

- 1. Assume that MEEI is a high value provider with rates generally below the median of MA providers. Partners says that MEEI will maintain existing commercial payer contracts thru end of current contract periods and that thereafter, MEEI will be included in Partners negotiations. Partners discusses rate increases and “needing commercial rate relief” which could be achieved thru Partners “allocating to MEE[I] part of the overall rate increases that it negotiates with payers”.**
 - a. How will Applicant document an increase in quality to justify any potential increase in costs?**
 - i. What are the quality measures?**
 - ii. What are the cost measures?**

The relationship between the quality and cost of care is complex and not a one-for-one relationship. Numerous policy groups have been investigating the link between the two concepts, including the Institute for Healthcare Improvement. Through their evaluation, policy and academic organizations agree that more research is needed to fully understand the causal relationship between quality and cost. Moreover, recent data on the status of CMS accountable care organization (“ACO”) demonstration projects highlight the intricate connection between quality and cost with variation amongst participants in financial performance and quality results. “This variation underscores that payment reform alone is not enough to improve quality and reduce costs, but rather that organizations must also transform the way care is delivered. Care transformation is difficult and takes time to get right.”¹ This shift in how care is provided and system transformation impacts rates, as the cost of care is based on numerous factors including administrative costs for providing integrated care, such as the cost of multi-disciplinary care teams rounding on patients, the cost of integrating health information technology systems, the cost of providing access to psycho-social enabling supports, such as case managers that can help patients address the social the determinants of health, etc.

ACOs, including Partners HealthCare’s ACO, have risk-bearing agreements with insurance companies to provide services and care coordination for their patients. These agreements set performance benchmarks for quality and spending by the ACO. Accordingly, the infrastructure already exists through these agreements to closely track and monitor quality indicators to determine whether a provider is meeting certain quality benchmarks.

Since 2012, Partners HealthCare has entered into new contracts with all the major insurers including the Centers for Medicare & Medicaid Services (CMS), commercial payers, and MassHealth. After four years in the Medicare Pioneer ACO Model, Partners HealthCare saved \$31.5 million. With an overall quality score of 96%, Partners HealthCare is among the best ACOs in the nation for delivering high-quality care to patients. Partners HealthCare’s Pioneer ACO provided care to 84,000 Medicare patients. In 2017, Partners HealthCare became a Next Generation Medicare ACO, a new model geared toward health care organizations with previous experience managing large populations.

¹ Muhlestein, D., Saunders, R., & McClellan, M. (2016, September 9). Medicare Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues. Retrieved August 22, 2017, from <http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/>

Since December 2016, Partners HealthCare has been one of six organizations participating in the MassHealth ACO pilot program, with the goal of providing more tailored and individualized care to MassHealth patients while reducing costs. It is anticipated that Partners HealthCare's Medicaid ACO will be responsible for managing the care of nearly 100,000 of the state's Medicaid patients.

Recognizing that governmental and commercial payers are continuing to develop global payment models and other value-based contracts for clinically integrated healthcare delivery systems, MEE has determined that its best strategy for ensuring its long-term viability is to join Partners HealthCare, a comprehensive, clinically integrated health care system. In addition to becoming a full participant in Partners HealthCare's ACO and risk bearing arrangements, as a member of Partners HealthCare, MEE will be able to realize cost savings from being part of a large and financially stable system. Specifically, MEE will be able to reduce operating costs and ultimately focus these savings on continuing its clinical and research missions.

- b. How will you measure any changes/increase in out of pocket costs to patients and insurers in a post-merger world?**
 - i. What specific measures will be taken with respect to any change/increase in out of pocket costs to patients and their insurers in a post-merger world?**

The liability of patients for out of pocket costs are determined by their individual contracts with insurers. The Applicant does not have information on the obligations of patients set by the various payors. As a result, we cannot track these costs.

