Atrius Health

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August 26, 2016

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 July 19, 2016, 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

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Cost Growth.

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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

- **Drug costs (including specialty drugs, biologics as well as generic drugs) are increasing on average by 10-12% per patient; this continues to be a concern and affects overall health care spending in the Commonwealth.**
- **Hospital charges per admission seem to be increasing at a much faster rate than we had anticipated.**
- **Demographic changes in the state's population, including an increase in the number of seniors in the state and patients with chronic medical and behavioral health conditions such as diabetes and substance abuse disorders have major impact on ability to meet the growth benchmark. In addition, the rising number of people working past age 65 and maintaining commercial coverage seems to be driving up commercial costs.**

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

- **Implementing site-neutral payments - The state should consider implementing site-neutral payments that would considerably reduce the overall cost of care for patients, as Medicare has done.**
- **Lifting the moratorium on Ambulatory Surgery Centers - The current Department of Public Health (DPH) moratorium on issuing Determinations of Need (DONs) for Ambulatory Surgery Centers (ASCs) restricts the ability of organizations such as Atrius Health to construct their own ASC to care for patients in a much less expensive, yet high quality setting, and contributes unnecessarily to increased health care costs.**
- **Revising outdated regulations – There is considerable need to bring existing state regulations up to date to allow providers to adopt innovative approaches to the delivery of health care and control health care costs. Examples of regulations that require updating include DPH regulations related to Determination of Need (105 CMR 100.000), clinic licensure (105 CMR 140.000) and dispensing procedures for clinic and hospital pharmacies (105 CMR 722.000).**

2. **Strategies to Address Pharmaceutical Spending.**

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Plans to Implement in the Next 12 Months

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: **Note: In response to question (vi) above: This applies only to commercial and Medicaid risk contracts**.

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. **Strategies to Integrate Behavioral Health Care.**

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

- **Unlike many other ambulatory care practices in the state, Atrius Health has robust outpatient behavioral health services available at most of our practices. Each department consists of between 5 and 15 clinicians, including MDs, NPs, LICSWs and PhDs. We accept referrals from both pediatrics and internal and for both therapy and psychopharmacological management. The use of an integrated electronic medical record (Epic) allows us to co-manage patients**
- **Atrius Health offers a large range of behavioral health treatments for our patients and we are in the midst of developing sub-specialty lines, including Trauma, Personality Disorder, Addiction and Eating Disorder.**
- **We are currently developing a seamless network of both inpatient and partial program affiliates that will improve both quality and patient experience.**

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

- **Despite a large department (140+ clinicians) we still do not have the capacity to provide rapid access for all referrals. We have addressed therapy referrals by building a psychotherapy affiliate network to which we refer our less complex patients; this has improved our access to appointments from 3-4 months to 2-3 weeks. However, we continue to struggle with waits of 2-3 months for psycho-pharmacology referrals. We do provide same day urgent care access to behavioral health clinicians and have protocols to assist and manage patients in crisis to avoid unnecessary utilization of emergency room departments and inpatient care whenever possible.**
- **Current state law limits the ability of behavioral health clinicians to share information which poses a significant barrier to the provision of coordinated and cost-effective care. Similarly, the mandate of open access to behavioral health providers, regardless of insurance product type limits our ability to integrate care when our patients go outside of our practice for care.**
- **Low reimbursement rates by the payers, particularly from behavioral health "carve outs," limit our ability to expand behavioral health services within our practice.**

4. **Strategies to Recognize and Address Social Determinants of Health.**

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

- **Atrius Health is taking a population health approach to patient needs by developing registries of patients that have been identified as being at high risk for having SDH issues (e.g., patients on MassHealth or patients who are high utilizers of health resources). For our pediatric patients, we have deployed new staff whose role is to identify patients at risk and who are responsible for proactively managing the care of these patients and work with the entire family in providing supportive services. A multi-disciplinary team (including a care facilitator, nurse case manager, site-based social worker and primary care provider) meets regularly to focus on patients who are medically complex and have intense social needs. The goal of this meeting is to identify action steps that ensure the whole family is supported. Two-thirds of our pediatric practices will have this care model by the end of 2016; all will have it by the end of 2017. For our adult patients, we also identify patients who are high utilizers of health care, and use a proactive approach to connect these patients with support services. We have started to employ community health workers to assist in active outreach to patients to ask them about a variety of issues such as safety and food and help identify barriers to improved health. Anecdotally, this effort has been well received and we are currently measuring the impact. We are also exploring both tele-medicine and a mobile integrated healthcare pilot utilizing nurse practitioners and VNA nurses who visit patients at home since we have found that many of these high-risk patients have transportation issues. Additionally, we work with our clinical pharmacy team to identify causes of medication non-compliance and often find that patients are non-compliant solely because of their inability to afford medications. In such cases we assist our patients in applying for medication assistance programs offered by pharmaceutical manufacturers. Finally, our home care and hospice agency, VNA Care, has a behavioral health program to provide home-based treatment for such issues as depression for patients in the home.**

