Neighborhood Health Plan™

September 8, 2014

David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Executive Director Seltz:

On behalf of Neighborhood Health Plan (NHP), thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's request dated August 1, 2014, under Exhibits B and C as provided for in Massachusetts General Law, chapter 6D §8.

NHP currently serves approximately 3.8 percent of the fully-insured commercial market in the Commonwealth. In addition, commercial represents approximately 26 percent of our total book of business with the remainder being government sponsored and funded.

NHP is a Massachusetts-based not-for-profit corporation with operational headquarters located at 253 Summer Street in Boston. NHP is fully licensed as a health maintenance organization by the Massachusetts Division of Insurance. Our mission is to promote the health and wellness of our members and to help ensure equitable, affordable, health care for the diverse communities we serve.

Our testimony is provided in the attached submission templates. I, as a legally authorized and empowered representative of Neighborhood Health Plan, Inc., sign under the pains and penalties of perjury, that the testimony located at Exhibit B and C to the best of my knowledge is complete and accurate.

Sincerely,

David Segal
Chief Operating Officer

253 Summer Street, Boston, MA 02210 | 800-433-5556 | fax 617-772-5513 | www.nhp.org

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

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

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: NHP has a focused plan to engage in alternative payment methodologies, continuing focus on care and utilization management activities that promote both quality and lower costs, and overall collaboration with our provider community to ensure as much alignment as possible.
   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      NHP has built on existing global payment arrangements with a large multi-speciality group practice, and we have contracted with a large integrated delivery system (IDS) for a new alternative payment arrangement. Furthermore, NHP continues to work with its community health centers to evolve our shared savings program. In every case, our goal is to actively engage with our provider community and to leverage near real-time actionable data to help drive success. NHP continues its focus on care and utilization management activities, carefully balancing the need to reduce costs with ensuring members receive necessary, high-quality care.
   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?
      We will continue upon our current path and learn from both our successes and challenges.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high quality, efficient care delivery.
   SUMMARY: NHP, working in partnership with its providers, continues to make progress in securing alternative to fee-for service contracts. NHP has global payment arrangements with two large provider organizations. In these two cases, the provider is taking both upside and downside risks. NHP is in the process of negotiating other arrangements like this. At the same time, NHP recognizes that not every provider is prepared for downside risk-taking. Therefore, we are working with providers, especially community health centers, in this situation to create alternatives to fee-for-service payment methods while not subjecting them to downside risk-taking until they have the infrastructure to do so.
   a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models,

but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.
As of August 1, 2014, approximately 44% of NHP's total membership have selected primary care providers (PCPs) who participate in an alternative to fee-for-services payment methodology (APM).Twenty-one percent (21%) of these members have selected PCPs who participate in NHP's shared savings program. Approximately 23% have selected PCPs who participate in global payment arrangements with NHP. Both the shared savings program and global payment arrangements include pay-for-performance quality measures.

APMs help drive down utilization. For example, in its global payment arrangement with a large multi-specialty group practice, NHP has seen a 15.8% reduction in inpatient utilization for the time period 2010 -2013.

Irrespective of payment method, NHP continues to focus on quality. NHP's network-wide 2014 HEDIS results show that fourteen Medicaid measures and seven commercial measures are at the national top ten percentile. These measures include children and adolescent well visits, breast cancer and cervical cancer screening, chlamydia screening, lead screening in children, follow-up after hospitalization for mental health, avoidance of antibiotic treatment for adults with acute bronchitis, appropriate testing for children with pharyngitis, and appropriate treatment for children with upper respiratory infections.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?
NHP will continue negotiations with additional providers for APM contracts. We are in discussions with multiple integrated delivery systems that include primary care providers, hospitals, specialists, and ancillary providers for global payment arrangements. Additionally, NHP plans to expand its shared savings program to include additional sites in 2015.We are in conversations with three integrated delivery systems that would add, in total, an additional 5% of NHP’s membership who participate in an APM.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.
   SUMMARY: The table below lists the number and percentage of physicians participating in global risk contracts with NHP.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	2302	11
CY2013	7713	38