- c. More generally, how will the merged entity manage costs?**

From a financial perspective, the parties' goal is to enable MEE to ensure its financial viability to continue to provide world-class ophthalmology ("OPH") and otolaryngology ("ORL") services to patients in the Commonwealth and to continue to conduct cutting edge research seeking cures for deafness and blindness. The Transaction will facilitate MEE's future financial sustainability in a number of ways. As a member of Partners HealthCare, MEE will be able to realize cost savings and other financial benefits from being part of a large and financially stable system. MEE will gain access to capital at a lower cost and improve its investment returns. Extending PHS corporate and administrative services (including information systems, research administration, revenue cycle, treasury, employee benefits, payer contracting, real estate and materials management services) to MEE will result in lower costs for all Partners HealthCare organizations (including MEE) because PHS will be able to spread the aggregate costs of these services for the entire system over a larger base, thereby reducing the unit costs of these corporate services for each individual Partners HealthCare organization. MEE will also be able to purchase goods and services at a lower cost through Partners HealthCare's vendor arrangements. Being part of Partners HealthCare's "single bottom line" and common balance sheet will enable MEE to obtain capital and operational support that may be needed to sustain its missions.

In addition, MEE can integrate its growth strategies and facilities development plans with PHS. For example, the parties anticipate that MEE will be able to avoid the capital costs of building new operating rooms ("ORs") in community settings by utilizing both existing and subsequently

developed ORs at Partners HealthCare’s community hospitals and outpatient sites. This will enable MEE to offer more surgeries to patients closer to their homes and will result in more efficient use of ORs at these Partners HealthCare community sites. There are also opportunities for MEE to develop OPH and/or ORL clinical sites at a lower overall cost within ambulatory centers that Partners HealthCare may develop over the next several years. The MEE locations proximate to MGH and Longwood provide an opportunity for PHS, its affiliated organizations and MEE to engage in joint long-term real estate planning to determine the most efficient and integrative use of their collective space.

There are also many other potential cost savings and operating synergies to explore due to the existing collaboration between MEE and MGH and the proximity of their two campuses. For example, following the Transaction there may be opportunities to integrate certain services, such as laboratory and other ancillary services, and for MGH to provide or support long-term clinical operational services for MEE, such as management of its nursing and physical therapy staffs, and operational services such as on-site security and parking. After completing the Transaction, the parties will develop specific integration plans that will include timelines and quantification of many of the financial and other benefits that have been described above.

d. With respect to managing costs, what benchmarks does Applicant propose to use for the annual reporting?

The parties project that MEE will be able to reduce the annual rate of growth in its operating costs from approximately 5% (the average annual rate of growth during MEE’s FY13-FY17) to approximately 4% during the initial three years after the closing of the Transaction (assumed to be FY19-FY21). Additional cost savings are expected to be realized after MEE migrates onto Partners HealthCare’s full array of clinical, research, financial and administrative systems, including PeopleSoft (general ledger and research financial management as well as human resources and employee benefits) and eCare.

2. Partners outlines a variety of benefits of the transaction. Specifically, the application references incentives to manage care more efficiently which incentives will be aligned by virtue of the transaction.

- a. What are those incentives?**
- b. How are those measured?**

As discussed in the Summary Section and Section F1.b.i of the Applicant’s Determination of Need application, fee for service reimbursement is being replaced by payments tied to quality metrics, defined health outcomes and associated patient cost.² Under these new models, physicians are financially accountable for the quality of care they deliver and effective stewardship of healthcare resources. These forms of payment are all considered risk bearing arrangements as they provide financial incentives to providers to manage care effectively. Risk bearing contracts are diverse in nature, but typically set out terms with noted quality and cost benchmarks that an ACO must meet. If the ACO achieves the enumerated benchmarks, providers within the ACO share in financial incentives (such as shared savings). However, if benchmarks are not achieved providers share in

² Colbert, J. A., MD. (2016, November). Understanding the Four Stages of Risk-Based Contracting. Retrieved August 22, 2017, from https://cdn2.hubspot.net/hubfs/394315/assets/News_Articles/AccountableCareNews_Nov16.pdf?t=1495229182009

the losses. Each payor and contract establishes the benchmarks that must be met in order for the provider to share in the savings achieved by the provider.

