NetworkHealth

September 16, 2013

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, Sixth Floor
Boston, MA 02116

Dear Mr. Seltz:

Thank you for the opportunity to comment on health care provider and insurer costs and cost trends in Massachusetts. We believe the costs of health care services in the Commonwealth and nationally warrant immediate attention, and we strongly support efforts by the Health Policy Commission (the Commission) to educate stakeholders and the public on these issues and to explore options for viable solutions.

In what follows, and to the extent possible, we have responded to the questions sent to us by the Commission and commented on costs trends observed in the 2013 reports released by the Attorney General's Office and the Center for Health Information and Analysis. It should be noted, however, that Network Health's lines of business for 2012 were limited to MassHealth, Commonwealth Care and the Medical Security Program. Network Health entered the commercial market space in the spring of 2013 with the introduction of our Commonwealth Choice product; however we have not yet gained enough experience nor collected enough relevant data to provide a comprehensive perspective on this population. We appreciate the opportunity to testify on trends we have observed in the State's publicly subsidized programs.

I am legally authorized and empowered to represent Network Health, LLC for purposes of this testimony.

I attest that, to the best of my knowledge and belief, the attached testimony is true and accurate.

Submitted under the pains and penalties of perjury on this 16th day of September, 2013.

Thomas A. Croswell
President
Network Health, LLC

NetworkHealth

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?

Brief Summary: To meet the benchmark for health care cost growth established under the state's cost-containment law, Chapter 224 of the Acts of 2012, ("Chapter 224"), Network Health, LLC ("Network Health") is continuing to focus on the two main drivers of cost—provider unit costs and utilization. We have seen reductions in unit costs between CY2010 and CY2012 and will build upon existing programs and strategies to reduce the growth in health care costs.

Response: As part of our effort to meet the cost growth benchmark established in Chapter 224, Network Health is committed to reducing provider unit costs through the further development of our high-value provider network built around providers who demonstrate both high quality of care and cost-efficiency. As part of this strategy, we seek to contract with providers that can deliver quality care within the benchmark for growth. We view our relationships with providers as a partnership and are working with many of our network providers to move to more risk sharing reimbursement models that align our incentives and result in contained cost growth for the consumer. Network Health currently employs this strategy with three out of our four lines of business, including our small group and individual commercial product, launched in April 2013. For our remaining line of business, serving individuals and families in MassHealth, we will continue existing programs wherein we seek to direct enrollees to lower cost providers, such as our Preferred Pediatric Program, instituted four years ago in response to the substantially higher costs charged by one contracted pediatric academic facility. In its first two years, this program yielded over $6 million in savings. As demonstrated in the attached chart for Exhibit C1, Network Health has seen a trend in unit cost reduction between CY2010 and CY2012 with the most significant decrease, over 5%, occurring in the past year.

Due to the nature of the populations we serve, Network Health's membership tends to include individuals with higher DxCG risk scores than the general population and this contributes to the increased overall utilization we have experienced over the past few years. We have also observed an increase in admissions related to detoxification and are working to outreach to at-risk enrollees to address substance abuse issues.

Therefore, Network Health maintains strong clinical programs focusing on delivering the right care in the right setting. Network Health's care management program is nationally recognized for best practices and includes the following key design principles:

- Improved enrollee outcomes provide both increased quality and decreased costs
- Integration of medical, behavioral, and social services in a patient-centric model
- Enrollee engagement as the foundational component of interventions
- Provider identification, stratification, and targeted outreach to high risk enrollees with chronic or acute medical conditions, mental illness, and/or substance abuse.
- Provider engagement as an essential element to strengthen health plan/provider partnership, especially targeted on higher risk enrollees/patients
- Data-driven strategies based upon enrollee experiences, including our internal risk predictor model used to stratify membership for targeted interventions
- Expanded efforts to provide actionable and timely data to practices including leveraging our leadership in the health information exchange.

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?

Brief Summary: Network Health strives for continuous improvement and innovation in meeting enrollee health care needs. We work to ensure that enrollees obtain high-quality care in the right place, at the right time, and in the most cost-efficient way possible by engaging enrollees and providers and employing data-driven strategies and analytic expertise.

Response: Based on the premise that quality care outcomes reduce medical expense, Network Health has fully integrated its quality improvement initiatives into the clinical protocols. Integrated teams identify, develop, implement, measure, and evaluate outcomes for all clinical-quality initiatives. Therefore all quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), the State's Quality Improvement Program (QIP), External Quality Review Organization (EQRO), and National Committee on Quality Improvements (NCQA) requirements are supported by cross-functional integrated teams. These teams utilize evaluation tools that are presented on a scheduled basis to our Quality Improvement Committee to assess success toward goals and barriers to achievement of goals, and allow for course correction/modification in a more "real-time" environment.

