Atrius Health

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September 8, 2014

BY E-MAIL (HPC-Testimony@state.ma.us)

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Executive Director Seltz:

On behalf of Atrius Health, attached please find testimony in response to Exhibits B and C (Questions for Written Testimony) of the Health Policy Commission's letter dated August 1, 2014 in preparation for the upcoming public hearing on health care cost trends.

I, Guy Spinelli, M.D, depose and state under pains and penalties of perjury the following: I am Chairman of the Board, Atrius Health, Inc. I sign the attached responses for and on behalf of Atrius Health, Inc., and am duly authorized to do so. I attest that the factual statements set forth in the foregoing responses are true and accurate to the best of my knowledge. The facts stated in these responses are not all within my personal knowledge, and those facts which are not within my personal knowledge have been assembled by authorized Atrius Health, Inc. employees and/or counsel, and I am informed and believe that they are true.

Please let me know if we can be of further assistance.

Sincerely,

Guy Spinelli, MD
Chairman of the Board, Atrius Health, Inc.

Exhibit B: HPC Questions and Appendix

Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. **Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.**

   SUMMARY: Atrius Health continues to work on an ongoing basis to contain health care costs, increase quality and improve patient care through six strategies: (i) care coordination (ii) high risk patient management; (iii) better management of chronic disease; (iv) ensuring that our patients receive care in the right place at the right time; (v) increased focus on the use of the "right" care (e.g., reducing overuse, misuse and underuse to reduce total cost of care and improve quality); and (vi) improving internal efficiencies to reduce cost.

   a. **What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends**.

      In 2010-2011 the commercial risk gross revenue growth rate was 4.2% but has been steadily declining since that time and is currently less than 2%. Utilization of office visits in our practice is increasing because of an increase in the number of patients choosing Atrius Health medical groups. Utilization of hospital admissions is declining as detailed in question 7a.

      From 2010 through the present, we are seeing decreases in the growth rate of the total cost of care as measured internally for our risk business; for some parts of our risk business we have actually been able to reduce the total cost of care. This decreased spending is the result of our work to reduce hospital admissions and re-admissions, the length of stay in Skilled Nursing Facilities, and use of certain diagnostic tests and imaging, and to increase use of preferred facilities and providers.

      We are actively working to reduce hospital utilization and use of non-preferred hospitals by our patients and are investing significant resources in care coordination, high risk patient management and better management of chronic diseases. Staffing continues to be flat with no projected increases.

      Atrius Health has seen a significant increase in drug expenditures over the past year primarily due to Hepatitis C drugs and increases by as much as 50% in the

cost of many generic drugs. In addition, the growing use of expensive specialty drugs and biologics is a significant cost driver to the health care system. This trend is an area of deep concern for us and we strongly encourage the HPC to examine this issue of specialty drugs, biologics and drug cost increases more closely as it affects overall health care spending in the Commonwealth.

b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Please see our 2013 response, Exhibit B, Question 1(a). We continue to work hard to reduce the total cost of care. We have negotiated contracts with many of the payers that decrease the rate of growth in our revenue, or actually decrease our revenue over the next few years.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

Atrius Health currently is restructuring our governance to allow us to streamline back office operations by centralizing certain functions and eliminating redundancies. We are continuing with the strategies described above and are making better use of home health and hospice in an effort to reduce hospital admissions and readmissions In addition, we continue to work with our community hospital partners to provide high quality care at a lower cost and are internally working to reduce practice pattern variation.

At Harvard Vanguard Medical Associates, our largest affiliate, we are actively engaged in efforts to address the challenges of caring for our Medicaid population. This population has many medical and socioeconomic needs that make it both difficult and costly to achieve optimal outcomes. These include but are not limited to chronic illness, chronic substance abuse and mental illness; lack of financial resources to support transportation, healthy home environments and healthy diets; cultural and language barriers; and internal structural practices that make engaging in care more difficult. A multidisciplinary team meets regularly to identify interventions that might enhance the quality and value of care of this population. Experiments in two practices (Chelmsford and Quincy) for example include: inviting a select high risk population to walk in for care whenever they deem it necessary; hiring and training care facilitators who will support intensive care coordination for our complex and needy patients; Primary Care Provider led multi-disciplinary roster review sessions where the concerns and goals of the patient are highlighted and addressed; provision of overdue services when patients present in the office for any reason; and the coordination of care with behavioral health providers. We are also working to improve linkages to community services for our patients. We are tracking admit rates, ER utilization rates, cost

per patient, patient experience and quality metrics such as well care rates and diabetic outcome scores to measure the effectiveness of these efforts. We are working together with Neighborhood Health Plan (NHP) on this mission and are very pleased to have an NHP representative working together with us on our steering committee.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
We continue to fully support the policy changes outlined in our 2013 response, Exhibit B, Question 1(c).

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

SUMMARY: Atrius Health has been accepting full risk under a global budget and similar arrangements for approximately 50% or more of our patients for decades. We believe this has contributed to our outstanding and consistent quality performance.

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

Atrius Health has been accepting full risk under a global budget and similar arrangements for approximately 50% or more of our patients for decades. We believe this has contributed to our outstanding and consistent quality performance. Because we are paid a global budget for many of our patients, we are incented to ensure that patients receive the right care in the right place at the right time. Therefore, we provide telephone access to Advanced Practice Clinicians 24/7 as well as weekend and holiday urgent care, utilize Advanced Practice Clinicians and, where appropriate, refer patients to less expensive high quality hospitals or community hospital partners, and encourage patient use of our robust patient portal. We have developed a preferred SNF network, preferred ambulance network, and acquired VNA Care Network & Hospice and VNA of Boston. We have also developed sophisticated analytics that utilize patient claims and the electronic health record to support daily clinical work, and have developed web portals with many of the most utilized hospitals to reduce redundancy and improve communication.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

We have not conducted any analyses on the implementation of APMs since we have been taking significant risk through global payment and similar contracts for many years.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population

We have not conducted any analyses on the implementation of APMs on either patients paid for under APMs or for the overall patient population because we have taken significant risk through global payment and similar contracts for decades.

