Neighborhood Health Plan

September 16, 2013

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, thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's (HPC's) request dated August 16, 2013, under Exhibits B, C, and D as provided for in Massachusetts General Law, chapter 6D §8. We share the concerns that many have expressed about the impact health care costs are having on the residents of Massachusetts.

Neighborhood Health Plan serves approximately 2 percent of the commercial market in the Commonwealth. In addition, commercial represents 25 percent of our total book of business with the remainder being government sponsored and funded. Given this unique context, NHP welcomes the opportunity to work with the HPC on providing this written testimony to help inform a successful outcome to the hearing process.

Neighborhood Health Plan, also known as 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. NHP's 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 responses to the questions located in Exhibit B, Exhibit C, and Exhibit D serve as NHP's written testimony. I, as a legally authorized and empowered representative of Neighborhood Health Plan, Inc., sign under the pains and penalties of perjury, that the testimony herein located at Exhibit B, Exhibit C, and Exhibit D to the best of my knowledge is complete and accurate.

Sincerely,

David Segal
Chief Operating Officer

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EXHIBIT B – Health Policy Commission (HPC) Questions for Testimony

1. ***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%.***

   a. ***What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?***

      Neighborhood Health Plan has taken a holistic view of reaching this benchmark:

      - We have implemented, and continue to pursue, alternative payment methodologies with our providers that include upside and downside risk or upside savings only, depending upon the readiness of a given provider.
      - We are ensuring these methodologies include pay-for-performance goals that are quality-focused using standard quality measures (e.g., HEDIS®).
      - We have realigned key parts of our organization to focus on proactively engaging our provider colleagues to make the transition to global payments a collaborative effort.
      - We have explicitly begun the process of building innovative care models with a large integrated delivery system.
      - We are redesigning and realigning business processes that focus on communicating with our members to ensure that they understand their benefit program, cost sharing, and wellness opportunities with the goal of engaging them as early in the health care process as possible.
      - We have implemented a product portfolio that is consistent with the goal of aligning incentives and simplicity in product design.

   b. ***What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?***

      NHP works closely with our provider colleagues on patient-centered care models, quality initiatives, and alternative payment arrangements. Affording our provider community direct access to financial, quality, and other relevant clinical information about their membership has been at the forefront of NHP investments. By leveraging this information, providers, in collaboration with NHP, are able to identify and act on trends to positively affect quality and efficiency. In addition, NHP has focused on, and is an industry leader in eliminating racial and ethnic disparities in the delivery of care.

   c. ***What systematic or policy changes would help your organization operate more efficiently without reducing quality?***

      Ensuring greater regulatory and policy consistency across the public and private sectors would increase efficiency and effectiveness. In addition, greater standardization of reporting to government agencies supporting health care policy objectives would enable efficient operations. In both cases, quality of care would not be at risk.

d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

NHP sets premium rates based on (1) historical experience and (2) anticipated future changes in claims costs. Both historical experience and anticipated future changes reflect NHP reductions in spending.

1) Historical Experience – Claims experience is typically 24 months to 18 months prior to the rate projection period; this experience reflects cost savings initiatives implemented during and prior to the period.
2) Anticipated Future Changes – NHP forecasts trend, including reflecting future savings initiatives, in two ways. First, trend is based on historical claims patterns that reflect our ability to manage claims trend. Second, trend reflects known initiatives including unit cost contract amounts as well as new initiatives.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?

With a focus on total medical expense (TME), NHP has taken a holistic approach to controlling overall health care costs, including price and utilization initiatives. Some examples include the following:

- We have established provider-contracting initiatives targeted to achieve lower unit costs.
- NHP introduced a shared savings program in 2012. Working collaboratively with providers, especially many of our community health centers, the program includes incentives to achieve both unit cost and utilization savings without risk to quality.
- NHP has an ongoing global payment arrangement with a large multispecialty group practice and a newly executed global payment arrangement with a large hospital delivery system; we continue to work with other provider organizations to further this goal.
- We have introduced new clinical programs aimed at managing utilization by improving care coordination.
- NHP has implemented targeted prior authorization initiatives.
- We have pharmacy management programs aimed at reducing both unit cost and utilization.
- NHP has executed vendor-contracting initiatives targeted to ensure alignment with NHP policies and operations, decrease vendor fees, and improve services to NHP members.