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.
   SUMMARY: NHP applies the DxCG Medical Classification System to risk adjust its APM contracts by line of business to more accurately reflect the differences in populations. The risk scores are updated periodically throughout the contract year.
   a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?
      Yes, NHP uses the DxCG Medical Classification System.
   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?
      NHP appreciates efforts to standardize risk measures in risk contracts.We believe this helps create a transparent and even playing field against larger competitors. Our key concerns regarding a statewide standardization of risk adjustment measures are ensuring that the risk adjustment methodology is transparent and that it is an open source or available for purchase, predicts reasonably well, is kept current, and limits score variety due to provider coding patterns.
   c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?
      To date, NHP has not implemented population-based socioeconomic adjustments to risk budgets. We are, however, exploring what other states and managed care organizations (MCOs) located within those states are doing in this area.
   d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of

any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?
Not applicable. NHP uses a single approach to risk adjustment.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.
SUMMARY: NHP uses quality measures that are based on standardized, nationally recognized datasets such as HEDIS.
    a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?
    NHP selects quality measures that are based on standardized, nationally recognized datasets such as HEDIS. In choosing measures, we consider factors such as where we need to improve as a health plan, areas where a particular practice needs to improve, and alignment with other measures required of a specific practice (e.g., Primary Care Payment Reform). Ultimately, the selected measures are the subject of a negotiation between a given practice and NHP.

    b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

    NHP believes all selected quality measures should be drawn from the Massachusetts Standard Quality Measure Set (SQMS) unless a purchaser (e.g., Medicaid, Medicare, GIC) has a requirement not represented in the SQMS. However, the entire suite of SQMS measures should not be required for a given provider. The health plan and provider should be able to select measures from the SQMS for those areas where improvement is needed. The advantage of this approach is that all parties are using common definitions that should simplify improvement activities, data collection, and consolidate areas of focus. NHP does not see a downside to this approach.

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: All NHP HMO members must select a primary care site and PCP at the time of enrollment. If a selection is not made, a PCP is assigned to the member using criteria that includes: geographic distance; consideration of a PCP's gender and specialty needs; and the member's history with a previous site/PCP, when applicable, to ensure continuity of care. Primary care sites are notified daily of enrollment activity specific to their practice through our secure provider portal, NHPNet. This information is provided to

assist sites in their patient outreach efforts. NHP has a PPO product that is sold only alongside the HMO. It is intended to meet the needs of employers who have a limited number of employees using providers that are not part of the NHP network. At this point, close to 100% of NHP's membership is in its HMO product. As a result, we do not have an attribution methodology at this time .

a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
    i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)
    Primary Care Physicians
    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
    N/A
    iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
    N/A
    iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
    N/A
    v. whether patients are attributed retrospectively or prospectively.
    Members are assigned a PCP on a prospective basis. In instances where a qualifying event occurs, PCPs may be assigned retrospectively.
b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?
    As of July 1, 2014, NHP offers a PPO plan that is only sold alongside NHP's HMO and is not sold as a stand-alone product. It is intended to meet the needs of employers who have a limited number of employees who use providers that are not part of the NHP network. This product is sold with stringent eligibility requirements. Because close to 100% of our membership is in our HMO product, NHP has not developed an attribution methodology.
c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?
    Overall, NHP believes that standardization of attribution methodology is a good practice. At the same time, as alternative payment methodologies evolve, room should be left for innovation and experimentation with a goal of standardization over time.
d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
    NHP requires all HMO members to select a primary care provider. NHP PPO membership, because it is an adjunct to our HMO, is very small and is expected to remain small. Therefore, NHP does not employ an attribution methodology for its PPO members.

7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.

SUMMARY: NHP's network, while comprehensive, could be considered limited in size relative to other major insurers in our market. Yet, the quality of NHP's network is high as reflected by HEDIS® 2014 results. It also important to note that NHP has one of the lowest average premiums of any health plan in Massachusetts (Page 11, Annual Report on the Performance of the Massachusetts Health System, CHIA, September 2014). In collaboration with a large employer group, NHP implemented a tiered provider network in 2007. An analysis of the impact of the tiering on utilization patterns, conducted for FY10, 11 and 13 did not yield enough data to draw a conclusion about the effectiveness of the tiering.