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3. **Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.**
SUMMARY: See response below.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

As a general matter, health status risk adjustment measures do not consistently account for changes in patient population acuity, primarily because of data limitations. Lack of sufficient utilization data in the pediatric population makes it difficult to use claims-based risk adjustment software output to make meaningful comparisons of this population.

Lack of sufficient utilization data in the pediatric population makes it difficult to use claims-based risk adjustment software output to make meaningful comparisons of this population. With respect to patients with Behavioral Health (BH) conditions, while the increased clinical risk associated with BH comorbidities is clearly established as a general matter, health status risk adjustment measures do not consistently account for changes in patient population acuity, primarily because of data limitations. Although the increased clinical risk associated with BH comorbidities is clearly established in the literature, because BH claims are blinded/de-identified, commercial risk tools are unable to account for those diagnoses in a meaningful way.
If pharmacy data is included in the risk algorithm but the data is incomplete, then the risk adjustment is not valid.

b. **How do the health status risk adjustment measures used by different payers compare?**
Payers use different risk adjustment software. All commercial tools that run on administrative claims data have similar problems, but the nature and extent of those problems varies by tool and payer data input. Claims lag also forces retrospective application of health risk adjustment tools, and the timing of the lags and period of retrospective application also varies among payers.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Most of the Atrius Health risk contracts (commercial, Medicare and Medicaid) are structured as either a percentage of premium or as a global budget arrangement. The revenue associated with either arrangement is "risk adjusted" throughout the year, with a final adjustment at the time of settlement. The "risk adjustment" reflects changes in the underlying health status of the population associated with each of the risk contracts. The use of risk adjustment tries to ensure that the revenue we receive to care for these populations is proportionate to the clinical morbidity (health status) of the populations.

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

SUMMARY: To provide effective and efficient care to our patients, regular access to raw data to calculate value-based performance metrics is critical. Such data would include raw data for clinical quality and safety measurement, patient, medical expense and utilization of care measurement.

ANSWER:

To provide effective and efficient care to our patients, regular access to raw data to calculate value-based performance metrics is critical. Such data would include raw data for clinical quality and safety measurement, patient, medical expense and utilization of care measurement. As accountability measurement methods are constantly evolving, raw data is far more useful than processed metrics since raw data enables organizations to conduct more rigorous planning and financial modeling activities.

Broadly calculated benchmark data on major value-based metrics would be helpful to our organization. However, such benchmark data is only helpful if the comprehensive measurement methodology is fully transparent and replicable. Only very high level

summary benchmarks are operationally helpful without full transparency of methods. Raw data spanning the spectrum of finance, clinical quality, and patient experience can be integrated with internal operational data to drive process improvements as well as develop predictive models to help provide more meaningful care to our patients and communities. Advanced analytics on limited data sources (claims only versus EMR only) are suboptimal for true value based analytics (cost + quality + patient experience).

For real-time clinical care, two sets of real-time data are needed. First, we need operational data about the real-time movement of patients across the healthcare system. Real-time ADT data exchanges are one example of useful operational data for hospitals. Similar data, if made available for SNFs and outpatient specialty services, would be helpful to provide more proactive support of care transitions and care coordination. Second, clinical data exchange is critical for clinicians who are seeing patients from a different provider network. Atrius Health currently enables bi-directional read-only web-access to complete medical record data for shared patients at our key partner institutions. We believe such access optimizes patient care, reduces unnecessary repeat testing, and significantly reduces the safety risks associated with informational discontinuity during care transitions.

Finally, we would welcome timely pharmacy claims and methodologies to identify patients' medication non-compliance in order to support better chronic disease management.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY: While alternative payment methods are gaining momentum among HMO products, the market continues to move towards PPO's as noted in reports by CHIA and the AGO. Attribution, although required by Chapter 224, is difficult to do and is not moving as quickly as we would have hoped. We believe that attribution is critical to developing and implementing alternative payment methods. We view the lack of meaningful attribution as a real structural barrier that would be worth continued discussion and have worked with other providers and plans to develop a recommended approach.

a. Which attribution methodologies most accurately account for patients you care for?

We are working closely with other providers and the major local commercial plans to establish guidelines for the attribution of commercial PPO patients to physician organizations to promote improvements in patient care and allow for quality and financial accountability. We would be pleased to share the work of this group with the HPC, CHIA and others to help guide the discussion on standardizing attribution methodologies across carriers for the purposes of risk contracts and payment. We expect to be ready to share this work in mid-September.

b. **What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?** We have a recommended approach and hope that HPC and CHIA will utilize our recommendation rather than undertaking a separate or additional effort.

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6. **Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.**

SUMMARY: Atrius Health expends significant resources due to reporting requirements across public and private health plans that are not coordinated and vary tremendously among plans and over time. As a large group we have attempted to bring more uniformity of metrics across our contracts.

ANSWER: Because we are a large organization with many practice sites and many contracts, there is considerable effort expended to report required quality measures to public and private payers. We devote three (3) FTE data analysts, two (2) project managers, and pull in various RN's during chart review periods, as well as utilizing a full time medical director, to complete reporting throughout the year. The Medicare Pioneer ACO reporting takes an especially large effort. This reporting is a large institutional resource expenditure.

One of the organizational challenges is variation in quality measures among health plans and over time. Every new measure requires that we look at the data source and ensure that, for those measures that are quantified through the electronic medical record, providers are entering the information in a way that it can be captured. It takes extraordinary effort to develop and train a large organization before we can begin to do reporting.

Unfortunately, it has been our experience that payers, both public and private, often approach quality measures as merely an aspect of a contract that may change easily from year to year, rather than envisioning these measures as important aspects of healthcare systems that need sustained progress, with corresponding long term reward systems for improvement. We have devoted significant time to leveraging our data analytic strength to offer a large but relatively uniform set of quality measures across all plans with the stipulation that they be constant for a longer period to time, so that we can consolidate efforts and build infrastructure for long term goals.

