BOSTON MEDICAL CENTER

HealthNet Plan

Response to:

State of New Hampshire Department of Health and Human Services'

Request for Proposals for Medicaid Care Management Services

RFP #12-DHHS-CM-01

ORIGINAL

December 16, 2011

BOSTON MEDICAL CENTER HealthNet Plan

ORIGINAL

December 16, 2011

State of New Hampshire
Department of Health and Human Services
Walter Faasen
Director of Contracts & Procurement
Brown Building
129 Pleasant Street
Concord, New Hampshire 03301

Re: BMC HealthNet Plan Response to Request for Proposals #12-DHHS-CM-01

Dear Mr. Faasen:

In response to the State of New Hampshire Department of Health and Human Services Request for Proposals # 12-DHHS-CM-01 (RFP), please find the response of Boston Medical Center Health Plan, Inc., d/b/a BMC HealthNet Plan, (BMCHP) to the technical proposal of the RFP.

BMCHP's fiscal agent is our Chief Financial Officer, Laurie Doran, who may be reached at the address below, by telephone (617-478-3550) or by email at Laurie.Doran@bmchp.org.

Our bidder's representative for all matters relating to the RFP is Scott Polansky, Chief of Business Development, who may also be reached at the address below, by telephone (617-748-6263) or by email at Scott.Polansky@bmchp.org.

This will acknowledge that BMCHP has read the RFP, understands it, and agrees to be bound to its requirements consistent with our enclosed response. BMCHP further accepts the terms, conditions and general instructions stated in Part 9 Mandatory Business Specifications, Contract Terms and Conditions. This will also confirm that a completed Exceptions to Terms and Conditions is included with our response to the RFP.

BMCHP's submitted proposal as a bidder to the RFP is valid for a minimum of two hundred and forty (240) days from the closing date for the receipt of proposals. Our proposal is submitted as of the above-referenced date, December 16, 2011.

As Executive Director of BMCHP, I am authorized by the organization to contractually obligate to it the enclosed response to the RFP and may be contacted at the address below, by telephone (617-748-6334) or by email at Scott.OGorman@bmchp.org.

Sincerely,

Scott O'Gorman
Executive Director

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.4 Table of Contents

Table of Contents

Technical Response:

3.2	*Transitioning to the Care Management Program*	**1**
3.3	*Pharmacy Management*	**8**
3.4	*Member Enrollment*	**18**
3.5	*Member Services*	**21**
3.6	*Cultural Considerations*	**41**
3.7	*Access*	**47**
3.8	*Provider Network Management and Requirements*	**65**
3.9	*Payment Reform*	**75**
3.10	*Behavioral Health Services*	**78**
3.11	*Care Management Overall Approach*	**85**
3.12	*Quality Management*	**123**
3.13	*Early Periodic Screening, Diagnosis and Treatment*	**129**
3.14	*Utilization Management*	**131**
3.15	*Data Reporting Requirements*	**147**
3.16	*Grievance and Appeals*	**148**
3.17	*Fraud and Abuse*	**151**
3.18	*Third-Party Liability*	**162**
3.19	*Administrative Quality Assurance Standards*	**168**
3.20	*Delegation and Subcontractors*	**173**

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.4 Executive Summary

6.4 Executive Summary

BMC HealthNet Plan (BMCHP) is well positioned to support the State of New Hampshire in successfully transitioning to a Medicaid managed care environment. We are a not for profit HMO, founded by Boston Medical Center in 1997, when Massachusetts implemented a managed care program for Medicaid.

We are passionately committed to meeting the needs of low income individuals and families who are often under-served. This is our mission. BMCHP now serves nearly 240,000 members in Massachusetts, 83% of whom are on Medicaid, making BMCHP the largest Medicaid HMO in the state.

BMCHP works collaboratively with our providers and members to achieve positive health outcomes. We have been recognized for our quality by the National Committee for Quality Assurance, which recently ranked BMCHP the #3 Medicaid health plan in America, according to NCQA's Medicaid Health Insurance Plan Rankings, 2011–2012.

Our performance is in the top 10% of all Medicaid HMO plans on more than a dozen measures included in the Healthcare Effectiveness Data and Information Set (HEDIS®), based on data submitted by over 130 Medicaid HMO plans to NCQA and published in the NCQA HEDIS 2011 Quality Compass. BMCHP believes that New Hampshire Medicaid members will benefit from our commitment to continuous quality improvement and success in managing members with complex physical, behavioral and social needs.

Our Massachusetts Medicaid provider network is comprehensive, including 58 acute care hospitals, 3,400 primary care physicians, nearly 12,000 specialists and ancillary providers, and 1,000 pharmacies. For New Hampshire, we anticipate having a broad provider network readily accessible for Medicaid members across the state.

BMCHP is partnering with Harvard Pilgrim Health Care (HPHC) to build a comprehensive provider network for Medicaid members in New Hampshire. Working together specifically on this key element of the New Hampshire Medicaid managed care program and building on the unique strengths of each organization, BMCHP and HPHC aim to develop a statewide Medicaid provider network that is as robust and as quality-focused as HPHC's existing commercial network. This will assure ready access to primary and preventive care for all BMCHP's New Hampshire Medicaid members, including those who live in the rural, northern part of the state. (Our memo of understanding with HPHC is attached.)

BMCHP's understanding of the population and experience both in Medicaid and in a state health insurance exchange will enable us to efficiently prepare for Medicaid expansion and any health exchange in New Hampshire in 2014 related to full implementation of the Federal Affordable Care Act. In Massachusetts, we work successfully with the state's health exchange, which offers BMCHP through two different

programs: as a commercial insurance option within Commonwealth Choice for individuals and small employer groups who pay 100% of their premiums, and as a participant in Commonwealth Care, subsidized insurance for adults age 19 to 64 who meet income and other eligibility guidelines. BMCHP entered the commercial market on November 1, 2011. We serve 40,000 Commonwealth Care members and have participated in that program since it began in 2006.

Fifteen years of experience in Massachusetts Medicaid has given BMCHP valuable perspective on working within state budget processes and tight finances. We respect that the New Hampshire Care Management Program is charged with achieving savings of $16 million and will do our part to contribute to those savings. BMCHP has managed medical costs carefully and successfully, enabling the company to post solid reserves that give us financial stability. BMCHP works aggressively and successfully to achieve administrative cost efficiency. For the fiscal year ended September 30, 2011, our administrative cost ratio was in the top 10th percentile of the most efficient Medicaid HMO plans in the nation. For the current fiscal year we forecast an administrative expense efficiency ratio of less than seven percent.

BMCHP has an established program management function and, if selected, will implement the new care management contract with DHHS using the same project management structure it has used to introduce other major market, product and infrastructure expansions. The project management structure includes identification of the program owner and key management person within BMCHP who will be accountable for the program. A core team represented by all functional areas within BMCHP will support the program owner.

Work on our potential New Hampshire Medicaid market entry is currently underway across the functional areas of BMCHP. We are in the process of securing insurance licensing with the State's Department of Insurance (DOI); our preliminary meeting with the DOI was extremely positive. As noted above, we are formalizing a relationship with HPHC under which we will collaborate in the development of a statewide network, capitalizing on HPHC's established network and relationships with providers. We have been meeting with our existing subcontractors to ensure their understanding of the project requirements and timeframes. BMCHP has made contact with several institutions throughout the state to gain a good understanding of the community resources available statewide. Weekly core team meetings are underway to strategize on preparing all program elements for readiness.

While the time constraints of implementing the New Hampshire Medicaid program bring challenges to any participating managed care organization, there are some elements that we would point out, based on our own past expansion and state program-building efforts. These would include items such as development of a provider network, location of in-state office space, meeting all state requirements and hiring of critical positions. BMCHP believes that all of these tasks will be completed in the timeframes required by the RFP. BMCHP's confidence comes in part from its success in expanding

into a Massachusetts statewide network, introducing Commonwealth Care with limited time, and expanding into the commercial insurance market place.

Building on its experience, BMCHP will be ready to implement and be accountable for all functions and deliverables in New Hampshire, starting July 1, 2012, as described in the RFP. Through this proposal we will demonstrate how our experience, infrastructure, and commitment to continuous quality improvement will bring sustainable results to the Medicaid population in New Hampshire. In selecting BMCHP, New Hampshire DHHS would gain a non-profit managed care partner with a strong record of quality and cost-effectiveness and a passion for meeting the needs of under-served populations.

We would welcome the opportunity to serve the State of New Hampshire and its Medicaid members.

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.5 Technical Response

Table of Contents

Technical Response:

3.2	*Transitioning to the Care Management Program*	1
3.3	*Pharmacy Management*	8
3.4	*Member Enrollment*	18
3.5	*Member Services*	21
3.6	*Cultural Considerations*	41
3.7	*Access*	47
3.8	*Provider Network Management and Requirements*	65
3.9	*Payment Reform*	75
3.10	*Behavioral Health Services*	78
3.11	*Care Management Overall Approach*	85
3.12	*Quality Management*	123
3.13	*Early Periodic Screening, Diagnosis and Treatment*	129
3.14	*Utilization Management*	131
3.15	*Data Reporting Requirements*	147
3.16	*Grievance and Appeals*	148
3.17	*Fraud and Abuse*	151
3.18	*Third-Party Liability*	162
3.19	*Administrative Quality Assurance Standards*	168
3.20	*Delegation and Subcontractors*	173

3.2 Transitioning to the Care Management Program

Q1. Describe your experience with initiating similar programs for such a broad array of populations and service in an expedited manner.

BMCHP has extensive experience in initiating and managing care management programs for diverse populations. We currently serve nearly 240,000 members across Massachusetts through our three product lines: MassHealth Medicaid, Commonwealth Care, and commercial (Commonwealth Choice). To serve our MassHealth and Commonwealth Care members, BMCHP contracts with nearly 60 acute care hospitals, 15,000 health care providers, and 1,000 pharmacies. For our Commonwealth Choice plan, BMCHP currently offers a network of select healthcare providers in eastern Massachusetts.

As an experienced managed cared organization, BMCHP routinely reviews, analyzes, and responds expeditiously to various requests for proposals from government agencies interested in establishing or enhancing care management programs. Building on this experience and reputation, BMCHP is very interested in partnering with the State of New Hampshire to successfully implement its Medicaid managed care program.

BMCHP's relevant experience initiating the above product lines is outlined below:

MassHealth Program

BMCHP began our participation in the Massachusetts Medicaid program, known as MassHealth, in 1997 in the Boston area. BMCHP expanded our service area over subsequent years, achieving a statewide network by 2008. As a managed care organization partnering with the state, BMCHP developed and executed multiple program requirements ranging from customer service to IT integration to reporting. Through these collaborative efforts, we are currently the largest Medicaid managed care organization in Massachusetts with nearly 200,000 members.

Commonwealth Care Program

BMCHP successfully launched the Commonwealth Care program in October 2006 in response to Massachusetts' healthcare reform law. We initiated the program within six months. Among other things, our participation required systems changes for billing, eligibility, claims and benefits. New policies and procedures were developed and implemented to meet the requirements of this new program. These and other changes were implemented quickly to meet applicable state requirements.

Commonwealth Choice

In further response to Massachusetts' healthcare reform law, BMCHP also recently joined the Commonwealth Choice program under which individuals and small

businesses obtain health insurance through the state's health exchange, known as the Commonwealth Health Insurance Connector Authority. As with our participation in other programs, BMCHP has developed new infrastructure and processes to successfully administer these products under aggressive timeframes.

Q2. Describe your proposed implementation approach for Step One

BMCHP is committed to a successful implementation of Step One of the New Hampshire Medicaid Care Management Program. Drawing on its extensive experience as a Medicaid managed care organization for the past 15 years, BMCHP has addressed many of the same kind of operational and other issues presented by this RFP.

BMCHP will implement Step One by using the same project management structure we have used to implement other major market, product and infrastructure expansions. BMCHP has an established program management function. Our structure and programs have resulted in the successful expansion of a statewide managed care network, the introduction of a government-subsidized program, Commonwealth Care, with limited time, and the establishment more recently of commercial products. In addition, we have applied our program management processes internally to make important system upgrades and process redesign activities.

As with all major initiatives, we will assign a program owner to be the accountable point of contact for the New Hampshire Medicaid Care Management Program. The program owner will be supported by an internal team which will represent all functional areas within BMCHP. For the course of the initial implementation, the team will be a mix of dedicated resources and shared resources depending on topic area. For example, we envision having dedicated resources in areas such as provider management, clinical services (including care management, quality and credentialing), finance and information technology.

In addition to the internal BMCHP team, we will work with other integral parties. We will specifically work with the Department of Human Health and Services (DHHS) to identify the key individuals there and at other relevant state agencies. We will also work closely with our subcontractors to meet project requirements and timeframes. BMCHP has an established structure for sharing information with key subcontractors so that monitoring occurs on a real time basis.

In implementing Step One, BMCHP program management approach will include the following steps:

- Develop a charter and scope – this will largely be driven by this document.
- Establish a process of working with DHHS to finalize the requirements that will be included in the contract.
- Complete a RAID (risks, assumptions, issues and dependencies) analysis and establish the RAID tracking tool.

- Define the communication structure – internal, with DHHS and with subcontractors.
- Implement weekly reporting structure with BMCHP executive team. This is used to resolve any potential resource issues.
- Create a project plan – tasks, resources, time frames and dependencies.

In particular, BMCHP will perform a RAID analysis. The RAID tracking tool is a key tool during the course of a project, as it supports the identification of issues and the resolution of those issues. The RAID tool can be used to facilitate discussions with DHHS. We understand that it will be critical too resolve open issues rapidly given the short time frames associated with the implementation.

Based on past expansion efforts, we are aware of those aspects of a program that can have significant time constraints and that represent a critical path for the project. For New Hampshire, these would include aspects such as expansion of provider network, location of in state office space, resolution of state requirements and hiring of critical positions.

BMCHP is confident in our ability to implement Step One and other phases of this program successfully through its demonstrated ability to analyze and execute a program management process that effectively addresses program requirements.

Q3. Describe your experience in managing care for dually eligible populations. What are the greatest challenges to meeting the needs of these groups?

As one of the National Committee for Quality Assurance's (NCQA's) top ranked Medicaid HMO plans in the nation for the past three years, we have substantial experience managing care for members with complex health and social needs. While BMCHP does not currently serve as a Medicare subcontractor for dually eligible members, we have significant experience with members, including Medicaid-eligible disabled members, who have complex, multiple health needs. Many of our members in care management have multiple chronic conditions, including both medical and behavioral health conditions, and difficulty accessing care and services.

A BMCHP core competency is integrating and managing care across an often fragmented delivery system. We collaborate with community agencies to coordinate care for members with complex health needs to ensure they have access to services they need. Our complex care managers are expert in helping disabled members learn to self manage their condition and get the medically necessary supplies they need to manage their day to day lives, and work collaboratively with their primary care givers to coordinate their care.

Ensuring members with chronic disease adhere to their medication regimens is integral to keeping them out of the hospital and in the community. Interventions that evaluate what drugs members are taking, where they are filling prescriptions, what doses they are taking and whether they are adhering to prescribed courses of treatment delivers significant benefit to a highly co-morbid, mental health intensive population, particularly as it relates to psychotropic medications.

Integrating medical and behavioral health

Our behavioral health partner, Beacon Health Strategies (Beacon), is experienced in managing dually eligible populations and provides services for dually eligible members and Medicare Advantage Special Needs Plans (SNPs) across 12 states. Together, BMCHP and Beacon we are well versed in offering integrated complex care management, encouraging preventive care for members with chronic conditions, and medical and behavioral health disease management for members across the continuum of care. We would work closely with Beacon in New Hampshire, using their expertise in the development of a care management program to serve the dual eligible population, assuring that behavioral health care services are fully integrated with medical care. Our approach to the plan design process would be holistic, integrating medical and BEHAVIORAL HEALTH clinical quality and design protocols, operational workflows, information technology and even local management structure.

Transition to home

BMCHP has a transition to home program for members who need monitoring and follow up when discharged from acute inpatient facilities to home. We would consider expanding the program to cover such transitions in New Hampshire. With Beacon, we work seamlessly to manage those members with medical and behavioral health or substance abuse diagnoses. We have medical and behavioral health care managers, care coordinators who work with members on social issues, nurses and social workers who can interface with state agencies when necessary and meet the needs of this challenging population. We work with community health centers and providers with whom members are established in order to continue care whenever possible. If an in-plan specialist wishes to become a disabled member's primary provider, we will make every effort to facilitate the request.

Mobile teams

Integrated care management relies heavily on a mobile, interdisciplinary team to drive results. This means that in addition to physicians and hospitals, non-traditional community providers such as social workers, peer navigators, nurse practitioners and educational support staff serve as "feet on the street" in the community to identify and address the needs of beneficiaries. This approach ensures people are getting the care they need when they need it, while still allowing for cost savings.

Home-based therapy and location of medical and behavioral health in a primary care setting

Case management and treatment services must extend to members' homes to successfully serve the most vulnerable of the dual eligible enrollees. Home-based therapy programs, medication management and care coordination services are essential for members who are unable to access traditional outpatient services or who otherwise would not adhere to treatment protocol, particularly following a hospitalization.

Co-location of behavioral health care providers in a primary care setting – such as a clinic or physician's office – is a common-sense approach to ensuring care is seamless and coordinated for such highly vulnerable members. In New Hampshire, we would make a special effort to include any such care sites in our network, thus giving members at these sites a team-based, patient-centered health home, increasing penetration of behavioral health services, reducing the likelihood of psychiatric hospitalization and, thus, generating medical cost savings.

Challenges and barriers

Geography is one challenge. We expect that the limitation in transportation and certain types of specialists north of the Franconia Notch are barriers for this population. We will reach out to the North County Consortium and begin working on building a strong network in the north. In the months prior to contract implementation, we will work to become more familiar with the population and geographic challenges.

One key challenge in managing the dual eligible population is insuring that members maximize their Medicare benefits including Medicare Part D, before reverting to their Medicaid benefit. This includes managing members who are approaching the end of life and have access to hospice benefits as well as palliative care benefits. Care management program training and education will be provided on how to facilitate conversations about treatment choices at the end of life.

The potential for fraud and abuse is higher with this population. BMCHP will put a process in place to monitor claims for fraud and abuse services delivered to those in the community to ensure that care billed for was indeed provided.

In addition to the approaches described above, in order to most effectively manage the dual eligible population, BMCHP will learn to know and ultimately become expert in working with New Hampshire state agencies in coordinating behavioral and medical care for members in the least restrictive setting.

In summary, we have are confident that we will be ready and able to offer integrated high quality services and coordination of care to the dual eligible population.

Q4. Describe your experience in managing the full range of long-term services and supports, including in-home supports, residential care and nursing home services

For fifteen years, BMCHP has been working closely with Massachusetts to develop and implement innovative solutions to the diverse needs of our members. In coordination with the New Hampshire Department of Health and Human Services, BMCHP will similarly develop effective long-term services and supports, including in-home supports, residential care and nursing home services.

We believe an important part of meeting the needs of members requiring long-term services and supports is through the integration of medical and behavioral health services. Along these lines, BMCHP will partner with Beacon Health Strategies (Beacon) and together we will manage the full range of long-term services and supports required to fulfill the New Hampshire contract.

In particular, Beacon has extensive experience providing assessment, triage, stabilization and coordination services across the full range of long-term care services. In other New England states, Beacon provides members with in-home (family home, residential program, nursing home, etc.) crisis evaluation, assessment and ongoing therapeutic and training services. For members with mobility challenges, in-home therapy and medication support services are available. More recently, Beacon has added telemedicine as another resource available to help bridge member and geographic challenges in accessing needed services.

An example is Beacon's partnership with a health plan in Rhode Island. Since 2002, their two organizations have been the sole managed care entity for all children in Rhode Island who are in the care and custody of the state. Over these past nine years, they evolved several strategies to offer excellent care whether transitioning from an inpatient stay or moving into a residential placement, including the establishment of case management team-based assessments, community-based services including intensive home-based therapy and acute residential treatment, and residential programs.

As noted, BMCHP and Beacon have experience working together as partners, collaborating on large implementations and our companies both have long histories of commitment to this underserved population. Culturally we are a good fit and have proved this during these past two years of side by side work. Together, our experience managing the medical and behavioral needs of children and adults with long term needs will make this transition successful.

Q5. In 2014, if PPACA is still in place, a great number of consumers will routinely move between Medicaid and subsidized coverage available on a health benefits exchange. DHHS is interested in minimizing the impact of these transitions on consumers. Please describe your current interest in potentially offering a product on the Health Benefits Exchange to allow members to maintain continuity of access to services as they transition from one program to another.