ANSWER: While NHP has a comprehensive network , relative to other major insurers in our market, NHP's standard network is smaller and could be considered "limited". Yet NHP's network is high quality as reflected by the HEDIS® 2014 results that show fourteen Medicaid and seven commercial measures are at the national top 10 percentile. Those measures include children and adolescent well visits, breast cancer and cervical cancer screening, chlamydia screening, lead screening in children, follow-up after hospitalization for mental health, avoidance of antibiotic treatment for adults with acute bronchitis, appropriate testing for children with pharyngitis, appropriate treatment for children with upper respiratory infections.

For one large employer group, NHP implemented a tiered provider network to encourage consumers to use high value providers. Other than for this group, NHP does not offer any other tiered products. The membership in this product represents approximately 9.4 percent of our total commercial membership. The design of the program currently focuses on specialty care and does not include hospitals.

Currently, copayments for the product are as follows:

	Tier 1 (Excellent)	Tier 2 (Good)	Tier 3 (Average)
Tiered Specialties	$25	$35	$45

NHP conducted a high-level analysis of member movement among primary care site tiers for Fiscal Years (FY) 2011, 2012, and 2013. NHP was not able to draw firm conclusions about the impact of tiering on behavior based on the results. The analysis is included as Attachment 1 to Question 7 in the Appendix to NHP's written testimony.

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8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that

seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: NHP introduced a two phase approach to provide cost estimate capabilities to our members who have deductible plans. In 2015, NHP will have enough data to track, trend, and plan actions that further support price transparency for our members.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	23	67	2
	Q2	28	99	4
	Q3	1416	36	Real Time
	TOTAL:	1467	202	

** Please indicate the unit of time reported.*

ANSWER:
NOTE: The unit of time is in days.
In Q2, response time increased due to a resource constraint that has been resolved.

NHP introduced a two phase approach to provide cost estimate capabilities to our members who have deductible plans. The first phase, in October 2013, included cost estimates by phone and email through NHP Customer Service. NHP's approach is to make the process simple and easy for our membership. A member may provide information such as the procedure name, provider, and location, and NHP determines an estimate based on the member's benefit plan, cost sharing, and the procedure. The second phase, introduced in July 2014, is a real-time self service capability through NHP's secure member portal. A member may log into their account, search for, select procedures or services, and receive cost estimates real-time. NHP leverages the Castlight Health tool as the infrastructure. Members may still call or email Customer Service as an alternative to the self-service approach. We leverage our member advisory boards to gain feedback and look for ways to further evolve the benefits of these tools and services. Additionally, we use an internal, cross-functional committee to share these results.

In 2015, NHP will have enough data to track, trend, and plan actions that further support price transparency for our members. For example, we will use our member advisory boards for qualitative observations and feedback and will leverage customer service call inquiry and appeals data for trending. NHP assesses the accuracy of cost estimates provided to members regularly. Because these features are in beginning stages, we quality check and conduct testing on the responses we provide to members to ensure accuracy. We intend to have more robust monitoring in place once we have more data and experience.

In 2014, the top ten most frequently requested price inquiries were for the following services:

1. MRI
2. Pregnancy
3. Colonoscopy
4. Physical Therapy
5. Obstetric and Gynecological Care
6. Hysteroscopic Biopsy
7. Nerve Testing
8. Laboratory Testing
9. Gastroenterology
10. Ultrasound

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9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.
   SUMMARY: NHP has provided grant support for community health centers who seek to extend their hours of operation, is contracting with urgent care clinics, has boosted ER copays for commercial members, and has made unnecessary ER use a cornerstone of APM contracts, in an effort to reduce ER use for minor acute illnesses. NHP also promotes the use of lower cost hospitals by providing practices participating in APM the relative cost of certain services at specific facilities.
   ANSWER: NHP believes that a factor contributing to overutilization of the inpatient setting can ultimately be traced to excessive use of the emergency room for minor acute illness. We have sought to address this by providing grant support for the community health centers seeking to extend their hours of operation, contracting with urgent care clinics, boosting emergency room (ER) co-pays for our commercial members, and making reduction of unnecessary ER use a cornerstone of our alternative payment model (APM) contracts. To promote the use of lower cost hospitals, NHP has provided practices participating in APM arrangements the relative cost of services (by service type: Med/Surg/OB) at specific Boston tertiary hospitals and suburban (community) hospitals. We do not yet have any data on the effectiveness of related care redirection activities.