- c. Which of those incentives is predicated on corporate alignment, and why?**
- d. Are there other types of affiliations that could affect a similar alignment?**

Within an owned, integrated system, providers have certain tools and a framework to share data that are only available to entities with common ownership because of legal and operational restrictions. These tools include (i) flexible and aligned partnerships between PCPs and specialists, (ii) a health information technology infrastructure that allows direct connectivity across provider types and care settings including computerized clinical decision support to improve integration of diagnosis of diseases, assist with management of care and reduce (even prevent) medical errors, and (iii) shared, appropriate measures of quality to evaluate and improve care.

As discussed in the Determination of Need application, MEE currently serves as the OPH and ORL provider for MGH and the OPH provider for BWH; however, even with these relationships with MGH and BWH, the lack of full financial, operational and clinical integration of MEE with Partners HealthCare creates barriers to the optimization of integrated care delivery in an ACO model. For example, because of the limitations on the sharing of protected health information imposed by HIPAA, MEE and Partners HealthCare clinicians do not have full, shared access to the medical records of all of their respective patients. A fully integrated health information technology system will allow Partners HealthCare and MEE to mutually identify a core set of OPH and ORL measures that will be used to improve the quality of the reporting process, the likelihood of shared savings, and the development of additional care improvement initiatives. In addition, having a flexible partnership between PCPs and specialists is a critical tool for patient care and care management. It enables PCPs to effectively screen patients for specialty services and specialists to understand the patient's other co-morbidities and psycho-social needs. Such flexibility is only achievable between physicians when there is alignment of incentives, finances, operations, coordinated decision-making and leadership. Absent alignment of PCPs and specialists with respect to performance metrics, patient care and care management methodologies, and finances, there is no way to fully integrate care for shared patients. As an independent hospital lacking PCPs and their attributed patients, MEEI does not realize financial benefit from the ACO.

Access to these tools, the integrated framework and to the other above described clinical, operational and financial resources of the Partners HealthCare System is critical to ensuring MEE's continued viability as a top-tier provider and to the ongoing availability of high quality eye, ear, nose and throat care, research and medical education in Massachusetts. These are only available through an acquisition and full integration of MEE into Partners HealthCare. Having seen the other independent specialty hospitals secure their continued mission by becoming part of a larger entity, MEE believes that this Transaction is similarly required for MEE's successful longevity, and for Partners HealthCare, the Transaction is necessary to ensure the Partners HealthCare ACO's continued access to high quality OPH and ORL services for its patients.

- e. Provide evidence for the assertion that the inclusion of MEEI in the Partners ACO will improve or increase access for Partners' patients compared to a pre-merger world.**

As discussed in Section F.1.b.ii of the Determination of Need application, the parties anticipate that the Transaction will provide Partners HealthCare's patient panel with improved access to OPH and ORL services that are fully integrated, thus providing for improved outcomes, patient quality of life and health equity. As a member of Partners HealthCare, MEE will participate in system-based strategic planning initiatives. These planning activities will seek to improve local access to specialty services and enhance care management for patients. By joining, Partners HealthCare and MEE will build upon their existing relationship and expand integrated care models beyond existing services at MGH and BWH to Partners HealthCare community hospitals. For example, MEE's specialists may potentially participate in new ambulatory care sites that are developed by Partners HealthCare, which will lead to increased access to specialty OPH and ORL services in the community setting.

Evidence of increased access may only be produced and evaluated post-Transaction. Accordingly, Partners HealthCare has stated in its Determination of Need application that it will measure access for Partners HealthCare patients via the following metrics:

1. The number of Partners HealthCare patients receiving OPH and ORL services from MEE physicians.
2. The average length of time between a primary care referral for OPH or ORL services to the date of an assigned appointment at MEE.

f. What are the benefits of this proposed merger to the MEEI patients and how will they be measured?

MEE patients will continue to be referred by a variety of providers. However, the Transaction will allow MEE to offer more robust enabling/support services for patients, including increased case management services, such as screenings for psycho-social supports that impact care, e.g. screenings for issues associated with the social determinants of health, etc. Access to increased quality and patient safety initiatives, such as participation in quality collaboratives will also be available to MEE's specialists; these quality initiatives, in turn, will impact outcomes for patients. Additionally, the Transaction will provide MEE with resources that will help the hospital combat issues with health equity and overcome health disparity issues among patients.

