Atrius Health

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September 11, 2015

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, Inc. ("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 6, 2015, in preparation for the upcoming public hearing on health care cost trends.

I, Steven Strongwater, MD, depose and state under pains and penalties of perjury the following: I am President and Chief Executive Officer of Atrius Health. I sign the attached responses for and on behalf of Atrius Health 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 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,

Steven Strongwater, MD
President and Chief Executive Officer

Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 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 in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

    In CY2014 and year-to-date 2015, our commercial risk gross revenue growth rate was and continues to be approximately 2-3%. Utilization (office visits) at Atrius Health practices has been flat due in part to the severe winter in 2014 and into 2015.

    For CY2014 and year-to-date 2015, we are also seeing 2-3% increases in the growth rate of the total cost of care as measured internally for our commercial risk business. Our Medicare and Medicaid risk patient costs are flat or decreasing slightly, due in part to our work in reducing avoidable hospital admissions and re-admissions and length of stay in skilled nursing facilities, reducing utilization of unnecessary diagnostic tests and imaging, and increasing use of preferred facilities and providers for these populations.

    We are investing significant resources in care coordination, high-risk patient management and chronic disease management while keeping overall staffing levels flat.

    Atrius Health has continued to see an increase in drug expenditures over the past year primarily due to Hepatitis C drugs. This rise is slightly lower year-to-date CY2015 than in CY2014, but drug costs are still increasing on average 10-12% per patient. The growing use of expensive specialty drugs and biologics is a significant cost driver to the health care system. This trend is a great concern for us and we strongly encourage the HPC to examine the issues related to specialty drugs, biologics and drug cost increases more closely as they affect overall health care spending in the Commonwealth.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Since January 1, 2014, Atrius Health has continued to invest significant resources in efforts to help the Commonwealth meet the healthcare cost benchmark. Specifically, we are focusing on strategies to (1) ensure our patients receive care in the right place at the right time; (2) provide the "right" care (e.g., reducing overuse, misuse and underuse of services to reduce total cost of care and improve quality); and (3) improve efficiencies to reduce cost. These strategies include the following:

- Providing telephone access to a clinician 24-hours/day as well as extended weeknight and weekend urgent care hours to reduce the unnecessary use of hospital emergency rooms.

- Improving integration with our affiliate, VNA Care Network Foundation, to create strong partnerships with its home health and hospice programs for post-acute care.
- Increasing utilization of our preferred hospitals with a focus on moving care into community hospitals wherever appropriate. This enables us to provide the same or better quality care at lower cost. For example, we have begun to use Winchester Hospital instead of Lahey Hospital where appropriate for patients in our northern region. We also re-organized our OB/GYN services, eliminating a service at Brigham and Women's Hospital while adding one at Winchester Hospital. More of our patients are referred to lower-cost, high quality providers at BID-Needham and BID-Milton than in prior years. We continue to work to bring services in-house where the cost is lower than at hospital-based facilities, and the care is more convenient and can be better coordinated for patients.
- Developed a dispatch system that ensures that the appropriate ambulance type (e.g., chair car) is used for non-urgent cases.
- Continuing to conduct ongoing reviews of patients who are at high risk for hospitalization. These reviews help identify opportunities to provide interventions which can reduce unnecessary avoidable hospitalization and readmission.
- Implementing the waiver available to Atrius Health as a Pioneer ACO that permits admission to skilled nursing facilities without a 3-day hospital stay when clinically appropriate.
- Participating in OneCare and Senior Care Options (SCO) dual-eligible programs with Commonwealth Care Alliance and Tufts Health Plan respectively. We believe that working with these programs will improve care and reduce cost for our patients who receive benefits from both Medicare and Medicaid.

In addition, Atrius Health re-examined and reorganized its governance structure to enable us to centralize certain functions such as billing and contracting, and operate more efficiently.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

   Atrius Health has participated in the Medicare Pioneer ACO program since its inception and plans to continue in the program in 2016.

