Atrius HEALTH, INC.
DETERMINATION OF NEED APPLICATION 24061110-AS

Don Questions For The Applicant Due to the Program by

Responses should be sent to DoN staff at DPH.DON@State.MA.US

While you may submit each answer as available, please

- List question number and question for each answer you provide;
- Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer;
- When providing the answer to the final question, submit all questions and answers in one final document;
- Submit responses in WORD or EXCEL; include a table in data format (NOT pdf or picture) with the response.
- When providing a table of data, provide a narrative explaining the trends or significance of that information (such as what reason for the year over year changes are attributed to and how it relates to information already provided.)

In order for us to keep on track and review this project in a timely manner, **please return by September 5th.** You may respond on a rolling basis with all of the responses amalgamated in order into one final document.

1. You note that after the COVID pandemic the patient panel grew due to hiring physicians and assuming patients from the closure of Compass Medical. Please provide more information on the scope of these occurrences.
   From 2021 to 2023, the Applicants' primary care provider FTEs grew by 22.27 FTEs, this includes the primary care providers that previously worked at Compass Medical. The addition of these FTEs resulted in the Applicant's patient panel growing during this period by 17,894 new unique patients from Compass Medical.

2. Please provide the gender for the patient panel and for the Surgical cases.

Table 1. Patient Panel

	CY2020		CY2021		CY2022		CY2023	
	Total	% of Total	Total	% of Total	Total	% of Total	Total	% of Total
PATIENTS	**560,698**	**100%**	**554,154**	**100%**	**550,915**	**100%**	**573,888**	**100%**
Age								
Children (0-18)	116,534	20.78%	114,212	20.61%	113,675	20.63%	112,833	19.66%
19 - 64	192,397	34.31%	187,364	33.81%	187,779	34.08%	195,418	34.05%
65 and Over	251,767	44.90%	252,578	45.58%	249,461	45.28%	265,637	46.29%
Gender								
Female	318,447	56.79%	313,867	56.64%	311,130	56.48%	323,939	56.45%
Male	242,234	43.20%	240,271	43.36%	239,758	43.52%	249,878	43.54%
Other	17	0.00%	16	0.00%	27	0.00%	71	0.01%
Race								
Asian	47,950	8.55%	48,140	8.69%	49,692	9.02%	52,511	9.15%
Black	42,127	7.51%	42,264	7.63%	43,455	7.89%	43,415	7.57%
Caucasian	371,283	66.22%	360,858	65.12%	359,179	65.20%	371,406	64.72%
Hispanic	28,510	5.08%	29,109	5.25%	31,264	5.67%	33,688	5.87%
Native American	1,110	0.20%	1,101	0.20%	1,151	0.21%	1,151	0.20%
Other	22,286	3.97%	29,291	5.29%	23,374	4.24%	26,866	4.68%
Declined	47,432	8.46%	43,391	7.83%	42,800	7.77%	44,851	7.82%
Payer Type								
Medicare Risk	60,199	10.74%	52,675	9.51%	57,720	10.48%	58,850	10.25%
Medicare FFS	27,911	4.98%	35,574	6.42%	31,596	5.74%	37,750	6.58%
Medicaid Risk	39,992	7.13%	43,110	7.78%	46,233	8.39%	45,036	7.85%
Medicaid FFS	3,007	0.54%	2,861	0.52%	2,592	0.47%	2,196	0.38%
Commercial Risk	278,573	49.68%	266,043	48.01%	265,068	48.11%	274,371	47.81%
Commercial FFS	151,016	26.93%	153,891	27.77%	147,706	26.81%	155,685	27.13%

Table 4. Surgical Patients

	CY2020		CY2021		CY2022		CY2023	
	Total	% of Total	Total	% of Total	Total	% of Total	Total	% of Total
PATIENTS	**12,573**	**100%**	**13,162**	**100%**	**14,288**	**100%**	**15,396**	**100%**
Age Group								
0 - 18	955	7.60%	839	6.37%	1,201	8.41%	1,517	9.85%
19 - 64	3,219	25.60%	3,483	26.46%	3,692	25.84%	3,701	24.04%
65 and Over	8,399	66.80%	8,840	67.16%	9,395	65.75%	10,178	66.11%
Gender								
Female	7,602	60.46%	8,023	60.96%	8,506	59.53%	9,200	59.76%
Male	4,971	39.54%	5,139	39.04%	5,782	40.47%	6,196	40.24%
Payer Type								
Commercial	7,297	58.04%	7,708	58.56%	8,013	56.08%	8,833	57.37%
Medicare	4,266	33.93%	4,201	31.92%	4,800	33.59%	5,100	33.13%
Medicaid	1,010	8.03%	1,253	9.52%	1,475	10.32%	1,463	9.50%
Race / Ethnicity								
Asian	420	3.34%	478	3.63%	629	4.40%	630	4.09%
Black	869	6.91%	1,046	7.95%	1,049	7.34%	1,101	7.15%
Caucasian	9,933	79.00%	10,244	77.83%	11,037	77.25%	11,974	77.77%
Hispanic	427	3.40%	550	4.18%	636	4.45%	699	4.54%
Native American	31	0.25%	36	0.27%	41	0.29%	41	0.27%
Other	175	1.39%	197	1.50%	180	1.26%	197	1.28%
Declined	718	5.71%	611	4.64%	716	5.01%	754	4.90%

3. Table 8 please explain what is included in “Other” Surgical category
   “Other” in Table 8 represents surgical procedures that did not have a facility claim associated with them.