BMCHP is very interested in offering products through the Health Benefits Exchange to allow members to maintain continuity of access to services as they transition from one program to another. This is exactly the approach we have pursued in Massachusetts where we participate in MassHealth (Medicaid), Commonwealth Care and Commonwealth Choice. The latter two programs are offered through the Commonwealth Health Insurance Connector Authority. Commonwealth Care is a program for adults who do not have access to employer sponsored insurance (ESI) and do not qualify for Medicaid. Commonwealth Choice is a commercial product available to individuals and employers with 1-50 eligible employees.

This strategy in Massachusetts allows us to offer our members a full spectrum of program options as their eligibility changes. We would absolutely look to pursue a similar strategy in New Hampshire.

3.3 Pharmacy Management

Q6. Recognizing DHHS' PDL/Formulary approach, describe your general approach to pharmacy management. Provide specific details in the following areas:

- **Describe your Medication Adherence programs and how they are coordinated with your care management programs**
- **Describe your specialty pharmacy program and how it is coordinated with your care management programs**
- **Describe your approach to pharmacy utilization management**
- **Describe your approach to pharmacy lock-in programs**
- **Describe your approach to making pharmacy services information, such as claims history, drug information, etc) accessible to members**

BMCHP has developed a comprehensive pharmacy program that offers a clinically appropriate and cost-effective drug formulary to address the complex needs of our underserved population. In collaboration with our pharmacy benefits manager (PBM), informedRx®, we coordinate the benefits of the program, monitor prescription utilization and cost trends, and integrate the program into medical and behavioral health services offered by BMCHP. We primarily manage the pharmacy benefit through clinical utilization management strategies and point-of-service drug utilization review (DUR) edits programmed within the claims adjudication system.

BMCHP utilizes an advanced claims adjudication system, RxClaim®, to provide real-time point-of-services edits to verify eligibility, limit refill thresholds, and drug utilization review (DUR) evaluations. This tool helps to control the cost and quality of prescription medication care, while also identifying member and prescribing practitioner abuse patterns. DUR edits include, but are not limited to, prompts for drug-drug interactions, drug-pregnancy alerts, underutilization or overutilization, and drug-allergy warnings.

BMCHP has a Pharmacy and Therapeutics Committee (the Committee) consisting of actively-practicing physicians and pharmacists from distinct geographic areas of Massachusetts that meets every two months throughout the year. The purpose of the Committee is to develop, manage, and ensure that the formulary, guidelines and protocols, and clinical editing are up to date, reflect current medical knowledge and practice, and comply with all applicable legal, regulatory, and accreditation standards. The Committee annually reviews therapeutic drug classes and clinical protocols to ensure objectivity and the credibility of the recommendations.

Describe your Medication Adherence programs and how they are coordinated with your care management programs

BMCHP collaborates with two specialty pharmacy vendors, Accredo® and Ascend® Specialty, to implement programs for complex conditions in promoting medication

adherence. The specialty pharmacy vendors provide value-added clinical services on behalf of BMCHP through proactive outreach to members encouraging medication adherence and improvement in symptoms with limited adverse events. In addition, outreaches are made to providers to coordinate prescription refills and verify dosage regimens. These services are provided for complex conditions such as rheumatoid arthritis, psoriasis, pulmonary hypertension, respiratory syncytial virus prophylaxis for preterm infants, and asthma. Our specialty pharmacy vendors' active management provides opportunities for referrals to BMCHP's care management programs. Examples of frequent referrals received include members on Xolair® treatment for uncontrolled asthma or Synagis® prophylaxis for preterm infants.

BMCHP maintains a monthly registry that identifies members who have demonstrated patterns of medication non-compliance and over-utilization of emergency department visits. This registry is used to identify and outreach to candidates for our care management programs. For enrollment into one of BMCHP's care management programs, logic consisting of both medical and pharmacy claims is applied.

In addition, BMCHP's internal Pharmacy Department directly collaborates with the care management programs. Licensed clinical pharmacists participate on daily and weekly rounds to provide medication expertise and consultations to nurse case managers and medical directors. BMCHP's clinical pharmacists also conduct direct member outreach for medication reconciliation reviews to provide individualized counseling. It is an opportunity for both the pharmacist to identify clinical interactions and evaluate polypharmacy and for members to question and express concerns regarding their medications. Additional outreaches to the prescribing practitioners are made on behalf of the member to further address any concerns or issues identified as a result of the outreach.

Medication use plays a significant role in the management of clinical conditions and collaboration between BMCHP, specialty pharmacy vendors, and internal pharmacy staff is an integral component of overall coordination of care. BMCHP continues to identify areas of improvement and works to enhance the clinical programs to achieve the most beneficial outcomes for our members.

Describe your specialty pharmacy program and how it is coordinated with your care management programs

BMCHP's specialty pharmacy program was established for the management of high cost medications used in the treatment of complex or rare conditions. Specific inclusion criteria are applied to identify medications appropriate for the program. Criteria include limited distribution network established by the manufacturer, high cost, complex administration and/or handling, high risk adverse event profiles, special storage requirements, and complex therapies requiring patient education and frequent monitoring for treatment optimization.

Medications included in the specialty pharmacy program are handled by one of BMCHP's two contracted specialty pharmacies. In addition to the specialty pharmacy's primary role of dispensing medications, there are value-added clinical services provided by the specialty pharmacy vendors as described above that are an additional source of care coordination for BMCHP members. Care coordination is focused on medication adherence, monitoring of side effects and facilitating continuation of treatment in collaboration with prescribers. Through the management of these clinical conditions, members are evaluated for care management and referrals are made to BMCHP's care management programs.

Describe your approach to pharmacy utilization management

BMCHP manages a two-tier and three-tier open formulary. Our prescription drug formulary includes coverage of the majority of prescription medications and a subset of over-the-counter (OTC) medications approved by the United States Food and Drug Administration (FDA). BMCHP has a limited number of medications/drug classes that are excluded from coverage. These include but are not limited to, medications used primarily to treat cosmetic conditions, male erectile dysfunction and infertility.

BMCHP utilizes a number of pharmacy programs including new-to-market, mandatory generic, prior authorization, step therapies, and quantity limitations to manage pharmacy utilization and costs for non-excluded medications. A description of each of the utilization management programs is as follows:

New-to-Market

BMCHP reviews new drugs for safety and efficacy before adding them to the drug formulary. New drugs require prior authorization until they are approved by the Committee.

Mandatory Generic

BMCHP promotes the use of generic drug equivalents. All brand-name drugs that have FDA-approved AB-rated generic equivalents require prior authorization.

Prior Authorization

Prior authorization is a process by which medications that are not covered at the point-of-sale may be covered upon submission of additional pharmacy and medical information by the prescribing provider. The information received is reviewed against evidence-based clinical protocols approved by the Committee. Medications may be placed on prior authorization for reasons including, but not limited to, high cost, abuse potential, complex monitoring, or significant adverse effect profiles.

Step Therapy

The program evaluates therapeutic drug classes that contain more than one medication within a therapeutic class for efficacy, adverse effects, and cost. Requirements for medications placed on step therapy include required trials of preferred medications within the same therapeutic class which have demonstrated similar or superior efficacy, similar or improved adverse event profiles, and lower costs.

Quantity Limitations

The quantity limitation program ensures the safe and appropriate use of some medications through limitations on the amount that can be dispensed at one time. All limitations reflect FDA-approved dosage recommendations and clinical practice. Quantities exceeding the allowed amount require prior authorization. The program helps to reduce waste and encourage optimization of medication regimens.

Describe your approach to pharmacy lock-in programs

We offer a Controlled Substance Management Program (CSMP) that identifies a member population at risk for inappropriate use of controlled substances. The program incorporates various member and provider interventions targeted at educating members on the risks of over utilizing controlled substances, encouraging coordination of care among involved health care providers, and promoting appropriate utilization of other non-pharmacologic healthcare services.

Specific criteria have been developed that assist in identifying the most actionable members. Interventions associated with the CSMP include medical/behavioral health care management outreach, provider outreach, and pharmacy and/or physician restrictions.

Members exhibiting patterns of using multiple pharmacies to fill controlled substance prescriptions are selected for restriction to one specific pharmacy location. All prescriptions must be filled at a central location to assist the pharmacist in conducting more inclusive medication drug utilization reviews. Members and their primary care physicians are notified of the restriction with 30 days prior notice to the effective date of the restriction. Pharmacy restrictions are individualized and locations are selected based on member residence and prescription fill history to limit barriers to medication access. Members may elect to request a change to a preferred pharmacy location once per year.

In addition, members have the option to submit a formal appeal to remove the restriction. Upon implementation, the selected pharmacies may in turn request to be exempt from the restriction should they demonstrate the inability to appropriately coordinate and manage the member's care. On a yearly basis, the member profile will be re-reviewed and a recommendation for removing the restriction or continuation of the lock-in will be made based on medication use patterns as evidenced by claims during the past year.

Describe your approach to making pharmacy services information, such as claims history, drug information, etc) accessible to members

BMCHP's external website includes an online patient education resource and audio library that is readily accessible to members. Materials are also available in traditional print format. The resource provides members with general background information on health conditions and medications including side effects, drug interactions and administration. This tool serves as a valuable resource to members in an easily understood, patient-friendly manner.

In addition, BMCHP's PBM provides an online tool at www.myinformedrx.com, that directly links to the pharmacy claims adjudication system. Through this tool, members have access to their prescription history, prior authorization history, and the ability to look up general drug information. Members enrolled in BMCHP's mail order pharmacy program are also able to see prescription claims history filled through the mail order program. Other valuable features of the tool include a pharmacy locator for available network pharmacies and determining member specific copays for individual medications.

BMCHP's medication formulary is available both at www.bmchp.org and at www.myinformedrx.com. Members can utilize this tool to determine the most up to date information on covered medications and specific coverage limitations, if any. A member may request a printout of BMCHP's formulary or their individualized prescription claims history via our Member Services or Pharmacy Services departments.

Q7. Describe your academic detailing program or other programs that support evidenced-based physician prescribing

In support of evidence-based physician prescribing efforts, BMCHP has implemented two quality initiatives targeting treatment of asthma and diabetes. Both programs were developed in accordance with nationally recognized treatment guideline recommendations.

The asthma program has been in effect for over five years and has been continually evaluated for improvement opportunities. On a quarterly basis, the Asthma Treatment Advisory Report (ATAR) is generated using logic consisting of pharmacy and medical claims. The report identifies members who have been diagnosed with persistent asthma filling a high number of rescue medications and low (or no) number of controller medications. According to the National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program guidelines, members diagnosed with persistent asthma are recommended to be on chronic treatment with a controller medication. The ATAR report includes the name, date and prescriber of all asthma medications for six months and dates of inpatient and/or emergency department visits for asthma in the past 12 months. The individualized report is mailed to all prescribers of asthma medications for each member identified. The most recent quantitative analysis demonstrated six-month effectiveness (≥ four prescriptions for a controller medication

and ≤ four rescue medications) of 12.35% of members identified who had filled a controller medication six months following the report. Additionally, the three-month effectiveness analysis (≥ two prescriptions for a controller medication and ≤ two rescue medications) demonstrated 10.64% of identified members filled a controller medication three months after following the report.

The diabetes program includes two semi-annual reports that reflect treatment recommendations from the Massachusetts Adult Diabetes guidelines. BMCHP was the first managed care organization in Massachusetts to implement the Medication Optimization report. It has been in effect for the last three years and identifies members with a diagnosis of diabetes on three or more oral medications with two or more overlapping prescriptions and not on insulin. In accordance with the Massachusetts Adult Diabetes guideline, patients on three or more oral medications should be considered for insulin treatment to achieve optimal diabetes control. The report includes name, date, and prescriber for all oral agents, dates and results of diabetic screenings (if available), and dates of inpatient and/or emergency department visits related to diabetes. The individualized report is mailed to all practitioners prescribing oral hyperglycemic medications. The quantitative analysis demonstrated that 6.15% of members identified initiated treatment with insulin three months following the report.

BMCHP also generates the Diabetes Treatment Alert (the alert) report that utilizes available laboratory results to identify members diagnosed with diabetes with HbA1c ≥8 and/or LDL ≥130 mg/dL. The alert incorporates laboratory results as well as the name, date and prescriber for all anti-hyperglycemic medications and HMG CoA-reductase inhibitors filled by the member. The alert is mailed to primary care physicians semi-annually notifying them of their patient's current clinical status and encourages consideration of the recommendations as outlined in the treatment guideline to improve the management of diabetes. The information shared is intended to promote coordination of care between all providers treating the member's diabetes in various settings.

Q8. Describe your strategy to create a robust network of pharmacies across the State

BMCHP's pharmacy network is contracted through our pharmacy benefits manager (PBM), informedRx®. Our PBM has a national network of pharmacies, including a network in the State of New Hampshire with 250+ contracted chain and independent pharmacy sites. On a quarterly basis, a report is generated to demonstrate the addition of and removal of network pharmacies for monitoring purposes. In addition, an annual geographic access report is generated to evaluate member accessibility to a network pharmacy. BMCHP's current Massachusetts pharmacy network has been able to support access to a pharmacy within three miles for 95% of membership and within five miles for 98% of membership.

Additionally, our contract with our PBM requires that they ensure an adequate pharmacy network as defined by BMCHP's standards. On request, the PBM will run ad

hoc reports based on member zip codes, and contract with new pharmacies in areas where access does not meet network standards.

Q9. Describe what role, if any, the pharmacies play in your disease and care management programs

BMCHP is proactive in coordinating care for members enrolled in our disease and care management programs. This includes direct outreach to prescribers and pharmacies when it has been determined that barriers are adversely impacting quality of care. Medication access can be an issue for members for a variety of reasons, including those that are prescriber related, systems related, or pharmacy related. Both care managers and pharmacy staff are proactive in assessing the problem and reaching out to our network pharmacies to resolve the issue. As the issues are identified, the pharmacies work with us to determine possible solutions and take action as necessary. Pharmacies have demonstrated a willingness to collaborate with BMCHP when contacted and to support BMCHP's care management program efforts to improve coordination of care.

In addition, BMCHP receives notifications from pharmacies when patterns of medication misuse are identified or if there are concerns with provider prescribing patterns. Each concern is evaluated internally and referrals are made for enrollment into care management when coordination of care is warranted.

As part of BMCHP's Controlled Substance Management Program, pharmacies play a large role in managing a member's medication use and coordinating with the prescribing providers to prevent overuse or abuse of prescription medications. In all circumstances, BMCHP works collaboratively with pharmacies to ensure appropriate use of medications without impacting care.

Q10. Describe your strategies to promote the use of e-prescribing

Providers in Massachusetts currently utilize e-prescribing tools to generate and send electronic prescriptions directly to pharmacies. BMCHP's pharmacy network has the capability to accept and process electronic prescriptions through BMCHP's claims adjudication system. In collaboration with our PBM, BMCHP is developing a strategy for implementing enhancements to the e-prescribing process utilizing the RxExchange® tool. The tool is an exchange utility that connects the PBM to third party e-prescribing switching vendors and allows providers to request a member's insurance eligibility and formulary information. This will enhance the prescribing process by informing the provider of member-specific historical and real-time prescription history and insurance coverage. With all information readily available, providers can avoid duplicate therapy, medication overuse or underuse, or potential drug-drug interactions as they decide on treatment. In addition, the provider will have access to any insurance-related limitations.

Promotion of this tool would include direct provider education and development of useful resources to simplify the learning process. Providers would have access to the

PBM for questions and concerns. BMCHP would also incorporate information about the RxExchange® tool into our provider education mailings, such as the Provider Newsletter.

Q11. Describe strategies you employ to make your formulary and prior authorization accessible to your provider network

BMCHP makes all clinical policies and medication formularies readily accessible to providers at via our website as well as through our PBM. Providers may directly request a copy of BMCHP's formulary and/or clinical policies from BMCHP or the PBM.

In 2010, BMCHP collaborated with MassHealth to publish our formularies on Epocrates®, a clinical provider resource. Providers can look up specific medication coverage information for BMCHP via the Epocrates® online web resource or personal digital assistant devices. The formulary files on Epocrates® are updated weekly as new medications become commercially available and a large file update is sent with each new pharmacy implementation.

On an annual basis, BMCHP contracts with the Massachusetts Medical Society to publish our formularies in the Formulary Guide made available to providers across Massachusetts. The Formulary Guide is a reference guide consisting of plan formularies for commercial and Medicaid health plans throughout Massachusetts. It serves as an alternative resource for providers as they evaluate patient care and make treatment determinations.

We will work with the state and providers to implement similar programs in New Hampshire.

Q12. In regards to pharmacy claims adjudication:

Who adjudicates your pharmacy claims?

informedRx®, Inc., a subsidiary of SXC Health Solutions, Inc.

Describe how you ensure adequate oversight and monitoring of the pharmacy claims processor.

BMCHP ensures adequate oversight and monitoring of our pharmacy claims processor through established contract terms with the PBM that address appropriate and timely processing of pharmacy claims. The contract terms are in accordance with all regulatory and contractual requirements required of BMCHP, which is overseen by the Director of Pharmacy Services. Annual reports are required of the PBM to audit the claims system and demonstrate all metrics and thresholds are in compliance with contract terms. Additional ad hoc reports are also requested of the PBM to ensure compliance throughout the year. On a yearly basis, BMCHP employs auditing consultants to conduct on-site and system audits to ensure compliance with all processing guarantees.

If pharmacy claims are paid through a different claims platform than medical claims, describe how third-party liability information is coordinated and shared.

BMCHP receives daily files feeds of claims data that are processed through the PBM's claims adjudication system. All data is stored in BMCHP's data warehouses and is available for internal reporting. BMCHP contracts with a third-party liability vendor that utilizes BMCHP's medical and pharmacy claims data to handle drug related recoveries. Please see TPL information included in Section 3.18, Q91 for further details.

If pharmacy claims are paid through a different claims platform than medical claims, describe how encounter data are aggregated.

Encounter data for pharmacy claims are aggregated by the PBM on behalf of BMCHP. In collaboration with Massachusetts MassHealth program, BMCHP and the PBM developed a quarterly report incorporating all necessary data fields. The report is automated and generated quarterly for submission. With regard to medical claims, these are processed via BMCHP's internal claims processing system. We are in the process of updating system capabilities to accept specific medication details required for encounter data. In parallel, BMCHP will be implementing requirements for providers to begin including all necessary data fields on claims submissions. Once captured, medical encounter data will be aggregated by BMCHP and submitted in parallel to the pharmacy claims encounter data. BMCHP would work with DHHS to develop encounter data for both pharmacy and medical claims in accordance with DHHS' requirements and regulations.

If pharmacy claims are paid through a different claims platform than medical claims, describe how pharmacy utilization data are used in your disease and care management programs. Describe how pharmacy data are linked with Medical claims data at the member level in these programs.

BMCHP receives daily claims file feeds from the PBM and all data is stored together with medical claims within our data warehouse. Both medical and pharmacy claims information is available for internal reporting and incorporation into our disease and care management programs. BMCHP's monthly registry incorporates both medical and pharmacy claims in the member identification logic. The use of both medical and pharmacy claims is key in identification of high-risk members requiring coordination of care for improved clinical outcomes. For example, the asthma care management program logic identifies members on steroid medications or Xolair®, have ED visits, inpatient acute admissions, or prior identification on the ATAR report described above.

All pharmacy and medical data are also available within our CareEnhance® Clinical Management Software (CCMS®) that serves as the primary tool for BMCHP's care management programs and utilization management processes. Member profiles within CCMS® show prescription claims history, medical services, diagnoses, prior

authorization requests, and member demographic information to aide our nurse case managers in developing individualized and effective care management plans.

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

3.6 Cultural Considerations

Q29. Describe how you will assure cultural competency throughout your network. What training programs and support do you offer staff and providers regarding cultural competency?

BMCHP has almost 15 years of experience successfully managing care for widely diverse Medicaid populations, each with unique experiences and needs. To assure the delivery of culturally and linguistically appropriate services throughout our network, BMCHP employs three fundamental elements in developing the composition of our provider network; access, engagement and retention. This is supported by our Availability of Practitioner Services Policy, which states, "The organization acts upon data collected by adjusting the network composition to ensure the membership needs and preferences are met." Additionally, the organization strives to link the member to the practitioners who can best meet the member's cultural, ethnic and linguistic needs and preferences.

In order to meet our commitment of cultural competency, and the challenge of the ever changing shifts in racial, ethnic, linguistic, gender orientation, special needs, disability, and religious diversity, we have implemented a number of strategies to assure cultural competency, including but not limited to: ongoing support to our providers, in-house trainings to BMCHP staff, providing members with written notices in their preferred language and making sure those patient related materials are easily understood. These same strategies will be employed for the New Hampshire Medicaid population, provider network and staff. A description of each strategy is as follows:

Provider Support

BMCHP's provider manual has a section titled "Cultural and Linguistic Responsibilities of All Contracted Providers" which offers guidelines to providers to assist them in interacting with members and families from other cultures. These guidelines were developed by BMCHP based on the Office of Minority Affairs, National Standards, for CLAS (Cultural and Linguistic Appropriate Services in Health Care). They are intended to help providers work effectively with members and families who are from other cultures. Examples of these guidelines include: interpreter guidance, instructions to providers to ask patients about their culture, and how to avoid making assumptions based solely on a patient's country of origin.