7. **An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers**.

SUMMARY: Hospital utilization trends for Atrius Health patients shows an increase in the use of community hospitals over the past two years.

a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Attachment #2 shows hospital utilization trends in admissions/1000 for the last three years by Adult Commercial and Adult Medicare populations. The mix between academic medical centers (AMCs) and community hospital adult admissions stayed about the same in 2012 and 2013. A total of 67.9% of the 19,621admissions were to community hospitals in 2012 as compared with 16,967 admissions of which 66.5% were to community hospitals in 2013. These charts are for adult admissions only and include obstetric admissions, but not behavioral health. Reliant Medical Group is not included in these tabulations as we do not have this information readily available.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

We have worked to increase the use of our preferred community hospitals in lieu of AMCs using several strategies. First, we have reinforced the message to our clinicians and patients regarding our relationship with community hospitals in their locale and our preference to hospitalize patients in these facilities rather than at an AMC in Boston. Second, we have expanded the preferred community hospital options for our patients and clinicians, including BID-Milton, Winchester Hospital, Beverly Hospital, and BID-Needham Hospital in recent years. Third, we have worked with our AMC partners to drive more hospital utilization to the communities. For example, we have entered into a collaborative agreement with Boston Children's Hospital ("BCH") to redirect more specialty, emergency and hospital care for our pediatric patients from BCH's primary location to their several lower cost community practices. We are working within the BIDMC system as well to determine how to more effectively use their affiliated community hospitals rather than BIDMC for care that could appropriately be kept in the community.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

SUMMARY: Atrius Health tracks the number of admissions/1000 patients to post-acute care as described below and in Attachment #3.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

Atrius Health tracks the number of admissions/1000 patients for admission to skilled nursing facilities, IRFs/LTACs and for home health agency care; this is reported by payer type (Medicare Advantage, Pioneer ACO and commercial insurers) which is illustrated in Attachment #3. In addition, for SNFs, the Average Length of Stay (ALOS) and percentage readmission within 30 days of SNF admission is also tracked at the payer level. We further track differences in the ALOS and 30 day readmission rate by SNF attending clinician type (employed by Atrius Health versus non-employed). Performance on the metrics is sent to the selected SNFs on a quarterly basis.

With regard to home health agency care, we routinely track the percent of patients who had an ED visit or who were hospitalized during the home health agency episode of care. We also track the number of IRF/LTACs admissions/1,000 and break the rate down by payer type. Significant variation exists in the admissions to IRF/LTACs when comparing the Medicare Advantage and Pioneer ACO populations. We believe that one key contributor to the variation is that all admissions to an IRF/LTAC for a patient with a Medicare Advantage plan requires the approval of a physician reviewer. The reviewer process is not in place for Pioneer ACO Medicare Fee-for-Service patients. This difference has been brought to the attention of CMS.

The post-acute care entities all apply objective criteria (e.g., Interqual, Milliman, MDS, or CMS guidelines) to confirm the appropriate level of care and validate the admission. Our Nurse Case Managers follow patients who receive post-acute care either telephonically or in person at the IRF/LTAC or SNF. Our philosophy that discharge planning should begin on the day of admission is reinforced routinely. In addition to transferring patients to the next level of care when it is safe to do so, Atrius Health also offers a robust home-based primary care program for patients who are home-bound both for the short and long term. The Intensive Home Based Program and the Home Runs program are physician-supported and nurse practitioner-run care programs that provide continuity of care and also support seamless care transitions. Atrius Health has developed and distributed SNF facility and SNF provider expectations to ensure that there is a clear understanding and compliance with quality care. Atrius Health applied and was approved by CMS for a waiver of the "Three-day Inpatient Stay Requirement Coverage for SNF Services." This direct SNF admission option for Medicare Advantage patients has been in place for a considerable time and has proven beneficial in avoiding unnecessary, and often inappropriate, hospitalization. It is anticipated that the direct SNF Admission for Pioneer ACO patients will produce the similar results. Our goal is to have the patient receive the right care in the right place.

b. How does your organization ensure optimal use of post-acute care?

Objective admission criteria are applied to verify the appropriateness of an IRF/LTAC, SNF or home health agency referral. Atrius Health Nurse Case Managers coordinate and manage care as the patient moves along the care continuum to ensure seamless care transitions. Nurse Case Managers work closely with the post-acute providers to confirm appropriate utilization. Barriers to discharge from a program are identified at the time of admission and efforts are made early to remove the barrier. Our preferred SNFs are expected to complete an INTERACT packet anytime a patient has an unplanned transfer to the SNF; the circumstances around the transfer are reviewed at the SNF Inter-disciplinary team (IDT) meeting and the findings are shared with Atrius Health.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY: Atrius Health has established procedures to comply with this provision of Chapter 224. We have had a relatively small number of requests from patients for prices.

On January 1, 2014 Atrius Health launched a pricing tool to estimate a patient's out-of-pocket expense for office visits and procedures. We purchased enhancements to certain software (at a cost of approximately $50,000 per year on top of the cost of the underlying software license) that can provide detailed, contract-based payment information to determine the cost of the physician portion of these services. This software allows for the accurate calculation of insurance "allowables" for most major payers in the state and will allow us to determine applicable deductibles, co-insurance and other patient responsibilities. Patients are informed that these are estimates and that their insurance company can provide the most accurate estimate of out-of-pocket expenses.

Additionally, Harvard Vanguard Medical Associates, one of our affiliates, has established an easy-to-use Excel look up table that allows designated business staff at our practices to enter the patient's insurance product information and one of the top 100 procedure codes and bring up the cost of the procedure. With this, we are able to provide real time, maximum cost information for frequently requested procedures which is often what our patients are requesting. Thus far, our experience has been that most of our patients are not

"price shopping" but rather are seeking an estimate of how much a particular service will cost them.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: We are unable to complete the chart above as we do not track requests in this format or level of detail. However, as of August 1, 2014 we have received approximately 300 requests for detailed pricing information as described above. As noted, more of our patients are looking for information on the maximum costs of procedures, which we are able to provide immediately in most cases. Harvard Vanguard Medical Associates, one of our affiliates, currently receives approximately 25 such requests per week for the maximum cost. The most frequent requests are for the costs of laboratory tests, radiology/advanced imaging services, colonoscopies, and initial visits.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.