3. C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?

As of August 1, 2013, approximately 46 percent of NHP's total members have selected PCPs who participate in an alternative to fee-for service payment methodology. Twenty-one percent have selected PCPs who participate in NHP's shared savings program and approximately 25 percent 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. Factors that challenge execution of these strategies are related to provider network experience managing under alternative payment arrangements.

4. ***C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.***

   All NHP members must select a primary care site and a primary care provider (PCP) at the time of enrollment. If a selection is not made at enrollment, NHP assigns a PCP to the member using criteria that includes:

   - Geographic distance (i.e., a site within 15 miles of a member's residence)
   - Consideration of a PCP's gender and specialty
   - The member's history with a previous site/PCP, when applicable, to ensure continuity of care

   In some care management circumstances, a member may be assigned to a pediatric nurse to help coordinate care with the member's primary care physician as well as other specialty providers.

   Through our secure provider portal NHPNet, primary care sites are notified daily of enrollment activity specific to their practice. This information is provided to assist the sites in their own patient outreach efforts.

5. ***Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?***

   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 HEDIS® and achieves lower overall TME. NHP's lower TME is reflected in Figure 10, page 17, of the *Annual Report on the Massachusetts Health Care Market*, and demonstrates that our TME is about 10 percent below market average.

   In 2007, in collaboration with a 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 percent of our total commercial membership. The design of the program focuses on primary care and specialties and does not include hospitals.

   Currently, copayments for the product are the following:

	Tier 1 (Excellent)	Tier 2 (Good)	Tier 3 (Average)
Primary Care Sites	$15	$25	$30
Tiered Specialties	$25	$35	$45

   For Fiscal Years (FY) 2011, 2012, and 2013, NHP conducted a high-level analysis of member movement among primary care site tiers. Copayments and differentials are exactly as they are today for each fiscal year studied. Our high-level analysis was not able to account for changes in membership. The following table describes the results.

Member Movement*	FY11 July 2010-July 2011	FY12 July 2011-July 2012	FY13 July 2012-July 2013
Changed within same tier	59.9%	84.3%	66.9%
Changed to lower copay tier	17.6%	5.8%	25.9%
Changed to higher copay tier	22.5%	9.9%	7.1%

*Based on members enrolled on July 1 in both the first and last months of each period

The year-over-year variability in results makes it difficult to draw firm conclusions about the effectiveness of this particular program. In addition, because it is limited to one employer, it is also difficult to draw firm conclusions about the effectiveness of product-based incentives to use high-value providers.

6. ***Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.***

   NHP has not observed any impact on medical trend over the last 3 years because of changes in mergers, acquisition, or network affiliations. However, trend was positively impacted through a strong clinical affiliation with a large, multispecialty provider group. As this provider entered into a risk-sharing arrangement in 2009–2010, NHP and the provider also entered into a close collaboration around care coordination. From 2009 through 2012, NHP observed a reduction in excess of 10 percent of total medical expense for this provider.

7. ***Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.***

   Beginning October 2013, NHP members will have two new options, via phone or NHP's secure website, to obtain the estimated or maximum allowed amount or charge for a proposed admission, procedure, or service. Additionally, members will be able to obtain the estimated amount the insured will be responsible to pay for a proposed admission, procedure, or service that is a medically necessary covered benefit. The estimates will be based on the information available at the time the request is made, including any facility fee, copayment, deductible, coinsurance, or other out-of-pocket amount for any covered health care benefit.

   NHP is taking a phased approach to this implementation and is working with a vendor, Castlight, to implement an automated solution for providing cost estimates. The targeted implementation date for the Castlight solution is July 1, 2014.