BMCHP also developed and distributed a provider education tool called "Twelve Steps to Cultural Competency" based on these same guidelines. Further, in our Pay for Performance incentive programs, we required any participating providers to document that they have completed cultural competency training. We also offer basic cultural competency training via our provider Internet portal.

Staff Training

BMCHP has accomplished basic cultural competency training for all staff, including, member services, clinical, IT, provider relations, claims and human resources. As new staff is on-boarded, they are required to complete a cultural competency on-line course as part of our on-boarding program. This course is designed to educate our staff on why it is business critical that managed care organizations like us have the ability to provide care to members with diverse values, beliefs and behaviors and tailor our delivery of that care to meet our members' social, cultural, and linguistic needs.

In addition, BMCHP contracts with Network Omni and Language Line to ensure that translation by interpreters is immediately available for non-English speaking members who call the Member Services Department. All staff interacting with members receive training about accessing and using these interpreter services.

Language Assistance Services

BMCHP employs bilingual staff in all of our clinical program areas and also in our customer service/call center. Currently, 35% of the Call Center representatives are bilingual and when vacancies occur, efforts are made to recruit bilingual staff. For incoming calls, transfers can be accomplished to Spanish speaking staff via an automated prompt system. For outgoing calls, if a member has identified another language as primary language spoken, BMCHP provides same language services through our contract with Network Omni and Language Line.

For its hearing-impaired members, BMCHP provides a dedicated TDD/TTY telephone number. This line is provided for deaf and hearing-impaired members and translates conversations into typed messages on the member's home TDD/TTY system. The TDD/TY telephone number is listed in all BMCHP provider directories in the Member Handbook and on the BMCHP Web site. Efforts are underway to develop and offer American Sign Language video clips for any materials where this format is required. In addition, upon request our Member Services representatives currently, and will continue to, read aloud to blind or vision-impaired members any written member communications. This includes new-member materials. Upon request, the member handbook is also available in Braille.

Similarly, our 24 hour nurse advice line provides bilingual services to members in English and Spanish and access to additional language translation services as necessary.

Member Materials

BMCHP's Quality Department is able to stratify member data by linguistic identifiers. This allows us to provide appropriate literature as needed to these members for quality initiatives. Currently written translation services are also available in Spanish. Therefore, when a member identifies Spanish as his/her preferred language, all communications are mailed to that member in Spanish. For other non-English speaking members, a

"Babel" card is enclosed with all member handbook mailings. This card informs the member in 11 threshold languages and reads as follows:

> "Important! This information is about your BMC HealthNet Plan benefits. It needs to be translated right away. BMCHP can translate it for you. If you need help with the translation or other help, call BMC HealthNet Plan at 1-877-957-5300."

In addition, a free language translation service is available to members, upon request, to help with questions about BMC HealthNet Plan administrative procedures. This service provides you with access to interpreters who can translate over 140 languages."

Additionally, BMCHP collects language and information on special populations served by our provider network including but not limited to, homeless, persons with disability, children with severe disabilities and dual-diagnosis and makes it available in both written and online directories. This allows members the ability to view and choose providers who speak their primary language and/or who serve a special population.

Plan Customer Service

We recognize that customer service impacts every part of our member experience from both dealing directly with our staff on site to dealing with their provider. Therefore, BMCHP has three regional offices based in Boston, Springfield and New Bedford. These offices allow us to provide member and provider focused services, as Behavioral Health, medical care managers, provider relations and community relations staff are directly located at all locations. These regional office locations provide assistance to both members and providers in their own communities and assists in our commitment to cultural competency.

In keeping with this regional strategy, our Provider Contracting Department follows a group contracting model that typically results in the inclusion of physicians from virtually all cultural groups. The capacity of a physician group to accommodate a significant number of cultural groups is assessed as part of the contracting process.

To ensure that the cultural needs of our membership are met on an ongoing basis, BMCHP offers linguistic and other special needs information collected through the enrollment process to call center and health services personnel whenever they interact with members. We store individual race, ethnicity and language data that is collected during the enrollment process in a dedicated data warehouse which can be used for analysis and targeted clinical quality interventions. Currently our race, ethnicity and language data collection status for all lines of business is 45.1%. In order to accurately collect this data on an ongoing basis, our member services staff has been trained on how to best ask the question when speaking with our members.

BMCHP's commitment to meeting its members' cultural and other special needs is compliant with regulatory and accreditation requirements, including Federal Civil Rights regulations and National Committee for Quality Assurance (NCQA) standards. BMCHP is also a member of the National Health Plan Collaborative to Address Racial and Ethnic Disparities and through that venue stays abreast of and shares best practices with the ten other plans who participate.

Cultural competency issues are also discussed at BMCHP's Quality Improvement Committee. This speaks to our emphasis on providing high quality services to our members and is one of the reasons why we were name the #3 Medicaid Plan in America by the National Committee for Quality Assurance (NCQA).

Q30. Describe how you will ensure that your provider network is ethnically diverse and similar to the demographic profile of your members.

BMCHP serves a diverse population representing multiple ethnic and language groups. Our goal is to meet the health care needs of members by providing high quality and comprehensive care consistent with their cultural and linguistic needs. One of our corporate values includes: "a commitment to meet the healthcare needs of all vulnerable and low-income people in Massachusetts and to serve the ever-changing healthcare needs of our members, while honoring their ethnic, religious and cultural differences". We will employ this same philosophy in serving the New Hampshire Medicaid population.

As part of our commitment, we strive to identify and address the cultural, ethnic, racial, linguistic and other special needs on an ongoing basis. This helps ensure that all BMCHP members:

- Have access to appropriate care when they need it
- Understand their benefits and how to use them
- Have access to customer service if they experience any problems

To ensure that our provider network is ethnically diverse and similar to the populations we serve, BMCHP has formalized this commitment in the Availability of Practitioner Services Policy and Procedure, which it will adopt for the New Hampshire Medicaid Program. This policy states:

> "The organization acts upon data collected by adjusting the network composition to ensure the membership needs and preferences are met. Additionally, the organization strives to link the member to the practitioners who can meet the member's cultural, ethnic and linguistic needs and preferences. The Plan collects language information from providers and makes it available in both written and online directories. Members may choose providers who speak their primary language."

One of our provider contracting strategies is to follow a group contracting model that typically results in the inclusion of physicians from virtually all cultural groups. The capacity of a physician group to accommodate all significant cultural groups is initially assessed as part of the contracting process. If a specific unmet cultural/linguistic need is identified in the network, contracting personnel will recruit new providers to the network.

To maintain an ethnically diverse provider network, BMCHP adjusts the availability of providers when we identify members with unmet cultural or other special needs and has multiple processes in place to identify them, including: the member enrollment process, the customer service process, the appeals and grievances process, the quality management process, the medical management process, and periodic review of demographic data. BMCHP has dedicated resources within all the above areas and in the contracting and claims department to ensure that the needs identified are being met and our provider network is analogous to our membership.

Additionally, BMCHP's Provider Relations staff routinely assesses the number and types of providers using data from internal and external sources. Internal data is obtained by monitoring enrollment projections, assessing out of network authorizations and reviewing geographic reports that identify the location of members and providers. External data includes information from Grievances and Appeals; CAHPS® survey results, provider satisfaction surveys, and feedback from our provider partners.

Further, our internal Access & Availability Oversight Group which consists of representation from Provider Relations, which chairs this meeting, Contracting, Quality, Compliance, Corporate Analytics, Office of Clinical Affairs and Public Partnerships meets monthly to monitor network information and ensure that our members continue to have adequate access.

Additionally, we expect to leverage information and experience on assuring ethnic diversity in our provider network gained by Harvard Pilgrim Health Care, our strategic partner for provider network development. A network Cultural Competency Survey was conducted by Harvard Pilgrim in November 2010. Harvard Pilgrim, working in conjunction with Culture InSight of the Harvard Pilgrim Foundation, solicited input

from providers in our network to gain a better understanding of the cultural competency activities in New Hampshire and other New England states in which it does business.

This survey was intended to provide baseline measures of cultural competency activities that are currently in place among Harvard Pilgrim's contracted practitioners and providers. Cultural competency activities included assessments of current and future needs for interpreter services, current ability to meet interpreter needs of patients, types of interpreter services available, policies for training and assessing interpreters, incidence of recruitment programs, cultural competency training and cultural competency evaluations for non-clinical leadership and administrators, other non-clinical staff and clinical staff.

3.7 Access

Q31. Describe your approach to building a viable network of services in the rural areas of New Hampshire and how you will ensure access to primary and specialty care in these areas.

Four core elements drive BMCHP's approach to building a viable and accessible provider network across all service categories:

- **Quality**: BMCHP creates a quality network of providers then engages them in the process of enhancing quality and improving health status.
- **Accessibility**: Our network supports adequate primary care and specialty physician services, hospital services and ancillary services to all members. By meeting distance and volume standards we ensure responsiveness to member needs and timely care access that minimizes disruption of care and optimizes care delivery.
- **Partnership**: We include providers in the creation and management of health plan processes, policies, and decision making directed to the care and health outcomes for members.
- **Relationships**: We maintain strong provider relationships that evolve via dialogue and respectful interaction.

Since the RFP did not provide a definition of rural New Hampshire counties, BMCHP utilized the US Census Bureau's definition of rural and urban counties. Since all 10 New Hampshire counties are described as metro, BMCHP then examined county typology via the 2003 Rural-urban continuum code (1 to 9) (also known as the Beale Code) to create a rural category.

2003 Rural-Urban Continuum Codes – USDA Economic Research Service

Code	*Description*
	Metro Counties
1	Counties in metro areas of 1 million population or more
2	Counties in metro areas of 250,000 to 1 million population
3	Counties in metro areas of fewer than 250,000 population
	Non-metro Counties
4	Urban population of 20,000 or more, adjacent to a metro area
5	Urban population of 20,000 or more, not adjacent to a metro area
6	Urban population of 2,500 to 19,999, adjacent to a metro area
7	Urban population of 2,500 to 19,999, not adjacent to a metro area
8	Completely rural or less than 2,500 urban population, adjacent to a metro area
9	Completely rural or less than 2,500 urban population, not adjacent to a metro area

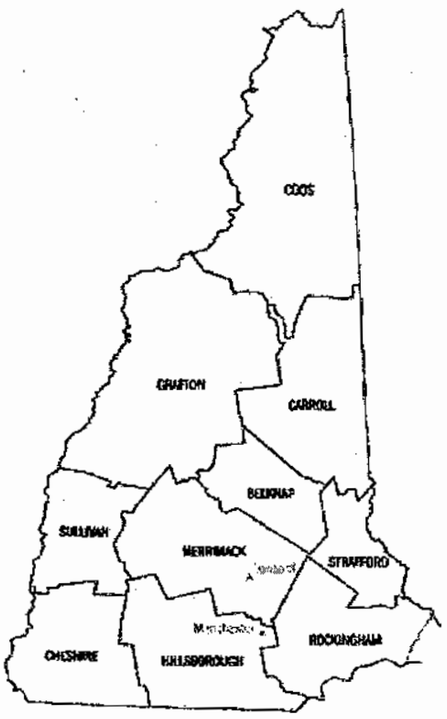
BMCHP designated those counties with a rural-urban continuum code of four or greater as rural counties. The counties listed below are designated as rural and urban based on this methodology. Because the state capital, Concord, is located in Merrimack County, and given the population of this one city, Merrimack County is considered an exception and labeled as urban. Total NPI Providers listed are from the NPI data set and are not Medicaid only.

County	*Rural-Urban Code*	*Designation*	*Total NPI Providers*
Belknap County	4	Rural	494
Carroll County	8	Rural	335
Cheshire County	4	Rural	585
Coos County	7	Rural	256
Grafton County	5	Rural	1774
Hillsborough County	2	Urban	3470
Merrimack County	4	Urban	1444
Rockingham County	1	Urban	2236
Strafford County	1	Urban	929
Sullivan County	7	Rural	220

Given these rural county designations, BMHCP will meet the geographic access standards as set by the RFP for rural New Hampshire Medicaid members, when at least one or two providers of each type participate in Medicaid in each county.

BMCHP recognizes that the New Hampshire Medicaid Program may standardize the urban/rural designations and if different from the BMCHP designations, we will adjust our definition and access requirements accordingly.

Frequently, rural residents are faced with limited health care resources in their communities. To ensure access to health care for rural members, BMCHP has contacted and invited over 7,000 providers statewide to engage with BMCHP via Letters of Intent (LOI). This includes both Medicaid and non-Medicaid physicians in rural areas to participate in the BMCHP provider network.



Communications with providers have highlighted BMCHP's status as a not-for-profit Medicaid HMO, along with a successful history, low administrative costs, and national recognition as the number three-ranked Medicaid health plan in America, according to NCQA's Medicaid Health Insurance Plan Rankings 2011-2012.

Accessibility of primary care, specialty physician, hospitals, and ancillary services

Given the above rural county designations, BMCHP shall meet the geographic access standards as set by the RFP for rural New Hampshire Medicaid Program Members, when sufficient providers participate in Medicaid in each county.

It is essential that services are available to all Medicaid members with minimal disruption to care and with the least amount of travel, allowing members to remain in their own communities where they have access to familiar places that have familiar faces; while at the same time, ensuring that the necessary health care can be delivered efficiently and effectively.

Traditionally, Medicaid members gravitate to the closest available providers and those that are most familiar to them. Understanding this, BMCHP has identified health care providers in border state communities of Norway, Maine; Island Pond, Lyndonville, St. Johnsbury, White River Junction, Windsor, Springfield, Bellows Falls, Putney, and Brattleboro, Vermont; and others, inviting them to participate with us and the New Hampshire Medicaid Program as long as such providers can be granted New Hampshire Medicaid Participation status.

Per the RFP's request, BMCHP is sensitive and focused on ensuring maternity services in Coos County and will seek to continue the enhanced inpatient maternity benefits to critical access hospital Androscoggin Valley Hospital in Coos County while seeking other potential maternity options for members. To further address the challenges in rural Coos County, BMCHP will not only work with Androscoggin Valley Hospital for maternity services but also engage Upper Connecticut Valley Hospital and Weeks Medical Center to ensure that they understand we view them as partners in effective health care for other services.

To be specific about access requirements, BMCHP will utilize a combination of the state's access standards coupled with provider adequacy member ratios as illustrated below.

Below are the published RFP Access Standards:

Specialty	*Access Standard - Rural*
PCPs	Two (2) within forty-five (45) miles
Specialists	One within sixty (60) minutes or sixty (60) miles
Hospitals	One within sixty (60) minutes or sixty (60) miles
Mental Health Providers	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One, seven (7) days a week, within thirty (30) minutes or thirty (30) miles

Below is an additional level BMCHP uses to determine adequacy in addition to the DHHS requirement above:

Provider Type	*Adequacy Measure - Rural*
Acute Care Hospitals	1 Per County or Access Radius
Adult Medical Day Care	1 Per County or Access Radius
Advanced Practice Registered Nurses	1 :500 Members
Ambulance	1 Per County or Access Radius
Audiology	1 Per County or Access Radius
Day Habilitation Center	1 Per County or Access Radius
Dental	1 Per County or Access Radius
Family Planning Services	1 Per County or Access Radius
FQHCs/Rural Health Clinics	1 Per County or Access Radius
Home Health Services	1 Per County or Access Radius
Hospice	1 Per County or Access Radius
Lab (pathology)	1 Per County or Access Radius
Medical Services Clinic	1 Per County or Access Radius
Non Emergency Transportation	1 Per County or Access Radius
Nursing Facility Services for Children with Severe Disabilities	1 Per County or Access Radius
Podiatrist	1 Per County or Access Radius
Primary Care Physicians	1 :500 Members
Private Duty Nursing Agency	1 Per County or Access Radius
PT/OT/ST	1 Per County or Access Radius
Radiology	1 Per County or Access Radius
Skilled Nursing Facilities	1 Per County or Access Radius
Specialty Physicians	1 Per County or Access Radius
Vision Services	1 Per County or Access Radius

Assumptions: *Often Rural areas may not meet Per Thousand adequacy calculations. Per County or Mileage accessibility are standard alternate measures.*

In some areas of New Hampshire, medical services may not be available within these guidelines. In these cases, we will demonstrate to the New Hampshire Medicaid Program the scope and extent of our network development efforts and continue to work to secure health care provider services. BMCHP shall only request exceptions when all other means of securing health care services have been exhausted.

When contracted services are not available within these guidelines, BMCHP will authorize services to be performed by non-contracted providers at offices and facilities that are equipped to provide the required services locally and shall transport the members to the nearest available health care service provider utilizing emergent or non-emergent transportation based upon medically necessary criteria (see Question 59).

BMCHP will contact providers who are frequently used in this manner and target them for recruitment and network-building activities. In this way, BMCHP will gradually expand its network to include providers that members prefer and already utilize frequently.

BMCHP also has a commitment to telemedicine, when it is appropriate and implemented in a member-centric manner. We have found through our research that through the use of telecommunication and information technologies, clinical health care can be delivered at a distance. When used judiciously, telemedicine assists in the elimination of distance barriers and can improve access to medical services that would often not be consistently available in rural communities. In the future, BMCHP proposes to investigate and actively explore the use of telemedicine for rural areas of New Hampshire.

BMCHP recruitment approach

To achieve the right mix of quality and accessibility, BMCHP utilized several data sources to create our list of targeted providers. We followed a disciplined four-step approach during the limited time span for proposal development to achieve the most effective network possible. Because of this thorough, disciplined groundwork, we are well positioned to execute provider agreements quickly if awarded a contract.

- Widespread communication via fax to 7,000 Medicaid and non-Medicaid providers;
- Targeted fax and telephonic outreach to the Top 25 providers by category in the RFP data book based upon claims volume;
- Further targeted outreach both telephonically and via fax to 100% of the New Hampshire Hospitals, Community Mental Health Centers, Rural Health Clinics, Family Planning Clinics, and Federally Qualified Health Centers; and
- Site visits to key providers and provider groups.

BMCHP understands how busy these offices are, and in order to lessen the impact on these offices and facilities, we provided the physician offices the ease of returning LOIs via fax. We additionally scheduled webinars to introduce BMCHP and answer initial questions about our organization to interested providers both during and after office hours.

Additionally, since a significant portion of the health care in rural areas are provided by Federally Qualified Health Centers, Rural Health Centers, local Advanced Practice Registered Nurses, Community Mental Health Centers and Public Health Departments, BMCHP will develop close affiliations and relationships with these essential health care providers in New Hampshire, leveraging our considerable experience with community health center partnerships. We also understand that there may be members that have

difficulty leaving their place of residence; to better serve these members, BMCHP will be investigating the availability of physicians, advanced practice registered nurses, and other specialties for "In Home" services.

BMCHP is committed to building a strong provider network. We interacted with many providers and those who collaborate with providers and continue to schedule meetings, both face-to-face and telephonic to introduce our organization. BMCHP has also established a strategic partnership with Harvard Pilgrim Health Care to work together in order to leverage their commercial network expertise in order to build a Medicaid network. We have enclosed a signed Memorandum of Understanding indicating Harvard Pilgrim's willingness to negotiate access to its physicians, should BMCHP be awarded a contract. The Memorandum of Understanding can be found at Exhibit 6.5.A. This up front work positions us well to quickly establish a robust and accessible provider network, should BMCHP be awarded a contract.

In addition, Harvard Pilgrim has a proven ability to build comprehensive New Hampshire networks to support diverse populations. Most notably, for many years Harvard Pilgrim had the sole Medicare HMO plan in New Hampshire, and in 2010 was awarded the New Hampshire Healthy Kids contract. In both cases, the timeline to negotiate contracts with rates lower than traditional reimbursement levels was aggressive, yet Harvard Pilgrim was able to build lower cost networks with ample access by the respective effective dates of the plans.

We have encountered some challenges along the way that we are working diligently to address but that require a unified resolution with the state. Our ability to demonstrate the extent of coverage we will have in place is somewhat restricted by provider concerns regarding policies and rates associated with the current program. For instance, we were informed by acute care hospitals including Dartmouth-Hitchcock, New Hampshire's largest hospital and PHO, that, as a party to a current lawsuit over low Medicaid rates, they are not signing LOIs with <u>any</u> potential managed cared organizations at this time. Critical access hospitals, including Androscoggin Valley Hospital, have also communicated that they are declining to sign LOIs with all requesting carriers. BMCHP continues to outreach to providers who will not execute a letter of intent to contract this time, and we believe that our strong track record of proven performance, low administrative costs, and commitment to member health outcomes will secure participation by some of the largest providers once we are awarded a contract.

BMCHP understands how busy these offices are, and in order to lessen the impact on these offices and facilities, we provided the physician offices the ease of returning LOIs via fax. We additionally scheduled webinars to introduce BMCHP and answer initial questions about our organization to interested providers both during and after office hours.

