HPC Pre-Filed Testimony Questions – Atrius Health

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1. Shifts in Enrollment in Health Insurance Products with Risk Arrangements - Despite being a national leader in the implementation of alternative payment methodologies (APMs), Massachusetts has seen a decline in the number of patients enrolled in the traditional health plan products that allow providers like Atrius Health to accept meaningful risk. The Center for Health Information and Analytics (CHIA), in its February 2018 Databook, reported that Massachusetts residents enrolled in HMO and POS insurance products, where risk arrangements are more prevalent, decreased by 125,113 enrollees, or 5.3%, between September 2015 and September 2017. During this same time period, enrollment in PPO and EPO products, in which providers are generally not at-risk and patients are more loosely managed, increased by 121,171 enrollees, or 8.5%. In addition, even within the traditional HMO and PPO product market, there has been continued movement from fully-insured to self-insured products (where APMs are still evolving), including within the Group Insurance Commission's offerings,

   Collectively, these market shifts have been disruptive to providers such as Atrius Health that participate in meaningful risk arrangements and actively work to manage total medical expense (TME). Our ability to sustain the infrastructure, processes, and care management protocols that support the delivery of integrated, high-quality, cost-effective care depends on a reimbursement and incentive system that encourages coordination of care and rewards value and quality. The shift away from risk contracts is a troubling one, and we encourage the HPC to support policies and practices across the Commonwealth to promote the use of robust APMs. We believe that over time this model has the best chance of continuing to bend the cost curve while simultaneously improving the quality of care across our Commonwealth.

2. Pharmaceutical Costs - Pharmaceutical costs, including for specialty drugs, biologics and generics, continue to be a major concern for patients, payers and health care providers. As reported by CHIA during the 2017 Annual Cost Trends hearing, health care spending increased in all claims-based service categories from 2015 to 2016, with pharmacy increases representing the most significant increase of 6.4%. In 2017, Atrius Health experienced an average increase in pharmaceutical spending of 5%, and we anticipate that there will continue to be considerable financial pressures as a result of new drugs coming to market as well as overall price increase. We believe this area warrants additional oversight by the HPC.

3. Pending Initiatives Related to Nurse Staffing Ratios in Hospitals - We are deeply concerned about the potential implications of Question 1 on the November 6th Ballot - the "Initiative Petition for a Law Relative to Patient Safety and Hospital Transparency" and other efforts to mandate nurse staffing ratios statewide. While these requirements would not affect Atrius Health directly, their impact on our TME could be considerable as affected institutions would need to increase staffing, with attendant increases in costs of care and difficulty for Atrius Health in recruiting nurses to support ambulatory and home-based care. Since moving care out of the hospital and into ambulatory and home-based care is a key part of decreasing spending over time, the impact of the requirements would be to forestall innovation that drives down cost. Moreover, we do not believe the imposition of staffing ratios will have a material impact on patient safety; this type of mandate represents unnecessary interference in the business operations of health care entities which are already highly regulated and accountable to numerous governmental agencies for patient outcomes. We believe these initiatives would have a direct impact on the ability of all providers to meet the established benchmark.

4. Legislation Needed to Remove Regulatory Barriers for Providers and Reduce Health Care Costs (see below).

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?

There are a number of statutory changes that should be considered to in the upcoming legislative session including the following:

- Enacting legislation that enhances transparency of pharmaceutical costs associated with manufacturers and Pharmacy Benefit Managers (PBMs). It is critical for the state to take decisive action to ensure that prescription drug price increases are warranted and that pharmaceutical manufacturers as well as PBM's, like health plans and providers, are actively engaged in the Commonwealth's effort to make health care more affordable. In addition, the state should assess the impact that coupons have had on the cost of care in the Commonwealth. A number of publicly available reports suggest that even when less expensive generics exist, coupons encourage the utilization of more expensive brand name drugs, and boost retail sales of those drugs by 60 percent or more.
- Nurse Staff Ratio Ballot Question – The HPC should expeditiously perform and publish a detailed analysis of the cost impact of the nurse staff ratio initiative. If the question passes, legislators should pass changes to minimize the impact, including lengthening the time to implementation, allowing for changes in the case of emergencies such as the Boston Marathon, reviewing and updating the statutes every few years to adjust for the impact of technology and changes in scope of practice, noting other health practitioners who may be substituted for nurses (either alone or in combination), etc.
- Elimination of Scope of Practice Barriers - Atrius Health strongly supports the enactment of legislation to eliminate remaining practice barriers for Nurse Practitioners (NPs), specifically those related to prescriptive practice. As payers recognize, and providers increasingly rely on, NPs as primary care providers with their own patient panels, it is critical that they be permitted to practice fully within the scope of their knowledge, education and training if we hope to improve access to care, reduce administrative burdens on physicians and contain costs. Similarly, we believe that the current requirements for Medical Assistants to administer vaccines are too restrictive and limit the ability of providers to efficiently and cost effectively provide care. Finally, Clinical Pharmacists should be recognized as billing providers since they provide another lower-cost alternative