4. For the Surgical Patient Panel Payer Mix, please explain further why there is no tracking of the Non APM patients. What percentage of the patients does this comprise.
   To provide the patient data in the Application on the Surgical Patient, including the payer mix, the Applicant used the claims data that it receives from payers for APM patients, which provide information related to the Surgical Services for Applicant’s patients that receive Surgical Services from Applicant’s physicians and from non-Applicant physicians. The Applicant does not receive claims data for non-APM patients, and is therefore not able to report on this information.

5. Please explain your methodology for projecting that 6 operating rooms is the correct number to meet the patient panel need for this site.
When evaluating how many operating rooms would be need for the Proposed Project, the Applicant estimated the number of cases that would be expected to migrate from their current setting of care (either a Hospital Outpatient Department (HOPD), an unaffiliated Ambulatory Surgery Center (ASC), or a Hospital Inpatient Department (HIPD)) to the Proposed Project. To do this, the Applicant reviewed the current mix of Surgical Services received by Applicant's Surgical Patients and made assumptions on expected case migration based on eligibility criteria, such as clinical appropriateness and comorbidities. Based upon this evaluation, the Applicant estimates that 1,264 cases would shift from an ASC, 4,242 from HOPD, and 727 from HIPD to the Proposed Project.

Once the estimated case volume was established, the Applicant calculated how many operating rooms were needed for the Patient Panel based upon the mix of Surgical Services. This was based on the total operating room hours needed to perform the estimated annual cases, which were calculated based on the average time it takes to perform a specific type of procedure in an operating room. Please see table below.

OR / PR Capacity in Year 2					
OR Utilization	**Volume**	**%**	**Scheduled Hours**	**Projected OR Utilization**	
Operating Room	6,233	100%	9,984	83%	
Total	**6,233**	**100%**	**9,984**	**83%**	
OR Capacity	**Rooms**	**Hours / Day**	**Capacity / Day**	**Work Days / Year**	**Annual Capacity**
Operating Room	6	8	48	251	12,067
Total					**12,067**

6. Relative to Factor 1(e), competition, please provide anticipated cost savings relative to the sites where patients are currently going at other ASCs in MA or hospital sites.
The Applicant estimated cost savings based upon the difference in the cost to payers of procedures that are performed in an ASC compared to the cost of providing the same procedures in a HOPD or an HIPD. The Applicant estimated that the cost savings for shifting cases from a HOPD and HIPD would be approximately $2,550 per case, totaling an estimated savings per year of approximately $16 million. The Applicant did not assume that there will be cost savings for cases shifting from other ASCs to the Proposed Project.

7. Questions regarding the CPA report:

- Documentation reviewed by the CPA includes historical audited Atrius financial statements. Please provide the specific years of those audited reports.
  Veralon reviewed historical financial statements, which included the consolidated financial performance of all of United Health Group's subsidiaries, including Atrius Health, Inc., for years ending 2021, 2022, and 2023.

- There is a mention of Key Metrics without any reference to what they are for the proposed project and whether they are reasonable and within industry standards.
  "The Key Metrics used in this report fall into three categories: liquidity, profitability, and solvency metrics. Liquidity ratios measure the quality and adequacy of assets to meet current obligations as they come due. Profitability ratios are used to assist in the evaluation of management performance. Solvency ratios are used to evaluate a company's ability to meet its liabilities. "
  The following was provided by Veralon:

  Table 1 presents the key metrics (the "Key Metrics") reviewed in our analysis along with definitions.

Table 1

Summary of Key Metric Calculation Definitions	
Key Metric	**Calculation**
Liquidity	
Days Cash on Hand	Cash/ ((Operating Expense-Depreciation Expense)/365)
Profitability	
Operating Margin	Operating Income/Net Revenue
EBIDA Margin	EBIDA/Net Revenue
Solvency	
Current Ratio	Current Assets/Current Liabilities
Total Net Assets	Total Assets-Total Liabilities

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company's ability to meet its liabilities. Table 2 shows the results of the Key Metric calculations based on Atrius Waltham Prospective Financial Schedules.

Table 2

Atrius Waltham Summary of Key Metrics	2026	2027	2028	2029	2030
Liquidity Ratios					
Days Cash on Hand	109	155	248	337	423
Profitability					
Operating Margin	-4.7%	11.0%	11.3%	11.6%	12.0%
EBIDA Margin	15.1%	21.6%	21.6%	21.6%	21.6%
Solvency					
Current Ratio	1.56	2.27	3.11	3.93	4.71
Total Net Assets	$16,686,129	$19,735,405	$22,997,202	$26,497,097	$30,244,442

Based on the Atrius Waltham Prospective Financial Schedules, 2026-2030.