3. Other than/in addition to the efficiencies of scale and ability to raise rates, what is Partners' committing to in terms of helping MEEI out financially? How will those be measured over time?

MEE recognizes that emerging market changes will continue to put pressure on its revenue and costs, making it difficult to achieve further improvement in its operating results, and that its own financial resources and capabilities are limited. Joining Partners HealthCare will help to ensure MEE's long term financial viability and ability to execute on its missions by addressing the following challenges currently faced by MEEI:

- First, MEE's status as an independent, unaffiliated provider organization makes it difficult for MEE to maintain its current market position with a shift to ACO models of care. From a financial perspective, the parties' goal is to enable MEE to ensure its financial viability

to continue to provide world-class OPH and ORL services to patients in the Commonwealth and to continue to conduct cutting edge research seeking cures for deafness and blindness. Currently, MEE is the last stand-alone eye and ear hospital in the United States; a cohort of similar specialty hospitals around the country have found it necessary to become a “subsidiary” of a large healthcare system in order to continue their missions. The Transaction will facilitate MEE’s future financial sustainability in a number of ways as discussed throughout these responses.

- Second, lacking its own primary care network and not being part of an organized ACO, MEE depends heavily on patient referrals from other providers. However, as these other providers join integrated ACOs with extensive population health management programs and related financial incentives, these other providers are being increasingly directed to reduce utilization of specialty care services (such as OPH and ORL) and to reduce referrals to non-ACO providers, including MEE. This lack of a primary care base prevents MEE from developing its own ACO. Thus, MEE has no patients “attributed” to it under risk contracts and cannot share directly in any savings generated by such risk arrangements. As a member of Partners HealthCare, MEE will be able to directly share in the savings generated by the improved care management that will result from the Transaction.
- Third, the ongoing emphasis on healthcare cost containment will continue to exert downward pressure on rates from the Medicare program, the Commonwealth and commercial payers. It will also cause providers to continue to consolidate into ACOs to control the costs of services.
- Fourth, in addition to these volume and rate pressures, regulatory fees and other costs of providing excellent patient care continue to increase. For example, MEEI is a “specialty hospital” (as defined by CHIA), and while it does not benefit financially from the ACO delivery model due to a lack of attributed members, MEEI incurs the same fees that are levied by the Commonwealth on acute care hospitals who can realize financial benefits from the ACO model. MEE is also faced with market driven increases in other costs, including nursing and other labor rates, pharmaceutical costs, pension expenses, real estate, utilities and medical device costs. Such costs have increased substantially in recent years, adding millions of dollars in expenses to hospital providers. As a relatively small, independent hospital, these increases are particularly challenging to absorb and threaten MEE’s financial sustainability.
- Fifth, in the event that MEE is required to improve or expand its facilities, as a result of this Transaction, MEE will have better access to capital and at lower rates through Partners than MEE could have achieved as a freestanding organization.
- Finally, reductions in federal research and medical education funding and increased competition for available funds have diminished MEE’s access to external funding to support MEE’s world-class research and graduate medical education programs. However, despite these reductions in funding, MEE must still maintain a substantial infrastructure to support its research mission. Since MEE’s ability to use its balance sheet resources to

support research is inherently limited, MEE has been relying increasingly on philanthropy to maintain its premier research programs. However, philanthropic sources of funds are limited and are unpredictable; as a result, this is not a sustainable model for continued achievement of MEE's important research mission to cure blindness and deafness.

The cumulative impact of these continuing cost pressures has threatened MEE's ability to generate adequate financial results to support continued investment in its mission. As a member of Partners HealthCare and its ACO, MEE will be able to ensure its long-term viability through lower operating costs.