   Members are notified of the availability of the cost estimator in several ways. Messages will be placed on NHP customer phone lines and the NHP member portal. Messaging will also be included in relevant member mailings and in our member newsletter. Additionally, customer service staff have been trained to utilize a process today to respond to members when they call for a cost estimate or to inquire about cost and benefit information. Finally, NHP uses plan materials, including the

Explanation of Benefits, Summary of Benefits, and Summary of Benefits and Coverage, to communicate cost and benefit information of covered health care benefits.

8. ***After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.***

   NHP represents approximately 2 percent of the overall health care market. In addition, NHP's business is 75 percent government sponsored and funded, with only 25 percent commercial. This background is needed to put the CHIA findings into context. NHP is pleased that CHIA and NHP leadership have mutually agreed to meet so that NHP can further elaborate on this context and enable future findings to be reported in that light.

EXHIBIT C- Office of Attorney General (OAG) Questions for Testimony

1. ***Please submit a summary table (EXHIBIT C1 AGO Questions to Payers Table) showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 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).***

   The following table (Exhibit C1) shows NHP's actual observed allowed medical expenditure trends for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013.

EXHIBIT C1 AGO Questions to Payers

Actual Observed Total Allowed Medical Expenditure Trend by Year						Portion Trend Due to:			
	Unit Cost	Utilization	Provider Mix	Service Mix	Total Trend	Demog.	Buy Down*	Health Status**	Total Adj.
CY10	1.0%	-3.5%	-6.0%	5.4%	-3.1%	*Data not available*			
CY11	1.4%	0.6%	-4.9%	2.7%	-0.6%				
CY12	1.2%	-2.3%	-6.3%	3.2%	-4.4%	2.1%	-2.4%	-1.5%	-1.8%
YE Q12012					-0.6%				
YE Q1 2013					-5.4%				

*Buydown is based on IDF factors and reflects utilization component only

**Health Status beyond demographic age gender change

2. ***Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:***

   a. ***Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)***

      The following table includes NHP's membership by market segment.

Membership by Market Segment
Snapshot as of December

Year	MassHealth	CommCare	Individual	Small	Large
2009	137,798	32,428	13,247	5,704	10,560
2010	147,806	37,015	18,942	8,156	15,099
2011	149,709	36,296	27,344	11,015	16,538
2012	158,768	30,682	33,769	12,788	16,922

   b. ***Membership whose care is reimbursed through a risk contract, by market segment (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 do not subject the provider to any "downside" risk; hereafter "risk contracts")***

      The following table includes NHP's membership in risk contracts.

Membership in Risk Contract by Market Segment
Snapshot of members as of December

Year	MassHealth	CommCare	Individual	Small	Large
2009	17,857	3,319	2,357	1,431	2,315
2010	18,556	3,435	2,732	1,658	2,683
2011	18,352	3,009	3,480	1,780	2,815
2012	20,486	3,161	3,899	1,854	2,861

   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)***

      As an HMO, NHP's current and historical book of business is 100-percent fully insured.

   d. ***Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)***

      The following table includes NHP's membership in a tiered network.

Membership in Tiered Network by Market Segment

Snapshot as of December

Commercial-HMO	
Year	**Membership**
2009	2,493
2010	3,261
2011	4,993
2012	6,184

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.)

NHP has a legacy limited network product on file with the DOI. In 2007, NHP developed the "Select Network" in direct response to a Connector business need. This network includes approximately 60 percent of our primary care providers and all contracted specialists and hospitals. The Select Network did not show significant financial savings, and as a result, NHP decided to discontinue selling the Select Network product to new groups.

Currently, the Select Network has fewer than 2,500 existing members and those members have been grandfathered. In the merged market, we will be working with small employers and individuals to transition approximately 1,400 members to ACA-compliant plans that will no longer leverage the limited network. In the non-merged market, we will have approximately 750 members that will remain grandfathered on the limited network product. The product mentioned above is not the product required by Massachusetts General Law, Chapter 224, Acts of 2012. NHP was granted a waiver for the requirement of a limited/tiered network with a 14-percent price differential based on Chapter 224, Section 177(3).

f. Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations)

The following table includes NHP's membership in a high deductible health plan.