   Atrius Health is entering into risk arrangements for behavioral health care with one of our largest commercial payers as of January 1, 2016. We are also working on developing an alternative payment arrangement with one of our specialty hospitals and are in discussions with several commercial payers regarding alternative payment arrangements for PPO members.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

1. Current state law that limits the ability of behavioral health clinicians to share information poses a significant barrier to provision of coordinated, cost-effective care. Payer prohibitions on billing for both medication appointments and counseling and/or shared medical appointments on the same day also reduce efficiency in the delivery of care for providers and patients. This restriction imposes a significant inconvenience to patients who must make two separate appointments, results in less care than needed at times and does not have a clinical foundation.
2. We support review and revision of open access laws regarding behavioral health, OB/GYN, and emergency department services. We understand that these laws were intended to support patient choice and ensure patients can access certain services, but their breadth limits the ability of primary care providers to effectively coordinate care and discourages alternative payment arrangements where providers assume risk for payment for the full range of health care services.
3. The administration, legislators and the HPC should help foster reforms on both the state and federal level that lead to reimbursement for innovative technologies such as telemedicine that drive down TME. Expanding such reimbursement would encourage more efficient operations by allowing patients to be cared for in the home when transportation, mobility issues or other factors might limit a patient's ability to come for an office visit.
4. The state should enforce the requirement in Chapter 224 that the health plans attribute PPO patients to PCPs (or physician groups) and share the claims data with that PCP. This would enable the same kind of risk assessment that we can do on our HMO patients so that we can proactively provide services to keep patients out of the hospital. This should include behavioral health data so that we can similarly assess risk for these patients.
5. The state should require hospitals to provide the interoperability that would allow community providers to view the medical records of their own patients.
6. We support efforts that would require hospitals/skilled nursing facilities to consult with the patient's primary care provider for the preferred referral to home health agencies
7. We urge the HPC to work with other state policymakers and stakeholders to develop a requirement that hospitals notify the patient's primary care provider upon a patient's admission to a hospital. There is considerable variation among hospitals in providing this information, which results in poor coordination of care - and thus increased risk and reduced quality of care - both during the hospital stay and upon discharge.
8. Price transparency has been difficult for payers and providers. A different approach to consider would be to have the state develop a real-time, online self-service program for consumers that would allow them to access this information in one place.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

Until very recently there had not been an agreed upon patient attribution methodology that was acceptable to the major health plans and providers in the state to advance the adoption of alternative payment methods for non-HMO patients (such as for PPO products). Since there is now consensus on a single method of patient attribution, health plans and providers can now focus on developing alternative payment models. It is critical that the health plans provide adequate funding and financial incentives in these models to support the delivery of high quality and coordinated, cost effective care. Atrius Health will be working with health plans on these new alternative payment contracts in the coming year.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

Over the past 12 months Atrius Health has continued to focus on population health with a particular emphasis on the four areas listed above. Since we began our participation in the Pioneer ACO program, we have expanded our care management and medical management programs as described below to reach a larger proportion of our patients:

<u>1) Spending on Post –Acute Care and Reducing Avoidable 30-Day Readmissions</u>

We have partnered with our home health and hospice agency affiliate, VNA Care Network Foundation, to improve the efficiency and effectiveness of post-acute care (described in greater detail below in our response to Question 7). We consider home health key to our success in caring for patients with chronic and complex medical conditions.