We believe that our ability to achieve success in both quality and efficiency of care depends on the role we play in improving the health and well-being of our enrollees, which in turn is dependent on successful accomplishment of our quality objectives. Accordingly, Network Health's quality management and quality improvement program are integral components of our overall approach to enrollee care. We have found that providing quality and efficient care, is often dependent upon having the data, analytic expertise, and other resources to support the goal of monitoring and improving enrollee care and service as well as working with our provider partners. This allows Network Health to identify and prioritize opportunities for improvement; develop appropriate interventions to improve care and service; and re-measure program performance to determine the effectiveness of enacted interventions. One example of this has been the introduction of our online analytic and reporting platform that providers can access anytime, from anywhere to view their own performance data and benchmark it against their peers. This online tool provides both the data and a mechanism for identifying and managing cost, utilization, and quality outliers in all clinical focus areas, including pharmacy, inpatient/outpatient care, and quality, among others. On a routine basis, a cross-functional team of physicians, care managers, social workers, and data analysts at Network Health visit high-volume primary care practices to (1) present performance data; (2) identify and establish improvement goals; and (3) engage providers in a two-way dialogue on how these goals can be achieved. Providers' progress toward their goals are tracked on an ongoing basis, and discussed with provider groups at subsequent engagements.

Network Health also utilizes quality improvement techniques gleaned from participation in the Institute for Health Care Improvement work groups and proto-typing communities. This rapid cycle process supports Network Health's agile quality improvement process flows. The analytics/cost management team supports Network Health in this by performing data analysis and reporting on a monthly basis to help identify opportunities for improved care outcomes.

The most substantial limiting factor we have encountered is the ability to "find" enrollees. In a population that is somewhat mobile, the need to have reliable demographic information is vital. Network Health partners with its provider community to enable access to the most recent demographic information. Additional limiting factors include access to certain services for enrollees who live in remote locations; language barriers between enrollees

and providers which may cause knowledge deficits regarding treatment plans, and the limited coordination of services between physical health and behavioral health providers.

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

Brief Summary: Network Health proposes the following systematic or policy changes to operate more efficiently without reducing quality: 1) require out-of-network providers contracted with MassHealth to accept case-mix-adjusted MassHealth Standard Payment Amount Per Discharge (SPAD) rates for inpatient services, MassHealth Payment Amount Per Episode (PAPE) rates for outpatient services, and the MassHealth fee schedule for professional services; 2) require hospitals to accept "triage fees" for subsidized individuals who receive care in an ED for a non-emergent condition; 3) prohibit the use of "facility fees" for procedures not performed at a facility; and 4) utilize, to the maximum extent possible, data already available via the All Payer Claims Database (APCD).

Response: The Executive Office of Health and Human Services (EOHHS) establishes three specific payment rates for use in the state's Medicaid program, SPAD for inpatient services, PAPE for outpatient services at acute care hospitals and the Medicaid fee schedule which governs payments to physicians and other providers. EOHHS, in turn, uses these payment rates as a basis to set the capitation payments made to the Medicaid managed care organizations (MCOs), assuming that the MCOs are reimbursing providers based on a percentage using these rates. As a Medicaid MCO, Network Health uses these established rates as a basis for payments to contracted providers for all of our subsidized lines of business, typically paying an inflator on top of the EOHHS established rates, as this has historically been the expectation of providers. As a policy change designed to achieve savings without compromising quality of care, we propose that out-of-network providers that have a contract with MassHealth should be required to accept, from any MCO, case-mix-adjusted MassHealth SPAD rates for inpatient services, MassHealth PAPE rates for outpatient services, and the MassHealth fee schedule for professional services for all enrollees receiving government-subsidized health care, including those enrolled in the Qualified Health Plan (QHP) wrap plans which will be offered through the Massachusetts Health Connector Authority ("Health Connector") beginning in January 2014. Currently, the MassHealth contract with providers requires them—when out of a Medicaid MCO's network—to accept MassHealth reimbursement rate levels from the Medicaid MCO for all emergency and post-stabilization services. Establishing limits on all services would reign in costs associated with out-of-network providers, but more importantly, would provide leverage to the Medicaid MCOs in negotiating reasonable in-network reimbursement rates. Network Health has been working with the other Medicaid MCOs to pursue this policy change through the legislative process.

ED utilization for non-emergent conditions has been a well-documented driver of health care costs, particularly among low-income individuals who are unfamiliar with the health care delivery system. While Network Health has made great strides in reducing our ED utilization, more than 50% of enrollee ED visits for CY2012 and CY2013 to date can be characterized as low acuity/non-emergent (LANE) or potentially avoidable. Medicaid MCOs are in a unique position in addressing this issue, as we do not have the same tools available to manage costs that are available to the commercial plans, specifically the lack of flexibility around benefit design and cost sharing that prohibit financial incentives to encourage enrollees to reduce ED use. At the same time, some hospitals and hospital systems seem to encourage the use of EDs by advertising things such as the average wait time at their ED, potentially driving individuals to seek care there rather than in a more appropriate setting. One solution to this problem is to allow health plans serving government-sponsored, subsidized populations to reimburse non-emergent ED visits using "triage fees," which are less expensive. This would achieve savings and align health plan and provider incentives to encourage enrollees to seek care for non-emergent conditions in the most appropriate setting.