4. What is the benefit to the MEEI specialists of the proposed merger? And how will those be measured over time?

MEE's specialists will benefit from this Transaction through increased access to additional clinical and research resources, as well as ensuring the long-term viability of their employer. This Transaction ensures the financial viability of MEE so that it can continue to provide world-class OPH and ORL services in the Commonwealth and conduct cutting-edge research seeking cures for deafness and blindness. With respect to clinical care, market forces (integrated ACOs, risk sharing reimbursement models and population health management) threaten the financial stability of MEE. Lacking its own primary care network, MEE depends on referrals from primary care providers. However, as these providers join integrated ACOs, with extensive population health management programs and related financial incentives, primary care physicians are being increasingly directed to reduce utilization of specialty care services, including those provided by MEE, and to reduce referrals of such specialty care services to non-ACO providers, such as MEE. Even if MEE participated contractually with an ACO, without its own primary care base – and thus no patient “members” attributed to it – MEE cannot share directly in any savings generated by the ACO under risk sharing arrangements. Further, even though it is a specialty hospital (as defined by CHIA), MEE incurs the same fees that are levied by the state on acute-care hospitals to support the MassHealth ACO delivery model, but as indicated above without its own primary care members, MEE is unable to benefit financially from the ACO delivery model. In short, MEE has no way to benefit from today's risk-based ACO healthcare market short of becoming a fully integrated member of an ACO like Partners HealthCare.

Accordingly, for MEE, a key clinical benefit and goal of the Transaction is the closer affiliation with a primary care base, which ensures a seamless flow of patients to MEE specialists through consistent referrals. The Transaction will similarly facilitate smoother access for MEE to Partners HealthCare specialists for those cases when MEE patients need higher acuity generalized care. Specifically, as a member of Partners HealthCare, MEE and its specialists will participate in system-based strategic planning initiatives to improve local access to specialty services and enhance care management of patients. Partners HealthCare's primary care physicians and MEE's specialists will also explore ways to collaborate on care for more effective management of chronically ill patients.

As a member of Partners HealthCare, MEE's specialists will be able to establish relationships with a much larger pool of scientists, have access to a more efficient research infrastructure, including a dedicated clinical trials office, and the ability to participate in large scale data management, data

storage and biobank development, all of which are expected to generate material cost savings to MEE and more opportunities for specialists to participate in clinical innovation. Similarly, in the face of reduced funding for medical education, MEE will be able to reduce its costs by using Partners HealthCare's extensive medical education infrastructure. Utilizing Partners HealthCare's centralized support services will enable MEE to manage and grow its research and educational activities in a more cost-effective manner and allow for more research opportunities for MEE's specialists.

5. In describing the Partners patient panel, you provide data in F1a.i and a chart in Appendix 1. In that context, define what you mean by “underlying” “related condition” and for each, what the impact of the proposed merger will be for those Partners patients and for the MEEI patient panel (are they part of the MEEI patient panel already?) For those OPH and ORL patients with the underlying or related conditions, how many sought treatment at MEEI; at another Partners Facility; and/or at a non-Partners facility.

Section F.1.a.1. of the Determination of Need application and the tables in Appendix 1 refer to “PHS patients with ENT-related conditions” and “PHS patients with eye-related conditions.” To determine the number of patients within the panel that have specific eye, ear, nose and throat-related conditions, PHS staff utilized a specific list of relevant eye, ear, nose and throat-related diagnosis codes. As noted, in the references document of the Determination of Need, patient data was evaluated based on the presence of relevant diagnosis code(s) (ICD-9 or ICD-10).

As stated in the Summary Section of the Determination of Need application, MEEI currently serves as the OPH and ORL specialty care provider for MGH and the OPH provider for BWH. However, given limitations on data systems, Partners Health Care is currently unable to determine how many patients sought treatment at MEE, another Partners HealthCare facility or a non-Partners HealthCare facility. In regard to the number of patients seeking treatment at non-Partners HealthCare facilities, this information may be obtained via CHIA's All-Payer Claims Database.