<u>2) Extended Care Facility (ECF) Medical and Care Management Program</u>

Select Extended Care Facility (ECFs) in our service area are staffed by Atrius Health physicians and/or NP's providing on-site care and medical management. These clinicians have had success in reducing hospital readmission rates for patients admitted to a SNF which they attribute to: expertise managing an episode of complex care; strong physical presence in the facility; attendance at family and team meetings; bringing services to the facility such as mobile x-ray and being on-site to receive results real time; working closely with case management staff (either our own, or a health plan's) in planning for discharge with the facility's social worker and the local VNA; and medication reconciliation/optimization following hospital discharge. ECF case managers complete a comprehensive medical review and case management plan for these patients to support a successful discharge. These clinical teams have also helped reduce average length of stay for SNFs for our Medicare beneficiaries, enabling our patients to return home sooner. From 2012 to 2014, Atrius Health reduced SNF length of stay for Medicare Pioneer ACO patients from 21.5 days to 19.6 days and reduced the length of stay for our Medicare Advantage patients from 14.9 days to 14.1 days for the same period. In addition, the program has reduced the rate of readmission from SNF to hospital.

Case Management - Atrius Health uses case managers for our highest risk patients. These case managers act as a single point of contact, facilitating coordination among the patient, primary care team, hospital and other providers and social supports. Close alignment with the local elder services agency, home health and hospice, and access to various internal and external programs helps assures a smooth transition of care. Our case managers communicate the care plan and any concerns to other providers through the electronic medical record, and work with the patients to ensure they understand their medications and follow-up plan, and get timely care from their PCPs. Each of our practices has Population Managers who use data from Atrius Health's data warehouse to guide outreach and educational efforts for patients, improving the team's ability to monitor these patients and increase their use of appropriate screening and other forms of preventive care.

Medication Management Our clinical pharmacists participate in roster reviews to evaluate drug therapy for patients who take many medications and make recommendations to improve medication efficacy and efficiency. These clinical pharmacists are available for consultation on patients recently discharged from the hospital and other high risk patients. In addition, clinical pharmacists meet with patients who have uncontrolled or newly diagnosed chronic conditions. The pharmacist evaluates medication adherence, provides medication and disease education and helps patients achieve desired clinical goals. In addition, we have extensive decision support in our EMR to assist clinicians in high quality cost effective prescribing at the point of care.

3) Reducing Avoidable ED Use –

Atrius Health has increased the availability of urgent care services and evening and weekend appointments. We now provide some level of service 365 days per year. We also provide access to clinicians with telephone visits and via email through our patient portal. Our weekend and after-hours telecommunications service is staffed with nurses and advanced practice clinicians who triage patient needs and provide clinical advice, write prescriptions, connect patients to on-call physicians, and schedule next day appointments. In 2014 we opened the Dedham Medical Urgent Care Center Affiliated with Beth Israel Deaconess Medical Center, which is staffed by board-certified emergency room physicians who can provide a higher level of urgent care for our patients and which provides walk-in care for a variety of illnesses and injuries. All of these efforts help us provide the right care at the right time and help reduce avoidable ED use.

4) Focused Care for High-Risk/High-Cost Patients

Multidisciplinary Roster Review - Claims data is integrated into our proprietary population health tools and strategies to identify patients at highest risk of hospitalization or advanced illness. We create roster tools and workflows focused on specific diseases/risks. Primary care teams then use these tools to conduct a standardized "roster review" using a whole patient approach to understand the many clinical and social challenges a patient faces. A multi-disciplinary team including primary care, case management, social work, clinical pharmacy, and geriatrics develops a comprehensive plan of care that meets each patient's clinical needs and care goals, and may lead to referral to programs such as the home-based primary care program described below.

Home-based Primary Care Program - Some of our practices have been providing short-term, intensive post-hospitalization home-based primary care for high risk patients within a limited geography for several years. Since we started our Pioneer ACO work, Atrius Health has expanded this program across a greater service area and by adding a long-term component for patients who are not able to transition back to ambulatory care. A geriatric NP leads a multidisciplinary team to coordinate home-based services and stay in close contact with a patient's PCP. Patients with a discharge diagnosis of CHF, COPD or pneumonia are referred to the program, as well as patients who have had two or more non-elective admissions in the past 12 months. Key aspects of the program include medication management, advance care planning, palliative care, coordination with hospice and visiting nurse agencies, as well as a dedicated phone line for patients and families to contact the assigned nurse practitioner. This program achieves outstanding results in terms of quality, patient experience and total cost of care reduction, primarily driven by reduced hospital.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