to physicians. Atrius Health currently utilizes Clinical Pharmacists to support medication titration, under physician supervision, but without reimbursement. With the worsening trend to provider shortages at all levels, we need to expand the availability of all reasonable lower-cost alternatives for care.

- Telehealth - Telehealth holds considerable promise in reducing healthcare costs and providing patients with convenient, high quality care for many common conditions. Despite its many innovations in both technology and health system payment reform, Massachusetts remains behind other states in the use of telehealth as statutes here have failed to keep pace with advancing technology and the potential for improved access and convenience for patients. Atrius Health strongly recommends the state enact legislation quickly to reflect this important and evolving change in healthcare.

Additionally, Atrius Health believes the following should also be considered by policymakers:

- Urgent care centers affiliated with AMC's should be under the purview of the HPC since these have the ability to refer patients to higher cost hospitals when more advanced care is needed.
- The HPC should examine the cost of oncology services by provider and setting. Some providers are paid twice what others are paid to provide exactly the same services because of their brand or special Medicare exemptions. It is difficult to move patients away from the higher cost facilities that have very strong brands.
- Following the initial passage of Chapter 224, the Health Planning Council was created; however, the Council has not met for several years due to a lack of resources. Atrius Health believes that the Health Planning Council created a unique opportunity to evaluate the availability of health resources statewide in order to ensure that healthcare services meet the needs of residents without duplicating or adding additional costs and should be re-instituted.
- The state should require hospitals/skilled nursing facilities to consult with the patient's primary care provider for the preferred referral to home health agencies (while continuing to give patients the choices that Medicare requires). Atrius Health tries to use its home health agency, VNA Care, which is an integral partner in providing coordinated and more cost effective home health and hospice services to our patients; however we frequently find that hospitals/skilled nursing facilities push patients to their own or other home health care providers.
- State legislation, regulations and policies should be fast-tracked where they will foster innovation in the delivery or care to patients.
- Finally, an additional area that warrants continued review by the HPC is the expansion of Academic Medical Centers (AMCs) statewide and construction of new outpatient facilities. While ostensibly less expensive than their downtown, tertiary counterparts, these entities are still able to charge facility fees and refer to more expensive hospitals, both of which increase the overall cost of care. Atrius Health supports the principle of "site neutrality" with respect to payment for certain outpatient health care services. Applicable state law should be amended to require notices of material change in advance of AMC's building new outpatient centers in community settings.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

Atrius Health's top three strategic priorities to reduce health care expenditures include the following:

1. Shifting care to lower cost settings – We continue to increase utilization of our preferred hospitals, including community hospitals, and other low cost settings such as freestanding Ambulatory Surgical Centers (ASCs), as well as facilitate care for patients in their homes when such settings are clinically appropriate; we believe these venues often offer the same or better quality of care at a lower cost, and permit better care coordination and convenience for our patients. Atrius Health was the first provider in Massachusetts to move Total Joint Replacement surgery for appropriate patients to an ASC with follow-up home care (a practice that has been done in other parts of the country for a decade). This initiative of moving care to lower cost settings is estimated to deliver several million dollars in annual medical expense savings while continuing to achieve excellent clinical outcomes. Feedback from our patients has been extremely positive since this is also more convenient and lower out-of-pocket costs for them.