Limiting facility fees charged for hospital-based care and eliminating facility fees for outpatient care received at a physician's office could also reduce costs without compromising quality of care. These types of fees, charged on top of other negotiated rates and fees, inflate the cost of healthy care for government, employers, and consumers. The Boston Globe ran a series of articles in January 2013, addressing the issue of facility fees charged for procedures performed in a physician's office. These fees are often arbitrary and not directly related to the cost of care, and when a procedure is performed in an office setting, paying hospital charges and operating rooms fees makes little sense. While health plans could currently refuse to reimburse for facility fees, this could in turn lead to a termination of the relationship with the provider, disrupting enrollee care, therefore a change in policy could best facilitate this change.

Finally, Network Health encourages greater use of the state's APCD to reduce duplicative data requests, which add to administrative overhead costs, and streamline the collection and dissemination of data across state agencies. While not as significant a factor as medical cost growth, the growth of administrative expenses has contributed to the increase in overall health care costs over the past several years. While Massachusetts health plans have the lowest administrative costs of any plans in the country, just 10% of premiums, we are subject to several data reporting requirements and ad hoc requests requiring employee time and resources. We are supportive of the recommendations included in "Streamlining state mandated administrative requirements in health care—steps to be taken by state agencies to reduce administrative and filing requirements on health carriers and health care providers" released in November 2012 by the Administrative Simplification Working Group convened according to Section 56 of Chapter 288 of the Acts of 2010.

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

While Network Health has only recently entered the commercial insurance marketplace, we have demonstrated the ability to significantly reduce medical spending in our Commonwealth Care and Medical Security Program lines. By leveraging our high-value network, managing care, and maintaining low administrative costs, Network Health has been able to reduce medical expense in both programs, saving the Commonwealth an estimated $55 million from 2010 to 2012 with our Commonwealth Care Plan and $39 million in 2012 with our Medical Security Program, while producing double-digit reductions in premiums for enrollees.

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?

Brief Summary: Network Health has also observed the growth in medical care prices as a key driver in the overall increases in health care spending. To address this trend, Network Health has actively worked to reduce the cost per unit paid to the highest-cost providers to be more in line with the premiums we receive from the Commonwealth for our government-subsidized lines of business. We have also continued to develop our high-value network and are working to move more providers from a fee-for-service payment methodology to alternative payment methodologies (APMs).

Response: Network Health evaluates rates paid to hospitals, physicians and other facilities and providers of medical and behavioral health services on an ongoing basis. Consistent with the findings described by the

Attorney General's Office in its "2013 Examination of Health Care Cost Trends and Cost Drivers," Network Health has observed the growth in prices for medical care at the core of medical spending increases. For our subsidized products, many of our contract rates are tied to three state regulated payment types explained in response to question 1.c - SPAD, PAPE, and the MassHealth fee schedule. Underlying increases given to hospitals and physician providers through the SPAD, PAPE, and fee schedule by EOHHS therefore impact the cost to the Medicaid MCOs. Over the past several years, these rate increases to hospitals and physicians have outpaced premium increases provided to Medicaid MCOs. At the same time, medical trend has continued to increase across the state. To address the resulting discrepancy between required increases to prices paid to providers and premiums paid to the Medicaid MCOs, Network Health reviewed existing contract rates and employed a re-contracting strategy to better align rates paid to hospitals and physicians to premiums received from state government. We have also continued the development of our high-value network and believe that in the near future, our re-contracting efforts may require the use of a narrower network of hospitals and providers in order to achieve this strategy. This is most often due to providers systems that are able to demand higher rates due to consolidation, reputation, and/or geographic isolation.

Another approach Network Health is undertaking to address the impact of growth in medical care prices on medical trend includes discussions with several key providers to move from a fee-for-service payment methodology to APMs involving shared risk and the alignment of incentives. Currently, these types of arrangements range from shared-savings models, to per enrollee per month (PMPM) budgeted medical expense target with both upside and downside risk sharing, to a global payment model based on a percent-of-premium methodology, with shared surplus and deficit sharing. Network Health has experienced some success in moving toward sharing risk and better alignment of incentives; however, many providers are slow to adopt these models for vulnerable and chronically ill populations, who currently make up a significant portion of our government-subsidized lines of business.

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?

Brief Summary: Network Health is committed to using value-based purchasing approaches such as shared-savings/shared-risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and global payments in our provider network contracting to encourage provider organizations to adopt the best practices related to cost containment, quality improvement, and patient protection. Our strategic plan includes as an objective "maximizing effectiveness of integrated care management to improve quality outcomes and manage cost trends," and outlines a process for linking financial accountability with care accountability and transitioning more providers to APMs. By 2015, our goal is to have 73% of our membership covered under an APM.