Atrius Health plans to continue the work described above in each of these four areas. We also plan to explore additional opportunities with our home health and hospice programs and innovations such as telemedicine. We recently launched an innovation center to accelerate our work on care delivery models to address these areas.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indication of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
   a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

      Acceptable reasons for price variation include geography due to underlying differences in the cost and availability of labor, real estate, and other variables, or special services that are rarely used but must be provided to meet the emergency needs of the community. Additionally, risk adjustment based on socioeconomic factors could also be used to support price variation. Site of service is not an acceptable reason for price variation in the outpatient setting.

      We believe that Total Medical Expense (TME) is a more important metric than price. Price variation may be acceptable when a provider can demonstrate that a higher "price" reflects provision of additional, non-billable services that are necessary to achieve a lower TME.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

Higher prices, particularly when associated with providers that are increasing their market share, contribute to the overall cost of health care in the state, both directly and indirectly. All providers should be seeking ways to reduce health care costs and simultaneously improve the health of the community (e.g., improving overall health, reducing unnecessary hospital admissions/readmissions, increasing advance care planning and promoting optimal use of post-acute care). It is important to ensure that there are high quality, lower cost providers in the community focused on serving local needs.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 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.
   a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

(1) Our analysis of our own experience reflects the trends cited in the recent 2014 Cost Trends Report Supplement. Unlike many other ambulatory care practices in the state, Atrius Health has robust outpatient behavioral health services available at most of our practices. Behavioral health clinicians work closely with their primary care and other specialty colleagues to coordinate care and ensure that high-risk patients have access to appropriate behavioral health clinicians. We also have protocols to assist and manage patients in crisis to avoid unnecessary utilization of emergency room departments and inpatient care whenever possible.

We are currently transforming our care model so that outpatient services will be coordinated through a standardized referral and triage process that ensures prompt access to needed behavioral health services for the patients with the most complex issues. With this change, we expect to more effectively address the concerns of those behavioral health patients with more severe and/or complex issues, and also focus on those with chronic health problems. Our clinicians will be utilizing empirically supported treatment principles that will guide episodic, goal-oriented, time-limited interventions for patients with about 12 different conditions. The new care model is the result of two years of research and planning on how to address the concerns of patients with the most challenging issues. The model will be supported by a network of preferred outside referral partners who have agreed to provide treatment for our patients with less complex issues (e.g., traditional psychotherapy services). These providers have also agreed to

provide consistent information back to us on patient progress, so that patient care does not break down in transition from our practice to the outside partner. Our new care model completed its pilot phase in mid-2015 and is on schedule for full implementation system-wide in 2016.

(2) Atrius Health is working on developing better collaboration with emergency departments and inpatient facilities for behavioral health patients through the use of a care facilitator. As currently envisioned, the care facilitator will provide classic behavioral health case management for 50% of his/her time and perform behavioral health population management, and risk management for the other 50%. This role will facilitate coordination with primary care and other specialties and foster relationships with local hospital emergency departments so we know when our patients enter an emergency department with behavioral health needs; we then can collaborate on the patient's specific needs before an admission. The care facilitator is a new role and is currently being piloted.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

As described above, behavioral health care services are already integrated into the majority of our practices and our transformation plan will be implemented in the next twelve months. We expect to continue to develop the care facilitator role and examine the effectiveness of the position in reducing unnecessary utilization of emergency rooms and inpatient care. We will also continue to work on building more formal partnerships with inpatient units, partial programs, detox programs and other external services to meet the needs of our patients. The purpose of these partnerships is to ensure that patients do not fall through gaps in the system during care transitions. We are particularly committed to collaborating with emergency departments in the next 12 months to improve care for our patients seeking care in that setting.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

Almost all of Atrius Health primary care practices, including both adult and pediatric departments, are certified as NCQA Level 3 PCMH's. In addition, Atrius Health has an established health IT infrastructure that has received recognition as HIMSS level 7, the highest certification for an integrated information technology system. This infrastructure supports coordination of high quality patient care that is the foundation to our success as a Medicare Pioneer ACO with one of the highest quality scores in the country.