- **We have developed a comprehensive database of community based resources addressing issues such as homelessness and domestic violence (searchable by geography) that is available to all practices/clinicians when providing care. Plans are currently underway to enhance this database to allow clinicians and others on the care team to rate various community services (similar to Yelp) to provide other clinicians insight on their personal experiences in dealing with outside agencies.**
- **We have developed practice-wide family councils to seek input on our pediatric care model and utilize information gathered from patient experience and satisfaction surveys, specifically focusing on questions related to coordination of care.**

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

Barriers to understanding and/or addressing the social determinants of health for our patients vary from site to site; however, there are several that are common:

- **Overcoming cultural differences to develop a level of trust between members of the care team and a patient or a family. We find that patients are often reluctant to disclose personal information that they may consider embarrassing. These include but are not limited to acknowledging safety concerns or their inability to afford medications, rent or food. Although we may be able to connect patients with community-based resources, developing the level of trust so that a patient or family is willing to disclose this critical information is often difficult because of cultural barriers.**
- **Lack of good screening tools for SDH. Although Atrius Health uses screening tools for both behavioral health and developmental concerns, some patients find the existing tools for SDH highly intrusive in terms of the nature and level of detail of the questions. In addition, patients can be reluctant to complete these types of screening tools (the results of which are recorded in the electronic health record) because of concerns that the information might somehow be used against them.**
- **Inadequate community resources to address social determinants of health, including lack of low-cost housing, insufficient food programs, and insufficient inpatient BH programs.**

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

While we believe specialty and ancillary care delivered by Atrius Health provides the highest value for our patients, we will always need to partner with high value community providers to augment our internal capacity. Atrius Health is committed to referring patients to high value specialty care, ancillary care, and community providers across system affiliations. At each of our community based practices, our primary care and specialty care physicians develop and use a specialty preferred provider list that is integrated into our electronic medical record. Our expectations for high value care include high quality and appropriateness of clinical care (minimal misuse, overuse, and under-use), the quality and timeliness of communications back with our practices, the service experience of our patients with those

specialty providers, and the appropriate stewardship of Atrius Health resources when caring for our primary care patients.

We have built and continue to expand high value specialty care within Atrius Health and work to build personal relationships among primary care providers and specialists. This year we have introduced e-consults for 5 specialties to support primary care providers in avoiding unnecessary specialty visits while ensuring the patient gets the care needed in a timely way. We will be expanding this to other specialties in the coming year. Our electronic medical record (Epic) allows clinicians making referrals to select locations and/or preferred providers within our network based on geography as well as by preferred providers.

In addition, we have made significant efforts to identify and establish relationships with high quality, lower cost hospitals and post-acute providers, about which we then educate our providers and encourage them to use as clinically appropriate.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
Not Applicable

ii. If no, why not?

Two reasons – one is operational and the other is philosophical.

First, the costs of outside specialty services are highly variable with each specific referral and include variability based on a patient's selection of health plan options. The ability to calculate and provide accurate information at the point of care/referral is limited. Our experience developing systems for our internal patient navigator center has underscored the dynamic variability that can lead to unintentional misinformation presented to both the provider and the patient at the point of care.

Second, focused value measured at the specialty consult level is different at a system level and not just defined by cost or quality. The best example is the expansion of value measurement of inpatient care services into bundled measurement that include both the quality and value of the index hospitalization, but also the post-discharge care and services. Specialty consult value is inclusive of cost, quality, patient experience of the index consult, but also extends to what happens beyond the consult. The follow up, the integration and coordination of care for the patient, the commitment to ensure informational continuity for everyone on the expanded clinical care team. The specialist who mails a paper copy of the consult note is less efficient than the specialist who provides electronic access. The specialist who uses clinically appropriate judicious follow up to assess a patient may be more effective and efficient that one that orders dozens of tests automatically on every initial consult. In either example, the measurement of specialty value is captured much more broadly. As we discussed 2-3 years ago in the HPC Technical Advisory Workgroup on the topic of episode groupers, the precision of the attribution of claims to the episode and the precision of attribution of claims to a specific specialist severely limit the discriminatory ability of these episodes to differentiate whether one specialty is "different" from the other. Only gross outliers can be appropriately differentiated on either end (highest and lowest performers).

Without accurate data, the provision of partial information (e.g. showing just high level cost or just summary quality information at the point of care) can misrepresent reality and force inappropriate shared decision making between the provider and the patient. Atrius Health believes this assessment of value should be done at the specialty line management level using a broader perspective and with deep understanding about the strengths and weaknesses of the data. Frontline providers are shown the end assessment of such analyses as preferred providers are highlighted in the electronic medical record at the point of care/referral.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
40T

ii. If no, why not?
Information such as specific fee schedules, the types and costs of tests or procedures that will be performed is not available. (See above).