SUMMARY: Limited and tiered networks add complexity to referrals and can get in the way of providing coordinated care. Patients often do not understand limitations of these limited or tiered health plan products that they have purchased, and get angry or upset at their provider as a result.

ANSWER:

The impact of limited networks on our practices is different from that of tiered networks due to the difference in plan design. Limited networks actually exclude certain facilities and physicians from the network, and if patients with these products are seen by nonparticipating providers or at nonparticipating facilities, the patient is responsible for the entire cost of this care. Tiered networks typically include all providers and facilities in

the full network products but patient out-of-pocket costs differ based on the tier assigned by the health plan to that provider and/or facility.

It can be more difficult to manage the care for those patients with limited network products. Some of Atrius Health's preferred hospitals and specialists are not included in certain limited network products. Where our preferred provider or specialist is out-of-network, patients must be sent for specialty care to specialists with whom the PCP's do not have any relationship. There may or may not be a feedback loop to get information back to the PCP, making it very difficult for the PCP to coordinate the patients' care. In some cases, where care is needed quickly and the in-network Atrius Health clinician only has privileges at an out-of-network facility, patients must be sent through the ER of a participating hospital to get needed care, which results in duplication of services, an unnecessary ER visit, and possibly a delay in obtaining care for the patient.
This situation is exacerbated when patients change their insurance to a limited network product during an episode of care. Examples include pregnant women in the 2nd or 3rd trimester who have been seeing an OB/GYN who delivers at a nonparticipating hospital. This creates undue anxiety for these expectant mothers.

While many patients (but not all) choose a limited network plan because of the lower premium costs, they are poorly informed about the limitations of their networks. It also is very difficult for our staff to keep track of all the variations of network limitations in the different health plan limited network products, which can result in a patient with a limited network product being inadvertently directed to an out-of-network provider. Patients get angry at Atrius Health when they receive the out-of-network bills for services rendered.

Because tiered network plans include the same facilities and providers as full network plans, there is no issue of coverage when directing patients to specialists and facilities for needed care. The difficulty is that, depending on the assigned tier, patients have differing out-of-pocket requirements. When an Atrius Health preferred specialist or facility is tiered in a higher tier, patients become angry with their clinicians and Atrius Health at being directed there. In this situation, patients who are knowledgeable about their plan and tiering information insist on being sent to providers and facilities where their PCP does not have a relationship. This leads to the same concerns about the ability of the PCP to truly coordinate patient care.

Although certain facilities and providers are typically excluded from most health plan limited networks, there is no consistency about other facilities and providers. The same inconsistency exists for tiered products, which makes it nearly impossible at a busy practice to effectively direct patients to participating or lower tiered facilities and clinicians.

Atrius Health is working to reduce the total cost of care and improve quality across all of our contracts. Unfortunately, tiering is based on retrospective and sometimes outdated information such that pricing changes do not change the tiering right away so we do not look to change pricing mid-contract because of tiering. We do not have any way to track volume changes due to tier placement.

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY: See response below.

a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

Atrius Health fully supports the integration of behavioral health into primary care. Behavioral Health is an integral service at many of our practices including virtually all of the sites of Harvard Vanguard Medical Associates, one of our affiliates. Some of the Atrius Health medical groups have embedded a behavioral health clinician within the internal medicine department to offer on-site access to patients who need to be seen immediately and to clinicians for consultations. We have added a depression screen in primary care for our elder patients as part of our Medicare Pioneer ACO Work. Because of the current reimbursement structure and the short supply of behavioral health clinicians who are willing to work in this type of practice setting, it remains challenging to fully staff Behavioral Health departments to meet the needs of our patients. We encourage the HPC to support increases to current behavioral health and substance abuse reimbursement which is the only true way to change this dynamic. Further, we hope that the Health Planning Council will identify substantive ways to increase the number of providers working in medical group and hospital settings.

As with other patients identified as high risk, we frequently provide a case manager to assist with specific needs for these patients. Additionally we staff some of our practices with social workers who can address other social issues that result from or are caused by these behavioral health conditions (e.g. homelessness, lack of companions for support, hunger).

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

Atrius Health is currently engaged in preliminary discussions with one of the payers on a risk contract that will include behavioral health, with an anticipated start date of 2016. This will allow us to redeploy and in some cases add resources, thereby resulting in better coordination of care and avoid unnecessary

ED use. Under the current FFS model, we are unable to do the type of case management we believe is essential to follow up on patients who are failing to follow treatment plans (e.g. appointments and prescribed medication). If behavioral health is part of the risk contract, we will be better able to provide case managers will have the ability to more closely monitor patients, particularly the most complex patients who might be more at risk of utilizing the ED. In addition, in early 2015 we will launch a pilot project in behavioral health department at our Chelmsford practice that will implement a triage system to better manage our behavioral health patients by referring some patients who do not require complex care to outside agencies and therapists. We anticipate this effort will improve access and follow up for patients with complex behavioral health needs who are more likely to utilize hospital emergency rooms. The system will be rolled out to all of our practices if successful. In addition, we do offer widespread urgent care availability evenings and weekends as one way we also work to reduce ED use.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

We continue to experience challenges in reimbursement as well as in our ability to coordinate care, which are described in our 2013 response, Exhibit B, Question 3(b) and 3(c).

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Not applicable.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY: Atrius Health has 37 practices that are accredited as NCQA Level 3 PCMH's. Approximately 98% of our patients receive care at accredited PCMH practices.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

Atrius Health has 37 practices that are accredited as NCQA Level 3 PCMH's. The only exceptions are several small practices that have joined Atrius Health within the past 12-18 months (approximately 98% of our patients receive care at accredited PCMH practices)

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Approximately 98% of our patients receive care from PCP's under the PCMH model.