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10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    SUMMARY: As active and collaborative partners, NHP and its behavioral health partner, Beacon Health Strategies ("Beacon") have worked together on the development of a

shared behavioral health clinical strategy. This strategy is founded on the belief that the provision of high quality, cost effective, and efficient behavioral health services requires the proper amount of service and intensity, delivered at the right time, in the right setting, for the right duration. NHP utilizes data and benchmarks to track and ensure efficient and effective use of resources. NHP also seeks input from both consumers and a panel of subject matter experts. These principles are also demonstrated by the integrated behavioral services that Beacon's NCQA and URAC accredited Clinical Management Department provides NHP members through utilization management, case management, and specialty programs.

a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.
   NHP's Integrated Partner Model exemplifies a strong commitment to the integration of care, case management, and proactive discharge planning activities through co-location of behavioral health (Beacon) clinicians within NHP's Clinical Department.

   NHP developed a pilot program focused on integrating behavioral health and physical health care services at the provider site level for NHP members with complex care or expanded wellness education needs.A goal of the program is to initiate and improve the care coordination for a subset of NHP members at community health centers. The pilot program targets those members who are projected to or have demonstrated high costs and high utilization of services and sub-optimal health outcomes. The pilot program addresses both behavioral health and physical health needs of a patient at the provider site and/or community-based level. In addition, the pilot program aims to provide face-to-face care coordination rather than only telephonic coordination.

b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.
   NHP, in conjunction with Beacon, created a collaborative, integrated care management model, the Integrated Partner Model (IPM). The IPM operates through a variety of mechanisms including co-location of "front line" behavioral health, utilization review, and care management clinicians at NHP offices. Integrated clinical workflows, including utilization review and care management processes, have been synthesized to encourage daily interactions between clinical teams. This collaboration helps to ensure seamless coordination of care management strategies for high-cost, high-risk NHP members by supporting immediate case-by-case consultation and shared understanding of these members. A primary care manager is identified through integrated case reviews and actively collaborates with the member, family/guardian/ caretaker, and the health care team to develop a personalized care plan. The care manager also advocates for and assists with linkages to necessary supports and services, and facilitates coordination with family and others involved.

11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.
SUMMARY: NHP offered financial support through the Executive Office of Health and Human Services (EOHHS) program under Chapter 305, Section 30. of the Acts of 2008.
ANSWER: NHP met all the requirements of the EOHHS program. Given that the program has terminated, NHP has not conducted any additional analyses regarding its impact, including providing data to EOHHS to support their analysis of the initiative. Since this was a joint effort between EOHHS and the Medicaid Managed Care Organizations, NHP did not conduct its own analysis.

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12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY: We do not have any comments at this time.

ANSWER:

Exhibit C: Instructions and AGO Questions for Written Testimony

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

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Completed in Attachment AGO Payer Exhibit 1

   See Attachment AGO Payer Exhibit 1 in the Appendix to NHP's written testimony.

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
   c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
   e. Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
   f. Membership in a high cost sharing plan by market segment

(Hereafter “high cost sharing plan” is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

   The growth in MassHealth membership represents normal organic growth and the addition of the MassHealth Essential (Rating Category VII) members into the MCO plans in July of 2010.

   The growth in Commonwealth Care membership from 2009 to 2011 represents normal organic growth. The decline in membership observed in 2012 relates to NHP no longer being eligible to receive auto-assigned members from the Connector (only the lowest priced plans were eligible to receive auto-assignment).

   The commercial membership growth was due to NHP’s competitive price position and the expansion of NHP’s provider network to create greater access.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

   Please see Attachment AGO Payer Exhibit 3

Attachment 1 to Question 7

Original Question

Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.

QUANTITATIVE ANALYSIS RESPONSE:

For Fiscal Years (FY) 2011, 2012, and 2013, NHP conducted a high-level analysis of member movement among primary care site tiers. Our high-level analysis was not able to account for changes in membership.