Other initiatives include developing a hospital at home program. Atrius Health is successfully piloting this approach which saves on average over $5000 per hospitalization and has the additional benefit of engaging patients in their homes around other areas critical to improving health, such as nutrition, medication adherence, fall risk reduction. A bundled payment methodology adopted by payers is needed to support the expansion of this program.

2. Medical Expense Management –Atrius Health has invested heavily in other initiatives to improve quality and control medical expenses, such as programs to reduce avoidable hospitalizations and re-hospitalizations and to eliminate low value testing.

For example, our "Care in Place" program, which is a partnership between Atrius Health providers and VNA Care nurses, provides urgent care in the home for older patients who we have identified as high risk of being hospitalized and who are unable to come in for an office visit, due to lack of transportation or because they feel too ill to travel. For older, frailer patients, emergency room visits typically lead to admission, and hospital treatment may cause further complications that result in longer hospital stays and worse health outcomes. Once the determination is made that the patient needs a same day appointment, and does not need to be sent immediately to an emergency room, the nursing staff can contact the Care in Place Referral line to request an urgent home care visit. A designated nurse from VNA Care will then go to the patient's home, provide an assessment (including medication review) and contact the assigned Medical Control Officer (MCO) while in the patient's home to review the patient's condition and develop a treatment plan. The MCO places any necessary orders, documents the visit as an urgent home care encounter, and sends the encounter to the PCP. The PCP team picks up the follow-up care. From January 2017 through July 2018, there were a total of 1,365 patients referred to the Care in Place Program that we estimate has resulted in savings of $1.7 million in ED/hospital avoidance.

In addition, Atrius Health provides telephone access to an advanced practice clinician 24 hours/day, 7 days/week, as well as offering extensive same-day appointments and extended weeknight and weekend urgent care hours to reduce unnecessary use of hospital emergency departments. We use historical claims data and predictive modeling to identify patients who are at a higher risk of being admitted to the hospital within the next six months. These patients are flagged internally and are triaged to be seen immediately in the office or are referred to special programs like the one referenced above. We identify adult and pediatric patients eligible for end-of-life/palliative care using this same type of modeling.

Finally, under our Medicare Advantage program and with a NextGen waiver, we are able to admit qualified patients directly for SNF care without a prior 3-day hospital stay. We continue to work closely with our preferred SNFs that offer high quality care and are committed to patient satisfaction. Many of these SNFs have an Atrius Health affiliated physician or advanced practice clinician on site caring for Atrius Health patients. Medical staff at the SNF has the ability to obtain the patient's current medical record from our EMR, allowing for better communication about the patient's health status and medications between the SNF and the patient's primary care provider. Preferred SNFs are expected to adhere to a list of expectations by Atrius Health to improve care and have agreed to comply with these expectations, which include sending a discharge summary to the PCP, thus improving care transitions. Home health may be provided after the SNF visit. On average we have reduced the cost of SNF stays by approximately $3,000 per stay for SNFs where we have our own coverage as compared with care that is not directly managed in this way.

3. Pharmaceutical Cost Management – Recognizing the critical nature of managing pharmaceutical costs and improved patient outcomes, Atrius Health has a robust clinical pharmacy department that continues to focus on clinically appropriate, evidence-based, cost-effective medication prescribing. A team of 14 clinical pharmacists works directly with our physicians, other health professionals and patients to ensure that the medications prescribed contribute to the best possible health outcomes, are affordable to patients, and are the most cost-effective option.

While we are not able to bill for these services, we believe it is essential to invest in this important initiative. Atrius Health's clinical pharmacy team continually monitors for the availability of new generics, blockbuster brand name drugs, and any changes in costs of medications. Once identified and if appropriate, the clinical pharmacy team develops an initiative to focus on prescriber and staff education with helpful reference material, changes to EMR tools to guide prescribing, and targeted prescribing reports - all of which lead to medication conversions where appropriate. One example of a recent major initiative was educating clinicians about a new generic inhaled corticosteroid and long acting beta agonist combination inhaler which is the therapeutic equivalent of a more expensive brand inhaler. This initiative resulted in annualized savings to Atrius Health of $1.5 million in just 10 months, as well as reductions in out-of-pocket expenses for patients.