Additionally, since a significant portion of the health care in rural areas are provided by Federally Qualified Health Centers, Rural Health Centers, local Advanced Practice Registered Nurses, Community Mental Health Centers and Public Health Departments,

BMCHP will develop close affiliations and relationships with these essential health care providers in New Hampshire, leveraging our considerable experience with community health center partnerships. We also understand that there may be members that have difficulty leaving their place of residence. To better serve these members, BMCHP will be investigating the availability of physicians, advanced practice registered nurses, and other specialties for "In Home" services.

BMCHP is committed to building a strong provider network. We interacted with many providers and those who collaborate with providers and continue to schedule meetings, both face-to-face and telephonic to introduce our organization. BMCHP has also established a strategic partnership with Harvard Pilgrim Health Care to work together in order to leverage their commercial network expertise in order to build a Medicaid network. Harvard Pilgrim has mailed the following letter to their contracted network of providers to inform them of our plans to partner in support of the New Hampshire Medicaid program. A copy of this letter can be found at Exhibit 6.5.B.
We have encountered some challenges along the way that we are working diligently to address but that require a unified resolution with the state. Our ability to demonstrate the extent of coverage we will have in place is somewhat restricted by provider concerns regarding policies and rates associated with the current program. For instance, we were informed by acute care hospitals including Dartmouth-Hitchcock, New Hampshire's largest hospital and PHO, that, as a party to a current lawsuit over low Medicaid rates, they are not signing LOIs with any potential managed care organizations at this time. Critical access hospitals, including Androscoggin Valley Hospital, have also communicated that they are declining to sign LOIs with all requesting carriers. However, our upfront work and ongoing work with Harvard Pilgrim Health Care's partnership position us well to quickly establish a robust and accessible provider network, should BMCHP be awarded a contract.

BMCHP's value proposition to providers: including providers in health plan management, processes and policies

BMCHP offers providers a shared decision making process, not only between physicians and their patients, but in collaboration with contracted physicians, hospitals, ancillary services and our organization. This will be accomplished through the invitation to physicians, hospitals and ancillary providers to participate in our various health plan committees, such as the Pharmacy and Therapeutics Committee, credentialing meetings, HEDIS and quality meetings.
We will also develop and invite providers to participate in the Provider Advisory Committee that will meet periodically throughout the year in locations easily accessible to providers. The Provider Advisory Committee agenda will include but not be limited to discussing daily difficulties the providers identify, addressing these issues, and working together to create solutions; proposing BMCHP program initiatives; and seeking stakeholder input from the committee participants.

BMCHP has made contact with the New Hampshire Medical Society and the New Hampshire Hospital Association presenting our commitment to their membership and

to the Medicaid members of New Hampshire. Through contact and collaboration with these essential organizations, we are better able to understand and act on issues and concerns they may be experiencing. These meetings have already begun, and we propose to continue periodic meetings and maintain an open dialogue with these organizations to enable us to understand and act on issues facing health care providers.

Through our site visits with key local physicians and physician groups, including local hospitals and hospital/physician organizations, BMCHP has begun to outline our proposed collaborative efforts. Providers have responded well to this approach. By meeting with these health care providers early, we demonstrate our vision of collaboration in providing the best medical care and services at the appropriate levels, and provide them a seat at the table in the decision making process of the management of members' health care going forward.

BMCHP's value proposition to providers: responsiveness to health care service providers' needs

It is one measure to include physicians and hospitals in decision making committees and quite another to provide the day to day efficient services that they require to care for the Medicaid population. Accurate and timely payment is paramount to providers, as is knowing who to call when questions or problems arise. BMCHP also offers a best-in-class provider website to streamline operations and facilitate communication.

Accurate and prompt payment is critical to providers. BMCHP has worked diligently to facilitate this for our network including as follows:

- BMCHP currently is reimbursing providers within 9.4 days of receipt of clean claims with 98.3% of overall claims paid within 30 days.
- We have achieved an accuracy rate of 96% for the past 12 months, which well exceeds the requirements of the New Hampshire Medicaid Program, outlined as "MCO shall pay or deny 95% of clean claims within thirty (30) days of receipt; shall pay interest on any clean claims that are not paid within thirty (30) days at the interest rated published in the Federal Register in January of each year for the Medicare program and shall pay or deny all claims with in sixty (60) days of receipt."
- BMCHP follows the CMS established definition of "clean" claim which is "a clean claim does not have any defect, impropriety, lack of any required substantiation documentation, or particular circumstance requiring special treatment that prevents timely payment."

At all times the BMCHP Provider Relations team is available to provide information or specific answers to provider questions, and is the primary connection between the network providers and BMCHP. Provider Relations staff are assigned to providers and work with the providers by orienting physicians, ancillary providers, clinicians, vendors, administrative staff, hospital staff and other personnel on policies and procedures. They

respond promptly to provider calls, questions and concerns, and they are available for ongoing education and support to the provider network. The BMCHP Provider Relations team is required to return calls within 24 hours of receipt. We monitor and track our service levels to providers, adjusting and revising staffing as needed to meet the providers' needs.

BMCHP also offers electronic services to our contracted providers via our interactive web site. This website, which will be customized for the New Hampshire Medicaid Program with information specific to New Hampshire, is much like having a provider service representative in their office. Through our comprehensive web site, providers can submit claims electronically; we currently offer electronic claims services through Emdeon (WebMD/Envou/McKesson) ProxyMed/Med Avant or the SSI Group. Claims are accepted through NEHEN for providers who are able to submit claims directly to us. Also we provide electronic remittance advices, claims status inquiry, remittance history, coding information, prior authorization and pharmacy authorization forms.

The BMCHP provider manual is easily accessed through the web site and it includes a table of contents to allow the provider office staff to easily find resources and answers to their questions. Through periodic site updates, providers will receive network notifications, keeping them up to date in real time about changes in programs and processes and eliminating paper and phone calls in and to their offices.

Providers are able to electronically verify member's eligibility in several ways, using BMCHP Web Services, where logins control access and keep the information in HIPAA compliant format, or through HIPAA standard 270/271 transactions through any of the following partners: NEHEN, Gateway EDI, Passport Health, TransUnion (formerly MedData), and HDX/Siemens.

A current prior authorization matrix is available for easy reference and use by the provider's office staff.

Providers may also access clinical resources, cultural competency training, credentialing and provider enrollment information, and clinical practice guidelines on our web site.

All of these efforts, combined with the unique value proposition BMCHP offers, mean BMCHP will be able to build a provider network across New Hampshire that allows us to meet the accessibility requirements as defined by the New Hampshire Medicaid Program, but more importantly, to meet the health care needs of New Hampshire Medicaid Program members.

Q32. Describe your strategies for provider recruitment for providers who currently do not accept Medicaid.

BMCHP has proactively contacted over 7,000 New Hampshire providers including providers that do and those that do not currently provide Medicaid services. For those providers that are not currently actively providing services to Medicaid members,

BMCHP has developed a four-point approach for the recruitment of these providers. The four-point recruitment plan consists of:

- Partnering with Harvard Pilgrim to leverage their existing relationships with New Hampshire providers
- Identifying Medicaid as a new revenue source
- Providing experience to the physician practice and preparation for the Patient Protection and Affordable Care Act (PPACA) in 2014
- Ease of working with a non-profit organization whose focus is on the Medicaid Members and the health care providers

Identifying Medicaid as a new revenue source

In the current national healthcare environment, many physician practices are looking for sources of revenue to supplement the trend of decreasing reimbursement from the for-profit, commercial payors. With fewer persons eligible to receive health care through their employers, fewer commercial members are utilizing the services of providers. These providers have become accustomed to the higher number of members in their office resulting in higher revenues. While many struggle to retain the revenue, many of these providers may not have given consideration to their participation with Medicaid as a resource for supplementing this lost income.

BMCHP will identify for the non-Medicaid physician practices the potential retained revenue stream available through participation in Medicaid. Through their participation with BMCHP, as a Medicaid managed care organization, providers will be reassured to work with us with our focus on quality and support of the health care providers. This means that less of their time will be involved in following up with and collecting from self-pay patients. During our conversations with the non-Medicaid participation providers, we will offer to send the providers a State of New Hampshire Medicaid provider application. We will allow them to state their preference for obtaining this information through fax, email, or through the provision of the direct link, to the New Hampshire Medicaid Program website link. The link to this information is:

http://www.nhmedicaid.com/Downloads/Forms/ProviderEnrollmentApp-final04.pdf

BCMHP will also be available to assist the providers in completing the form, answering questions and providing assistance to them where they may need it. We feel by offering to assist the offices, we will be ensuring the completion of the application and the providers will more readily be willing to complete and submit the application form, thereby demonstrating our true goal to work collaboratively.

BMCHP is accustomed to the development of HEDIS quality incentives, Primary Care Case Management (PCCM) program incentives, medical home compensation, and will

work diligently in our efforts to ensure the health care dollars stay in the local doctor's practices, thereby supporting the practices and the communities in which they reside.

Health care reform

By participating with BMCHP in the New Hampshire Medicaid Program, providers who have limited or no experience with managed care and government programs will begin to become more familiar with systems, policies and requirements that they will be faced with in the very near future with the Health Care Reform mandates due in 2014. As always, easing providers into new program, program changes and/or new requirements, is the best approach and one that allows the providers and their staff to understand and gradually accept the inevitable changes.

BCMHP will approach the physician community from a supportive, helpful perspective. We are preparing to provide to the physician and hospital community a complete and comprehensive training and education on the requirements of New Hampshire Medicaid Program, we believe that education is the best approach and that through full disclosure of what the providers can expect, they will agree to participate with BMCHP and the New Hampshire Medicaid Program. We will draw our education program from our 15 years of experience in managing a non-profit Medicaid health plan as well as from our commitment to providing health care services to the Medicaid Members and ongoing support of the health care providers.

Ease of working with a non-profit organization whose focus is on Medicaid members and the health care providers

As a non-profit health plan, BCMHP focuses on the care of the member and support to the physician and health care community providing the services. We do this through Provider Relations Department and our easy to access and easy to use systems.

Our Provider Relations Department is committed to assisting potential Medicaid providers with their questions or concerns promptly and efficiently. We have experienced trained Provider Relations staff who are dedicated to supporting and assisting providers. Our Provider Relations staff are individually assigned to providers to assist them with services under our plan, the New Hampshire Medicaid regulations and with other information the health care providers may need to be successful. Our goal is to make the providers successful and limit the administrative time they need to spend researching and finding out information on their own. By contacting their assigned Provider Relations staff, they can be assured of prompt and efficient assistance with their questions or concerns, resulting in a decrease of administrative time and a constant, reliable resource to tap for a response to their questions.
BMCHP will emphasize the value of online support tools, including our state-of-the-art website and how they support providers' daily operations.

BMCHP will detail our provider manual and how it is easily accessed through the website, including through its table of contents to allow the provider office staff to easily

find resources and answers to their questions. Through BMCHP periodic updates to the website, providers will receive network notifications which are posted for changes in programs and processes allowing the provider offices to keep up to date in real time, eliminating paper and phone calls in and to their offices.

Providers who are currently non-Medicaid providers will be informed of their ability to electronically verify member's eligibility in two ways: (1) using the BMCHP Web Services, where we will provide a login to keep the information in HIPAA compliance format and (2) through HIPAA standard 270/271 transactions through any of the following partners: NEHEN, Gateway EDI, Passport Health, TransUnion (formerly MedData) and HDX/Siemens

Since questions always arise surrounding prior authorization requirements, the non-Medicaid providers will be educated on the placement of the current BMCHP prior authorization matrix available on our website, which is easy for provider office staff to reference in use. We periodically update this information to ensure the health care staff has the most current information. They will be made aware of notifications that are posted to the web site, specifically discussing and identifying changes and updates as they occur, striving to keep the providers and their staff up to date and current with the New Hampshire Medicaid Program.

Providers who do not participate in Medicaid will also be informed about BMCHP's claims reimbursement processes. Accurate and timely payment is paramount to Medicaid and non-Medicaid providers. BMCHP currently is reimbursing providers within 9.4 days of receipt of clean claims with 98.3% of overall claims paid within 30 days. We have achieved accuracy rate of 96% for the past 12 months, which well exceeds the requirements of the New Hampshire Medicaid Program. BMCHP follows the CMS established definition of "clean" claim. Clearly identifying these requirements and our compliance to these requirements, allows for understanding by the health care providers and staff. We will make this information known to all potential non-Medicaid providers.

Providers may also access information on clinical resources, cultural competency training, credentialing and provider enrollment information and clinical practice guidelines on our website. A specific website will be created for the New Hampshire Medicaid Program with information specific to the New Hampshire Medicaid Program and with the same interactive components. You may visit our web site at: http://www.bmchp.org/about-us.

Through all of these efforts and in addition to many other efforts, BMCHP is confident in our ability to contract with non-Medicaid providers, enabling us to build a comprehensive provider network throughout New Hampshire for the New Hampshire Medicaid Program.

Q33. Submit a list of all providers, by provider type/specialty, in New Hampshire in your network, or who are expected to be in your network. Include an indication of the level of agreement that has been reached at the time of the RFP response.

In response the Question 33, BMCHP has prepared an attachment that appears at Exhibit 6.5.C. which contains a listing of all:

- Letters on Intent physically received by BMHCP during the pre-RFP recruitment process; and

A summary grid by provider type is provided below:

Summary of providers by LOI

Type	*Count*
Facility	3
Hospital	3
Inpatient MH	5
Other	49
Outpatient MH	189
PCP	122
Pharmacy	39
Specialist	109
Total providers	519

In addition, 554 provider service locations have stated that they will explore contracting post-RFP award with us including 17 New Hampshire hospitals. These providers are listed at Exhibit 6.5.D.

As a health plan new to New Hampshire, BMCHP has taken a multi-pronged approach to building a network in the state. Through our own initial efforts we have successfully obtained LOIs from 519 providers in the relatively short proposal development period. As noted above, we are now also working with Harvard Pilgrim to supplement these network development efforts using their statewide commercial network. These efforts demonstrate our strong commitment to New Hampshire, as well as to quality, accessibility, partnership.

BMCHP is also extremely well-positioned to quickly execute contracts with additional providers, should BMCHP be awarded a contract. As shown in the table above, BMCHP has entered into a memorandum of understanding (MOU) with Harvard Pilgrim Health Care, a well-respected commercial plan that has topped the list of America's Best Health Plans for eight years in a row. This MOU allows us to work together in order to leverage Harvard Pilgrim's commercial network expertise to build a robust Medicaid network. We have also had productive conversations with many providers, including New Hampshire hospitals, indicating they will consider joining our network, but have not

been able to complete LOIs before the proposal due date. We will build our partnership with Harvard Pilgrim and work together to advance network development while the State considers our proposal.

Q34. Identify the projected ratio of primary care and specialty providers to members by county and rationale you have used to determine that the network is sufficient.

Ratios and methodology

BMCHP's provider adequacy methodology utilizes a combination of provider to member ratios for primary care and a provider count per county for specialty care:

- One Adult PCP for every 200 adult members per region
- One Pediatric PCP for every 300 pediatric members per region
- Rural Specialists: Minimum 1 per type per county
- Urban Specialists: Minimum 2 per type per county
- Rural Hospitals: Minimum 1 per type per county (if available)
- Urban Hospitals: Minimum 2 per type per county (if available)
- Ancillary: 2 per type per county, regardless of rural or urban designation

These sufficiency calculations are then overlaid with the access standards and wait times established by the New Hampshire Medicaid Program. We then perform a multi-dimensional assessment of network adequacy comprised of sufficiency, accessibility and timeliness.

Below is the BMCHP Adequacy Ratio Calculation Table illustrating required providers per county by primary care and specialist ratio.

		Membership			*Adequacy*				
	County	**Total**	**Adult**	**Child**	**PCP**	**PED**	**Specialist**	**Hospital**	**Ancillary**
Rural	*Belknap*	6,454	2,323	4,131	11.62	13.77	1 / County	1 / County	2 / County
Rural	*Carroll*	5,136	1,849	3,287	9.24	10.96	1 / County	1 / County	2 / County
Rural	*Cheshire*	8,283	2,982	5,301	14.91	17.67	1 / County	1 / County	2 / County
Rural	*Coos*	3,550	1,278	2,272	6.39	7.57	1 / County	1 / County	2 / County
Rural	*Grafton*	9,572	3,446	6,126	17.23	20.42	1 / County	1 / County	2 / County
Rural	*Merrimack*	15,729	5,662	10,067	28.31	33.56	1 / County	1 / County	2 / County
Rural	*Sullivan*	4,698	1,691	3,007	8.46	10.02	1 / County	1 / County	2 / County
Urban	*Hillsborough*	43,041	15,495	27,546	77.47	91.82	2 / County	2 / County	2 / County
Urban	*Rockingham*	31,709	11,415	20,294	57.08	67.65	2 / County	2 / County	2 / County
Urban	*Strafford*	13,227	4,762	8,465	23.81	28.22	2 / County	2 / County	2 / County
	Total	***141,399***	***50.904***	***90,495***	***254.52***	***301.65***			

Even with effective adequacy definitions to guide network development activities and achieve measurable results, it is important to note that building an effective provider network is an iterative process that is never fully complete due to the constantly changing Medicaid and provider environment, updated experiential data, and ongoing managed care organization approach innovation. BMCHP embraces this dynamic process and utilizes network-building to enhance provider relationships while incenting correct behaviors and improving care delivery models based upon experiential data. Harvard Pilgrim brings considerable experience with this process in New Hampshire.

Rationale

PCP and pediatric ratios

BMCHP has utilized the proposed network adequacy ratios for adult and pediatric PCPs over the past 15 years. These ratios have proven to be adequate and have enabled BMCHP to achieve national recognition for quality of care.

- One adult PCP for every 200 adult members per region
- One pediatric PCP for every 300 pediatric members per region

Specialists, hospitals and ancillary providers

BMCHP currently does not have prescriptive member per thousand calculation requirements for specialists, hospitals and ancillary providers. Instead, we focus on meeting access standards based upon mileage accessibility from each member's residence. However, it is often useful to have a simplified metric against which to track network strength.

Therefore, BMCHP proposes adding an additional adequacy measure to include a target count of providers per county (based upon availability). This additional measure coupled with the mileage access standards ensures a minimum level of sufficiency and adequacy. BMCHP will strive to provide access to all providers in New Hampshire that wish to participate and meet the requisite participation requirements, and are not excluded from participation on the Medicare or Medicaid program.

- Rural specialist: Minimum 1 per county
- Urban specialist: Minimum 2 per county
- Rural hospitals: Minimum 1 per county (if available)
- Urban hospitals: Minimum 2 per county (if available)
- Ancillary: 2 per county

Examples of specialists, hospitals and ancillary providers:

- All members in urban Hillsborough County would have access to at least 2 specialists within the access standards specified by the New Hampshire Medicaid Program.
- All members in rural Belknap County would have access to at least 1 in-county Hospital.
- All members in all counties would have access to at least 2 ancillary providers per county.

In summary, the proposed standards will enable BMCHP to duplicate our quality focus and recognition in New Hampshire. They also represent a balanced approach to sufficiency of providers, access to care, and timeliness of care and create a true illustration of network adequacy against which to focus on member health status.

Q35. Describe how you will ensure that members have access to providers who are knowledgeable about genetic or chromosomal conditions (related health risks, and understand the issues of health disparities for individuals with intellectual/developmental disabilities and the prevention and management of secondary disability(ies).

BMCHP is sensitive to the unique challenges faced by members with intellectual and developmental disabilities. Access to providers who are knowledgeable about genetic or chromosomal conditions and the related health risks, understanding of health disparities and the prevention and management of the secondary disabilities is essential.

BCMHP will ensure that our members have access to providers who specialize in the treatment of these conditions by effectively recruiting and retaining them within our network. BMCHP will focus first on the recruitment of primary care physicians who specialize or have a preference for treating intellectually/developmentally disabled individuals will be sought.

We will do this by asking the providers to indicate on the letter of intent form whether they specialize in providing services to these individuals. This will allow their care givers to immediately identify these providers. BCMHP will then work to contract with these providers and include them in our provider network. For example, we are actively seeking agreements with Elliot Health system and Dartmouth-Hitchcock, both of which have specialty departments for genetic and chromosomal conditions and consulting. Additionally, any specialty providers will be included in our provider directory in order to identify their ability to treat intellectually/ developmentally disabled persons. Finally, we will partner with Harvard Pilgrim to leverage existing agreements with a broad array of physicians who treat both genetic and chromosomal conditions and related health risks.