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

We have not conducted any analysis directly related to the impact of PCMH accreditation on outcomes, quality or costs of care because our internal medicine practices have operated as PCMH for so many years (first recognized for Bridges to Excellence in 2007 timeframe). However we note that the accreditation process is a costly and labor intensive process and many elements of it do not add value to patients.

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY: Both of these reports seem reasonable and not inconsistent with our experience.

ANSWER: Both of these reports seem reasonable and not inconsistent with our experience.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. **Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Provider Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.**

   Completed in Attachment AGO Provider Exhibit 1

   As Atrius Health staff discussed with the AGO, we are unable to provide Claims-Based Revenue or Budget Surplus (Deficit) Revenue because that is not how we are paid on our commercial risk contracts. Instead, we are paid an estimated net capitation revenue on a monthly basis that is adjusted as needed during the year based on a review of claims paid to providers outside of Atrius Health (i.e., total budget or gross capitation revenue minus claims paid outside of Atrius Health equals net capitation revenue) with the goal of having the smallest possible settlement at year-end. We do not receive (nor do the plans, to our knowledge) do an assessment of our claims priced at our PPO pricing in comparison to a final budget.

   You expressed that the AGO wants to understand how providers are incentivized by risk contracts and how much of our revenue is at risk. Our incentive in this type of contract is to ensure our patients receive "the right care at the right time at the right place," where the right care is evidence-based whenever possible and duplication of testing is avoided, the "right time" is when the patient believes he/she needs it and the "right place" is close to home and at a lower priced site of care (e.g., home or office instead of hospital or post-acute facility). We believe that all of our globally paid contracts are at full 100% risk to us, with that risk mitigated by the way in which we take appropriate measures to manage that risk (through our culture, systems, processes and financial tools).

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2. **Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and**

plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Atrius Health's participating medical groups have managed significant levels of risk for decades. To do so, we have established sophisticated analytical tools and financial processes and have established a culture focused on achieving the triple aim of lowering total medical expenses, increasing quality and improving patient experience simultaneously. We have worked with the payers to establish processes for adjusting payments on a monthly basis to help us to manage cash flow and uncertainty. We manage such a significant number of risk lives already and have been doing it for so long that we do not quantify or analyze contracts relative to our ability to manage risk, nor do we analyze the per member per month costs associated with bearing risk or project or plan for deficit scenarios.

We consider the risk that we bear to be significant and appropriate, and seek to take risk as well on PPO products. We feel that we can best manage risk when the majority of our contracts are risk arrangements, rather than having some payments fee for service and others as risk arrangements.

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3. **Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, any technical barriers to making or receiving referrals, and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization.**

   We believe that the best and safest care is coordinated and integrated care. Furthermore, many tests and procedures are less expensive when done at physicians' office rather than in a hospital outpatient or inpatient setting. For that reason, we prefer to refer patients within Atrius Health where our clinicians can also access a single electronic medical record to avoid duplication and to consider the patient's medical history. Patients may also self-refer within medical groups at Atrius Health. When we need to refer to outside specialists, we look first to those groups who are affiliated with the local hospital to which a site refers, again for reasons of coordinating care. Our EPIC electronic medical record includes a referral module which allows us to list our preferred specialists in order of preference to facilitate making referrals.

4. **Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians through electronic health management, care management, disease management, large case-management or other clinical management programs.**

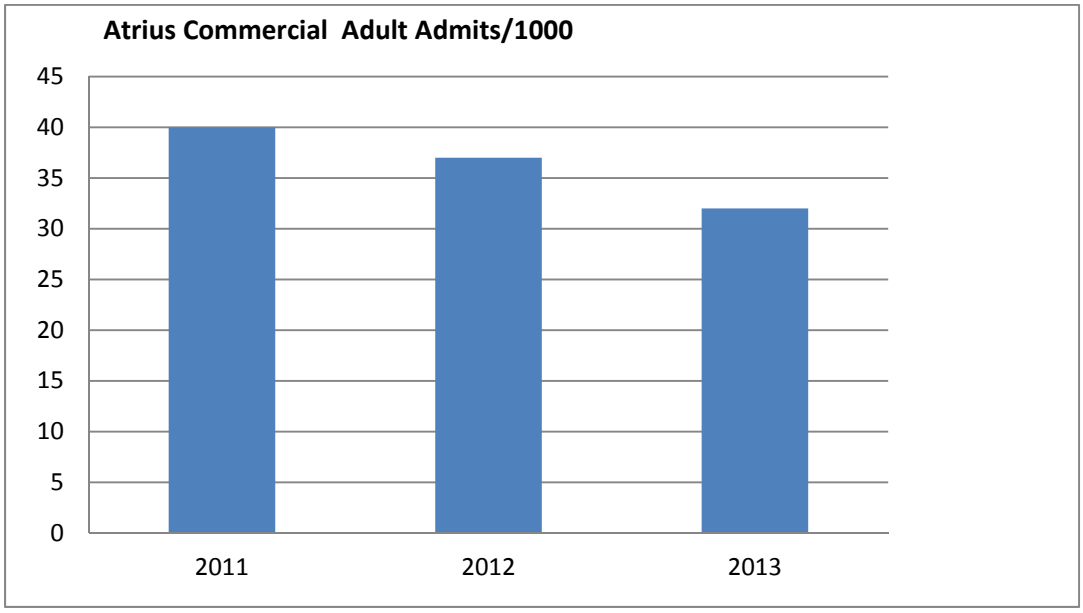
Attachment #4 describes an initiative launched in late 2013 to educate our clinicians on the cost of common imaging, laboratory procedures and referrals. This information is not intended to influence a specific patient decision at the point of care, but rather to support the clinicians in general education about the cost of the tests and procedures they order. This effort continues and subsequently, we recently received funding from the Robert Wood Johnson Foundation to continue our work in this area. As part of the study, the price information now resides in the electronic medical record and is available to the clinician at the point of care. This information is not for use with patients since prices for patients vary based on their health plans. Under this new study which is for outpatient tests and procedures, physicians have been randomized to see nothing, 1 median price for the selected tests/procedures, or 2 median prices for selected tests/procedures (2 prices reflect internal and external cost). The study is ongoing therefore we do not yet have any results on the impact on test ordering at the present time.