Atrius Health's Pharmacy & Therapeutics (P&T) Committee meets quarterly to monitor high volume and high cost medications as well as to make decisions on new or emerging medications and their place on the Atrius Health Formulary. While clinicians are able to prescribe medications that are not on the formulary, they are strongly encouraged to prescribe from our formulary, which is based on efficacy, safety, and cost. Of the medications prescribed at Atrius Health, 89% consist of generic medications.

Finally, we have implemented Collaborative Drug Therapy Management, and several of our clinical pharmacists see patients in clinic by clinician referral for medication teaching related to uncontrolled hypertension, type 2 diabetes and hyperlipidemia, depression, anxiety and insomnia. These pharmacists modify and adjust medication therapy by protocol with the focus on each individual patient reaching their optimal goal of therapy and healthier outcomes. The education and patient engagement in their own care increases compliance and adherence to therapy. Healthier and adherent patients with improved outcomes have a major impact on reducing total medical expenses (TME). Since pharmacy is a major contributor to overall healthcare costs, dedicating resources to establish a strong clinical pharmacy program to monitor,

control, and educate on cost-effective prescribing has helped lower prescription costs and contribute to lowering overall TME.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.*

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

Not Applicable

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

Number of unique patient visits	

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	
Percentage of patient visits where the patient is referred to a more intensive setting of care	

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.

Not Applicable

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?

Not Applicable

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).

We provide telephone access to an advanced practice clinician 24-hours/day, 7 days/week, as well as providing extensive same-day appointments and extended weeknight and weekend urgent care hours to our patients in order to reduce the unnecessary use of hospital emergency rooms and improve access. In addition, Atrius Health offers video visits for behavioral health and urgent care.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.

Because there is no direct affiliation between alternative care sites and a patient's primary care provider, we believe that use of urgent care centers can result in fragmented care since our clinicians have no way of knowing that a patient has been seen at such a location, what the diagnosis or treatment was or any other information such as medications prescribed or follow-up. In addition, we are concerned that hospital-based urgent care centers, which appear to be growing at a rapid pace with little oversight, may result in increased healthcare costs since we believe that patients may be referred to hospital-based specialists and hospital-based primary care providers.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and

families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

- ☒ Legal barriers related to data-sharing
- ☒ Structural/technological barriers to data-sharing
- ☒ Lack of resources or capacity of your organization or community organizations
- ☒ Organizational/cultural barriers
- ☐ Other: Click here to enter text.

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

Atrius Health applauds the Commonwealth's commitment to addressing health-related social needs, including plans by the Executive Office of Health and Human Services to address housing and nutrition insecurity through DSRIP Flexible Services. Atrius Health encourages policymakers to facilitate a statewide strategy to address health-related social needs that includes a family-and community-focused and referral-based network of community-based organizations that Accountable Care Organizations can access in order to assist patients in meeting their needs.

The state should further invest in programs that advance community-clinical linkages, e.g. through additional funding through MassHealth and through the Prevention and Wellness Trust Fund. Finally, recognizing that a patient's health is often affected by outside factors (e.g. health disparities, lack of transportation, poverty, domestic violence, access to healthy foods and housing insecurity) outside of the control of their health care provider, we believe it is critically important that policymakers address these through public health policy outside of the healthcare delivery system.

Finally, state and federal privacy laws make it difficult for providers to communicate with other entities about a patient who is receiving treatment from multiple providers without their pro-active consent. We would like to see an opt-out option for Mass Hiway, and clear guidelines for the MassHealth ACOs and community-based organizations around data sharing.

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. 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.

   See Attached.

   Atrius Health is 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 perform, to the best of our knowledge) an assessment of our claims priced at our PPO pricing in comparison to a final budget.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries **n/a	Aggregate Number of Inquiries via Telephone or In-Person *
CY2016	Q1		
	Q2		567
	Q3		774
	Q4		800
CY2017	Q1		833
	Q2		787
	Q3		837
	Q4		874
CY2018	Q1		1027
	Q2		986
	TOTAL:		7485

*Note: the totals represent telephone inquiries only. In-person pricing requests are not tracked. Atrius Health does provide real time estimates for informal, in-person patient inquiries at our practices utilizing an Excel look-up table that allows designated business staff to enter the patient's insurance product information and any of the top 100 procedure codes and assists our patients in identifying the cost of the procedure.