- 6. Applicant says that the transaction won't affect access for non-Partners patients and that the transaction documents address that specifically.**
- a. How will this be tracked; what are the measures to show that this is the case?**
 - b. How will the newly merged MEEI address payment and coordination of care including discharge follow-up.**
 - c. What is the average length of time it takes to get an appointment at MEEI? Is that anticipated to change? Will it be different for Partners or non-Partners patients? How will that be confirmed in reporting?**
 - d. How will that compare post-merger, specifically comparing Partners and non-Partners patients? What measures will you use to track and ensure compliance?**
 - e. Specifically, where MEEI offers a specific type of care (e.g., eye services for diabetic patients) how will Applicant protect access for non-Partners patients?**

As a licensed hospital enrolled in Medicare and Medicaid, MEE's services have always been available to all patients; there is no intention to change that open access. As is the case today, MEE services will continue to be made available to all patients regardless of referral source. The average time for an appointment varies by specialty and provider. MEE is always recruiting additional providers to meet the growing demand for services.

More specifically, MEE will remain accessible to non-Partners HealthCare patients by continuing current agreements with non-Partners HealthCare providers and not limiting future participation in non-Partners HealthCare networks. For example, MEEI is party to a Strategic Affiliation Agreement with Atrius Health Care through which the parties are engaged in efforts to enhance collaboration on clinical services with a focus on patient-centered, affordable, high-quality care. MEEI also has a contractual relationship with Children's Hospital Ophthalmology Foundation (CHOF) through which CHOF provides medical direction and pediatric ophthalmologists to staff a Pediatric Ophthalmology Clinic at MEE. The relationships between MEEI and these organizations are longstanding and MEEI is committed to retaining them. In addition, MEE physicians offer specialty care services to patients in other networks through Provider Participation Agreements. Specifically, some of MEEA physicians are approved providers in contracts with the following payors: Hallmark Health PHO, Beth Israel Deaconess Care Organization, Steward Health Care and Highland Health Care Associates, PA. MEE is committed to continuing to serve as a resource for OPH and ORL services for patients both inside and outside the Partners HealthCare network by maintaining these contractual arrangements.

Beyond making itself available to all patients, MEEI has no ability to influence where other providers refer their patients for specialty care. Currently, MEE has been made aware that insurance companies and providers are telling patients to seek care within their own networks and not use MEE for specialty care. Insurance companies and providers are taking these actions presumably to protect the financial viability of their own networks, even before MEE becomes part of Partners HealthCare. For additional information, see the response to Question 3 (specifically, the second bullet) which summarizes MEE's financial vulnerability due to lack of referring physicians.

As a member of Partners HealthCare system, it is expected that coordination of care and discharge follow-up will be enhanced for patients discharged from MEE to Partners HealthCare post-acute and rehabilitation facilities.

7. In OHP and ORL, what percentage of the research dollars in the respective fields does MEEI hold? Please explain how you have derived those numbers.

In FY 2016, MEEI received \$30.1M for OPH research and \$13.5M for ORL research. Given the large amount of research funding available from a variety of sources (private, government, industry, other sponsors), it is impossible for MEE to determine the percentage of research dollars it holds in ear, eye, nose and throat research. However, MEE in partnership with Schepens Eye Research Institute, comprises the world's largest vision and hearing research centers.

8. Will separate cost reports for MEEI still be made available to CHIA?

As stated in the Determination of Need application, MEEI will remain a separately licensed hospital. As such, the hospital must file its own cost report.

9. Will MEEI be assessed any fees such as an overhead or a management fee by Partners? Please describe the nature of that fee, if any and how it is derived. Will this impact the profitability of MEEI?

MEEI will be charged for Partners HealthCare’s corporate services consistent with how other Partners HealthCare’s organizations are charged for similar services. The savings in operating costs that will be achieved for MEEI from being able to access these corporate services will allow MEEI to realize a profit margin over time and direct these savings to its clinical and research missions.