Response: Network Health continues to engage higher-volume practices and delivery systems to move toward risk-based or shared-savings arrangements. Network Health currently promotes APMs and value-based purchasing across all our lines of business to achieve maximum leverage in our provider relationships and generate the greatest impact on performance and enrollee outcomes. In 2012, nearly 20% of our membership was covered under provider contracts based on an APM, thereby reducing our reliance on fee-for-service payment mechanisms as directed by Chapter 224. For 2013, we have increased that number to 30% and anticipate even higher numbers in the near future, particularly as we work with EOHHS and providers to execute contracts in

compliance with the state's Primary Care Payment Reform Initiative (PCPRI). We also envision that the PCPRI, as well as our existing risk-based arrangements, will position us well to increase the level of risk sharing in future years.

We are just completing our third year of experience with the budgeted global payment contract and continuously evaluate effects of this new payment model on cost and quality improvement. To date, the best example of our experience with payment reform is our relationship with Cambridge Health Alliance (CHA), the last public hospital system in Massachusetts and Network Health's former parent company. In 2009, CHA committed itself to a long-term vision of transforming into a high-performing accountable care organization (ACO) and embraced both delivery system and payment reform. Network Health played a key role in this strategy by moving to a global payment model with CHA. On July 1, 2010, this model went into effect for the Network Health-CHA shared cohort. The model aligned financial incentives for all stakeholders, including the hospital delivery system, physician organization, and health plan, in the care of a mutually associated cohort of patients. The arrangement uses a percent-of-premium global budget approach with upside and downside risk sharing to achieve financial alignment. This arrangement encourages all providers in the system to make decisions that optimize population health and wellness, and facilitates integrated, effective care management of chronic health conditions.

The alignment of incentives and the nature of the collaboration have led to significantly more focused efforts from both parties to improve quality and manage costs. These efforts include redirecting referrals from higher cost institutions to more appropriate settings, reducing ED utilization, improving care coordination for high-risk patients, reducing unwarranted readmissions and developing other concrete steps to improve care.

Network Health has also been an active partner in the Commonwealth's Patient Centered Medical Home Initiative (PCMHI), where public payers and private health insurers support a multipayer PCMHI development and transformation program for participating practices. Network Health's chief medical officer co-chaired the shared-savings and data reporting subgroup and has provided strong leadership in bridging gaps between payers and practices in the proposed shared-savings methodology and in practice reporting. Network Health was also asked, along with two PCMHI participant sites, to be the payer representative and take the lead in developing and testing the "Protocol for Coordinating Clinical Care Managers and Payer Case Management Activities." We look forward to receiving the information from the state on the results of the first year of the program.

Discussions are currently underway with several providers on value-based payment models. When Network Health approaches providers about participating in an APM arrangement, we believe it is critical to provide transparency around data and information to understand the population being served. In addition, we approach discussions with providers collaboratively and work with providers to determine what services and tools are needed for performance improvement.
As noted previously, in identifying challenges to moving providers into APMs, we have observed that while many Massachusetts provider systems have significant experience operating under various APMs, there has been some reluctance to adopt these models for subsidized populations, due to concerns over both state program funding and enrollee engagement. Nevertheless, Network Health continues to work to engage higher-volume practices and delivery systems to move toward risk-based or shared-savings arrangements. We believe our focus on supporting the development of practice-based care coordination/care management will ensure success with various APM efforts.

4**.** C.224 requires health plans, to the maximum extent feasible, to attribute all enrollees to a primary care provider (PCP). Please describe, by product line, how your organization is meeting this expectation, including, as of July

1, 2013, the number of enrollees 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.

Brief Summary: Network Health prioritizes the attribution of enrollees to a PCP across all of our lines of business. We have developed assignment logic to match enrollees who do not actively select a PCP with the best match based on available information resulting in nearly 100% of enrollees across all lines of business being attributed to a PCP.

Response: Network Health uses extensive efforts to encourage enrollees to select a PCP within 15 business days of the enrollee's effective date of enrollment. Our provider directory, available online and in printed form, encourages enrollees to call Network Health for assistance with selecting a PCP. In addition, our enrollee handbooks repeatedly encourage enrollees to choose a PCP and provide education about the role of the PCP. Network Health enrollee services representatives (MSRs) are also available to assist enrollees who contact Network Health for help with PCP selection by conducting system searches for an appropriate PCP match, filling requests for information to facilitate PCP selection, and assisting enrollees with special communication needs. Requests are completed within one business day.

Network Health uses the same assignment logic and processes for our subsidized products as for our commercial product. Using historical data stored in a repository and enrollee module, and transaction data from the HIPAA 834 enrollment file, we work to match enrollees with a PCP. If an enrollee's record comes across on the 834 enrollment file without valid PCP data, Network Health initiates our PCP auto-assignment process. Auto-assignment occurs immediately upon receiving the record, so Network Health engages in extensive efforts to encourage PCP selection as a change subsequent to the assignment if needed. Network Health's PCP auto-assignment uses the following logic sequence:

1) If the enrollee was previously enrolled with Network Health, the system assigns the enrollee to his or her most recent PCP, if that assignment remains appropriate.
2) For certain limited geographic areas with significant provider competition, if an enrollee's PCP is not indicated on the 834 enrollment file and no historical PCP record is on file, the auto-assignment process seeks a preferred provider (one determined to have a cost/quality advantage in the applicable geographic area).
3) If there is no enrollment history with Network Health, or if the previous PCP assignment is no longer appropriate, and there is no preferred provider, the system then seeks any appropriate PCP located in the enrollee's ZIP code accepting new patients. If the system finds no match based on ZIP code, the system broadens its search to the city of residence. If there is no match, the system looks for the closest PCP accepting new patients.
4) At each stage of this process, the auto-assignment logic considers a series of demographic characteristics, including enrollee age (to ensure children are assigned to pediatricians or family practitioners, and adults are not assigned to pediatricians); gender (to prevent males from being assigned OB/GYNs serving as PCPs); language; and handicap accessibility (to match provider site accessibility with enrollee disability data from the 834 enrollment file). The PCP assignment system maintains a log of how each enrollee is assigned, allowing Network Health to monitor compliance with applicable time and distance standards.

We are currently in the process of preparing to incorporate new data elements not currently or completely resident in our systems into the PCP auto-assignment process. For example, we have implemented processes to capture provider expertise in serving special populations. Once this data has been collected and is loaded within Network Health's systems, we will create logic, based on providers' training and expertise with demographic and special

populations, and will attempt to match enrollees whose special health care needs are identifiable on the enrollment file. Following auto-assignment, should information about a enrollee's health care needs become available, Network Health will conduct targeted outreach to ensure that the original PCP assignment meets the enrollee's needs.

Network Health will continue to explore other opportunities to improve our PCP auto-assignment processes. For example, we are exploring the feasibility and availability of technology to match enrollee residences and PCP sites, based on public transportation accessibility. We are also assessing how enrollee and provider race and ethnicity data may assist us in ensuring enrollees have access to culturally and linguistically appropriate services.

Table 1: **Network Health enrollees attributed to a PCP**

PCP Assignment Methodology	Product	Percent of Enrollees Assigned to a PCP
Auto-Assigned	Commonwealth Choice	68.00
Enrollee has previous PCP on file	Commonwealth Choice	0.36
PCP on 834	Commonwealth Choice	31.64
TOTAL		100.00
Auto-Assigned	Commonwealth Care	36.77
Enrollee has previous PCPon file	Commonwealth Care	31.67
PCP on 834	Commonwealth Care	31.56
TOTAL		100.00
Auto-Assigned	MassHealth	23.33
Enrollee has previous PCP on file	MassHealth	58.39
PCP on 834	MassHealth	18.29
TOTAL		100.00
Auto-Assigned	Medical Security Program	76.25
Enrollee has previous PCP in on file	Medical Security Program	14.57
PCP on 834	Medical Security Program	9.17
TOTAL		100.00

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?

Brief Summary: Network Health encourages all enrollees to use high-value providers. To date, initiatives such as the introduction of our high-value provider network for our Commonwealth Care, Medical Security Plan and Commonwealth Choice products, and our Preferred Pediatric Program have been successful in encouraging a shift to high-value providers.

Response: In response to Health Connector's rate discussions in 2010, Network Health implemented a high-value provider network lowering costs and maintaining quality providers as well as geographic adequacy across the state. By strategically focusing our network, we were able to achieve a low-cost position as one of the two lowest-cost plans in the Commonwealth Care program and lowered our rates to the Health Connector by 15% while reducing enrollee premiums, delivering double-digit savings both to the Health Connector and consumers who purchase our plans. This network continues to serve our Commonwealth Care enrollees and has expanded to include the Medical Security Program, where it produced significant savings for both the Commonwealth and enrollees, and our newly launched Commonwealth Choice product, which accounts for 40% of our total membership. This initiative has enabled us to deliver network cost savings by limiting use of higher-cost

providers and renegotiating contract rates with certain other providers seeking to remain in our networks. We also expect this high-value network to be utilized as our QHP network, beginning January 1, 2014.

As noted previously, another example of an initiative employed to encourage enrollees to utilize high-value providers was the implementation of Preferred Pediatric Program in 2009 to encourage the use of preferred providers in order to promote and direct care to the most appropriate setting, based on cost, quality, and type of service. In this program prior authorization is required for outpatient, specialty and non-emergent inpatient admissions. Referrals are approved for continuity for care reasons or when specific services are not available at other in- network facilities. Network Health expects to expand the use of these types of program as a way to support alternative payment models and other product offerings.

6. Please describe the impact on your medical trend over the last three 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.

While Network Health has only recently entered the commercial insurance marketplace and therefore has limited experience in this space, we have experienced similar impacts on medical trend in the subsidized market due to changes in provider relationships. The SPAD and PAPE rates set by EOHHS vary by facility, and the price variation observed in the commercial market space between high-cost and low-cost facilities is similar. For example, SPAD rates can be as much as $7,000 more expensive at the highest-cost versus the lowest-cost facility.

Additionally, market consolidation has resulted in our having to exclude certain large provider systems from our high-value networks due to prohibitive costs. As more and more low-to-moderately priced providers are acquired by high-cost provider systems, we could see either a further narrowing of provider network or increased costs or both.