Atrius Health has the infrastructure and capacity to meet Massachusetts' ACO requirements, including population health management, sophisticated data analytics capabilities, clinical pharmacy, case management, integrated behavioral health, managing to global budgets and the ability to achieve and maintain consistent high quality scores. To further illustrate our commitment to patient-centered care, earlier this year, Atrius Health launched an Innovation Center, earmarking $10 million over the next several years to develop and improve patient-centered care delivery models that meet the needs of today's health care market. The Innovation Center will focus on programs developed within Atrius Health as well as on external programs that have a strong likelihood for improving quality and experience for a significant number of patients and demonstrating some financial return. Atrius Health practices and the Innovation Center will work together to generate and assess ideas, taking necessary steps for implementation across the organization once an idea has been shown to be effective.

7. Since 2013, Atrius has acquired the Visiting Nurse Association of Boston and affiliated with Beth Israel Deaconess-Plymouth Hospital (BIDH-Plymouth). Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.
    a. How have costs (e.g. prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?

        Since the affiliation with VNA Care Network Foundation and the acquisition of VNA of Boston, Atrius Health has been actively working to increase the percentage of patient referrals to the VNA Care Network Foundation providers to improve coordination of care for our patients. Our most recent data shows that a combined total of 58% of our Tufts Medicare Preferred and Pioneer ACO patients were referred to VNA Care Network Foundation providers for home care services. This helps reduce total medical expense, because the Atrius Health home health providers continue to show lower cost per case than other home health agencies our patients use. The average cost per case of VNA Care Network Foundation providers, including VNA of Boston is $2,818, which is 4% lower than all other home health agencies (at $2,926) utilized by Atrius Health patients in 2014.

        In late 2014 Atrius Health and VNA Care Network Foundation also launched a program for joint replacement patients where patients are identified and evaluated by visiting nurse before surgery and, when appropriate, receive their post-surgical nursing and rehabilitation services within the home in lieu of going to a more expensive rehabilitation facility. The results of this program are still being evaluated.

        With respect to BIDH-Plymouth, because the clinical affiliation has not been fully developed (see response to Question 7.b., below), there is no data to report in response to this question.

    b. With respect to the clinical affiliation with BIDH-Plymouth (formerly Jordan Hospital), Atrius stated that "Atrius and Jordan Hospital will become more clinically aligned to improve the care of our patients and to ensure coordination and collaboration across the continuum of care. The arrangement will include developing programs to achieve the

parties' shared goals of providing high quality, cost effective care in the most appropriate setting." Please describe any programs that Atrius and BIDH-Plymouth have developed to improve quality and/or enhance cost-effectiveness.

The clinical affiliation with BIDH-Plymouth was primarily intended to support South Shore Medical Center, which was a participating organization of Atrius Health at the time. South Shore Medical Center withdrew from Atrius Health effective January 1, 2015; as a result, we have not developed the above referenced programs.

c. With respect to the acquisition of the Visiting Nurse Association of Boston, Atrius stated that "the affiliation will also allow Atrius to provide the right care in the right place by coordinating patients' transitions from acute and post-acute facilities back to their homes." Atrius also stated that the affiliation "will enable the Atrius groups' primary care physicians to better coordinate care beyond the doctor's office through initiatives such as telehealth monitoring, physical and occupational therapy in the home, as well as culturally-competent care and a process for collaborative care planning and hospice care." Please describe any initiatives that Atrius has developed to enhance care coordination and any measured improvement in appropriate utilization, cost, or quality of care.