Next, BMCHP will seek providers in the ancillary service community who offer speech therapy, physical therapy and occupational therapy services, ensuring adequate coverage and locations to ensure services are available. If there are providers in these specialty areas that specifically specialize in intelligence/developmental disabled, they too will be specifically identified in the provider directory. Home health services will be provided as needed for wound care as deemed an appropriate and effective.
Beacon Health Strategies, our behavioral health partner, understands the connection between medical and behavioral health conditions. Closing the loop between behavioral health and medical providers is central to its clinical philosophy. Beacon's care management program aims to engage those members who have complex behavioral and/or medical needs, such as those individuals with genetic conditions and or intellectual disabilities. To ensure that members do not fall through care gaps and get the right care at the right time from the right provider, Beacon identifies candidates for its care management program through analysis of medical, behavioral and pharmacy claims data and through referrals from Beacon's internal utilization review staff, primary care clinicians, behavioral health providers, and enrollees and their families. Once a member becomes involved in the program, he or she is assigned a case manager who facilitates the development of an individualized care plan involving the individual and his or her family members and all treating providers. This individual care plan consolidates treatment goals and potential interventions for both medical and behavioral health conditions, which ensures that the individual has access to appropriate providers and care.

Through the promotion to physicians of lead screening for children at ages one and two years and then at ages 36 to 72 months, BMCHP will take an active role in the prevention of future disabilities of this nature. Ensuring that the lead screening is performed by the physicians and further monitoring of the results will be performed allowing BMCHP to address potential adverse outcomes.

Portions of the intellectually/developmentally disabled population seek treatment from specialist physicians and primarily receive services directly from the specialists, for example, pulmonary specialist. BCMHP proposes to investigate the potential of identifying these and other such specialist providers as a member's primary care physician, allowing for ease of access and eliminating barriers to care.
Through the promotion of prenatal care and education programs targeting alcohol consumption education during pregnancy, BMCHP will provide guidance on the risks and concerns that may face resulting from this behavior. Specific outreach will be made by our case managers to pregnant women to reinforce and encourage the need for prenatal care and abstinence from alcohol during pregnancy. As well, referrals to behavioral health specialists will be provided as needed.

Mental depression is often a secondary disability incurred by the intellectual/ developmentally disabled. BMCHP will work collaboratively with the Community Mental Health Centers to ensure availability of providers and appropriate treatment of these members is easily accessible.

Communities have multiple organizations and groups that specifically support the intellectually/developmentally disabled populations. BMCHP will work in collaboration with community services such as Easter Seals, Arc, Parent to Parent of New Hampshire, and the programs established by the State of New Hampshire DHHS, further ensuring the services are available and accessible to these Members.

Should BMCHP find there are insufficient contracted providers to provide services to the intellectual/ developmentally disabled population, we will authorize services to be performed out of network to ensure access to health care services for these members. Special attention will be given to these members during the transition period through contact of the individual's care givers and identification of services that they are currently receiving. Through the development of individual care plans we will have the ability to monitor and ensure these individuals' health services are maintained.

BMCHP's overall goal is to work with providers and the communities to develop interventions that can prevent pathology from becoming impairments and impairments from becoming functional limitations, functional limitations from becoming disabilities and any of these conditions from causing secondary conditions.

3.8.3 Provider Engagement

Q36. Describe your strategy for ongoing provider communication and outreach. Include a description of the mechanisms you currently use and will use to communicate with providers and the content you anticipate including in communications.

Our 15 years as a provider-sponsored managed care organization has shown us that a key driver of provider satisfaction is the relationship between the provider and the provider's BMCHP Provider Relations representative. The representative is the primary, one-on-one connection between BMCHP and our network providers, assisting with all aspects of Plan participation and administration. In addition, BMCHP's Community Outreach Department works with providers on patient health initiatives such as health fairs, and also furnishes providers with wellness materials that can be accessed by all patients.

Another effective tool of provider outreach in communication is our online Provider Manual, located at http://www.bmchp.org/providers/provider-manual-table-of-contents. The Provider Manual, which is always kept current with frequent updates, contains the policies and procedures necessary to administer BMCHP benefits, claims and other processes within provider offices, and also contains information to assist medical providers with delivering quality care, particularly with respect to a diverse Medicaid audience. The Provider Manual is part of the provider's contract with us.

BMCHP also communicates with providers in a number of other ways, including through the following:

- Website – BMCHP.org contains much of the information described here. In addition, and as important, the website contains a critical provider tool – the provider portal, which allows providers to perform functions such as checking member eligibility or the status of a claim, as well as to receive a variety of electronic reports. Note that this function is being expanded to include submitting online authorization requests. Changes and upgrades of our website are communicated through the vehicles listed here.
- Network Notifications – These are numbered and dated descriptions of changes that have been made to clinical or administrative policies and procedures. Once a Network Notification has been approved, it is posted to our website, and we postal-mail a postcard to providers notifying them of the online availability of the new Network Notification. We also email a direct link to the Network Notification. Network Notifications reflect changes made to the Provider Manual, and it is updated as appropriate.
- Emails – We supplement all postal mail communications with emails to those network providers who choose to share their email addresses with us. This is the

fastest means of communicating since emails can be sent and received as soon as the messaging has been approved.

- Newsletter – Provider News, our quarterly newsletter for network providers, is postal-mailed, emailed and posted to our website. The newsletter content includes information of both an administrative and clinical nature. For example, the most recent edition included articles on our updated website – including important provider portal features – as well as news about the administrative appeals process and guidelines for pediatric care. Provider News has also served as an important tool for helping BMCHP in achieving excellent accreditation from the National Committee for Quality Assurance (NCQA) four times in a row.

Going forward, BMCHP will continue with these successful means of communicating with providers in New Hampshire. Note that, as part of our ongoing goal of examining strategies to improve our communications systems and methods, we will focus additional efforts in expanding our electronic communications capabilities since this is the fastest, most efficient means of delivering information.

Q37. Describe how you will develop, engage, and utilize a provider advisory board. Describe the approach you currently take and will take to assess provider satisfaction, including tools you plan to use, frequency of assessment, and responsible parties.

As BMCHP is a provider-sponsored organization, we listen to our providers and are committed to strengthening the provider and patient relationship. BMCHP believes that providers who are most attuned to the health care needs of BMCHP's members and immersed in the community are in a position to offer valuable insights. These insights have been incorporated into BMCHP's strategies, operations and clinical decisions. BMCHP has also used these insights to offer solutions to our state managed care program partners.

BMCHP seeks to partner with the provider community in New Hampshire to build a high quality innovative New Hampshire Medicaid program. The purpose of the provider advisory board (PAB) will be two-fold: (1) to offer input to BMCHP regarding major policy decisions, and (2) to provide staff with input regarding how the provider community perceives new rollouts and ongoing operations. In addition, BMCHP will include its strategic partner, Harvard Pilgrim, in its approach to working with the provider community and, in particular as a key member of its Provider Advisory Board.

More specifically the PAB will be organized and charged as follows:

Responsibilities / Role

- Provide guidance for enhancements to the provider grievance system and provider satisfaction with health plan processes.

- Provide input regarding provider communications materials and education.
- Make recommendations regarding provider quality improvement activities (e.g. provider access survey, network management, corrective action, provider contracting).
- Review aggregate data related to service delivery, access, and compliance with corrective actions.

Membership

Membership would be comprised of five or more physician or non-physician members, each of whom is contracted with BMCHP or is an administrator of a community partner. In addition, ex-officio, non-voting members will consist of BMCHP's Director of Provider Relations, Quality Improvement Manager, and on an ad-hoc basis, the Provider Services Representatives. The designated Medical Director of the New Hampshire Medicaid Program would also be a non-voting Chairperson of the Committee.

Meeting Frequency

BMCHP proposes that the PAB meet on a quarterly basis or more frequently as needed.

Recruitment

PAB members will be recruited from BMCHP's network of contracted providers and their staffs, and other community partners. Recruitment will be accomplished by recommendations from providers and BMCHP's staff, and through provider newsletters and bulletins. Recommended or interested potential members will be sent a letter of recruitment from the Provider Relations Department. BMCHP's Office of Clinical Affairs staff will also recruit and recommend members to sit on the PAB.

Member Selection Process

The staff's recommendations will be forwarded to BMCHP's Quality Improvement Committee for the appointment of the members.

Provider Satisfaction

With respect to our efforts to assess provider satisfaction, BMCHP and Beacon, our behavioral health partner, will conduct annual satisfaction surveys. BMCHP employs a telephonic tool to survey our providers. We collect and analyze this data to determine satisfaction levels. Beacon uses similar tools, including: one to assess clinician satisfaction with Beacon, one to elicit administrative satisfaction, and a "combined" version for solo practitioners and others who fill dual clinical/administrative roles.

We anticipate following this same approach to assess provider satisfaction with our administration of the New Hampshire Medicaid program.

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

Q39. Describe your process for using input derived from the advisory board and surveys to inform possible changes in program design and/or administration.

BMCHP firmly believes that in order to improve the quality and cost effectiveness of health care for our members we must work together and engage our medical community. Our primary goal is to put our members' healthcare needs at the center of everything we do and we recognize that we cannot accomplish this without strong working relationships with our members' physicians and other health care providers.

BMCHP's current model for using input to inform program design and/or administration is through our Quality and Clinical Management Committee that oversees the quality and medical utilization management activities and is coordinated by our Chief Medical Officer. The Quality Management Program and our Quality Management Committees formulate policies, set standards and guidelines and oversee the delivery of services to members. Membership on these committees includes actively practicing physicians from various provider groups throughout the network.

The committees and their major responsibilities are:

Quality & Clinical Management Council (Q&CMC) - Oversees the Quality Improvement Program to ensure that program activities to improve the clinical care and service provided to our members and goals are supported.

Pharmacy & Therapeutics Committee - Monitors and evaluates the clinical pharmacy program and provides support to all network clinicians for safe, effective and economical use of pharmaceuticals in all clinical practice settings.
Credentialing Committee - Conducts medical peer review including but not limited to: evaluating the quality of care and services provided to our members; determining whether health care services were performed in compliance with applicable standards of care; handling the credentialing and recredentialing of providers and practitioners.

Medical, Policy, Criteria, Technology Assessment Committee - Provides a process that includes the timely review, discussion and approval of medical policies for new medical technologies, new uses of existing technologies and other clinical policies to support BMCHP's utilization management and quality activities. Policies are based on scientific evidence.

On an ongoing basis feedback is received through these committees and is used to inform our Annual Quality Improvement Program Plan and Work Plan as well as policies, procedures and planning.

We also solicit provider feedback through provider satisfaction surveys and requests for input on various initiatives. For example, we received feedback from providers that some of their inquiries regarding administrative processes were not being addressed in a timely, efficient manner. As a result, BMCHP changed our internal processes to improve both the timeliness and accuracy of responses by establishing service level agreements and having subject matter experts respond to questions.

For quality initiatives, we have involved actively practicing network physicians in the review of member and provider communications (e.g. letter to PCP regarding follow-up to needs identified during an EPSDT screening). Providers were also involved in the selection of performance measures used in our pay for performance program in the past.

We solicit provider feedback on various reports and member lists that we distribute relating to quality initiatives (e.g. children in need of a well child visit lists, diabetic treatment reports). Based on comments received, we have revised reports to make them more useable to providers.

Prior to implementing our outsourcing of the management of the durable medical equipment benefit, we reached out to primary care physicians, specialists and durable medical equipment providers to discuss the outsourcing and obtain their thoughts, concerns and identify potential barriers. We also outreached to the DME Trade Association in order to discuss the idea and get their feedback.

In working with the New Hampshire Medicaid program, we envision a model similar to that with our behavioral health partner, Beacon, who shares our philosophy, that a strong working relationship with providers is central to ensuring our members get the highest quality health care. Beacon has established provider and member advisory boards or committees in each state in which they operate behavioral health programs for their Medicaid health plan partners. In addition, as previously mentioned, on an annual basis, Beacon, as does BMCHP conducts a satisfaction survey to gain input from stakeholders. Beacon combines its gathered input with other data regarding program performance, such as utilization and quality metrics. These measures include such indicators as inpatient admission and readmission rates and selected HEDIS measures, including seven-day ambulatory follow-up after discharge from mental health inpatient treatment.

Managers from each of behavioral health's departments, including clinical and network operations and quality management and improvement, analyze all of this information. And the team does the following:

- Identifies opportunities for improvements in program design or operational processes;
- Designs the new program or process;
- Reviews the new program or process with the advisory group(s);
- Implements the program or process on a pilot basis to ensure that it performs as intended;
- Modifies the program or procedures based on results of the pilot; and then
- Implements the program.

Ongoing evaluation is conducted to determine whether the new program or procedure is achieving intended results. This information is shared with the advisory group(s) and other stakeholders. Recognizing that providers are key stakeholders in the development and execution of program initiatives it uses a multifaceted approach to incorporate provider thoughts and feedback.

Q40. Describe your experience in other state's managed care programs you administer – the percentage of providers who you have credentialed compared with the provider population and how many providers were added or terminated during the first 3 years of the programs' implementation date.

BMCHP currently has approximately 63.9% of all Massachusetts providers credentialed and participating in our network. These include physicians, behavioral health providers, and acute care hospitals, who predominantly provide services to members in both MassHealth and Commonwealth Care.

BMCHP adheres to NCQA standards as well as MassHealth, Connector, and Commonwealth of Massachusetts credentialing requirements.

BMCHP is a a member of HealthCare Administrative Solutions (HCAS), an organization founded in 2005 by Health Plans in Massachusetts in order to streamline administrative processes for providers. The first initiative chosen for this effort was a plan to streamline credentialing.

The HCAS process offers a single point-of-entry for providers to submit credentialing information that HCAS participating health plans use to verify a provider's qualifications prior to network participation. HCAS participating health plans partner with CAQH® to collect and store a provider's credentialing information. Information is collected one time from providers, reducing the need for providers to submit multiple applications to different sources.

Since joining HCAS, our IT staff developed a process to electronically send information to, and receive information from an NCQA certified Credentialing Verification Organization. This organization takes updated provider information from CAQH and performs primary source verification. The organization sends files back to BMCHP and at the same time sends data through a preprocessor before loading it into Cactus, BMCHP's credentialing software.

The simplified process allows BMCHP to consistently exceed the turnaround time in the Statement of Principles, a voluntary agreement between Massachusetts stakeholders, including hospitals, the Massachusetts Medical Society, Massachusetts Association of Health Plans, and Health Plans, to process clean and complete initial applications within 30 days 95% of the time.

BMCHP recredentials provider every two years based on the month and year (odd/even) a provider was born utilizing the CAQH applications and the process as above. Between recredentialing cycles, BMCHP conducts ongoing monitoring of information from external sources, such as sanctions from the state licensing boards, MassHealth, or Medicare/Medicaid. This information is reviewed by the Credentialing Committee.

In 2010, BMCHP centralized its provider enrollment function and combined it with its Credentialing Department in order to integrate aspects of the provider set up and maintenance process, improve provider data quality, and decrease the end to end enrollment time for providers. Provider Enrollment staff handles processing for new providers, changes, terminations, and welcome letters for the Plan.

In addition to decreasing overall turnaround time, this new model for credentialing and enrollment saves time for our Provider Relations staff and assures their availability to meet providers' needs. Instead, providers submit an enrollment form to a centralized Provider Enrollment Department email address to staff who then begin the process for credentialing.

3.9 Payment Reform

One of DHHS' goals for the Managed Care Initiative is to transform New Hampshire's Medicaid program from an FFS system that rewards the volume of services to one that rewards improved outcomes and reduced costs for episodes of care. DHHS believes that such a transformation will require the MCOs and providers to work together to create new approaches and partnerships.

Each MCO shall describe in detail its plan to promote new methods of value-based payment and other innovative partnerships with providers. The MCO shall take advantage of current New Hampshire based as well as Federal initiatives to improve the health care delivery system. This plan shall contain measurable goals and outcomes. DHHS will approve each plan and negotiate an incentive program equal to 1% of capitation revenue received that will reward or penalize the MCO based on its performance against its approved plan.

As part of this plan, each MCO should also demonstrate how it will provide incentive to providers to improve outcomes and, where appropriate, share in the savings resulting from the initiatives in the MCO's plan.

BMCHP is committed to the core principles that lie at the foundation of value-based health care. Specifically, these are: reducing/stabilizing medical expense trend through improved cost-efficiency, improving the health of our members through better integrated and coordinated prevention, and evidenced-based medicine, and optimizing members' experience of care through improved access and availability. We have a history of supporting programs that share financial benefits associated with successful medical care management with providers, and are committed to working collaboratively with our provider partners in the transition from volume rewarded (fee-for-service) reimbursement to quality-driven cost-effective care.

BMCHP commitment to working closely with our providers toward achieving these objectives is best represented in the history and evolution of our quality management programs. BMCHP's original Pay for Performance (P4P) programs engaged primary care providers in efforts to improve clinical quality in such areas as the treatment of chronic diseases (e.g., asthma and diabetes) by rewarding improvements in providers' HEDIS scores. These programs, which also targeted improvements in administrative quality and member satisfaction, provided financial incentives for improvements against baseline measures. Our P4P program evolved into the Clinical Innovation Transformation Fund (CITF) program in which financial incentives were introduced for improved cost and utilization efficiencies. The CITF programs facilitated improvements in such key areas as ER admissions for ambulatory sensitive conditions, medical/surgical readmissions, and inpatient admissions for asthma patients, providing financial incentives through shared savings.

In 2011, BMCHP established a strategic plan for accountable care designed to respond to and support our providers in their own transformation to an accountable care environment. The goal of our strategic plan is to develop and implement an approach and infrastructure that supports the delivery of affordable, high quality care to our members by Accountable Care Organizations (ACOs). Key goals in our approach include:

- Establishing partial and full financial risk-sharing arrangements, based on historical performance against global base medical costs, and mutually agreed-upon prospective budget targets
- Identifying medical cost improvement opportunities through cost and utilization analysis in such areas as ER use, inpatient admissions and re-admissions, pharmacy, and disease management
- Establishing quality measures, benchmarks, and performance targets,
- Assessing and reporting provider performance against financial, quality and member satisfaction targets and benchmarks, with financial incentives for improvement, and
- Collaborating with ACO provider partners in the achievement of performance targets, the refinement of reporting tools/methodologies, and the approach to performance improvement

We also point to our experience working collaboratively with Massachusetts state regulatory agencies as well as other payers in the establishment and implementation of such innovative programs as the Patient Centered Medical Home Initiative (PCMHI), a multi-payer program sponsored by the Massachusetts Executive Office of Health and Human Services (EOHHS). This three year demonstration program supports fundamental changes in primary care service delivery and payment reform, by facilitating comprehensive, coordinated, patient-centered care within a medical home environment. Along with several other payers, BMCHP provides financial support for infrastructure and care management activities, and includes a shared savings component.

Applying our conceptual framework for cost and quality improvement, and leveraging our historical approach and experience, we look forward to working closely with our provider partners in New Hampshire toward the delivery of value-based health care. Given the strong affiliation of hospitals and primary care providers throughout the state, the New Hampshire provider community is already well engaged and, thus, well positioned for further innovation and collaboration in the management of healthcare cost and quality.

BMCHP believes several key initiatives, on state (New Hampshire) and national levels, illustrate a close alignment with our own approach and experiences, such as the New Hampshire Citizens for Health's Medical Home project. This program, which promotes

close collaboration between the provider community and payers, and is designed to improve cost and quality of care in a primary care centered medical home environment, shares many similar objectives as Massachusetts' PCMHI. In addition, BMCHP points to the CMS sponsored Medicare Physician Group Practice Demonstration program (in which the Dartmouth Hitchcock Clinic participated) as an important model of innovation in the improvement of care through a broader focus on disease management and improved care management processes and tools. We welcome and look forward to the opportunity for leveraging important lessons learned, and working collaboratively with such high quality providers as the Dartmouth Hitchcock Clinic. We also support and are currently developing an application to CMS' Comprehensive Primary Care Initiative (CPCI), due in January, which aims at the further promotion of improved primary care coordination, quality and cost. It is through these and other emerging programs and opportunities that we will continue to engage the provider communities in New Hampshire as we do in Massachusetts.

BMCHP will leverage the foundation and approach in which we have historically engaged our provider community in our efforts to work collaboratively with our provider partners in New Hampshire toward achieving value-based healthcare. Specifically, our efforts in New Hampshire will focus on an infrastructure and approach which establishes and continually improves (a) a financial framework that facilitates provider reimbursement outside of the current fee-for-service environment, including partial and full risk-sharing arrangements, and shared savings opportunities, (b) quality benchmarks and targets, against which providers' performance will be measured; (c) reporting tools designed to identify and measure financial and quality performance, and member satisfaction; and (d) a coordinated, multi-departmental approach to engaging providers in the achievement of collaboratively defined financial and quality targets.

3.10 Behavioral Health Services

Q41. Describe your plan for implementing delivery system and payment reform. Describe your approach to creating partnerships with providers to support health care reform.