7. Please describe the steps that your organization has taken and will be taking to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, co-payment, deductible, coinsurance, or other out-of-pocket amount for any covered health care benefits as required under Chapter 224.

Brief Summary: Network Health currently provides enrollees with general information on cost-sharing requirements and is working toward making additional cost information available by October 1, 2013.

Response: Network Health has taken a variety of steps to address availability of cost information for enrollees. In the “Benefits and Cost” section of our enrollee website, we currently provide general information on costs and co-payments for covered services and medications, including coinsurance where applicable. Due to our focus on serving low-income families and individuals through government subsidized programs, the majority of Network Health enrollees (95%) have very limited cost-sharing. For 60% of our enrollees (MassHealth), the only co-payments are for prescription drugs.

In order to provide more information to consumers in compliance with the transparency provisions under Chapter 224, we are developing a process to allow us to respond to questions about the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the enrollee will be responsible by provider (physician, hospital, outpatient facility, etc.) for common medical services. As of October

1, 2013, enrollees will be able to request estimates for total allowed and out-of-pocket costs for a specific set of high-volume medical and behavioral health services, for the highest volume providers in our networks, by contacting our customer service department via telephone, web chat, or our website. We are planning to expand this functionality in 2014 by providing more web-based search functionality, a broader list of common services and providers, and more automation.

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.

Brief Summary: The reports issued by the Attorney General's Office (AGO) and Center for Health Information and Analysis (CHIA) draw several conclusions about the current state of the Massachusetts Health Care market, among them that significant variation still exists in the reimbursement amounts to care for patients of comparable health and that the growth in prices for medical services, not utilization, are still the primary drivers of cost. Further, the reports observe that provider consolidation and alignment have significant market implications, but this consolidation is often not for purposes of care coordination or risk contracting between payers and providers. Network Health has observed similar trends; however, some of the observations in these reports differ from our experience in the subsidized market.

Response: Network Health has very limited experience in the commercial market, having just launched a product in the Commonwealth Choice space in April 2013; therefore, our observations are based on our experience serving government-subsidized enrollees through the MassHealth, Commonwealth Care, and Medical Security Plan programs. For several years, reports compiled by the AGO and the Division on Health Care Finance and Policy (DHCFP), the predecessor agency to CHIA, have highlighted the variation in costs across providers, most often tied to market power, versus any specific correlation to quality of care. Network Health's experience has been similar, with providers commanding higher prices based on market share, reputation, uniqueness of service, and/or geographic isolation. Over the course of several years, one or more of these factors has surfaced in contract negotiations with providers seeking increased reimbursement. As noted in the AGO report, these variations exist whether reimbursement is calculated on a fee-for-service basis or using an APM. In our experience, provider systems that command a high fee-for-service payment for the reasons stated previously will command a higher reimbursement rate under an APM, so that even where savings are achieved, they may not be as significant as they have the potential to be. For Network Health's subsidized lines of business, the EOHHS-dictated SPAD and PAPE rates vary significantly by facility by as much as $7,000 as noted in response to question 7. This provides an uneven starting point for contract negotiations with certain provider systems and contributes to the variation in total medical expense.

The AGO report observes that in recent years, the driver of costs can be attributed to the growth in the cost of medical services rather than increased utilization. While this was true for our subsidized product lines in years past, looking at the data from 2010 to 2012, Network Health has seen a modest reduction in unit costs and an increase in utilization. The reversal of the trend toward higher unit costs can be attributed to Network Health's aggressive re-contracting efforts, putting processes in place to reduce utilization of higher-cost providers and the creation of our high-value networks, which included moving away from many high-cost providers. We believe the increase in utilization can be partially traced to an increasingly sick population, specifically those with chronic and/or co-morbid conditions. We have observed that, over the past few years, specifically with regard to our MassHealth population, the DxCG risk scores for our enrollees have increased. While Network Health has been

able to reduce specific categories of utilization, overall our experience has been different from that of the commercial market due to the populations we serve.

Finally, while reputation, uniqueness of service, and geographic location have remained factors in cost increases, it is the increase in market consolidation that has grown into a more significant factor in recent years. As noted in the AGO report, providers in Massachusetts have been exploring and executing affiliations, acquisitions, mergers, and consolidations. While the reasons cited often include better coordination of care and improvements to quality and efficiency, as noted in the 2013 report, as well as previous reports, the market power of certain hospital-based delivery systems continues to play a dominant role in increasing the cost of care without a corresponding increase in the quality of care. Without better tools to address the high unit costs, overall health care cost reduction will continue to prove challenging for health plans like Network Health. More levers are needed to reduce upward price pressures across the board, especially for government-funded, subsidized programs, as federal and state resources are already stretched to cover health care and competing programs.

Exhibit C: Questions from OAG

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2010 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.

Please see Attachment Exhibit C1 for a summary table showing Network Health's observed allowed medical expenditure trend.
(a) demographics of your population

The demographics of the populations served through Network Health's subsidized lines of business are a contributing factor to medical trend.

(b) benefit buy down

Network Health's subsidized lines of business do not have the option to change the benefit packages as they are established by the government contracting entity.