Member Movement*	FY11	FY12	FY13
	July 2010–July 2011	July 2011–July 2012	July 2012–July 2013
Changed within same tier	59.90%	84.30%	66.90%
Changed to lower copay tier	17.60%	5.80%	25.90%
Changed to higher copay tier	22.50%	9.90%	7.10%

****Based on members enrolled on July 1 in both the first and last months of each period. Copayments during the three fiscal years studied were as follows: Tier 1, $15; Tier 2, $25; Tier 3, $30***

Exhibit # 1 AGO Questions to Payers

****All cells shaded in BLUE should be completed by carrier****

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2011	2.1%	-2.9%	0%	1.0%	0.2%
CY 2012	2.5%	-2.9%	0%	-3.5%	-3.9%
CY 2013	3.8%	1.1%	0%	1.3%	6.2%

Provider mix - no material estimate of provider mix as there have been no major network actions between CY2011 to CY2013

Experienced large membership changes over the time period.

Negative trends were observed in CY 2011 and 2012; current and emerging trends however reveal a reversion to the mean.

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the change in provider. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

AGO Payer Exhibit # 2, Question #2

Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	38,810	33,638	27,249	18,777
Commercial Small Group	14,747	12,364	10,793	7,950
Commercial Large Group	17,692	16,821	16,270	14,814
Medicare	-	-	-	-
Medicaid MCO	167,529	157,712	148,712	146,688
MassHealth	-	-	-	-
Commonwealth Care	31,780	30,663	36,278	36,915
Other Government	-	-	-	-
Total	270,559	251,199	239,301	225,143

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	4,507	3,871	3,468	2,711
Commercial Small Group	2,053	1,799	1,744	1,626
Commercial Large Group	2,985	2,890	2,803	2,659
Medicare	-	-	-	-
Medicaid MCO	20,588	20,355	18,253	18,424
MassHealth	-	-	-	-
Commonwealth Care	3,246	3,160	3,015	3,435
Other Government	-	-	-	-
Total	33,379	32,075	29,283	28,855

c. In-State Membership by Commercial Market Segment and Product Line

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured	38,810	33,638	27,249	18,777
		Self-Insured	n/a	n/a	n/a	n/a
	PPO/Indemnity	Fully-Insured	n/a	n/a	n/a	n/a
		Self-Insured	n/a	n/a	n/a	n/a
Commercial Small Group	HMO/POS	Fully-Insured	14,747	12,364	10,793	7,950
		Self-Insured	n/a	n/a	n/a	n/a
	PPO/Indemnity	Fully-Insured	n/a	n/a	n/a	n/a
		Self-Insured	n/a	n/a	n/a	n/a
Commercial Large Group	HMO/POS	Fully-Insured	17,692	16,821	16,270	14,814
		Self-Insured	n/a	n/a	n/a	n/a
	PPO/Indemnity	Fully-Insured	n/a	n/a	n/a	n/a
		Self-Insured	n/a	n/a	n/a	n/a

d. In-State Membership in Tiered Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	0	0	0	0
Commercial Small Group	0	0	0	0
Commercial Large Group	6,495	5,845	4,946	3,220
Total				

e. In-State Membership in Limited Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	0	0	0	0
Commercial Small Group	0	0	0	0
Commercial Large Group	0	0	0	0

Total	0	0	0	0

f. In-State Membership in High Cost Sharing Plan by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	10,811	9,157	7,291	5,301
Commercial Small Group	3,029	2,342	1,850	908
Commercial Large Group	640	521	426	334
Total	14,480	12,020	9,567	6,543

Attachment AGO Payer Exhibit 3

Original Question

Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claims payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claims payments for such employers.

The grid below illustrates the total annual claims payments for members of commercial employer accounts during Calendar Years 2009–2013.

	2009	2010	2011	2012	2013	Grand Total
Total Accounts*	2,300	4,347	6,762	9,194	10,802	
Total Annual Claims	$83,601,541	$86,388,167	$99,858,135	$118,211,309	$160,275,192	$548,334,344

****Total accounts represent small groups enrolled through NHP's intermediary partners, as well as direct large and small commercial groups.***

NHP does not have any employer groups in its book of business for which we did not provide behavioral health network or management services.