- *"In forecasting prospective revenues, Atrius Management has taken into consideration case type when developing volume and revenue per case estimates."* Provide the payer-mix that was used throughout the projected timeframe.

Payer	% Total
Commercial	66%
Medicare	14%
Managed Medicare	11%
Medicaid	9%
Workers Comp	1%
Total	**100%**

- Is the "utilization rate" the same as capacity? How is 100% utilization calculated? "Year one case volume is estimated to be 55 percent of stabilized year two case volume. Year two volumes assume an 83 percent utilization rate of six operating rooms." Please explain further.

As used by the Applicant, the utilization rate means the percent of total operating room capacity utilized for the Surgical Services. For example, a 100% utilization rate would mean that each operating room would have cases being performed every hour that the Proposed Project is open, which does not account for downtime between surgeries and surgeon availability. An 83% utilization rate means that cases being performed would account for 83% of the available operating room hours at the Proposed Project. [1,2].

- Explain why physician expenses are not included in the Atrius Waltham ASC Prospective Financial Schedules since they are an expense related to the Proposed Project and why these salaries will be paid by Atrius, and not the ASC.
  The physician expenses are not included in the Atrius Waltham ASC Prospective Financial Schedules because ambulatory surgery centers ("ASCs") operate under a specific billing methodology where the facility charges are billed separate from surgeon's professional fees[3]. The ASC bills the third-party payors for facility services, which includes costs associated with the operations of the ASC including, but not limited to, nursing, recovery care, drugs, staffing, equipment, and overhead. Surgeons and anesthesiologists, who perform procedures at the ASC, bill separately for their professional services under the physician fee schedule.

  The Proposed Project is a free-standing ASC that will not employ the surgeons. The surgeons are employed by the Applicant, Atrius Health, Inc. who is responsible for the physician expenses.

- Explain what the impact of including Surgeon expenses in the ASC expenses would be. What percentage of expenses do they account for, and what percentage of NPSR is that? How would including those expenses impact your margins and days cash on hand?
  As noted above, surgeon expenses are not included in ASC expenses.

[1] See Becker's ASC Review "How Ensure Maximum Operating Room Utilization in a Surgery Center: Q&A With Dawn Q. McLane of Health Inventures" (February 2011).
[2] See Becker's ASC Review "Defining 'Full Utilization' of an Ambulatory Surgery Center: Q&A With Jim Scarsellla of Anesthesia Staffing Consultants" (February 2011).
[3] See, MedPac "Ambulatory Surgical Center Services Payment System" (November 2021).

- Explain what the management fee includes since the fees listed below appear to be separate.
  a) Management fees assumed to be approximately 1.2 to 1.3 percent of net patient service revenue;
  The management fees include traditional management services such as accounting, day-to-day operations, human resources, regulatory compliance, and supply management.

  b) Annual OM fees (back-office systems and processes, including: patient accounting system cost, clinical reporting, risk management/insurance, information technology, and related functions) assumed to increase 3 percent annually;
  These fees are for back-office systems and third-party vendors that help support the day-to-day operations of the Proposed Project. This expense covers items that are obtained from third parties.

  c) RBO fee (revenue cycle, billing, collections and coding) expense assumed to be approximately 1.3 percent of net patient service revenue;
  The RBO fee represents the fee for the Proposed Project's billing and collection services, including the costs of third-party vendors.

- Explain the impact on EBITDA of not including the surgeon expenses or the capital expenditures in the prospective financial statements.
  As noted above, the surgeon expenses are separate from the ASC expenses and will not impact the Proposed Project's EBITDA or the capital expenditures.

8. You state "The Applicant has been a market leader in the Commonwealth in leveraging APMs to deliver efficiencies that result in overall costs savings while maintaining a high quality of care. Under most of these arrangements, the Applicant is fully accountable for all care and treatment rendered to its patients." Please explain further:
   a. Specific efficiencies
   APMs encourage provider organizations to redirect patients from high-cost low value care to low-cost high value care. Through the APM arrangements, the Applicant is able to provide high quality care at the right time and in the right setting. Specific examples of these efficiencies include, but are not limited to, the Applicant[4]:
   - Prioritizing access to outpatient primary care and specialty care to prevent avoidable admissions and readmissions for its Patient Panel;
   - Establishing a Mobile Integrated Health program known as "ED at Home";
   - Implementing care coordination activities;

[4] See Massachusetts Health Policy Commission "2023 Pre-Filed Testimony PROVIDERS" (October 2023) 2023-cth_pft-provider_atrius.pdf (masshpc.gov)

- Reduced pharmacy spending through the use of the electronic medical record point-of-prescribing notifications; and
- Updating and improving patient reported race, ethnicity, language, sexual orientation, and gender identity data capture, which supports stratifying quality metric performance reports to identify opportunities to improve disparities.

b. What is meant by “fully accountable”.

Under the APM arrangements, the Applicant takes financial risk and is financially responsible for care delivered across the care continuum, meaning that the Applicant is responsible for the cost of covered services delivered by the Applicant and also for expenses incurred for covered services not provided by the Applicant.