(c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend)

The medical trend for Network Health's subsidized lines of business is primarily driven by the increased risk of the populations we serve. This is demonstrated by an increase in DxCG risk scores.

2. Please submit a summary table showing your total membership for enrollees 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.)

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")

Table 2: Network Health Total Enrollment by Product and Risk-Based Contracts, 2009–2012

	Year			
Product/Market Segment	**2009**	**2010**	**2011**	**2012**
Medicaid	117,602	135,958	125,417	140,555
Membership in risk contract	*N/A*	*10,272*	*25,281*	*28,837*
Commonwealth Care	47,944	45,736	56,095	71,611
Membership in risk contract	*N/A*	*2,563*	*8,641*	*11,879*
Other Government (Medical Security Program)	N/A	N/A	*N/A*	*16,192*
Membership in risk contract	*N/A*	*N/A*	*N/A*	*N/A*
Total Membership	**165,544**	**181,694**	**184,658**	**228,358**

Note: Membership represents the distinct count of enrollee RHN's as of December in each year. Total enrolleeship does not exactly add up to the sum of all products as a enrollee may have switched products during the month.

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)

Network Health did not have commercial membership for the years 2009–2012.

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.)

Network Health does not offer a tiered network product.

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.)

Network Health does not offer a limited network product.

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

Network Health does not offer a high-deductible health plan.

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.

Brief Summary: Network Health has seen some enrollee fluctuation due to the strategic introduction of our high-value network in 2011. Additional variation in membership can be attributed to State policy changes, wherein certain populations were added to, removed from, and reinstated to the subsidized programs we serve.

Response: For Network Health's Commonwealth Care line of business, a subset population, aliens with special status (AWSS), was removed from the Commonwealth Care program in August 2009. This accounts for the majority of the approximately 2,600 enrollee loss between 2009 and 2010. These AWSS enrollees were reinstated in the spring of 2012, and newly eligible AWSS individuals were added, contributing to the increase in membership between 2011 and 2012.

Then, in 2011, the Health Connector gave the Medicaid MCOs incentives to engage in an aggressive bid strategy by offering low-cost plans membership growth opportunities through auto-assigned enrollees. Network Health responded by creating a high-value provider network that removed high-cost providers and maintained high-quality, cost-effective providers while maintaining the necessary statewide access for enrollees. By strategically focusing on our network, we were one of two plans to reach the lowest-cost plan status leading to an increase in membership for the contract year July 2011 through July 2012. These contracts were renewed in July 2012 with Network Health maintaining our status as one of the lowest cost-plans, further increasing our membership.
For our MassHealth population, auto-assignment of enrollees to the Medicaid MCOs was suspended in February 2011. Until that time, Network Health has been receiving an average of 3,700 auto-assigned enrollees per month in the previous six months. We attribute the drop in our MassHealth membership to this policy change. Auto-assignment to the Medicaid MCOs was reinstated on a more limited basis in late 2012, accounting for some of the increased enrollment over 2011. Finally, the addition of rating category (RC) VII enrollees to the managed care program in July 2011 contributed to the increase in enrollees and mitigated some of the losses due to the suspension of auto-assignment.

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).

Brief Summary: Network Health has engaged in risk contracting since 2010, concentrating our approach on population-based budgets with providers who have sufficient Network Health membership to create actuarially sound budgets.

Response: Network Health entered into its first risk contract in July of 2010. In structuring the contract, Network Health employed a premium allocation methodology based on PMPM-budgeted global payment with upside and downside risk sharing and corridors as well as reinsurance and stop-loss. Additional models that are under

discussion with providers that include budgeted capitation with withholds, risk-corridors, and shared-savings arrangements. Considerations that factor into the development of budgets include the following:

a) Past claims experience and anticipated trends
b) Adjustments to reflect random variability
c) Opportunities for improvements relative to benchmarks
d) Risk-adjustment to reflect changes in populations

Our approach is not to carve out specific services at this time, but to develop global budgets that are inclusive of all covered services. We have also limited our approach at this time to budgets that are population based, as defined by PCP-assignment and attribution, and we have limited this to providers with sufficient Network Health membership to create actuarially sound budgets.

We are also committed to working with EOHHS and providers to execute contracts in compliance with the Primary Care Payment Reform Initiative (PCPRI). We believe the implementation of the PCPRI will further increase the number of enrollees covered under APMs and create viable alternatives to providers embracing these alternative payment arrangements.

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, distinctions 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.

Network Health requires sufficient membership volume for participation under a global budget model. In addition, for a shared-savings approach, there is an additional adjustment to reduce performance that is based upon random variation. To date, all risk arrangements have included some level of risk sharing based upon collaborative negotiation, transparent development of pro formas, and understanding of performance against claim history and benchmarks.

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.