** Written inquiries are not tracked. Approximately 10% of phone inquiries result in a written response being sent to our patients.

b) Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.

Atrius Health monitors customer service related metrics such as average speed of call answer, call abandon rate and length of time speaking with patients and reports are generated monthly. Performance is consistently within Atrius Health's customer service standards, with over 90% of calls from patients answered within 30 seconds and call abandon rate less than 2%. The average amount of time spent on these inquiries is approximately 3-4 minutes. Although we do not have formal process for monitoring the accuracy of responses to requests for price information, complaints by our patients regarding incorrect pricing information are rare.

c) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

The process of answering calls, researching requests, and providing a response is labor intensive. To make the process more efficient, Atrius Health developed a pricing template for the most commonly requested pricing information (e.g., colonoscopy with biopsy, endoscopy with polypectomy and mammogram screening with tomosynthesis). The development of this pricing template has allowed Atrius Health to provide immediate pricing response which we call "one-touch" service during business hours for 98% of pricing requests. Any requests for pricing information that requires additional research is provided within 2 business days.

3. For hospitals and provider organizations corporately affiliated with hospitals:

Not Applicable

a) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Not Applicable.

b) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each

line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

Not Applicable.

2014

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap 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					$ 216,943,828		$ 16,786,000		$ 2,880,687				
BCBSMA PPO										$ 156,412,134			
Tufts FI					$ 41,976,283		$ 1,500,000						
Tufts SI	$ 10,686,733		$ 670,000										
Tufts PPO (incl. CareLink)										$ 41,702,497			
HPHC FI					$ 71,204,840		$ 700,000						
HPHC SI					$ 78,251,019		$ 800,000						
HPHC PPO (incl. Passport & Independence)										$ 69,542,269			
NHP Comm			$ 298,000		$ 12,926,766				$ 1,817,825	$ 8,021,095			
Fallon	$ 6,627,049			$ 300,000						$ 76,842			
Aetna	$ 24,058,070			$ 150,000						$ 1,491,983			
Other Commercial (Any remaining payors not listed above - lump together)										$ 56,128,492			
Total Commercial	$ 41,371,852		$ 968,000	$ 450,000	$ 421,302,736		$ 19,786,000		$ 4,698,512	$ 333,375,312			
NHP Medicaid					$ 23,117,341		$ 1,000,000		$ 897,722	$ 2,494,626	$ 864,348		
Total Managed Medicaid					$ 23,117,341		$ 1,000,000		$ 897,722	$ 2,494,626	$ 864,348		
Medicaid FFS										$ 13,659,576			
Tufts Medicare Preferred					$ 83,985,625		$ 490,000						
Commercial Medicare Subtotal													
Medicare FFS										$ 74,582,475			
GRAND TOTAL	$ 41,371,852	$ -	$ 968,000	$ 450,000	$ 528,405,702		$ 20,276,000		$ 5,596,234	$ 424,111,989	$ 864,348		
												$ 1,022,044,125	

*Does not include non-Atrius Reliant Medical Group risk contracts (consistent with 2013). Includes RMG Atrius risk contracts with BCBS FI & SI and HPHC SI.

Includes HVMA, DMA, GMG, SSMC, SMG and RMG.

Effective 1/1/14, all Groups were at risk for HPHC SI.