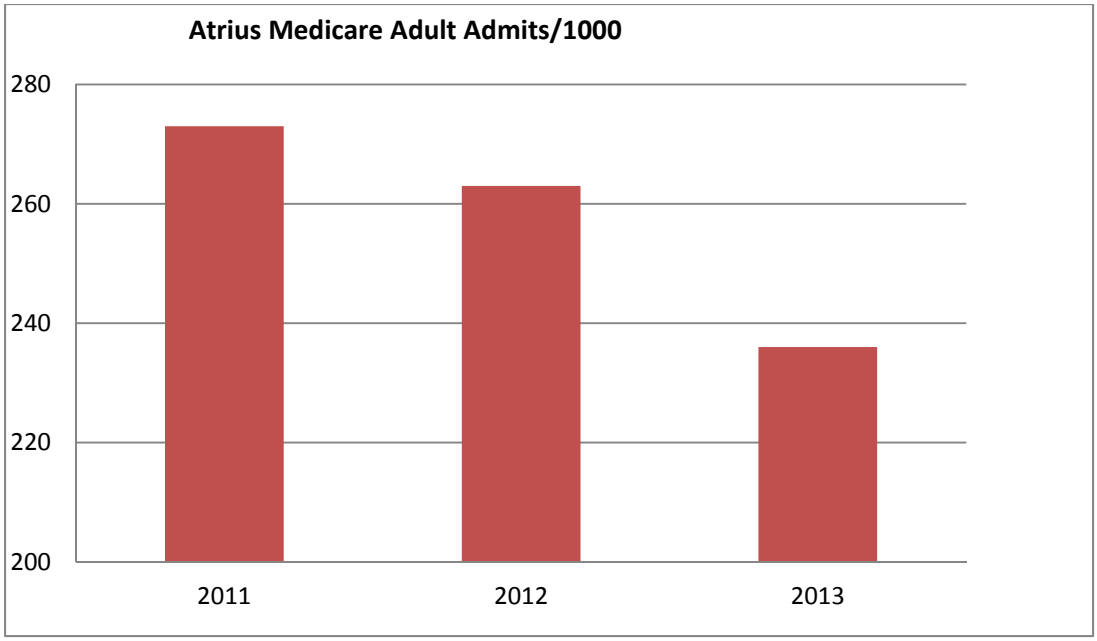
Quality information is used as part of our selection of preferred providers and is monitored and discussed regularly with those providers. This allows our clinicians to be confident in the quality of their referrals without need for looking at quality data at the point of care.

Attachment 2

Atrius Health Hospital Utilization Trends 2011 to 2013:

Adult Commercial and Medicare Risk Populations[1]





[1] Excludes Reliant Medical Group

Attachment 3

ATRIUS Health

Jan 2013 thru Dec 2013 YTD (Claims paid through Apr 2014)	PIONEER Q1 2013 v YTD 2013				TMP Q1 2013 v YTD 2013			
Utilization -								
Hosp admits/K	296	289	(7)	-2.3%	260	241	(19)	-7.3%
SNF admits/K	104	94	(10)	-9.7%	97	95	(2)	-1.6%
SNF days/K	2,313	2,048	(265)	-11.4%	1,479	1,388	(91)	-6.2%
30-day all-cause rehospitalization rate	16%	15%	-0.3%	-2%	16%	16%	0%	-1%

Notes:

We do not have claims for approx 5% of patients who have opted out of data sharing.

We do not have any substance abuse related claims for Pioneer population.

No claims data is risk adjusted.

TMP = Tufts Medicare Preferred, our Medicare Advantage patients

PIONEER = Traditional Medicare patients aligned to our Pioneer ACO

Atrius Health

Attachment # 4 – Atrius Health Relative Price Education Memo

This information was provided to Atrius Health Clinicians in late 2013. For the purposes of this submission prices have been removed

Atrius Health Relative Price Education

REFERENCE DOCUMENT FOR RELATIVE PRICES

This simple reference document describes relative internal and external pricing of common tests and medical interventions in order to educate Atrius Health ordering clinicians and other interested staff. **This Atrius Health educational initiative is targeted to an internal audience, and is not designed for specific patient education.** To fulfill our legal requirements and ensure great customer service, inquiring patients should be referred to their Group's billing/coding department or back to their insurance company, depending on the information being requested. This information is not for sharing outside of Atrius Health.

BACKGROUND & REASON FOR ACTION

Atrius Health is committed to the balanced framework of the Triple Aim (Quality, Experience, and Cost) to help us provide high-value healthcare. With increasing costs of healthcare, there is increased pressure to inform consumers about the price of their care. Recent Massachusetts health reform law (known as Chapter 224 of 2012) includes provisions for health plans and providers to share the estimated out-of-pocket price of a medical test, procedure, or hospital admission when requested by a patient or member. Additional information about this will be provided separately. Furthermore, clinicians and other healthcare staff are expected to be responsible stewards of our limited healthcare resources. However, clinicians themselves frequently do not know the prices of various diagnostic and therapeutic interventions.

Millions of tests and procedures are ordered annually for Atrius Health patients. In some cases, these might not be either medically necessary or recommended by available medical evidence. For tests/procedures that are necessary for the patient, we have an opportunity to better coordinate patient care, as well as to reduce costs, if these services can be provided at an Atrius Health site rather than at an outside facility. In 2014, we will implement a project in which relative prices will be clearly displayed in Epic (limited to certain staff, at first), so that staff making clinical decisions can be aware of and thoughtfully consider the cost when ordering certain tests or procedures. In the meantime, we hope that this reference document will support and encourage all of us to be responsible stewards of our limited healthcare resources. Ultimately, we support a culture of value-driven, high-quality healthcare at Atrius Health.