Network Health's evaluation process for determining a provider's participation in a risk contract includes membership thresholds and a provider's experience with risk and organizational infrastructure (financial and clinical). Our evaluation process also includes an examination of a provider's current performance, allowing us to present opportunities for improvement. While many provider systems have experience with risk contracts for commercial populations, there is a reluctance on the part of some providers to adopt these models for subsidized populations due to concerns about the underfunding of state subsidized programs as well as concerns about enrollee engagement. A fundamental component of our approach for providers that are new to APMs is to create a path for them to move along the continuum to greater levels of risk and complexity of models. It remains our goal to have the majority of our primary care providers operating in some level of an alternative payment model.

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.

Network Health does not offer tiered or limited network products.

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.

Network Health encourages enrollees and providers to use preventive and wellness services that are consistent with current medical guidelines. We provide general prevention and wellness education and materials through our website and through regular enrollee communications. In addition, we offer wellness benefits and incentives to help enrollees stay healthy and engage in recommended screening and prevention practices. Network Health also maintains a dedicated NurseLine staffed by nurses and available to enrollees 24 hours a day, seven days a week. The nurse line provides education and health support, guidance for true emergency situations, referrals to appropriate Network Health departments for follow-up, and coordination with Network Health's care management services. Further, we monitor adherence to treatment plans, support enrollee self-management, and encourage the use of available preventive health services, including:

- Periodic health exams for children and adults
- Prenatal care
- Voluntary family planning
- Nutrition counseling;
- Health education
- Early illness-detection screening

As part of our health and wellness program, Network Health also provides benefits provided in addition to covered services (EXTRAS) to enrollees designed to promote health and wellness, including bicycle helmets, home safety kits, as well as money toward Weight Watchers, gym memberships, and childbirth, newborn, and breastfeeding classes. We have not conducted an analysis on the cost/benefit of these offerings.

In addition to these general health and wellness programs available to all Network Health enrollees, we have targeted, population-specific wellness programs to assist enrollees with prenatal and postpartum care, diabetes management, and asthma management. Through our maternal wellness program, the largest of our population-specific programs, we work closely with providers to ensure that pregnant enrollees receive ongoing prenatal care, including targeting enrollees who may be at an increased risk to deliver preterm and/or low-weight infants. Recognizing that healthy pregnancies and healthy births sometimes require both medical as well as social supports, Network Health makes referrals for services ranging from high-risk obstetrics care management to

WIC, aiming to modify any risk factors that may contribute to birth outcomes. Since 2010, we have seen a decrease in the number of NICU admissions and the percentage of NICU admissions to live births. It is interesting to note that while the amount of NICU admissions has decreased, the cost per admission has increased by 21% since 2010. Network Health also has low birth weight and very low birth weight statistics that fall below both the state and federal averages. Following delivery, Network Health coordinates postpartum nurse visits to provide education and identify potential concerns for both mother and baby. Network Health has deep partnerships with visiting nurse associations that provide specially trained clinicians to help us meet goals of the maternal and child health program.

Network Health also offers a wellness program in collaboration with Neighborhood Diabetes to offer education and support to assist enrollees in self-managing their diabetes. In evaluating this program, we saw improvements in some, but not all, areas. One improvement that was observed was an increase in PCP visits for those enrollees participating in the program. While we cannot directly attribute this increase in PCP visits with decreased ED utilization, there may be an indirect correlation, and we are hopeful that the strengthening of the enrollee-PCP relationship will improve continuity of care and translate into meaningful reductions in ED utilization for diabetes management.

The third targeted, population-specific wellness program focuses on asthma management. This pilot program is smaller than the previous two and involves home visits, including assessments of the home environment, reviews of any medication and its proper administration, and education on asthma management. However, the small size of this program makes it difficult to draw statistically reliable conclusions.

All three of these programs are, in their current incarnation, new within the last few years and as such, no specific cost-benefit analyses have been conducted, though we do plan to examine this aspect of the programs in the near future. However, we can point to specific quality measures that support the assumption that these wellness programs have had a downward impact on cost, such as decreased ED utilization, decreased inpatient stays and, in the case of the maternal wellness program, the decline in NICU admissions.

Network Health's employee wellness benefits are managed by our parent company, Tufts Affiliated Health Maintenance Organization (TAHMO).

Exhibit D: Questions from CHIA

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?

Network Health looks forward to analyzing data related to spending trends and clinical quality performance of providers participating in the PCMHI; however, we are still waiting to receive this information from EOHHS for year one of the program.

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 enrollee months associated with the identified and comparative providers.

N/A

Exhibit C1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insur ed and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2010	-1.0%	1.7%	Unable to Determine	Unable to Determine	0.7%
CY 2011	-2.2%	4.7%	Unable to Determine	Unable to Determine	2.5%
CY 2012	-5.4%	3.5%	Unable to Determine	Unable to Determine	-2.0%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					-0.04%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					0.26%

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 changes. 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 the types of providers. 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.

Exhibit C1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insur ed and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2010	-1.0%	1.7%	Unable to Determine	Unable to Determine	0.7%
CY 2011	-2.2%	4.7%	Unable to Determine	Unable to Determine	2.5%
CY 2012	-5.4%	3.5%	Unable to Determine	Unable to Determine	-2.0%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					-0.04%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					0.26%

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 changes. 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 the types of providers. 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.