BMCHP made the decision to partner with Beacon Health Strategies (Beacon) in 2010 based on Beacon's commitment to delivering quality behavioral health management in New England and its demonstrated expertise in partnering with behavioral health providers. At the very heart of Beacon's approach to implementing a behavioral health system and corresponding payment reform is a "whole person" approach to providing care, which recognizes the relationship between medical, behavioral and social needs and the need for unique partnerships within the community. This model of care for complex populations creates shared value – improved clinical and quality-of-life outcomes for members, increased efficacy for providers through creation of a system of care, and improved financial outcomes for payers (both state government and managed care organizations). This approach to care planning and management serves as the foundation to BMCHP and Beacon's model of payment and delivery system reform.

In both philosophy and practice, New Hampshire's Community Mental Health Centers (CMHCs) already embody many aspects of the "whole person" approach to care, and are ideal partners to achieve the vision established under this procurement. In order to capitalize on the opportunities to improve care and cost-effectiveness under this RFP, the CMHCs and the awarded health plans must align themselves to provide continued high quality care for those with Serious Mental Illness (SMI) and other CMHC patients, and at the same time, ensure long-term financial sustainability for all parties. To maximize the potential for partnership created under the new New Hampshire Medicaid managed care program, BMCHP and Beacon are in the process of forging a relationship with the CMHCs that empowers them through enhanced care management infrastructure, and rewards them for their success in improving quality and containing costs for the complex behavioral health membership that they serve.

More specifically, under this proposal, BMCHP and Beacon plan to develop CMHC-based, regional behavioral health collaboratives to integrate care under a clinically and financially transparent model. The CMHCs and other behavioral health providers within each region will be organized under an informal network structure that will serve as the basis for evaluating and benchmarking performance along quality and cost dimensions, and facilitates coordination and communication across providers. In the true meaning of partnership, savings that Beacon and the collaboratives achieve under the program (including established inpatient and outpatient costs across behavioral health and acute domains) will be shared back with the CMHCs and affiliated behavioral health providers – shared incentives, shared success.

Through this model, the vision of payment and delivery system reform will be realized. The CMHCs and affiliated providers will be rewarded for desired outcomes – continued

improvement in delivering appropriate care (i.e., right service, right setting, right time) in the most cost-effective manner. At the same time, BMCHP and Beacon will have an accountable, coordinated behavioral health network that is appropriately structured to deliver the integrated care required for the complex behavioral populations enrolled within BMCHP.

BMCHP and Beacon appreciate that one size does not fit all, and that individual and family needs can change over time or instantly during times of duress. To that end, provider and community partnerships become pivotal in meeting the needs of Medicaid members. The following list provides examples of the types of initiatives that BMCHP, through Beacon, could implement in New Hampshire to support both members and providers, and that facilitate the vision for payment and delivery system reform described above:

- Co-locate behavioral health providers and care coordinators within primary care sites and/or co-location of medical staff in behavioral health sites;
- Standardize mental health/substance abuse (MH/SA) screening and referral protocol and assistance;
- Support provider-led development of new levels of care;
- Establish consistent criteria for behavioral health levels of care to provide transparent expectations to providers, and reduce variation in care across provider sites and geographic regions;
- Lead initiatives to expand access in rural areas such as expansion of telepsychiatry, home-based services, and/or mobile service providers;
- Deploy Intensive Case Management (e.g. coordinating community-based social services for at-risk members);
- Serve as liaison between state agencies and HMO; and
- Provide analytics and reporting to support effective care management.

Q42. Describe your experience with creating value-based payment arrangements, episodes of care payments, sub-capitation arrangements, and Incentive programs and their impact on improved quality and reduced cost.

Through careful design and active provider education, BMCHP's partner Beacon has achieved measurable success in performance-based contracting and value-based payment methodologies, using both financial and non-financial incentives.

Financial incentives for providers include both typical "lump sum" year-end performance bonus payments -- for achieving pre-set quality or utilization targets -- and preferential or enhanced fee scales tied to achieving a set of quality and utilization targets. Beacon's non-financial incentives program grants providers "most favored

nation" status for utilization review procedures in response to their achieving agreed-upon quality and utilization targets.
Quality targets for hospital providers reward achievement of high quartile post-hospitalization outpatient follow up rates and low quartile readmission rates. Quality measures for outpatient providers have focused on patient access, and rewarding timeliness of first appointments. Coordination of care measures, such as rates of documented communication with primary care providers, are also commonly included in both hospital and outpatient provider quality performance targets. Utilization targets may call for a percentage reduction in average length of stay or overall days per thousand for upper-end outlier providers. Rewards for meeting inpatient and outpatient quality targets can include financial and non-financial incentives as described, and can prove to be mutually beneficial to members, providers and the health plan.

An example of an area where Beacon is currently piloting a quality incentive program for inpatient providers on behalf of BMCHP is one where utilization review is conducted only on prior authorization, and further review is conducted in a clinical quality and utilization management (UM) metrics review. In the clinical quality review, the Beacon Utilization Review (UR) clinician assists the inpatient facility in discharge planning and accessing necessary resources for member transition into the community. In the metrics review, providers are held to a specific average length of stay; seven-day readmission rates; communication with the primary care provider; and adequate discharge planning, specifically the scheduling of a seven-day follow-up appointment. This program is a non-financial incentive program, allowing identified inpatient providers to manage a BMCHP member's care without the additional administrative burden of traditional UR. Inpatient providers enter into a secure web portal the member's treatment and discharge plan on a scheduled basis; telephonic clinical quality review is conducted only weekly on all members at the facility.

Q43. Describe your approach to Behavioral Health delivery system and payment reform in other states.

BMCHP believes that Beacon's longstanding vision of healthcare reform promotes patient-centered, integrated care where behavioral health is no longer "carved out," but acts as the portal to an individual's holistic treatment. Payment reform is integral to this process, and promotes a model of medical savings, particularly for the high-risk, high-cost population covered by this contract.

In Massachusetts, through the partnership with BMCHP and others, Beacon is covering new ground in payment reform and its role in the behavioral health delivery system. With more than 15 years' experience managing behavioral health benefits through risk-based relationships in Massachusetts, Beacon has demonstrated its ability to adjust clinical programming and provider rates over time to ensure a constructive working relationship with providers and regulators, and enjoy high consumer satisfaction with their business practices.

For example, as part of its relationship with BMCHP, Beacon uses provider incentives to promote quality care through the Beacon Select administrative simplification program. In this relationship, Beacon monitors admission, length of stay, aftercare and other clinical/quality indicators to determine a provider's inclusion in this program. Additionally, Beacon applies its analytic framework to all providers in both the specialty and primary care spaces, and uses the results to identify high quality providers who qualify to be rewarded with P4P payments. In the inpatient arena, Beacon focuses on a simple combination of follow-up rates and readmission rates to reward those facilities that engage in effective discharge planning where community tenure is maintained.

For another Massachusetts contract, Beacon has proposed transparent, easy-to-understand, and aligned organizational and financial arrangements in which Beacon will drive value over the tenure of the contract by transitioning all participating providers into regional behavioral health cooperatives – a form of an accountable care organization (ACO). This model is similar to what BMCHP and Beacon are proposing for the New Hampshire CMHCs and other regional providers. These cooperatives will synthesize behavioral health delivery systems to forge coordination and communication among all providers. On behalf of BMCHP, Beacon will lead the design and organization of these regional behavioral health cooperatives to ensure well-functioning organizations and an equitable participation in the financial benefits of a cooperative structure. A mutually determined, clinical and shared savings model rewards providers when recovery is sustained and utilization decreases. Regional behavioral health cooperatives' budget amounts, methodology and actual utilization will be shared with all system participants and be posted online.

Q44. Describe your direct experience in developing partnerships with Community Mental Health Centers. Separately describe your past and present subcontracting arrangements for individuals experiencing serious mental illness or serious emotional disturbance.

Since its founding in 1996, Beacon has had extensive experience partnering with Community Mental Health Centers (CMHCs). BMCHP and our partner Beacon view CMHCs as the de-facto psychiatric medical home for our most compromised members, and as such, have been proactive in cultivating a partnership. Examples of Beacon's work include the development of actionable analytic reporting designed to support CMHC staff in understanding both the co-morbidity of their membership as well as the patterns of care their members receive outside of the CMHC. For example, Beacon provides CMHC staff with quarterly reporting depicting where members access care outside of the CMHC so that care can be coordinated across disparate sites. Simultaneously, Beacon performs complex analytic work on prevalence of co-morbidity, adherence to medication, and ER utilization, all with the goal of ensuring that CMHC staff have a 360-degree view of a member's treatment experience.

Additionally, Beacon routinely provides in-service training to CMHC staff on best practice in evidence-based care as well as information on person-centered planning through the lens of recovery and resiliency. At all times, they work to refer members into

in network CMHCs when possible, and have supported financially the development of new levels of care to be an alternative to acute care, and where possible, to be a step-down from an acute setting. As a result of a very successful partnership with a CMHC in Rhode Island, Beacon has been able to expand a historically fragmented continuum of care (inpatient and outpatient services with limited intermediated service offerings) into a robust multi-tiered system of care capable of meeting the needs of specialty populations in the community. As a result, Beacon has reinvested approximately $5.4 million back into the community and out of the acute system while improving satisfaction and demonstrating commitment to partnering with CMHCs.

At times, based on contractual relationships, Beacon has paid CMHCs enhanced rates to support the extension of practice hours into the evening and on Saturdays to alleviate access issues. Beacon's most common payment methodology is fee-for-service for high-performing sites delivering care to individuals with SMI or SED (Serious Emotional Disturbance). Beacon has experience with pay-for-performance for those CMHCs demonstrating good coordination with other providers, low acute admission rates and evidence of employing key screening instruments.

Q45. Describe your direct experience in service delivery and payment for services for persons with serious mental illness and serious emotional disturbance requiring long-term care services and supports.

BMCHP has historically managed and coordinated care for members with serious mental illnesses (SMI) and serious emotional disturbances (SED) using an integrated medical and behavioral health model. This model specifically incorporates episodic inpatient and outpatient utilization management, disease management, and care/case management to provide ongoing support. Our partnership with Beacon has only strengthened this process. These members consume a higher proportion of health care resources and generally have a higher incidence of co-morbid/co-occurring disorders, including a greater amount of unmet needs for mental health services. The adult SMI members are eligible for Beacon's Behavioral Health Intensive Clinical Management (ICM) program, which has a concentrated focus on behavioral health services as well as a focus on medication compliance to achieve normalization or an improvement in daily life functioning and coordination with medical health services. The process used to manage these members will serve as the framework for managing the portion of this population requiring long term care services and supports.

SMI or SED members also often have relationships with multiple organizations offering long-term care services, such as residential supports and therapeutic vocational programs. In keeping with BMCHP's experience, Beacon's approach to care delivery is person-centered and seeks to coordinate member goals and support systems in a collaborative manner. Flexcare®, Beacon's proprietary management information system, serves as a conduit of information sharing critical member utilization data with multiple providers to provide a holistic approach to supporting a member's long-term care needs.

For example, Beacon has worked with two agencies in Rhode Island that had been providing long-term residential care for children with special health care needs for more than 25 years. Beacon introduced the concept of using acute residential treatment (ART) as a step-down from inpatient care, and these providers readily redesigned their facilities, hired appropriate clinical staff and opened the first ART four months after we initiated discussions with them. This process was replicated in the creation of home-based therapy services and intensive outpatient programs for children and youth. Another essential factor contributing to providers' willingness to create these new services, and sustain them over the long term, was Beacon's ability to provide payment at a fair but competitive rate (compared to other markets where these services already existed). In the first full year following the completion of service creation and expansion for this system of care for children and youth, $5 million less was spent on behavioral health services for these enrollees than was paid for the full year previous to implementation of these services.

In addition to its efforts to address the mental health needs of members with SMI, BMCHP recognizes the marked disparities in mortality and morbidity for individuals with SMI as compared to the general population. To address this disparity, BMCHP has historically used quality initiatives to target the overall health of individuals with SMI, to include improving the rates of preventive care in this population by working with Department of Mental Health (DMH) case managers and community support program staff to assist these members to access services such as mammography and routine physical exams.

In addition, past efforts have included meetings with DMH Metro Boston and Western area directors to identify members who had not received these preventative services. Also, BMCHP's original Practice Guidelines for Schizophrenia included recommendations regarding optimal medical monitoring and screening for individuals with SMI. BMCHP and Beacon strongly encourage preventive health screenings and follow-up with medical care for members in the SMI populations, as evidenced by regular reminders in newsletters.

Also, on a semiannual basis, BMCHP, via our partnership with Beacon, audits inpatient medical records to assess compliance with medical record standards and to ensure that medical necessity criteria are met and that treatment planning meets all applicable requirements. In addition, the audit includes a review of medical issue follow-up with PCP or specialist and a documentation regarding preventive screenings, such as mammograms and pap tests for female members. Increased awareness within this population to address these disparities will be a focus of both Beacon and BMCHP to support long term care needs.

In terms of commitment to providing a service delivery system for children with SED impacting both community-based and long term care, BMCHP has been a partner with the Commonwealth of Massachusetts in its implementation of Children's Behavioral Health Initiative (CBHI) under our state contract. Children with SED represent a segment of BMCHP's membership with some of the most complex and special needs.

Both BMCHP and Beacon have played an active role in assisting with development and implementation of a service delivery system in Massachusetts that would assist with coordination and communication between state and local behavioral health agencies, resulting in longer community tenure for these children and ensuring delivery of appropriate care (i.e., right service, right setting, right time). Activities supported by BMCHP and Beacon under CBHI include: development of a series of forums for primary care providers to train them on multiple screening tools, and to identify behavioral health needs for this population as part of EPSDT screening; training the state's behavioral health provider network on the use of the CANS (Child and Adolescent Needs and Strengths) Tool to allow for standardization in the assessment of children with SED; development and coordination of an RFP for wrap around services, also called intensive care coordination (ICC) or community case management, to provide care coordination and crisis intervention and peer support for children and families with SED (ICC now serves as the cornerstone of the state's CBHI system); and development of medical necessity criteria for in-home services for SED children and for all other Medicaid members.

By the late fall of 2009, six child and adolescent services planned under CBHI were fully developed and implemented, and have now served over an estimated 21,000 unique Massachusetts Medicaid children from July 1, 2010 – March 31, 2011.

3.11.8 System Coordination and Integration

Q46. Describe your overall approach to care management and how you integrate wellness.

BMCHP's care management model emphasizes integrated physical and behavioral health services, pharmacy management and wellness programs. We are strongly committed to this integrated model.

BMCHP's Care Management Program is designed specifically to achieve an integrated approach to overall care management and is a proactive process that efficiently coordinates services for targeted populations, while also benefiting the our entire population. Aspects of the Care Management Program include:

- Program focus on chronically ill, high risk members and those who have both behavioral health and medical diagnoses. This model includes screening for a comprehensive health and developmental history (including assessment of both physical and mental health development). BMCHP's interventions are member centric and provider based.
- A nurse advice line that gives members access to a specially trained nurse 24/7/365 in addition to access to an audio health library. BMCHP was the first managed care organization to market a nurse advice line in Massachusetts and to make this valued service available to our members. Our Care Management Department reviews calls received to triage for members who would benefit from care management.
- Members with behavioral health/physical medical health needs are co-managed by the both behavioral health and complex case management services. All care is coordinated between physical health and behavioral health providers. Our behavioral health partner, Beacon Health Strategies (Beacon) has care managers located on site who sit side by side with our BMCHP care managers. There are joint rounds to discuss co-managed cases.

Our care managers promote preventive care as well as advocate and facilitate access to needed health services. The central focus of our care management programs are member education and improving the members' ability to self manage their condition to stay well and avoid unnecessary hospitalizations.

BMCHP partners with providers to develop and implement care management programs that focus on wellness and prevention, health maintenance and disease management for those populations identified as being at risk. We identify potential candidates for these programs through predictive modeling, disease specific algorithms, hospital discharge review processes, and medical/ behavioral health claims data; pharmacy claims data, referrals through the nurse advice line, disease management program participation as well as direct physician or member self-referral.

Members may move between three levels of care management depending on the severity of their condition, intensity of care management needs and or education about their condition. Level 1 focuses on general education and mailings. Level 2 involves moderate severity requiring consistent care management (and social) interventions. Level 3 is complex care management requiring the most intensive and frequent interventions (social, medical and/or behavioral health). Members are assessed monthly through our sophisticated care management registry designs, provider referral or member/care giver referral.

DxCG risk scores, claims data, pharmacy data, health risk assessment data, lab data and race, ethnicity and language data are all available to our care managers to assist them in managing and coordinating care to our members.

BMCHP uses predictive modeling tools to identify members in need of care management or disease management services with both behavioral health and physical health needs as follows:

- DxCG predictive modeling tool is used to identify members with high prospective risk scores. The members' diagnosis codes are used by the DxCG model to predict their expected resource use in the following year.

Care management registries

BMCHP also utilizes care management (CM) registries to identify members who may benefit from care management. It uses DxCG and other criteria to identify members with the following conditions:

- Multiple conditions with high cost and high DxCG scores including rare diseases (complex care management),
- Complex newborns
- High risk pregnancy
- Pregnancy
- Emergency Department High Utilizers-Medical
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Asthma
- HIV/AIDS
- Cancer
- Obesity

- Hypertension
- Controlled substance use problems

Registries can and will be built to meet all contract requirements of the RFR. Registries are run monthly and cases are distributed to care management staff for outreach.

Other methods of identification

As noted above, members may also self identify for care management or be referred by utilization management staff or their providers. New members can be identified via the health risk assessments that are available on our website and sent as part of the new member welcome packets. Welcome calls for disabled members also identify potential members for care management. Referrals to and from Beacon are also sent on a daily basis through electronic file transfer.

Outreach

Care management staff conduct member outreach in many ways including by phone, mail, and provider site visits. Relevant health education materials are provided to members by our care managers. Throughout the care management process, the care managers are constantly assessing the member's progress toward Individual Care Plan (ICP) goals. They identify and address barriers, update the ICP as needed, and monitor outcomes of interventions toward completion of goals, and promote member self-management skills. Additionally, our care managers work to promote the concept of the PCP as the primary care manager. Care managers also facilitate communication between the members and PCPs to prevent PCP reassignment whenever possible.

Coordination of care

The hallmark of care management services is coordination of care. Our care management services involve the comprehensive assessment of the member's condition; determination of available benefits and resources, including family support and community resources; and the development and implementation of a care management plans emphasizing psychosocial support, self-management with performance goals, monitoring and follow-up. Care managers will assist these members in navigating the health care delivery system.

Q47. Describe how your member education supports your overall wellness and chronic care management programs.

BMCHP uses multiple member education strategies to support our overall wellness and chronic care management programs. First, care managers refer members to BMCHP's website which covers and promotes a wide range of wellness topics and activities appropriate to all of our members (many of which are available in English and Spanish) as well as topics and activities more appropriate for subsets of our membership. All information on our website is also available in traditional print format, and is sent to

members upon request. Members have access to a wide range of educational materials on the website or in hard copy through our member education library, which provides written material on a wide range of topics at a fairly low reading/literacy level. When working with a care manager, the material can be customized and mailed to the member.

BMCHP also addresses pharmacy related issues through two pharmacy management tools that are available on our website at the following section, "Personal Health Programs." The first tool helps identify and list over-the-counter drugs and dietary supplements and is used when prescription drugs are filled to help members understand any possible interactions and to prevent any complications. The second tool provides focused education about the use of controlled substances, emphasizing points for the safe use of controlled substances as well as information about non-pharmaceutical approaches to assist in managing pain, anxiety disorders, sleep disorders, and attention deficit hyperactivity disorder (ADHD). Education about non-pharmacologic management of underlying behavioral health disorders is also provided.

For New Hampshire members we would develop a New Hampshire Wellness brochure that includes contact information for professional resources such as: Quit Works, American Diabetes Association, American Heart Association, alliance on teen pregnancy, American Stroke association, and American Cancer society.

BMCHP would also partner with other programs to advance specific care management programs. For example, BMCHP would partner with the QuitWorks Program in New Hampshire to offer members interested in assistance with smoking cessation. Program enrollment information would be included in the member handbook, website, newsletters and the prenatal and asthma care management packets sent to members. In addition to the QuitWorks program, we cover both nicotine replacement therapy and group or individual counseling for smoking cessation in accordance with contract requirements.

BMCHP also supports wellness and chronic care management programs through our member newsletters. Our member newsletters have at least an annual "Wellness" edition insert that reviews all of the material available on the website and information about wellness and staying healthy. Each subsequent newsletter has a wellness focus. Chronic disease focused wellness mailings are sent periodically to all members with several conditions (population based) to remind them about necessary self management tips and tests necessary to stay well.

BMCHP has other programs to support member wellness. BMCHP offers pedometers to members to encourage exercise and offers discounts to fitness centers and Weight Watchers to encourage a healthy life style. BMCHP is considering similar programs for New Hampshire Medicaid members. All members have access to the 24 hour nurse advice line and audio library to learn about any condition, both of which will be available in New Hampshire. The audio library has topics that span from condition-based to activities like cross country skiing.