Key action steps to support high-quality care and responsible resource stewardship:

1. **Don't duplicate studies that have been done recently**
   - Review lab, imaging, procedure, hospital, and outside scanned data in Epic, and or in the hospital EMR

2. **Only order tests and procedures that are medically necessary**
   - Before proceeding, ask 1) is there evidence to support this choice, and 2) how the result will change the clinical plan
   - Unnecessary tests/procedures make additional work-ups more likely and increase the risk of false positives and/or safety events
     a. Avoid bundling when possible; order individual tests or procedures as medically necessary
     b. If you need another round of testing, you can always ask the patient to return; you do not need to be exhaustive in your initial work-up
   - Check Atrius Health resources (e.g., Up To Date), or other evidence-based sources (e.g., www.choosingwisely.org), or with local colleagues and specialists, about the need for the test or procedure

3. **If a test/procedure is medically indicated and is available within Atrius Health, encourage internal utilization (IU) rather than external utilization (OU).**
   - In most cases, this will be a cost-effective choice. If there is a slight difference in cost, internal utilization still ensures that we can cover our infrastructure costs and is therefore more economically prudent.
   - In all cases, keeping services inside Atrius Health is patient-centric, improving the coordination and continuity of care.

Atrius Health

Attachment # 4 – Atrius Health Relative Price Education Memo

This information was provided to Atrius Health Clinicians in late 2013. For the purposes of this submission prices have been removed

Atrius Health Relative Price Education Initiative: Select diagnostic, therapeutic, and other medical interventions

Please note: *These **median** dollar amounts are derived from **administrative claims data** for Commercial, Medicaid, and Tufts Medicare Preferred (TMP) risk patients from May 2012 through April 2013, excluding data from RMG.* The actual price for Atrius Health, the payer, or the patient may vary substantially based on location, professional fee, and payer product. We only include the internal price for the labs because this is where the majority of our testing occurs. Similarly, we only include the external price for cardiac catheterization, sleep study, and ED/hospital visits because these occur mostly external to Atrius Health. **This relative price information is an educational resource for clinicians and other staff; it is <u>not</u> meant for patient inquiries**.*

Epic Name	Internal Median	External Median	Epic Name	Internal Median	External Median
Cardiac Procedures			**Lab Tests**		
Carotid Ultrasound			Basic Metabolic Panel (BMP)		
Echocardiogram			B-type Natriuretic Peptide (BNP)		
Exercise Stress Test			C Reactive Protein (CRP)		
Myocardial Perfusion			CA 125		
Stress Echocardiogram			Helico Pylori Ab		
Scope Procedures			Hemogram w Auto Diff RFLX		
Colonoscopy			Hemogram (CBC)		
Endoscopy (Nasal)			HIV Ab		
Knee Arthroscopy			HSV (All)		
Nasal Endoscopy			Lipid Panel		
Flex Sigmoidoscopy			Lyme Ab		
Imaging Procedures			Lyme Western Blot		
Abdominal CT			Pap Test/ Thin Prep		
Abdominal US/Complete			Prostate Specific Antigen (PSA)		
Abdominal US/Limited			Syphilis Test (RPR)		
Bone Density Study			Sedimentation Rate (ESR)		
Brain MRI			Thyroid 4 T4, Free		
Breast MRI			Thyroid Stimulating Hormone (TSH)		
Cervical Spine MRI			Urinalysis (U/A)		
Chest CT			Vitamin D 25, Hydroxy (Total)		
Chest CTA			**Emergency Department Visits**		
Chest X-Ray PA & Lateral			Ambulatory-Sensitive*		
Head CT			*Sore Throat		
Head MRA (Angio)			*Dermatitis		
KUB X-Ray			*Hypertension		
Lower Extremity MRI			*Otitis Media		
Lumbar Spine MRI			*Pneumonia		
Pelvic US Non-OB			*Upper Respiratory Infection		
Thoracic Spine MRI			*Gastroenteritis		
Upper Extremity MRI			Asthma (Adult and Pedi)		
Other Specialty Procedures			Bronchitis		
Cataract Surgery			Chest Pain		
Dialysis Treatment			**Admissions (All Payer Median)**		
Orthopedic Injections (small, intermediate, major)			Asthma (Pedi)		
			Cellulitis		
Cardiac Catheterization (not part of hospitalization)			Chronic Obstructive Pulmonary Disease (COPD)		
Pulmonary Function Tests			Congestive Heart Failure (CHF)		
Electromyography (EMG)			Pneumonia		
Sleep Study			Total Hip Replacement		
			Total Knee Replacement		
			Urosepsis		

* For selection criteria and details for the actual codes used, please see Appendix document

- **Please contact XXX, in the Atrius Department of Medical Management, with questions/comments at XXXX.**

2010

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 182,048,362		$ 20,632,184						
BCBSMA PPO										$ 79,116,227			
Tufts FI					$ 26,369,130		$ 1,806,275						
Tufts SI	$ 10,316,239												
Tufts PPO (incl. CareLink)										$ 21,846,143			
HPHC FI					$ 79,906,305		$ 1,317,656						
HPHC SI									$ 50,938,532				
HPHC PPO (incl. Passport & Independence)										$ 43,880,909			
NHP Comm					$ 12,256,910		$ 150,000		$ 1,315,249	$ 403,703			
Fallon	$ 6,234,622			$ 326,000									
Aetna	$ 16,711,045			$ 150,000									
Other Commercial (Any remaining payors not listed above - lump together)										$ 41,996,802			
Total Commercial	**$ 33,261,906**			**$ 476,000**	**$ 300,580,707**		**$ 23,906,115**		**$ 52,253,781**	**$ 187,243,784**			
NHP Medicaid (incl CommCare)					$ 20,600,152		$ 422,000		$ 1,800,783	$ 1,906,035	$ 628,229		
Total Managed Medicaid					**$ 20,600,152**		**$ 422,000**		**$ 1,800,783**	**$ 1,906,035**			
Medicaid FFS										**$ 2,708,017**			
Tufts Medicare Preferred					$ 48,487,640		$ 532,420						
Commercial Medicare Subtotal					**$ 48,487,640**		**$ 532,420**						
Medicare FFS										**$ 38,630,214**			
GRAND TOTAL	**$ 33,261,906**			**$ 476,000**	**$ 369,668,499**		**$ 24,860,535**		**$ 54,054,564**	**$ 230,488,050**	**$ 628,229**		