Membership in High Deductible Health Plan by Market Segment

Snapshot as of December

Year	Individual	Small	Large
2009	n/a	n/a	n/a
2010	3,250	492	13
2011	6,084	1,465	118
2012	8,369	2,066	166

3. ***To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.***

   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 are 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.

4. ***Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g., HMO, PPO, self-insured, fully insured).***

   NHP has a global payment contract based on percent of premium with a large multispecialty practice that began in 2007. This contract applies to MassHealth, Commonwealth Care, and commercial members. The contract has been and continues to be a percent of premium arrangement with risk sharing; a percentage of the MassHealth premium was set aside for a pay-for-performance incentive program.

   In 2013, NHP put an additional risk contract in place that covers more than 11 percent of NHP membership that applies to MassHealth and commercial. The risk arrangement covers both upside and downside risk sharing. It also includes a pay-for-performance component based exclusively on achieving targets for selected quality measures.

   NHP's Shared Savings Program, designed for community health centers and larger group practices, has been expanded substantially for 2013 and 2014. The program is designed to provide upside potential to groups for earning more based on improved performance. It includes HEDIS-based quality measures and a measure for reducing total medical expense (TME); the TME target is risk adjusted. A group's performance will be measured across four tiers. The better the group's performance, the higher their payment will be. Substantial effort has been devoted to program reporting and the service model to support the group's efforts.

5. ***Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.***

   NHP does not currently have self-insured business and does not make adjustment for risk because of socioeconomic factors. The global payment and shared savings arrangements are risk adjusted as well as the reinsurance program with a large multispecialty group practice. All commercial business

is fully insured. NHP has different types and levels of risk arrangements with providers that include case rates, per diems, DRGs, shared savings, and global payments.

In an effort to control costs, NHP's preferred methodology is to have as much fixed pricing as possible and to negotiate where possible. As a direct result of the economic climate in Massachusetts, NHP has renegotiated and will continue to negotiate provider contracts that currently pay in excess of certain thresholds.

As mentioned previously, as of August 1, 2013, approximately 46 percent of NHP's total membership have selected PCPs who participate in an alternative to fee-for service payment arrangement. Twenty-one percent have selected PCPs who participate in NHP's shared savings program and approximately 25 percent have selected PCPs who participate in global payment arrangements with NHP.

6. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

NHP has one large multispecialty group provider and one large hospital delivery system on global payment arrangements that cover about 25 percent of NHP's total membership.

The multispecialty group provider has extensive experience in global payment arrangements with NHP as well as other payors. They have a high level of clinical integration across their network and have demonstrated their ability to use information and data for both cost and quality control purposes. Since 2009 and through calendar year 2012, there has been a reduction of total medical expense in excess of 10 percent. Additionally, inpatient utilization and cost, and ambulatory per member per month have trended downward since 2009. The use of data has allowed the group to modify treatment practices toward a desired outcome of reducing unnecessary use of the emergency room. Reductions in inpatient care, when a lower cost setting is just as viable and appropriate reductions of unnecessary high cost tests or procedures have been realized.

NHP's global payment arrangement with the large hospital delivery system became effective July 1, 2013; this provider has significant experience with risk contracts with other payors.

NHP has developed the following criteria for evaluating provider readiness for risk contracting:

1. Multispecialty groups only (with or without hospital partner)
2. NHP membership of at least 3,500 members
3. Provider executive and clinical leadership committed to assuming risk who:
    a. Accept, properly disseminate, and use data
    b. Provide NHP ongoing access to group/site financial information so NHP may assess initial financial liability and perform semi-annual review of financials to ensure ongoing viability. NHP may request financials at any time if provider viability becomes an issue.
    c. Effectively manage member ER utilization
    d. Obtain reinsurance (with NHP or an outside source)
    e. Commit to serve all NHP members

7. Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

Because NHP does not offer tiered or limited products to its broad commercial market, comparisons are not applicable for the following reasons:

1) Different population demographics and rich benefit designs make comparison to broader network difficult.
2) Relatively small populations and changes in tiering methodology over the years makes time series analysis difficult.