Finally, our outreach staff hold wellness activities at various sites to educate our members about our wellness activities and our care management programs. At times our clinical staff team up with our outreach staff and provide educational outreach to clinics and community sites to provide site of service education about various wellness or care management programs.

Q48. Describe your approach to wellness and prevention services. What strategies are you proposing to encourage member use of wellness and prevention services? Describe your experience with these approaches and document outcomes of these strategies.

Based on our long standing experience, BMCHP will use several strategies to address wellness and prevention services.

One important strategy centers on member communications. BMCHP currently uses our member newsletter to remind members about general health, wellness and prevention, immunization reminders and various behavioral health topics. BMCHP would partner and coordinate with New Hampshire's Wellness Incentive Program to give member access to information on this program via the BMCHP member website. BMCHP will also identify and use other media or methods that it determines can effectively educate members about wellness.

For our primary and specialty care providers, BMCHP uses our provider newsletter and website (www.bmchp.org) provider pages to communicate and promote to providers the importance of health education for members. BMCHP will also collaborate on any New Hampshire agency led health promotion and education activities with other managed care organizations on a regional or statewide basis. We have found that collaboration between managed care organizations on quality and prevention improves quality and decreases the administrative burden for providers. An example is agreement on and distribution of preventive health and clinical practice guidelines. BMCHP has worked with other Medicaid plans to collaborate on wellness initiatives to improve members' use of controller medications for asthma and the use of asthma action plans. Letters signed by all Medicaid plans went to all PCPs in the state with the same tools to be used for all patients. Sharing one set of practice guidelines for all plans makes the provider offices more likely to use them. BMCHP endorses this collaborative approach.

BMCHP sends reminders to members (and lists of members in need of screenings to providers) for preventive care and reminders for follow up care for chronic disease management. Examples include diabetic members in need of LDL screenings, HbA1c testing, dilated eye exams, and foot exams. Mailings may also include information related to well child visits, immunizations, preventive screenings for cervical cancer, breast cancer, and blood pressure monitoring.

BMCHP would provide information to its entire New Hampshire membership, through our website and member newsletter, about our care and disease management programs. Disease-specific information is and will continue to be communicated through these same methods, as well as through member-specific mailings targeted to those members

who have been identified as having specific diseases or medical conditions and who would benefit from enrolling in a care management program.
BMCHP will use the communication methods described above as well as any other means of communications appropriate to the needs and environments of members, including but not limited to members with special health care needs, adults who are seriously and persistently mentally ill, and children with serious emotional disturbances. Communications beyond web and newsletter may include printed materials/brochures, telephone outreach and community outreach and efforts to incorporate provider involvement whenever possible.

The following outcomes for BMCHP are from HEDIS® 2011 for our Medicaid HMO population and the corresponding 2011 NCQA Quality Compass Medicaid HMO percentiles. Our results in the 2010 measurement year (HEDIS 2011) were instrumental in our #3 NCQA ranking for Medicaid Plans in the nation.

Screening	*Results*	*NCQA Medicaid HMO Percentile*
Breast Cancer Screening	67.5%	75th
Chlamydia Screening	69.1%	90th
Cervical Cancer Screening	83.2%	90th
Advising Smokers to Quit	77.5%	50th
Cholesterol Management for Patients with Cardiovascular Disease LDL Screening	81%	75th
Diabetes HbA1c Screening	90.9%	90th
Diabetes LDL Screening	80.2%	50th
Diabetes Retinal Eye Exam	71.6%	90th
Diabetes Nephropathy Screening	87%	90th
Diabetes Blood Pressure Control	73.6%	75th
Timeliness of Prenatal Care	93.5%	90th
Postpartum Care	71.8%	75th
Frequency of Prenatal Care	78.5%	75th
Childhood Immunization Status: Combo2	83.9%	75th
Immunizations for Adolescents Combo 1	73.6%	75th
Lead Screening in Children	92.5 %	90th
Well Child Visits in First 15 months	84.8 %	90th
Well Child Visits 3-6 years	84.8 %	90th
Adolescent Well Care Visits	68.6%	90th

Q49. Describe your proposed smoking cessation program, particularly smoking cessation for pregnant women. Provide information on outcomes of similar programs you have deployed

BMCHP offers and promotes the Quitworks Program to all Medicaid members interested in assistance with smoking cessation. Program enrollment information is included in the member handbook, website, newsletters and the prenatal and asthma care management packets sent to members. In addition to the Quitworks Program, we cover both nicotine replacement therapy and group or individual counseling for smoking cessation in accordance with contract requirements.

Measurement of the success of BMCHP's providers in counseling members to quit smoking is demonstrated by the 2011 CAHPS® Advising Smokers to Quit results. We scored 77.5%, which exceeds the national average for this measure which is 68% (2011 NCQA Medicaid HMO 50th percentile). Our pharmacy data show that members who attempt to quit average one to two prescriptions for a treatment course of nicotine replacement therapy.

BMCHP would partner with New Hampshire Quitworks to offer and promote the Quitworks Program. We would continue to include information in the member handbook, website, newsletters and the prenatal and asthma care management packet sent to members. BMCHP would cover both nicotine replacement therapy and or group counseling for smoking cessation. We would implement a report of claims for nicotine replacement therapy in addition to other data to identify members who are in care management and or disease management programs so that the members will continue to receive support and counseling to quit smoking.

BMCHP's pregnant women who smoke would also be referred to Quitworks and encouraged to access their pharmacy benefits. While enrolled in our pregnancy program, they would receive counseling about the benefits of quitting smoking and the potential adverse effects smoking has on the baby. We would incorporate a more formal smoking cessation program in addition to Quitworks within our Sunny Start Program, our perinatal program, and would capture the outcomes of those members decreasing the number of cigarettes smoked; or if they quit. We would continue to coach and monitor for the first three months post partum to prevent relapse of smoking as well as to reinforce the risks of exposure to second hand smoke and steps that can be implanted to minimize exposure to their baby and other family members.

Q50. Describe your strategy to reduce childhood obesity. Provide information on similar programs you have employed.

BMCHP recognizes the potential heath risks of childhood obesity and the value of behavior modification. We understand the importance of targeting this group due to the higher incidence of childhood obesity among low-income and minority communities as compared to the general population. These children are more likely to have asthma, depression, diabetes, and other health issues.

BMCHP will enhance our registry to better identify children who would be candidates for our obesity care management program. Our care managers work with parents and or legal guardians to assess their readiness to implement behavior changes. Using motivational interviewing techniques, the care managers then develop customized action plans to support the parent and or legal guardian to assist the member through the continuum of change.

All our members have access to low-reading level educational materials on our website, including extensive information from our member education library. We also send customized materials by mail to members. We will refer our New Hampshire Medicaid members to information available through the DHHS.

Our member newsletters periodically include a special wellness insert that reviews all of the material available on the website and information about wellness and staying healthy, including weight management. Chronic disease-focused wellness mailings that include self management tips and reminders to get tests necessary to stay well are sent periodically to all members with diabetes and other conditions where weight control is key.

BMCHP offers pedometers to members to encourage exercise and offers discounts to fitness clubs and Weight Watchers to encourage weight management and a healthy life style. We would consider offering similar programs in New Hampshire. All members have access to our 24 hour nurse advice line and audio library to learn about virtually any condition including weight control, both of which will be offered in New Hampshire.

BMCHP will seek to partner with New Hampshire agencies and providers to develop and implement an evidence-based childhood obesity program that is collaborative as well as cost effective. Components could include incentives to lose weight, nutritional counseling when identified as necessary during an EPSDT screening, and enhanced educational resources specifically targeted to children.

Q51. Describe what web-based and/or telephonic tools you provide to assist members with their health care choices.

BMCHP uses several telephonic and web-based tools to assist members with healthcare choices.

For telephonic, BMCHP uses outbound calls from our Member Services Department. As part of the new member orientation call, members are educated about the importance of the relationship with their PCP and what benefits and services they're covered for as a member of our plan.

All members are also given access to our Nurse Advice Line. This is a 24/7 service that allows members to speak to registered nurses about health issues. Nurses advise members based on symptoms whether they should seek urgent or emergency care, contact their PCP for an office visit, or suggest how they might treat their condition at

home. Members also can access telephonically an Audio Health Library on an extensive number of health topics.

In addition, members can also call our Member Services Department for assistance with any questions they have about their health coverage. Members enrolled in our care management program receive regular contact from our care managers to assist them in making sure they're getting the care they need.

While BMCHP will continue to offer comprehensive telephonic opportunities for members to get answers and information on their healthcare concerns, we recognize the ever-increasing extent to which individuals rely on the internet for gathering information and making decisions. In keeping with this tendency, we maintain a variety of member tools and content on our website at bmchp.org that support members in making appropriate healthcare choices.

As mentioned above, while BMCHP encourages members to discuss their health and medication concerns with their PCPs, we maintain a "Living Healthy" section on our website where members can find links to our Health Education Center and our Wellness Center and gather information 24-hours-a-day, seven days a week.

BMCHP has engaged Krames Online to offer members information and answers to their questions about both health and medication concerns. Krames Online offers more than 4,000 topics related to health and medications and printable information sheets are available on a large number of topics.

BMCHP's online Wellness Center offers seasonal wellness flyers for staying healthy, such as how to stay active during the winter, and links to a variety of resources such as community wellness activities. We plan to expand our online Wellness Center in 2012 to include more interactive wellness tools such as a BMI calculator and greater links to wellness content that makes sense for our Medicaid membership from a literacy and feasibility/accessibility standpoint.

In addition to information and tools found within the site's "Living Healthy" section, BMCHP maintains distinct pages for each of our care management programs, e.g., pregnancy, asthma, diabetes. These pages assist members in making appropriate healthcare choices by offering low-literacy content and links to resources that help members understand and better manage their specific health condition.

Member web pages also promote the availability of the telephonic assistance mentioned above, and to assist members in determining which telephonic service might best suit their needs at a particular time, BMCHP maintains an "additional resources" grid on our care management web section that explains when and why a member might want to use a particular service. For example, members are encouraged to call our Nurse Advise Line if they aren't sure whether to make a doctor's appointment or treat a health problem at home.

BMCHP also reminds members throughout our website that, should they be dealing with an emergency medical situation, they should call 911 or go to the nearest emergency room.

BMCHP regularly promotes the availability of the aforementioned telephonic and online services that support healthcare choices to our members through broad-based communications such as member newsletters and new member materials. Our care managers also point members engaged in our care management programs to our online tools and information.

Q52. Describe how you identify new and existing members who have the greatest need for care coordination and how you provide this coordination.

Since its inception in 1997, BMCHP has gained experience with coordinating care and measuring outcomes for the Medicaid population. To date, we serve eligible members that qualify for Medicaid and Commonwealth Care (a health reform product). Current members include: adults and children with dual behavioral health and physical disorders, children and adolescents with special needs, adults and children with comprehensive commercial third party health insurance coverage and adult members. BMCHP manages and coordinates care using an integrated medical and behavioral health model that incorporates early identification through health risk assessments, risk stratification and disease management, targeted outreach, care coordination and care management, and utilization management. We partner with our providers to use this integrated medical and behavioral health model to best address the overall health care needs of our members.

BMCHP's care management program was designed specifically to achieve an integrated approach to overall care management and is a proactive process that efficiently coordinates services for targeted populations, while also benefiting our entire membership. Aspects of the care management program include:

- Program focus on chronically ill, high risk members and those who have both behavioral health and medical diagnoses. This model includes screening for a comprehensive health and developmental history (including assessment of both physical and behavioral health development). BMCHP's interventions are member centric and provider based. The care management program values the role that the community health center or medical home plays in terms of providing community support for some of our highest risk members.
- The implementation of a nurse advice line gives members access to a specially trained nurse 24/7/365 in addition to access to an audio health library. BMCHP was the first managed care organization to market a nurse advice line in Massachusetts and to make this valued service available to our members. Our Care Management Department reviews members who used the nurse advice line to triage for members who would benefit from care management.

- Members with behavioral health /physical health needs are co-managed by both behavioral health and complex care management services. All care is coordinated between physical health and behavioral health providers. Our behavioral health partner (Beacon Health Strategies) has care managers located on site who sit side by side with our BMCHP care managers. There are joint rounds to discuss co-managed cases.
- Our care managers promote preventive care as well as advocate and facilitate access to needed health services.
- BMCHP partners with providers to develop and implement care management programs that focus on wellness and prevention, health maintenance and disease management for those populations identified as being at risk. We identify potential candidates for these programs through predictive modeling, disease specific algorithms, hospital discharge review processes, medical/ behavioral health claims data, pharmacy claims data, referrals through the nurse advice line, disease management program participation as well as direct physician or member self-referral.

As a testament to the results of our care management initiatives, BMCHP was designated in the *10th Annual (2011) Report on the Disease Management and Wellness Industries* as one of only two Medicaid plans to win recognition as a "best health plan in disease management." Further, ours is one of the only Medicaid plans whose outcomes have been audited, verified, and financially guaranteed by the Disease Management Purchasing Consortium.

DxCG risk scores, claims data, pharmacy data, health risk assessments, lab data and race, ethnicity and language data are all available to our care managers to assist them in managing and coordinating care for our members.

BMCHP uses predictive modeling tools to identify members in need of care management or disease management services with both behavioral health and physical health needs as follows:

- DxCG predictive modeling tool is used to identify members with high prospective risk scores. The members' diagnosis codes are used by the DxCG model to predict their expected resource use in the following year.

Care management registries

Currently, BMCHP has the following care management (CM) registries to identify members who may benefit from care management. We use DxCG and other criteria for members with the following conditions:

- Multiple conditions with high cost and high DxCG scores including rare diseases (these members would receive Complex Care Management)

- Complex newborns
- High risk pregnancy
- Pregnancy
- Emergency Department high utilizers-medical
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Asthma
- HIV/AIDS
- Cancer
- Obesity
- Hypertension
- Controlled substance use problems

Registries can and will be built to meet all contract requirements of the RFP. Registries are run monthly and cases distributed to care management staff for outreach.

Other methods of identification

As noted above, members may also self identify for care management or be referred by utilization management staff (prior authorization or concurrent review staff), or their providers. New members can be identified via health risk assessments that are available on the web and sent as part of the new member welcome packets. Welcome calls for disabled members also identify potential members for care management. Referrals to and from Beacon Health Strategies (Beacon) are sent on a daily basis through electronic file transfer.

Outreach

Our care management staff conducts member outreach in many ways including by phone, mail, and provider site visits. Relevant health education materials are provided to members as the care managers follow up and communicate with them. Throughout the care management process, our care managers are constantly assessing the member's progress toward Individual Care Plan (ICP) goals. They identify and address barriers, update the ICP as needed, and monitor outcomes of interventions toward completion of goals, and promote member self-management skills. Additionally, care managers work to promote the concept of the PCP as the primary care manager. Our care managers also facilitate communication between the members and PCPs to prevent PCP reassignment whenever possible.

Coordination of care

The hallmark of care management services is coordination of care. It involves the comprehensive assessment of the member's condition; determination of available benefits and resources, including family support and community resources; and the development and implementation of a care management plan emphasizing psychosocial support, self-management with performance goals, monitoring and follow-up. Care managers will assist these members in navigating the health care delivery system.

Q53. Describe how you will assist members in identifying and gaining access to community resources that may provide services that the managed care program does not cover, but which support the member's overall healthcare needs and goals.

BMCHP assists with access to community resources for all of our members. Our care managers help connect members with different needs to a variety of community resources. Some examples include the following:

- For members with transportation needs who qualify for state transportation assistance, care managers will complete and submit the form on behalf of the member and follow up to ensure that the request is approved through the state.
- Members needing housing are given contact information for resources in their area that have available housing for low income families.
- For members who need food, care managers direct them to local food pantries that can help them.

Members also receive guidance on places to go for many other needs, including job training, fuel assistance, furniture, mental health, and more.

Our website, http://www.bmchp.org, lists many different types of resources, such as those described above, that are available to members in Massachusetts cities and towns. This section would be expanded to include information on resources available for members throughout New Hampshire.

Q54. Members who require care management are more often transient, difficult to locate, homeless, and difficult to engage. Describe the strategies that you will utilize to address these barriers to care management.

A key challenge for BMCHP's Care Management Department is locating and reaching members so that they can be engaged in the appropriate program. BMCHP uses every opportunity to reach out, and locate our members in need of care management services. We acknowledge that many of our current Massachusetts members are transient or homeless and do not have a stable address or phone number. Because of socioeconomic factors and financial stressors, members are often distracted by other immediate needs

and find it difficult to keep appointments, including aftercare appointments post hospitalization, to comply with medication regimens, and to prioritize their health care and comply with the treatment recommended by their providers. These functions challenge us and our provider's ability to provide effective health care and care management to these members. We anticipate the same barriers will be present with the New Hampshire Medicaid population.

Our experience and interventions, which have proven successful with our current population, will undoubtedly be helpful with the New Hampshire Medicaid population. Some of the successful strategies employed are listed below:

- BMCHP does not always have the most up to date demographic information, i.e., address and telephone number. This affects BMCHP's ability to conduct outreach, general member communications, and care follow up. We have addressed this issue by using an external service to "scrub" member addresses and contact information. We update approximately 80,000 addresses per year, and approximately 24,000 phone numbers. We use this updated information for care management including outreach via mail and telephone.
- When a member is discharged from a hospital, he/she will give a phone number that he/she can be reached at. Our concurrent review nurses capture this number in our care management system so that when a referral is made to care management, outreach can be more successful. The first contact is often from our Transition to Home Team. The Transition to Home Program is a pilot program that includes calling a member within 24 to 48 hours following an inpatient medical discharge. Our experience is that many members are easier to reach shortly after discharge.
- Many members have a cell phone. Our system is able to capture cell phone numbers that change less often than land lines.
- Our care coordinators (part of the care management team) are trained to assist members to prevent utility turn offs (including telephone) if they have a chronic medical condition.
- BMCHP has a limited number of "locked cell phones" available to members who do not have other ways of staying in touch with health care providers, BMCHP and our medical management partners (e.g., Beacon). The phone is programmed with the numbers of the member's providers as well as BMCHP so that members can make and receive calls necessary to maintain their health and meet their needs. The phone is then given to the member. Phones can also be mailed or dropped off at a shelter or at a PCP's office.
- Home visits are made to complex care members as needed. Visits for homeless or transient members can be at shelters, clinics, coffee shops or other public places. When necessary, they are made in conjunction with behavioral health staff when there is a dual diagnosis issue in need of care management evaluation.

- Often the PCP or practice has the most accurate contact information. Our care management staff will contact the treating practice to update information when BMCHP's information is no longer accurate.
- BMCHP has a toll free care management line. Many members will call in directly to care management when they are in need of services. This gives us an opportunity to update demographic information and assist our members in meeting their needs.

Q55. Describe how members are engaged with the development of their care plan and how they are encouraged to follow that plan.

The BMCHP care management (CM) team has been trained in motivational interviewing techniques as a way to engage and keep members engaged in CM. Motivational interviewing as most recently defined in 2009 is: "a collaborative, person – centered form of guiding to elicit and strengthen motivation for change." We believe this is a key skill in engaging and keeping members engaged in our care management programs. Our CM clinicians are also held to the CMSA standards of practice.

Members who are identified for our CM programs are engaged via the telephone or face to face visit when appropriate. Participating in CM is voluntary. Once a member is successfully contacted a simple description of how CM can benefit the member is described. During the interview process members identify what is of most concern to them and we work together to develop a plan of care in coordination with the member. The care manager works collaboratively with the member's PCP and other providers to coordinate care across providers and in the community.

All CM assessments include standardized questions pertaining to the following:

- General questions including cultural and linguistic needs, preferences or limitations and availability of caregiver resources
- Health status including condition specific issues
- Clinical history including medications, screenings, complications of condition or co-morbid conditions
- Utilization of services and resource needs
- Mental health status including cognitive function
- Life planning activities
- Functional status indicators including activities of daily living, substance use
- Treatment plan including member's scheduled doctor visits, understanding of medications

- Education section to address questions the member may have about their condition, the materials they received, and to assess the member's educational needs
- Evaluation of available benefits

Once the assessment is completed, the clinician develops an Individual Care Plan (ICP). The ICP will be individualized to address unique care needs for the member based on the initial or follow-up assessments. BMCHP will include identified problems, interventions and prioritized goals. The documented plan will address self-management goals and plans including how they are communicated to the member (verbally or in writing) as well as the obstacles or barriers to meeting those goals or complying with the ICP. The ICP will guide how the CM clinician will work with the member.

If appropriate, the CM clinician will consult with medical staff, behavioral health clinicians, or pharmacists to plan for and reach the best health outcome for the member. This may result in a three-way call between clinicians of multiple disciplines to discuss medication compliance or other co-morbid disorders. Senior medical directors may also be involved in the member's care by completing rounds to provide guidance and recommendations on complex cases.

