean, the more

7 information that we can get, the more it would, you

8 know --

9 MS. FELDMAN: I think we could probably, based on

10 the surgeries that were performed by this particular

11 group, might be able to give some anecdotal information

12 as to the extent that they had any sort of adverse

13 outcomes or unanticipated outcomes. Dr. Garber is that

14 present for Saint Francis?

15 MR. GARBER: So we can get complication data of any

16 complication we had at, not from the third party, but we

17 can get you a list of complications out of that, the

18 hospital documents. But we also, just of note, is Saint

19 Vincent's is where we did the majority of our work,

20 anyway. So you will have a good sample size to look at

21 our complication rates with just the Saint Vincent's

22 report. Saint Francis is a new institution that we

23 opened the office in Hartford a little over a year ago

24 before we were starting to do that. So, but we can get

25 you some data from the hospital that we can produce, as

1 well as the Saint Vincent's SARS report. It gives you a
2 good volume that you can look at our complication rates
3 at, which I think would be very helpful to you.
4 MS. RIVAL: And those were the notations that I
5 made for late files. Brian, did I miss anything that
6 you are aware of?
7 MR. CARNEY: Just one additional Jessica, that Dr.
8 Garber said, he had an article from CMS regarding
9 outpatient surgical facility having lower costs that he
10 was going to share with us.
11 MR. GARBER: Yes, it's Ambulatory Surgery Center
12 Association article. Which, if you don't have it, we
13 will get you a copy of it.
14 MR. CARNEY: That would be great. Thank you,
15 Doctor. That is all I have.
16 MS. RIVAL: Thank you.
17 HEARING OFFICER YANDOW: Attorney Feldman, how long
18 do you need.
19 MS. FELDMAN: Well, I do have a question about the
20 second late file, which is a three-year historical data
21 on LSG, presumably, performed at Saint V's. And we will
22 have one year for Saint Francis. Is that data that we
23 could easily get, Dr. Garber.
24 MR. GARBER: Yes. Yes. And we are also going to
25 produce the data from the Westchester Hospital, because

1 we think a good portion of those will come over. And
2 then we are going to produce from Mount Sinai, in the
3 City, and we are going to estimate what percentages we
4 think will come for each one of these hospitals, and we
5 will break them all out for you. We can get that, we
6 have that readily available and can get that.
7 MS. FELDMAN: So the answer your question, Hearing
8 Officer Yandow, we would request a week, but to the
9 extent we could submit it sooner, we will.
10 HEARING OFFICER YANDOW: Okay. Great. And just to
11 follow-up on what Dr. Garber had to say, you know, on
12 what he is projecting. Any other kind of information
13 that could, you know, support that projections, that
14 people, and we do have Dr. Garber's testimony, but any
15 kind of support that this proposed facility would draw
16 those patients in, would be good. We have your
17 testimony, and I understand what you are, you know, what
18 you, you know, that it's easier, people like the ACS,
19 but if there is any kind of statistics or any kind of,
20 you know, letters of support that would agree with
21 that, would certainly help back up the information that
22 you are giving us.
23 MR. GARBER: I will try our best. I think that
24 might be hard to come by, but --
25 HEARING OFFICER YANDOW: Yeah, and I am not, I am

1 **leaving that up to you.**

2 **MR. GARBER: Sure. Yeah. I can just tell you from**
3 **my past experience of doing this 20 years, patients will**
4 **go to whatever hospital, patients come to our practice**
5 **for a surgeon, and they will go any hospital that I tell**
6 **them to go to, to have the surgery, from experience. I**
7 **used to operate lots of different places, and I would**
8 **move people from hospital to hospital based on where I**
9 **can get OR time and people will go where we pretty much**
10 **tell them. But we will, I'll see if I can come up with**
11 **anything, but unlikely I will be able to come up with**
12 **anything else besides that.**

13 **HEARING OFFICER YANDOW: Okay.**

14 **MR. CARNEY: This is Brian Carney, just one further**
15 **thing. Like are there any wait lists, are there any**
16 **backlogs for scheduling, anything like that, sort of,**
17 **typically associated with, that would be good to mention**
18 **if there are.**