Therefore, NHP's standard network is limited relative to the major insurers in the market. We believe NHP's lower TME is reflected in Figure 10, page 17, of the *Annual Report on the Massachusetts Health Care Market*, and demonstrates that our TME is about 10 percent below market average.

8. Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.

Neighborhood Health Plan (NHP) offers a wide range of wellness programs and initiatives designed to encourage our members to make healthy behavior and lifestyle changes and promote their health. Our Care Management Program encompasses numerous wellness initiatives that are a critical component of NHP's spectrum of care management and network services. We offer a range of interventions through services, benefits, written resource materials for members, audio/visual materials based on specific conditions, and web-based information that encourage members to engage in wellness activities to promote healthy behaviors and lifestyle changes.

The aims of the Care Management Program are to build collaborative relationships with members and serve in a manner that promotes optimal health status and reduces unnecessary utilization. Success in care management activities is highly dependent upon building relationships with members. Programs include those designed for members at risk for more serious health problems, for adults and children with chronic, hard-to-manage medical conditions, to help members take charge of their asthma, and to help members manage their diabetes.

Specific programs and initiatives that NHP offers members to promote health and wellness include a maternity management program, tobacco cessation services, exercise center/fitness discounts, a 24/7 nurse advice line, and free book offers that include such titles as What to do for Teen Health, What to Do When Your Child Gets Sick, What to Do When You Are Having a Baby, Health Needs a Plan, Thumbs up for Healthy Food Choices, and Thumbs up for Blood Pressure Control.

NHP educates members so that they can make better health decisions and take an active role in their health care. NHP offers members access to WellSource, a comprehensive and confidential online health risk appraisal (HRA) that helps them manage their health through identifying risks for conditions such as heart disease, diabetes, or depression, and making healthy lifestyle changes. This self-management interactive tool asks questions about individual health and health history, creates a wellness profile, and provides a list of screening tests that the member may need. The tool supports screening for conditions and diseases by helping the member recognize when symptoms first appear or even before they appear. This helps members potentially reduce the impact of a condition or disease or prevent or delay serious problems. The tool uses the current recommendations of the U.S. Preventive Services Task Force.

NHP members also have access online at our website to over 8,000 health topics and interactive tools via the Healthwise® Knowledgebase. Members accessing the Knowledgebase have access to health questionnaires, fitness calculators, information on the medications they are taking, and a drug interaction checker.

In addition to the programs described, NHP offers value added product and services that promote the wellness of members and their families such as free car seats for select plans, free breast pumps, discounts on eyeglasses and/or contact lenses, discounts on select Safe Beginnings products for children, discounts on safety helmets, and free blood pressure monitors and glucometers.

While NHP has not conducted an assessment specific to the cost benefit of our wellness initiatives, in 2012, we conducted the following analyses:

1. Percentage of newly enrolled MassHealth RC2 and RC5 members who received incentives and completed a comprehensive health needs assessment. Although the goal of 30 percent was not met, 556 (31 percent) more assessments were conducted in CY12 over CY12.

2. Percentage of pregnant members who qualified /received an incentive to complete a prenatal assessment and percentage of those members who were identified as high risk for potential adverse birth outcomes and were offered enrollment in care management. In CY12, 21.4 percent of pregnant members qualified for and received the incentive. Of these, 98 percent were identified as high risk and offered enrollment in care management.

NHP does not currently conduct member satisfaction surveys to measure the effectiveness of our wellness programs. However, we conduct member satisfaction surveys on our care management programs including asthma and diabetes on an annual basis. Care management at NHP is designed to assist clinicians as they help their patients make effective use of available health care resources. NHP's holistic model is intended to support member adherence to clinician-recommended treatment and facilitate self-management. When members are satisfied with care management services, they are more likely to be engaged as partners in managing their health care status. NHP believes that cost savings will be realized as a result.

EXHIBIT D – Center for Health Information and Analysis (CHIA) Questions for Testimony

1. ***Do you analyze information on spending trends (e.g., TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?***

   NHP has not analyzed information on spending trends and clinical quality performance of the Mass Medicare Pioneer ACOs or the providers that participate in the Patient Centered Medical Home Initiative.

   a. ***If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.***