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
Atrius Health utilizes "Care Everywhere," an Epic product that allows secure sharing of medical record information with other providers that also use Epic and this product. We also have web portals which allow us to view information at approximately 13 other health care organizations, some of which also have "reverse web portals" which permit them to review information in our medical record. We also provide view-only access to certain specialty providers who meet certain criteria. We believe these interfaces and other connections are critical for patient safety, continuity of care and to help avoid duplicate testing. We require written agreements with entities to which we provide access; these agreements include commitments to protecting patient privacy and information security, as well as limits on who can use the interface and for what purposes.

ii. If no, why not?
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6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Atrius Health continues to be a leader in the Massachusetts marketplace in the adoption of APMs, with approximately 80% of our revenue associated with risk-based contracts. We currently have risk-based contracts for commercial HMO (both fully and self-insured) as well as Medicare Advantage and Medicaid Managed Care business. Atrius Health has been a Pioneer ACO since 2012 and has applied for NextGen for 2017. In addition, we are piloting APM's with some of our hospital partners; we have two APMs in place currently and will likely implement a third by the end of the year. Finally, we are evaluating expanding our alternative payment arrangements to include behavioral health as well as commercial PPO products.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

- **The single largest barrier to our ability to increase the adoption of risk-based contracts is the unwillingness of some health plans to fund the infrastructure necessary to support the expansion of care coordination and management for both PPO and behavioral health patients. This infrastructure includes but is not limited to care managers, clinical pharmacists, integrated behavioral health, sophisticated data analytics and multi-disciplinary roster review.**
- **Another barrier is slow adoption of the PPO patient attribution model developed and agreed upon in 2015 by providers and health plans in Massachusetts. While we are prepared to implement this model, we do not have many willing payer partners.**

c. Are behavioral health services included in your APM contracts with payers?
Yes **In some, but not all contracts. Many health plans continue to carve out behavioral health coverage to other third party payers with traditional FFS payment models.**

i. If no, why not?

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

The sheer number and variation among quality measures and reporting requirements requires us to devote significant resources to developing the administrative infrastructure necessary to establish multiple tracking mechanisms, educate clinicians and monitor and report results. The lack of alignment means that administrative, analytic and other staff, including clinicians, must further divide their attention and focus and attempt to identify which measures and activities should be priorities since it may be difficult or impossible to achieve all goals. This is particularly stressful for clinicians, contributing to physician burnout and the potential for a paradoxical result of a decline in the overall quality of care and time spent with patients.

We have worked collaboratively with our health plan partners to create a quality program built around our community of patients and providers – not each health plan – with a focus on measures that reflect the health of the community. While we have not been able to achieve a unified quality program with all of the health plans, we have identified a small common set of measures for a number of our APM contracts that will thus apply to a larger portion of our patients.

It is crucial that any statewide alignment efforts do not inadvertently create additional administrative burdens by conflicting with or adding to ongoing national quality efforts as well.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

There are a number of strategies that would be useful in reducing the burden of quality reporting. The attached opinion piece by Meyer et al in the British Medical Journal for Quality and Safety. (BMJ Qual Saf 2012;21:964–968) provides a nice overview of several of these (in particular, see the final section "*How We Can Achieve Balance and Parsimony*" for an excellent set of strategies). We think it is critical to reduce the number of required measures. As the article describes, building a parsimonious and balanced set of measures that reflects the needs of the particular patient population is fundamental. A reduction in the number of reportable measures should result in organizations being able to shift their measurement/improvement resources to those areas that need urgent attention.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
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Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 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.

   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 available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

      Atrius Health has a dedicated phone line for patients to call for formal pricing estimates. We are using a third party patient pricing tool to 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 allows us to determine applicable deductibles, co-insurance and other patient responsibilities. Atrius Health also continues to provide real time estimates for informal patient inquiries at our practices using 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 identify the cost of the procedure. The overall process has not changed since Chapter 224 but Atrius Health does routinely update the pricing tool so that the most up to date payer fee schedules are available to ensure accurate estimates. As of June 2016, Atrius Health has provided 567 formal pricing estimates for patients plus many more informal estimates using the Excel pricing tool for the most commonly requested procedures.

   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 analyses.

      We are able to monitor the number of formal pricing requests responded to each month using the pricing tool and a copy of the pricing response is stored for a minimum of 6

months. All pricing requests are handled in real time when the patient calls into the dedicated phone line unless we have to contact the payer or provider for additional information about the services to be rendered. All responses are made within two business days. We do not have a formal process to review accuracy, but on those limited occasions when we've had to review the estimate compared to what was assessed as the patient's responsibility, the estimates have been accurate.

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?

It is not possible to publish a "price list" (which would be the best approach to transparency) because there are so many different health plan products, including ones for individual employers, such that price must be checked on a patient by patient basis. Furthermore, we cannot have a self-pay price list that can be used when the patient is paying against their deductible because the patient's pricing must be the same as what was negotiated by the health plan.

The only issue that has arisen periodically as we look up individual pricing is that sometimes the procedure for which the estimate was requested was modified and/or changed by the servicing provider when services were rendered (based on clinical needs). While we always advise patients that this is a possibility and there is a disclaimer on the printed estimate, patients are sometimes surprised.

Finally, price transparency has been difficult for both 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.

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

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

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

(3) Includes HVMA, DMA, GMG, SSMC, SMG and RMG.

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) Atrius Health, Inc. now includes HVMA, DMA and GMG, only.