Report to the
Massachusetts Division of Insurance

on the Targeted Market Conduct Examination of
the Readiness of

Neighborhood Health Plan, Inc.
253 Summer Street, Boston, MA 02210

for Compliance with M.G.L. c. 176O, §5A

For the Period September 1, 2011 through December 31, 2011

May 7, 2012

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The Honorable Joseph G. Murphy
Commissioner of Insurance
Massachusetts
Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, a targeted examination has been made of the market conduct affairs of

Neighborhood Health Plan, Inc.
("The Company")

at their home office located at:

253 Summer Street
Boston, MA 02210

The following report thereon is respectfully submitted.

FOREWORD

This report on the market conduct examination of the Company is provided pursuant to the *NAIC Market Regulation Handbook*. Some practices, procedures and files subject to review during the examination were omitted from the report if no improprieties were noted.

The Commonwealth of Massachusetts conducted a series of targeted examinations to determine insurance company compliance with Massachusetts General Law (M.G.L.) Chapter (c.) 176O, § 5A. In accordance with that section, insurers are required to meet the following criteria no later than July 1, 2012:

1. Implementation of HIPAA compliant codes and forms;
2. Acceptance of standardized claim formats; and
3. Utilization of standardized code sets.

These examinations measured the companies' readiness to achieve 100 percent compliance with these requirements by July 1, 2012.

INS Regulatory Insurance Services, Inc. (INS) was engaged by the Division of Insurance ("Division") to conduct this series of targeted examinations, including the examination of Neighborhood Health Plan, Inc. In order to measure the Company's compliance with these impending requirements, INS engaged in the following:

- INS sent interrogatories to the Company which posed a series of questions regarding reports and information that demonstrate the Company's current level of compliance with M.G.L. 176O, § 5A.
- The Company provided responses to the interrogatories that included policies, procedures and reports illustrating their current level of compliance with the law.
- INS collected data samples from the Company, which were analyzed using ACL ® software.
- INS selected representative samples of claim data submissions and reviewed the same in an on-site visit to the Company.

PROFILE

Neighborhood Health Plan, Inc. is a nonprofit organization doing business as a Health Maintenance Organization (HMO) within the Commonwealth of Massachusetts. The Company was founded in 1986 by the Massachusetts League of Community Health Centers (MLCHC) and the Greater Boston Forum for Health Action to support the participation of Community Health Centers in managed care. The mission of the Company is to promote the health and wellness of the members, and to help ensure equitable, affordable health care for the diverse communities served. NHP, an NCQA accredited managed care organization, serves MassHealth, Commonwealth Health Insurance Connector Authority, and fully insured commercial members across Massachusetts.

The Company provides services in those designated areas of the state where the Company has developed a comprehensive network of primary care and specialty care providers, as well as a range of health care facilities and vendors. Much of the Company's service area is concentrated in the urban centers of Massachusetts and the adjacent low to moderate-income communities.

There are two provider networks within the Company's commercial plan service area: the Company's Comprehensive network and the Company's Select network which provides a more limited choice of Primary Care Providers. The Company's network of primary care sites includes community health centers, independent medical groups and hospital based group practices. These sites provide Members with a choice of over 3,800 primary care providers. In addition, Members have access to over 13,500 contracted specialists and 66 acute care hospitals. In order to complete the full range of health care services needed by the Members, the Company contracts with skilled nursing facilities, surgical and rehabilitation facilities and a variety of ancillary providers, including home care agencies, hospice providers, early intervention programs and others. Through a long-standing delegated arrangement with Beacon Health Strategies, a fully NCQA accredited managed behavioral health organization, the Company maintains a comprehensive network of behavioral health specialists and facilities that provide a full range of inpatient, outpatient and intermediate mental health and substance abuse services throughout our service area.

Most of the Company's primary care providers are paid fee-for-service. Emergency services, specialty care, acute inpatient hospitals and other healthcare facilities are paid fee-for-service based on contracted fees or a percentage of charges. The Company has a global risk capitated contract with Harvard Vanguard Medical Associates, a large multi-specialty staff model network, covering the full scope of services for members. Through the Company's outsourcing delegation and contract with Beacon Health Strategies, behavioral health service providers and facilities are paid fee-for-service.