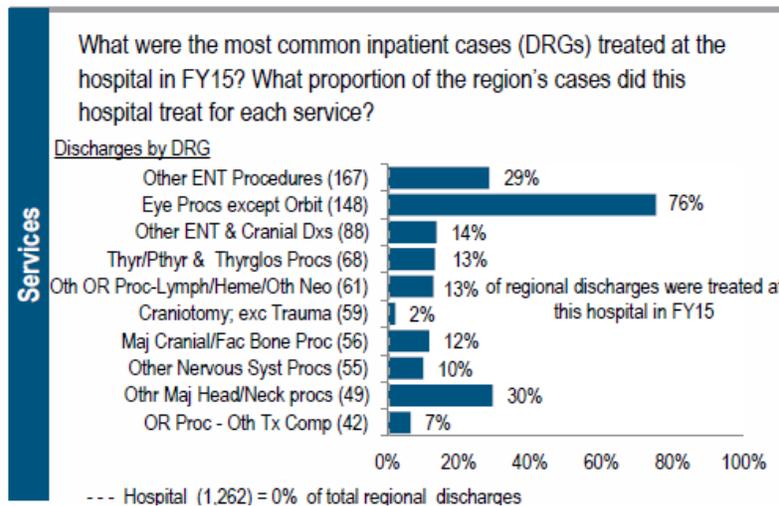
10. Provide a baseline for the “provenance” of patients seeking care at MEEI? Which health systems and physician organizations refer the most patients?

Attached please find MEE patient origin data by health service area. Like many providers, MEE is not able to accurately capture referral data for all patients. Anecdotally, MEE believes that most referrals originate from Partners HealthCare and Atrius. In addition, MEE regularly experiences patients referred from many other systems/physicians including Boston Children’s Hospital, Hallmark, Boston Medical Center, and South Shore Hospital to name a few.

11. What percent of the OHP and ORL markets in MA does MEEI hold? Please explain how you have derived those numbers.

The following graphic found in CHIA’s Hospital Profile for MEEI for FY2015 details what portion of the regions’ inpatient cases by DRG were treated at MEEI.

Graphic 1: Most Commons Inpatient Cases Treated at MEEI in FY15



It is important to note that 95% of MEE's clinical services are provided on an outpatient basis and that there is no reliable market share data for outpatient services. As a proxy, the number of employed physicians by specialty may also provide an indicator of market share. Since physician count data on specialists is inherently unreliable, MEE does not regularly utilize market-wide physician counts for planning purposes and therefore does not possess data reflecting market share for ophthalmologists or otolaryngologists. Relying instead on the publicly available data from CHIA for the total number of practicing physicians by specialty in the Commonwealth, MEEI calculated that it employs 12% of the ophthalmologists and 24% of the otolaryngologists in Massachusetts. Although CHIA data is not available for optometrists, MEEI believes they are clearly relevant to any market review because they provide many of the same services as are provided by comprehensive ophthalmologists. MEEI employs less than 2% (14/794) of Massachusetts optometrists, using the 2016 Healthcare Data Solutions Physicians Data as the data source.

12. Applicant refers to declining margins and recent operating losses related to inpatient services. In that or any other context, does MEEI intend to keep and operate all of its 41 licensed beds following the merger?

MEEI intends to keep its 41 licensed beds in total.

13. Provide a comparison between the MEEI rates for OPH and ORL services to those in other Partners and non-Partners facilities/systems?

Neither Partners HealthCare nor MEE has direct access to rates of their respective competitors as any such access would be collusive and have antitrust implications. However, this type of information is available to government agencies (only) through CHIA's All-Payer Claims Database. Accordingly, the Department of Public Health needs to obtain this information directly from CHIA, as Partners HealthCare and MEE are precluded from receiving this rate information.

14. Please describe how you determined the Total Value of the project?

The Department's "Filing Fee Guidance" dated May 12, 2017, includes the following provision around Total Value of a Project, "For the purposes of determining Total Value for a proposed transfer of ownership, an Applicant shall total the line item for net patient service revenues of the facility or facilities proposed to be acquired in order to calculate reported operating revenues." Accordingly, the Total Value of the project is the net patient service revenue of MEEI for FY2016 of \$185,328,882, as reported in its audited financial statement.

15. Table 3 of Appendix 1 includes demographic data on Partner's patient panel. Do you have corresponding data for MEEI since it will be incorporated into the existing patient panel?

See Attachment 1 for this data.