2015

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap 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					$ 95,808,638		$ 9,594,587						
BCBSMA PPO										$ 123,387,515			
Tufts FI					$ 23,220,938		$ 1,372,391						
Tufts SI	$ 11,580,139		$ 719,502										
Tufts PPO (incl. CareLink)										$ 30,713,016			
HPHC FI					$ 39,964,330		$ 471,232						
HPHC SI					$ 71,595,067		$ 2,071,886						
HPHC PPO (incl. Passport & Independence)										$ 53,462,881			
NHP Comm			$ 517,000		$ 12,001,990				$ 3,112,348				
Fallon	$ 3,319,424			$ 135,975									
Aetna	$ 18,922,602			$ 150,000									
Other Commercial (Any remaining payors not listed above - lump together)										$ 29,442,067			
Total Commercial	$ 33,822,165		$ 1,236,502	$ 285,975	$ 242,590,963		$ 13,510,096			$ 237,005,479			
NHP Medicaid					$ 24,916,824		$ 1,000,000		$ 5,919,288		$ 298,432		
Total Managed Medicaid					$ 24,916,824		$ 1,000,000				$ 298,432		
Medicaid FFS										$ 2,392,156			
Tufts Medicare Preferred					$ 51,889,142		$ 505,314			$ 1,447,360			
Commercial Medicare Subtotal													
Medicare FFS										$ 60,825,350			
GRAND TOTAL	$ 33,822,165		$ 1,236,502	$ 285,975	$ 319,396,929		$ 15,015,410		$ 9,031,636	$ 301,670,345	$ 298,432		

$ 680,757,394

(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.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.

2016

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap 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					$ 88,020,886		$ 9,061,866						
BCBSMA PPO										$ 126,523,361			
Tufts FI					$ 29,583,901		$ 1,260,852						
Tufts SI	$ 19,952,282		$ 1,281,387										
Tufts PPO (incl. CareLink)										$ 27,445,907			
HPHC FI					$ 37,100,381		$ 697,758						
HPHC SI					$ 95,261,280		$ 3,173,390						
HPHC PPO (incl. Passport & Independence)										$ 41,281,672			
NHP Comm					$ 23,960,187		$ 800,000		$ 1,812,932				
Fallon	$ 3,308,596			$ 129,640									
Aetna	$ 19,406,362			$ 149,779									
Other Commercial (Any remaining payors not listed above - lump together)										$ 24,440,335			
Total Commercial	$ 42,667,240		$ 1,281,387	$ 279,419	$ 273,926,635		$ 14,993,866		$ 1,812,932	$ 219,691,275			
NHP Medicaid					$ 28,356,572		$ 1,300,000		$ 246,147				
Total Managed Medicaid					$ 28,356,572		$ 1,300,000		$ 246,147				
Medicaid FFS										$ 1,582,154			
Tufts Medicare Preferred					$ 73,965,404		$ 503,662			$ 651,709			
Commercial Medicare Subtotal					$ 73,965,404		$ 503,662			$ 651,709			
Medicare FFS										$ 62,262,719			
GRAND TOTAL	$ 42,667,240		$ 1,281,387	$ 279,419	$ 376,248,611		$ 16,797,528		$ 2,059,079	$ 284,187,857			

$ 723,521,121

(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.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.

2016

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap 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					$ 115,716,188		$ 7,699,142						
BCBSMA PPO										$ 136,831,423			
Tufts FI					$ 30,670,666		$ 1,336,572						
Tufts SI	$ 20,860,936		$ 804,703										
Tufts PPO (incl. CareLink)										$ 26,786,148			
HPHC FI					$ 43,865,991		$ 620,543						
HPHC SI					$ 113,796,869		$ 3,428,234						
HPHC PPO (incl. Passport & Independence)										$ 41,227,943			
NHP Comm					$ 24,745,653		$ 831,589		$ 1,338,376				
Fallon	$ 3,573,875			$ 149,570									
Aetna	$ 20,889,677			$ 149,779									
Other Commercial (Any remaining payors not listed above - lump together)										$ 14,498,130			
Total Commercial	$ 45,324,488		$ 804,703	$ 299,349	$ 328,795,367		$ 13,916,080		$ 1,338,376	$ 219,343,644			
NHP Medicaid					$ 27,237,696		$ 1,158,299						
Total Managed Medicaid					$ 27,237,696		$ 1,158,299		$ -				
Medicaid FFS										$ 2,114,360			
Tufts Medicare Preferred					$ 72,362,629		$ 517,038			$ 1,275,568			
Commercial Medicare Subtotal					$ 72,362,629		$ 517,038			$ 1,275,568			
Medicare FFS										$ 85,309,476			
GRAND TOTAL	$ 45,324,488		$ 804,703	$ 299,349	$ 428,395,692		$ 15,591,417		$ 1,338,376	$ 308,043,048			

$ 799,797,073

(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.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.