19 **MR. GARBER: Sure. Yeah. I mean, we usually have**
20 **a, usually at least a six to eight week wait, most of**
21 **the time, to get in for surgery, at least. But we will**
22 **definitely, we can get you, we can look at historical**
23 **data of wait times. We definitely have access to that**
24 **data we can get for you.**

25 **HEARING OFFICER YANDOW: Well, let me just follow**

1 that up with a couple of questions. I mean, how many
2 procedures on the ambulatory surgery center, how many
3 procedures would you do in a day?
4 MR. GARBER: So depends if we use one room or two
5 rooms. But typically myself, when I, at one point I
6 just operated at Saint Francis on Long Island, I stopped
7 operating right now, so I haven't operated in a year,
8 but when I, I used to do 10 sleeves in a day. I would
9 have two operating rooms that bounce back so you didn't
10 have to wait for turnover. So I'd do five cases in each
11 room, and I would be done by 4:00 o'clock and start at
12 7:30 in the morning. So that is the best case scenario.
13 My surgeons aren't as fast as I am, so I would say eight
14 to ten cases in a day, we can easily, do at max capacity
15 in the facility with two rooms.
16 HEARING OFFICER YANDOW: Okay. All right. And so
17 knowing that information and tying it in with whatever
18 kind of information you give us on a backlog would be
19 helpful.
20 MR. GARBER: Sure. I am confident when we have the
21 facility, there should be no lack bog, because hospital
22 we have limited OR time. We have lot time, they give us
23 one or two days a week and that is all we have access to
24 an operating room, and sometimes we don't get two rooms,
25 we only get one. So by having the access to an

1 ambulatory surgery center, we should be able to do a
2 much larger volume quicker, to have unlimited OR time
3 like that.
4 HEARING OFFICER YANDOW: Brian, any follow-up
5 questions with that?
6 MR. CARNEY: No, that was it. Thank you.
7 HEARING OFFICER YANDOW: Okay. You're welcome. So
8 with the, I am going to issue an order that the
9 documents that are going to be provided, today is the
10 7th, so right now I am going to issue the order that
11 they be provided by next Wednesday, December 15th.
12 Attorney Feldman, if you need more time, just file a
13 request and, you know, onto the portal or to Brian and
14 I'll get it. You know, just a motion for more time.
15 But right now the order is that these are to be provided
16 by December 15th, and we will review those. I believe,
17 Brian, when the record closes is there an official
18 notice that goes out when the record closes?
19 MR. CARNEY: We will post it to the portal and we
20 can choose to have it be accepted so that, you know,
21 they get an e-mail sent out, generated that it has been
22 posted.
23 HEARING OFFICER YANDOW: I am sure once these
24 documents are looked at there may or may not be a
25 further, you know, request for document, you know, until

1 we look at everything. So, but you will get notified
2 when the record closes.
3 All right. Well I appreciate everybody's time.
4 And thank you, everyone. And we will leave the record
5 open and, but adjourn the hearing, okay.
6 MR. GARBER: Thank you, everybody. I really
7 appreciate everyone's time. Have a nice day.
8 HEARING OFFICER YANDOW: Thank you.
9
10 (Whereupon the hearing was adjourned at 3:20
11 p.m.)
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STATE OF CONNECTICUT

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3 I, THERESA BERGSTRAND, a Licensed Professional Reporter/Commissioner within and for the State of Connecticut, do hereby certify that I took the the

4 foregoing hearing testimony, on December 7, 2021 Via Zoom Videoconferencing Platform.

5 I further certify that the within testimony was taken by me stenographically and reduced to typewritten

6 form under my direction by means of computer assisted transcription; and I further certify that said

7 deposition is a true record of the testimony given by said witness.

8 I further certify that I am neither counsel for, related to, nor employed by any of the parties to the

9 action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or

10 counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

11

WITNESS my hand and seal the 29TH day of

12 December, 2021.

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Theresa Bergstrand, CSR.

19 My commission expires 3/31/2026

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