Our affiliation with VNA Care Network Foundation has allowed Atrius Health to launch a number of programs to enhance care coordination and ensure Atrius Health patients receive the right care in the right place. For example, since our affiliation, VNA Care Network Foundation providers have expanded their remote tele-monitoring program for our high risk patients with positive results for our patients. In a recent evaluation, Atrius Health heart failure patients receiving remote tele-monitoring had a 30-day re-hospitalization rate of just over 1% as compared to a 30-day re-hospitalization rate of 12% for heart failure patients without remote tele-monitoring. Reducing unnecessary hospitalizations lowers health care costs by reducing unnecessary treatment and testing and also reduces the likelihood of functional decline and changes in mental status for the elderly.

We are encouraging the use of tele-monitoring where appropriate for Atrius Health patients because tele-monitoring promotes improved care coordination and patient safety through the ability to monitor patients daily for signs and symptoms of exacerbating illness, compared to the usual certified home healthcare visit frequency of 2-3 times a week. Additionally, patients in home tele-monitoring have more frequent "check ins" than are typically available in-person either through home health or the physician's office. The patient is at the center of the tele-health interventions with patient goals driving the care and an emphasis on patient education of their disease process and self-management interventions to promote control of their disease process. The ongoing reporting relationship between the tele-monitoring nurses and the patient's primary care team also facilitates the delivery of high quality, integrated patient care. It should be noted that our low re-hospitalization rates for patients on tele-monitoring have been

helpful in encouraging MassHealth to consider reimbursing home health agencies for remote monitoring for high-risk patients effective November 1, 2015.

Care managers at Atrius Health and VNA Care Network Foundation providers have developed processes to ensure continuity of care when patients transition from an inpatient setting to home to ensure a "warm handoff" and that there are strong lines of communications between nurses in the home and the primary care provider.

Another important enhancement since the affiliation has been for the home health providers to regularly share data about medication reconciliation, falls risk and depression assessments with Atrius Health providers.

Atrius Health and the VNA Care Network Foundation providers work closely to increase appropriate use of hospice and palliative care services by providing extensive advanced care planning workshops for our clinicians. We now provide MOLST training for physicians as well as a "Hospice 101 and Palliative Care" training at virtually all of our sites. The emphasis on both palliative and hospice care is designed to ensure that patients receive community based care to provide appropriate pain and symptom management to patients, and to avoid unnecessary hospital emergency department visits and admissions whenever possible.

In 2014 we also launched a joint initiative to provide clinical pharmacist review for our home health patients to identify and address potential duplicative therapies and drug interactions that can result in potential falls and other adverse outcomes for many of our high-risk patients receiving home health services. Additionally, we have our home health nurses performing medication reconciliation in the home, regardless of payer.

Finally, Atrius Health is able to provide part-time management services and oversight to VNA Care Network Foundation which has allowed them to streamline staff. We are exploring additional opportunities to share information technology.

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 provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1				
	Q2				
	Q3				
	Q4				
CY2015	Q1				
	Q2				

We do not track consumer inquiries with the level of detail required to complete the chart above. We can provide the following summary information: in CY2014 we received approximately 500 requests for detailed pricing information. For the period January 1-June 30, 2015, we received approximately 300 requests. Most patients are looking for information on the maximum costs of routine services that we are able to provide immediately using a simple lookup tool described below. These most frequent requests are for the costs of laboratory tests, radiology/advanced imaging services, colonoscopies, and initial visits.

On January 1, 2014, Atrius Health implemented 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. This information is provided to patients in writing.

Atrius Health has also 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.

2. Please submit a summary table showing for each year 2011 to 2014 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. 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.