$ 713,437,783

2011

	P4P Contracts				**Risk Contracts**				**FFS Arrangements**		**Other Revenue Arrangements**		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 189,252,488		$ 23,088,551						
BCBSMA PPO										$ 84,174,909			
Tufts FI					$ 25,563,787		$ 1,921,796						
Tufts SI	$ 10,187,745												
Tufts PPO (incl. CareLink)										$ 25,776,366			
HPHC FI					$ 88,257,413								
HPHC SI									$ 49,072,335				
HPHC PPO (incl. Passport & Independence)										$ 48,519,518			
NHP Comm					$ 14,430,382		$ 120,000		$ 1,883,520	$ 874,773			
Fallon	$ 5,444,495			$ 240,000									
Aetna	$ 18,473,457			$ 120,000									
Other Commercial (Any remaining payors not listed above - lump together)										$ 48,975,885			
Total Commercial	**$ 34,105,697**			**$ 360,000**	**$ 317,504,070**		**$ 25,130,347**		**$ 50,955,855**	**$ 208,321,451**			
NHP Medicaid (incl CommCare)					$ 18,775,061		$ 409,000		$ 1,968,827	$ 1,679,337	$ 671,175		
Total Managed Medicaid					**$ 18,775,061**		**$ 409,000**		**$ 1,968,827**	**$ 1,679,337**			
Medicaid FFS										**$ 2,708,847**			
Tufts Medicare Preferred					$ 74,827,725		$ 547,000						
Commercial Medicare Subtotal					**$ 74,827,725**		**$ 547,000**						
Medicare FFS										**$ 44,154,694**			
GRAND TOTAL	**$ 34,105,697**			**$ 360,000**	**$ 411,106,856**		**$ 26,086,347**		**$ 52,924,682**	**$ 256,864,329**	**$ 671,175**		

$ 782,119,086

2012

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 158,402,031		$ 24,149,489						
BCBSMA PPO										$ 97,628,781			
Tufts FI					$ 28,712,648		$ 1,859,523						
Tufts SI	$ 9,304,865												
Tufts PPO (incl. CareLink)										$ 31,998,980			
HPHC FI					$ 67,806,361								
HPHC SI									$ 55,208,366				
HPHC PPO (incl. Passport & Independence)										$ 53,405,378			
NHP Comm					$ 17,262,809				$ 2,443,968	$ 1,293,526			
Fallon	$ 5,575,424			$ 300,000									
Aetna	$ 18,431,652			$ 150,000									
Other Commercial (Any remaining payors not listed above - lump together)				$ 321,000						$ 50,480,093			
Total Commercial	**$ 33,311,941**			**$ 771,000**	**$ 272,183,849**		**$ 26,009,012**		**$ 57,652,334**	**$ 234,806,758**			
NHP Medicaid (incl CommCare)					$ 24,788,742				$ 1,922,570	$ 1,421,801	$ 732,525		
Total Managed Medicaid					**$ 24,788,742**				**$ 1,922,570**	**$ 1,421,801**			
Medicaid FFS										**$ 3,522,258**			
Tufts Medicare Preferred					$ 62,251,456		$ 547,804						
Commercial Medicare Subtotal					**$ 62,251,456**		**$ 547,804**						
Medicare FFS										**$ 44,997,385**			
GRAND TOTAL	**$ 33,311,941**			**$ 771,000**	**$ 359,224,047**		**$ 26,556,816**		**$ 59,574,904**	**$ 284,748,202**	**$ 732,525**		

$ 764,919,435

2013

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue (2)		Net Cap Revenue (1)		Quality Incentive (2) Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 167,970,548		$ 25,642,000						
BCBSMA PPO										$ 106,994,733			
Tufts FI					$ 27,105,254		$ 1,900,000						
Tufts SI	$ 9,103,004		$ 700,000										
Tufts PPO (incl. CareLink)										$ 40,743,515			
HPHC FI					$ 55,301,055		$ 700,000		$ 765,902				
HPHC SI									$ 70,612,127				
HPHC PPO (incl. Passport & Independence)										$ 62,637,630			
NHP Comm				$ 500,000	$ 17,043,223				$ 1,712,690	$ 3,491,247			
Fallon	$ 6,490,383			$ 300,000									
Aetna	$ 23,185,737			$ 150,000									
Other Commercial (Any remaining payors not listed above - lump together)				$ 330,000						$ 53,777,336			
Total Commercial	$ 38,779,124		$ 700,000	$ 1,280,000	$ 267,420,080		$ 28,242,000		$ 73,090,719	$ 267,644,461			
NHP Medicaid					$ 28,412,498				$ 1,078,300	$ 1,446,584	$ 782,640		
Total Managed Medicaid													
Medicaid FFS										$ 9,122,899			
Tufts Medicare Preferred					$ 73,415,622		$ 550,000						
Commercial Medicare Subtotal													
Medicare FFS										$ 65,469,804			
GRAND TOTAL	$ 38,779,124		$ 700,000	$ 1,280,000	$ 369,248,200		$ 28,792,000		$ 74,169,019	$ 278,213,944	$ 782,640		

$ 791,964,927

(1) Represents Net Capitation Revenue which is the total revenue earned for each of our Risk Contracts. This is consistent with last year's filing. Atrius Health is not paid on a "Claims-based" (i.e. Fee for service) basis nor do we settle on surplus/deficit basis, so we are not able to provide the information exactly as requested.

(2) Represents estimates since final calculations/settlement do not occur until October/November