16. In terms of EHR – the Application refers to technical barriers like firewalls – are these legal barriers for which a merger is necessary? If Applicant asserts that these barriers to information sharing require a merger, please explain why.

Yes. The HIPAA Privacy Rule and other federal and state privacy and security laws require certain technical barriers (“firewalls”) to the sharing of protected health information across entities that are not under common ownership or control. The HIPAA terms refer to health care entities that share ownership or control as “Affiliate Covered Entities or ACE Entities” and those that do not have common ownership or control as “Non-ACE Entities.”

In this case, although Partners HealthCare and MEE currently share an electronic medical record system, Epic, since MEE is a Non-ACE entity to Partners HealthCare under HIPAA, components of the electronic medical record system are firewalled and managed in two distinct environments referred to as “Service Areas.” As a result, clinicians at MGH and MEEI do not have fully integrated access in each case to real-time patient information for their shared patients. In addition, there is duplication of resources in the creation of medical records and in the need for both parties to issue documents such as patient consents and notices of privacy of practice.

Through the Transaction, MEE will be able to become an ACE Entity within the Partners HealthCare System and MEE’s network infrastructure will be fully integrated with Partners HealthCare in the same Service Area. By fully integrating the two technology environments, over time, providers will have complete and immediate access to the medical records of their collective patients allowing for more effective care decisions and a decrease in the duplication of services and processes leading to improved outcomes, reduced errors and the elimination of costs. A fully integrated health information technology system will also allow Partners HealthCare and MEE to mutually identify a core set of OPH and ORL measures that will be used to advance the quality of the reporting process, the likelihood of shared savings and the development of additional care improvement initiatives.

17. Looking at the public health value (PHV) section F.1.b.ii

- a. How will the care management change from what it is now? Provide measurable examples.**
- b. What it is it about the current affiliation that stands in the way of achieving similar improvements without a merger?**
- c. What are the savings and improvements in care?**

As discussed in Section F.1.b.ii and F.1.c of the Determination of Need application, improved continuity and coordination of care for Partners HealthCare’s patient panel will be achieved through the integration of MEE into Partners HealthCare’s ACO model. This integration as detailed in F.1.b.ii will result in care efficiencies through the development of a redesigned care model for patients in need of OPH and ORL services. Through increased collaboration between Partners HealthCare’s primary care physicians and MEE’s specialists, patients will be managed in a more effective way, including the management of chronic diseases and care coordination for patients with head and neck cancers and vestibular disorders. Additionally, care transitions from the inpatient to the outpatient settings will be more effectively managed through shared resources and documented via an integrated health information technology system.

As discussed in the response to 2.d. above, within an owned, integrated system, providers have certain tools and a framework to share data that are only available to entities with common ownership because of legal and operational restrictions.

In regard to measurable outcomes, the Applicant outlined the following measures in Section F.1.b.ii of the Determination of Need application to assess the impact of the Transaction on care management, these measures will evaluate the change in care management processes post-Transaction.

- a. Annual eye exams for diabetic patients. This measure evaluates the linkage between Partners HealthCare and MEE in providing population health management to diabetic patients. The following metric will be reviewed: Percent of Partners Healthcare primary care patients with diabetes that are screened annually for an OPH exam by a MEE provider.
- b. Improved efficiency of administrative processes for pre-operative procedures. These efficiencies improve patient safety by ensuring that only appropriate tests are performed prior to surgery and reduce costs by eliminating unnecessary testing. The following metric will be evaluated: The percentage of time protocols are followed for eliminating unnecessary testing.
- c. Participation of MEE in Partners HealthCare's Pharmacy Infrastructure. Partners HealthCare has numerous initiatives in place to improve use of medications in the hospital and ambulatory setting. Through the proposed transaction, Partners HealthCare will integrate MEE into its current process to evaluate pharmacy costs and utilization for patients. The following structural measures will be reviewed: Tracking MEE participation in Partners HealthCare's pharmacy steering committees including the Partners Pharmacy and Therapeutics committee and subcommittees.

Through MEE's participation in the Partners HealthCare's ACO, the incentives for both organizations will be aligned to manage care more efficiently and share in the savings that are achieved.