   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.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of 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; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

   (a) We believe that the best and safest care is coordinated and integrated care. Furthermore, many tests and procedures are less expensive when done at a physician's 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 access a single electronic medical record to coordinate and avoid duplication of care. Patients may also self-refer within Atrius Health. When we need to refer to outside specialists, we look first to those providers who are affiliated with the local hospital to which the Atrius Health practice refers and/or has a clinical affiliation agreement with, again for reasons of coordinating care.
   (b) Our electronic medical record system includes a referral module which allows us to list our preferred specialists in order of preference to facilitate making and tracking referrals.

(c) **Attachment 1** 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 provide general education about the cost of the tests and procedures being ordered. This effort is ongoing and we are currently studying the impact of this type of information on services ordered or provided, which we hope will be available later this year. As part of the study, price information for certain outpatient tests and procedures is available in the electronic medical record. Participating 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).

Quality information is reviewed 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 care that will be provided as a result of their referral.

(d) Atrius Health employs Referral Coordinators who typically obtain information about a patient's insurance at the time a referral to an outside provider is made. If the provider being referred to is not contracted with the payer, the patient is advised that the care needs to be redirected to another provider within the payer's network if the patient does not want to pay out-of-pocket. If there is no specialist in the payer's network who provides that service, then a letter of medical necessity is completed by the clinician and submitted to the payer in support of a benefit exception which would allow the patient to see, and authorize coverage for, the non-participating specialist.

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

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 RMG risk contracts (consistent with 2013). Includes RMG Atrius risk contracts with BCBS FI & SI and HPHC SI.

Atrius Health

Attachment # 1 – 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 # 1 – 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
Cardiac Procedures		
Carotid Ultrasound		
Echocardiogram		
Exercise Stress Test		
Myocardial Perfusion		
Stress Echocardiogram		
Scope Procedures		
Colonoscopy		
Endoscopy (Nasal)		
Knee Arthroscopy		
Nasal Endoscopy		
Flex Sigmoidoscopy		
Imaging Procedures		
Abdominal CT		
Abdominal US/Complete		
Abdominal US/Limited		
Bone Density Study		
Brain MRI		
Breast MRI		
Cervical Spine MRI		
Chest CT		
Chest CTA		
Chest X-Ray PA & Lateral		
Head CT		
Head MRA (Angio)		
KUB X-Ray		
Lower Extremity MRI		
Lumbar Spine MRI		
Pelvic US Non-OB		
Thoracic Spine MRI		
Upper Extremity MRI		
Other Specialty Procedures		
Cataract Surgery		
Dialysis Treatment		
Orthopedic Injections (small, intermediate, major)		
Cardiac Catheterization (not part of hospitalization)		
Pulmonary Function Tests		
Electromyography (EMG)		
Sleep Study		

Epic Name	Internal Median	External Median
Lab Tests		
Basic Metabolic Panel (BMP)		
B-type Natriuretic Peptide (BNP)		
C Reactive Protein (CRP)		
CA 125		
Helico Pylori Ab		
Hemogram w Auto Diff RFLX		
Hemogram (CBC)		
HIV Ab		
HSV (All)		
Lipid Panel		
Lyme Ab		
Lyme Western Blot		
Pap Test/ Thin Prep		
Prostate Specific Antigen (PSA)		
Syphilis Test (RPR)		
Sedimentation Rate (ESR)		
Thyroid 4 T4, Free		
Thyroid Stimulating Hormone (TSH)		
Urinalysis (U/A)		
Vitamin D 25, Hydroxy (Total)		
Emergency Department Visits		
Ambulatory-Sensitive*		
*Sore Throat		
*Dermatitis		
*Hypertension		
*Otitis Media		
*Pneumonia		
*Upper Respiratory Infection		
*Gastroenteritis		
Asthma (Adult and Pedi)		
Bronchitis		
Chest Pain		
Admissions (All Payer Median)		
Asthma (Pedi)		
Cellulitis		
Chronic Obstructive Pulmonary Disease (COPD)		
Congestive Heart Failure (CHF)		
Pneumonia		
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.**