In 2006, the Company was selected by the Commonwealth Health Insurance Connector Authority to be one of four managed care organizations to offer Commonwealth Care plans to eligible residents of Massachusetts. In 2007, the Company was selected by the Commonwealth Health Insurance Connector Authority as one of six managed care organizations to offer Commonwealth Choice plans beginning on July 1, 2007. The Company continues to offer health plan products through the Connector's Commonwealth Care and Commonwealth Choice programs.

SCOPE OF EXAMINATION

The Division conducted an examination of the Company's status to be fully compliant with M.G.L. c. 176O § 5A as of July 1, 2012. Data was collected from the Company from the period of October 1, 2011 through December 31, 2011 (the "Examination Period"). Based on the submitted data, information was analyzed and sample files selected for review. The files were reviewed during an onsite visit, and the review included group and individual health insurance, but did not include disability income, long-term care, short-term travel, accident only, limited policies (including dental, vision, pharmaceutical policies, or specified disease policies) or policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act (Medicare). Only data for fully insured plans were included; self-insured or Administrative Services Only contracts were not included in the review.

EXAMINATION RESULTS

The following is a summary of examiner findings, along with related recommendations and required actions and, if applicable, subsequent Company actions made, as part of the targeted market conduct examination of the Company.

The Company identified a universe of 5,805 lines of claims with modifier 50, 51, 52, 59 and 91 that were reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 115,495 lines of claims with a V diagnosis code that were reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 40,686 denied claims reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 395,387 paid claims reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were

reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

Finding(s):

In response to the interrogatory, the Company indicated the percentage of compliance with each of the seven listed areas as follows:

1. HIPAA compliant codes and forms – 100%
2. HIPAA compliant forms - 100%
3. Standardized claim formats adopted by National Uniform Claim Committee (NUCC) - 100%
4. Standardized formats adopted by the National Uniform Billing Committee (NUBC) - 100%
5. Code sets for International Classification of Diseases (ICD) -100%
6. Code sets for Current Procedural Terminology (CPT) -100%
7. Code sets for Common Procedural Coding System (HCPCS) -100%

During the on-site phase of the examination the Company demonstrated that they have implemented HIPAA compliant codes and forms, acceptance of standardized claim formats and utilization of standardized code sets. The Company indicated that: "All submissions are checked on the Electronic Data Interchange load process against valid code set tables. Each code in the table is assigned effective and termination dates in accordance with the dates assigned by HIPAA Submitters of the electronic 837 claim file have their file submission rejected if they do not pass edits on any of the above fields. These rejection messages are attached to the electronic rejection notification. Paper claims are entered through the electronic process and run against the same edit checks."

Recommendation(s):

Based on a review of Neighborhood Health Plan, Inc.'s responses, it appears that the Company is in in compliance with M.G.L. c. 176O, § 5A. Consequently, no recommendations are warranted at this time to address any identified compliance issues.

REPORT SUBMISSION

This report of examination is hereby respectfully submitted.

Examiners:
INS Regulatory Insurance Services, Inc.

Frank W. Kyazze, Examiner-In-Charge
Sean Connolly, Examiner
Shelly G. Schuman, Supervising Insurance Examiner

APPENDIX

The following summarizes the data analysis conducted during the examination. All analyses were conducted utilizing ACL ® software. Duplicate claims were removed.

Total Number of Claims	436,073
Total Number of Paper Claims (claims submitted in hard copy form)	1,533
Total Number of Electronic Claims	434,540

Top 5 Reasons for Denial:

1. Payment is included in the allowance for another service/procedure	42.6%
2. The time limit for filing has expired	16.96%
3. Payment denied/reduced for absence of, or exceeded, pre-cert/auth	14.21%
4. Not covered charges	12.98%
5. Payment adjusted because this care may be covered by another payer per coordination of benefits	3.9%

Percentage of Claims Paid	90.67%
Percentage of Claims Denied	9.33%

Time to Process Claims

1-15 Days	25.27%
15-30 Days	62.02%
30-45 Days	7.57%
Over 45 Days	5.15%