The CM telephonic clinician establishes a follow-up schedule with the member and adheres to these outreach parameters. The follow-up schedule is documented. Schedules for follow-up include, but are not limited to, education, coordination of care, and self-management support. CM plans are updated regularly to reflect member progress throughout the CM process. In addition to the initial call, outreach generally occurs every 1-4 weeks as determined by the care manager and member until the case is closed.

Throughout the ongoing CM program, and with each point of contact with the member, the ICP is continually reviewed and updated to reflect the member's progress. Evaluation of the care plan measures the member's response and effectiveness to the services, care, and interventions provided to the member. Progress towards goals is captured. Any time a change occurs in the member's needs or acuity, the member's level of CM may change and the ICP may be updated. The number of calls to the member may increase or decrease depending on the member's needs. The CM clinician continually evaluates the progress made toward the achievement of the ICP goals and determines the overall success of the outcomes in collaboration with the member and health care team.

While members are actively engaged in CM they are continually assessed for community resource needs and care coordination with providers or agencies. CM coordinators coordinate the provision of transportation services, when medically necessary, and offer support and information regarding community resources, such as food, clothing, and housing. If the member has a need to coordinate with providers, the CM coordinator or care manager will liaise between the provider and the member (for example, to arrange provider specialist visits).

The CM staff will provide linkages with staff in other agencies (e.g. Department of Mental Health, Department of Children and Families, and Department of Youth

Services) and/or community service organizations if the agency/organization is already involved in meeting the member's needs or as appropriate.

Q56. Describe your process for communicating with members about their primary care provider assignment, ensuring/encouraging members to use their assigned provider, and ensuring/encouraging members to keep their scheduled appointments.

BMCHP believes strongly in the important role that a PCP plays in coordinating a member's care. We require members to have a PCP when they become effective in our plan. Members can choose a PCP upon enrollment in BMCHP. If members do not choose a PCP, we assign one to them. This is communicated to members via the member ID card that all members receive that includes the PCP name on the front of the card.

We recognize that many of our members are unclear on the purpose and importance of the PCP in their care. We want to make sure that members understand why and when they should see their PCP. We use our member newsletter and member handbook to educate members as to how the PCP can help them make sure they get the right care. We also cover this information with members through orientation calls that our Member Services Department make to new members.

Our care managers remind members about the importance of regular doctor visits and keeping scheduled appointments, which is particularly important for those members who are at risk for or currently seeking to manage chronic diseases. Our care managers also make medical appointments for members if the member is having difficulty making them him/herself.

As part of our 'Sunny Start' program for prenatal and postpartum mothers, care managers regularly remind members to keep their scheduled ob/gyn visits. If the care manager finds out from the provider that a member did not keep her appointment, the care manager will call the member to find out the reason and see if there is something that can be done to help.

Q57. Describe your programs and time needed to support practices to attain NCQA patient centered medical home certification.

BMCHP is well positioned to support practices to attain NCQA patient centered medical home certification. We have been part of the planning and implementation of the statewide PCMHI Massachusetts pilot program and have the basic reports already in production for our 36 medical groups in the PCHMI program. With the current reports, groups can identify: members in need of complex care management, members in need of outreach due to frequent emergency room use, members discharged from (acute) inpatient admissions (on a daily basis), and members assigned to each PCP in their group.

Additionally, within the next year, BMCHP will have a methodology for selecting quality measures for those groups entering into accountable care organization contracts with us,

so that these measures can be used as "quality gates" typically seen in any medical home arrangement. We have trained nearly all of our medical management staff, and contracting staff on medical homes including the importance of the value proposition within a medical home; that is decreasing utilization while improving quality especially for the chronically ill members. We are aware of the elements required for group registries, a necessary component of NCQA certification.

One requirement of the Massachusetts PCMHI Pilot is that all groups must acquire Level 1 NCQA Patient Centered Medical Home Certification within the first year of the pilot. One of the first actions BMCHP would undertake is to more fully understand what New Hampshire has learned from its own pilot. While we know it has been limited to commercial members, and has fewer practices than the Massachusetts pilot, we would first speak with the groups and physicians who have participated with the New Hampshire Citizens Health Initiative to understand the barriers and how they differ from those in Massachusetts. While different groups in New Hampshire will be at various levels of readiness, we have staff experienced with NCQA documentation requirements who will be available for consultation. This consultation (on care management and documentation for NCQA) would be ready within 6-12 months of implementation depending on what we have learned from the practices already involved in patient centered medical homes.

Q58. Describe your experience, approach, and time needed to supporting Health Homes as defined by SAMSHA.

BMCHP has experience in the development of a health home consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) requirements via our relationship with Beacon Health Strategies (Beacon). Specifically, Beacon is currently engaged in a statewide health home initiative in New York where one million individuals have been identified as meeting the inclusion criteria. Efforts include extensive analytic modeling of co-occurring disorders, the development of a comprehensive network of providers designed to meet chronic medical, behavioral and social service needs, and the establishment of a single case management record accessible by all community-based providers.

Recognizing SAMHSA's overarching goal of addressing an individual's total health needs through the identification of a single community-based case manager, Beacon has established systems of care inclusive of medical, behavioral, and social services (transportation, housing and faith-based organizations). Beacon has also been developing a comprehensive member profile that summarizes a member's current health care experience in a useable format to inform treatment needs and goals. At every step of development, Beacon has included peers as "resident experts" on system and care planning needs.

Member voice and choice is Beacon's guiding principle. Use of this principle is also consistent with the values used to develop Massachusetts' Children's Behavioral Health Initiative (CBHI), the child delivery system supporting standardized screening and

community based services implemented by BMCHP and Beacon collaboratively with the state and other managed care entities (MCEs) in Massachusetts.

Developing a comprehensive health home infrastructure in New Hampshire would take 12 months from contract award. During this time, data would be mined to determine the universe of potentially eligible individuals, develop a statewide system-of-care network, and deploy a web-based case management record.

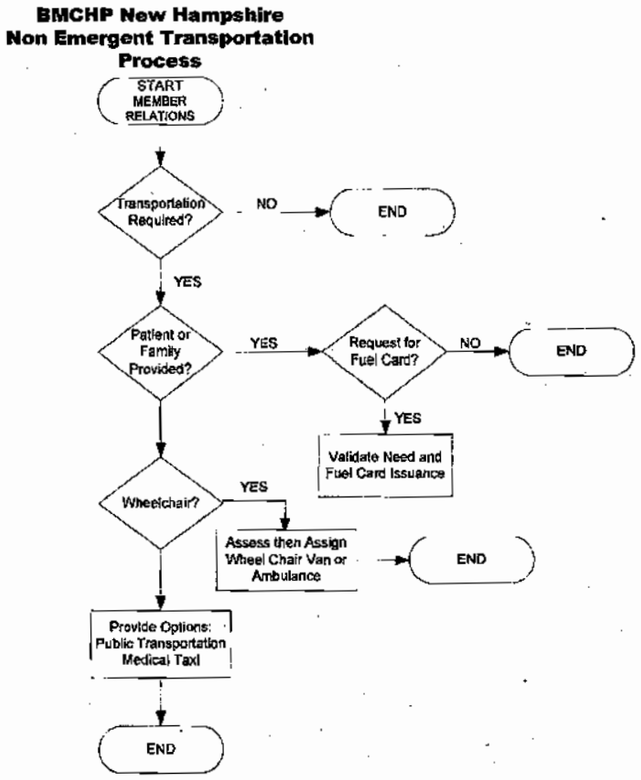
Q59. Describe your process and procedures for coordinating and facilitating non-emergency transportation for your Members.

BMCHP currently coordinates non-emergency transportation for members through our Care Management Department. As available throughout the State of New Hampshire, BMCHP will contract for the following non-emergent transportation services to meet the requirements of New Hampshire Medicaid Program:

- Ambulance
- Wheelchair Van Service
- Medical Taxi
- Public Transportation, and/or
- A fuel card to offset the costs of transportation for a caregiver, family or friend.

Member transportation needs will be determined according to the member's home or place of residence and the geographic location of transportation options, taking into consideration the distance, travel time and means of transportation ordinarily used by New Hampshire residents. Figure 1 illustrates the decision tree for transportation and is further stratified by those persons with and without physical mobility restrictions.

Figure 1



As illustrated in Figure 1, members will be encouraged to first utilize self transportation to/from a medical appointment.

If the member does not have transportation but does have a caregiver, family member or friend that is available to provide non emergent transportation; this is also highly encouraged and a fuel card is available on an as needed basis to offset the cost of fuel to/from the medical appointment.

He-M510.03 (r) Transportation services shall include reimbursing the family for the cost of travel such as mileage, or travel by taxi, common carrier, or other means, and other related costs such as tolls and parking expenses, that are necessary to enable an eligible child and the child's family to receive early supports and services.

If a member is in a wheelchair, a wheelchair van or ambulance is generally utilized for non-emergent transportation with ambulance usage being utilized only in the following circumstances:

- Certified as medically necessary by the member's physician or other qualified person
- The person is confined to a wheel chair and
- The transportation is to/from a qualified location.

Further detail follows below on BMCHP Processes and Procedures for non-emergent transportation.

Procedures for non-emergent transportation

Members with the ability and resources to privately transport themselves will be encouraged to use this mode of transportation as a first mode of transportation. When this mode of transportation is not available or the distance is greater than .75 miles from the member's home (weather permitting), BMCHP will coordinate and arrange for their transportation.

Members will be asked to contact our Care Management Department indicating their need for transportation, providing the date and the time of the medical appointment and the provider's location. Our Care Management staff may contact the physician office to confirm the member's appointment time and date. We will request the member contact BMCHP at least 72 hours in advance to allow time to secure and schedule transportation.

BMCHP's skilled and knowledgeable Care Management Representatives will review with members the potential modes of transportation that they may have available to them.

- BMCHP is in the process of identifying and contacting those persons who are volunteer transportation providers that are registered with the State of New Hampshire and provide medical transportation services to members on a volunteer basis to enable us to include this resource into our transportation management systems.
- If the member does not have private transportation BMCHP will begin the process of securing a mode a transportation that best meets the member's needs.
- Should members have access to free transportation offered by their place of residence or should the facility or location where the appointment is located offer transportation services, this mode of transportation will be identified and utilized when possible.
- BMCHP is in the process of identifying potential free modes of transportation provided through community services, medical facilities, or volunteer services.
- During our initial provider application process, BMCHP will survey through provider applications, primary care, specialists, hospitals and other providers to indicate whether they are located on or near public transportation lines. With this

information our Care Management Department will have available to them provider's locations and accessibility to public transportation.

- BMCHP will work with the various public transit systems within New Hampshire, such as Advance Transit, Nashua Citybus, CART Transportation, City Express, Cooperative Alliance for Seacoast Transportation, Community Alliance Transportation (CATS), Concord Area Transit, Manchester Transit Authority, Wildcat Transit, and Winnipesaukee Transit System, to secure agreements with them. The potential of purchasing transit vouchers to be provided to members and/or other potential reimbursement methods will be addressed. All agreements reached with transportation vendors will ensure their enrollment with the New Hampshire Medicaid Program and will follow and include the State of New Hampshire transportation guidelines, regulations and vehicle code guidelines.
- For rural members in need of transportation to urban areas when the local transportation does not avail itself to the distance members must travel, long distance bus services or other public transportation will be utilized when possible. BMCHP will begin discussions with Boston Express Bus with the intent to secure transportation for longer distance bus services.
- When public transportation is not available or does not meet the needs of the members, BMCHP will arrange for our contracted transportation vendor to provide transportation. We will be soliciting services from such organizations as Medical Transport Management, Logistics, Transportation Network, and/or taxi cab companies throughout New Hampshire to secure other modes of transportation services for members.
- All agreements reached with transportation vendors will ensure enrollment with the New Hampshire Medicaid program, follow and include State of New Hampshire transportation guidelines, regulations and vehicle code guidelines.

Members with mobility restrictions who have the ability and the resources to privately transport themselves will be encouraged to self transport as a first line of transportation. When this mode of transportation is not available BMCHP will coordinate and arrange for their transportation.

Members will be asked to contact our Care Management Department indicating their need for transportation, providing the date and the time of the medical appointment and the provider's location. Our care management staff may contact the physician office to confirm the member's appointment time and date. We will request the member contact BMCHP at least 72 hours in advance to allow time to secure and schedule transportation.

BMCHP's skilled and knowledgeable care management representatives will review with members the potential modes of transportation that they may have available to them.

If the member does not have private transportation we will begin the process of securing a mode of transportation that best meets their needs. During the call requesting

transportation services, our Care Management Department will ask the type immobility of the member, i.e. are they confined to a wheelchair, do they have difficulty walking, what assistance they need with entering and exiting a vehicle and other pertinent questions designed to ensure the appropriate mode of transportation and safety is secured.

Members with mobility restrictions may not have the ability to be transported via public transportation. Careful screening will be employed to determine the best transportation mode for each individual.

- Should members have access to free transportation offered by their place of residence; this mode of transportation will be identified and utilized whenever possible.
- BMCHP is in the process of identifying potential free modes of transportation provided through community services or medical facilities, and volunteer services that also may be utilized and are appropriate for members with physical mobility restrictions.
- If the member has a physical mobility restriction, but is able to utilize public transportation, our Care Management Department will have available to them provider's locations and the provider's accessibility to public transportation. BMCHP will work with the various public transit systems within New Hampshire, such as Advance Transit, Nashua Citybus, CART Transportation, City Express, Cooperative Alliance for Seacoast Transportation, Community Alliance Transportation (CATS), Concord Area Transit, Manchester Transit Authority, Wildcat Transit, and Winnipesaukee Transit System, to secure agreements with them, and include discussion of the potential of purchasing vouchers to be provided to Members, and working out other details of potential reimbursement methods. We will also investigate the ability of these public transportation vendors of their ability to transport persons with physical mobility restrictions. At all times our Care Management Representative will be mindful of the safety of the members.
- For rural members with physical mobility restrictions who are in need of transportation to urban areas when the local transportation does not avail itself to the distance members must travel, BMCHP will begin discussions with Boston Express Bus for longer distance bus services, ensuring their ability to transport persons with physical mobility restrictions.
- All agreements reached with transportation vendors will ensure enrollment with the New Hampshire Medicaid program, follow and include State of New Hampshire transportation guidelines, regulations and vehicle code guidelines.
- When public transportation is not available or does not meet the needs of the members, BMCHP will arrange for our contracted transportation vendor to provide transportation. We will be soliciting services from such organizations as Medical Transport Management, Logistics, Transportation Network, and/or taxi cab companies throughout New Hampshire to secure other modes of

transportation services for members. All agreements reached with transportation vendors will ensure enrollment with the New Hampshire Medicaid program and follow State of New Hampshire transportation guidelines, regulations and vehicle code guidelines.

- Ultimately when none of the above services meet the needs of the physical mobility restricted members, BMCHP will contact and schedule transportation vendors providing Wheelchair and Stretcher Van services. We will contact and work to reach agreements with Ambulance and Wheelchair Van vendors such as Hummingbird Wheelchair Van Service, Trilogy Wheelchair transportation, and other disabled and stretcher van transportation vendors throughout the State of New Hampshire. All agreements reached with transportation vendors will ensure enrollment with the New Hampshire Medicaid Program, follow and include State of New Hampshire transportation guidelines, regulations, and vehicle code guidelines.
- BMCHP will develop a Request for Transportation checklist to ensure that our care management representatives identify the needs and requirements of members as well as exhaust all third party obligations prior to scheduling transportation services. This checklist will include but not be limited to the name of the provider, location, phone number, time and date of the scheduled appointment, name, address and phone number of the member, if the member has other insurance coverage. A monthly utilization report will be developed to enable monitoring of the transportation and quickly enable us to identify any potential of fraud and abuse of these services.

Q60. Describe your direct experience in managing substance abuse benefits provided through Medicaid programs, including Screening, Brief Intervention and Referral to Treatment (SBIRT).

BMCHP has historically managed and coordinated care for all members by using an integrated medical, behavioral health and substance abuse (SA) model, with experience managing and coordinating the full spectrum of substance abuse treatment services. This model of management continued after BMCHP's partnership with Beacon Health Strategies (Beacon) in 2010. Beacon provides management of SA benefits for 28 Medicaid health plans in 12 states, covering 2.9 million members. In Massachusetts and Rhode Island, Beacon maintains a provider network that includes almost all SA providers in each state. These Medicaid programs include all levels of care in the SA treatment continuum, from acute detoxification through outpatient treatment. This continuum includes intensive outpatient, short-term residential, medication-assisted opiate (and other substances) withdrawal and maintenance treatments, and specialized treatment and case management service for pregnant and postpartum women affected by SA.

Beacon manages the SA benefits by collaborating with both primary care and specialty mental health and SA providers. Beacon's role is to facilitate access for members to needed services and to ensure that services are clinically appropriate and delivered in the

most effective setting at the intensity and for the duration needed by the member to enter and maintain recovery. Beacon staff members who provide care management services are independently licensed behavioral health clinicians with SA treatment training and experience and usually hired from the communities in which health plan members are located. For example, Beacon co-locates clinicians in each of the regional offices that BMCHP offers throughout the Commonwealth of Massachusetts in order to best understand the mental health and SA issues, barriers and resources specific to the area. Beacon employs additional clinicians who serve as lead substance use clinical specialists serving specific health plan clients or defined regions where Beacon works with more than one plan.

These clinicians collaborate with SA providers to create comprehensive care plans for members with complex SA conditions, often co-occurring with other medical and behavioral health concerns. These lead clinicians also serve as liaisons to professional associations and advocacy organizations such as New Futures, New Hampshire. Through relationships with provider and advocacy organizations, as well as state agencies such as Massachusetts' BSAS (Bureau of Substance Abuse Services) and the Department of Public Health (DPH), Beacon and BMCHP are able to gain excellent feedback regarding the SA needs of our membership and how we can meet those needs through clinical programming. BMCHP historically, and now in partnership with Beacon, has used this feedback to evaluate the spectrum of SA services for our population, condensing services where it makes sense while tailoring other offerings to best serve specific communities.

It is through relationships with these types of organizations that both BMCHP and Beacon have supported the development of Screening, Brief Intervention, Referral and Treatment (SBIRT). In most instances where SBIRT is used, it is provided in primary care sites, and most often, in emergency departments. BMCHP and Beacon have worked collaboratively with BSAS to support the development of early SA intervention and prevention programs, which are primarily delivered in Massachusetts through Boston Medical Center (emergency department and outpatient clinics), Boston based community health centers and multiple regional hospital emergency departments. Beacon has been able to arrange for provider training regarding SBIRT through resources such as the specialized program at the Boston University's School of Public Health. (For more information on this program, please see the following link: http://www.bu.edu/bniart/sbirt-in-health-care/what-is-sbirt/.) Through partnering with Beacon and utilizing their call center, BMCHP also provides PCPs and emergency departments with access to staff members who are able to facilitate referrals to specialty SA providers within the BMCHP/Beacon network.

Q61. Describe your organizational approach to the following: data sharing and integration to promote care coordination for members with special needs, such as mental illness, substance use disorders, and Human Immunodeficiency Virus (HIV).

BMCHP currently has care management systems in place to promote the coordination of medical and behavioral health care for our current Medicaid (MassHealth) and Medicaid expansion (Commonwealth Care) members. BMCHP contracts with Beacon for the

utilization management of behavioral health and substance use disorder care and services.

BMCHP is attuned to the issues and complexities of data sharing and integration to promote care coordination for members with special needs since we currently face and address these issues with the members we serve. BMCHP, in partnership with Beacon, has implemented data sharing processes that are seamless and include the following:

- Two-way secure email;
- A daily referral file;
- Secure, read-only access to each other's care management systems and;
- On-site access to staff in each region.

BMCHP and Beacon make every effort to gain member consent to share information with the member's primary care provider and other practitioners as necessary. For example, Beacon, requires that inpatient and outpatient contracted providers ask each BMCHP member to sign a release to share information with their PCP. Our care managers do the same with members in these protected categories when coordination of care is necessary. Our motivational interviewing training of care management staff is key in helping our staff engage our members and build the kind of therapeutic relationship that reinforces trust and allows for success when these sensitive issues arise. Any member in a sensitive category who meets our care management criteria gets an outreach call from one of our care management staff. The goal is to better coordinate care and assist the member in self management of his/her condition. With the proper permission, educational materials are distributed to the member, the member is assigned a care manager and coordination of services is provided.

Each initial interaction with a care manager begins with a comprehensive assessment. Many of our assessments are individualized to the condition and others are general. The assessment includes the member's understanding of his/her condition, ability for self care, availability of or need for caregiver resources, assessment of community services, and depression and substance abuse screening among other parameters. Based on the results of the assessment, an individual care plan is developed with the member and when possible coordinated with the primary caregiver. The care manager sets up the next appointment. Ancillary services and durable medical equipment (DME) needs are arranged for as well. Referral to Beacon for behavioral health assessment or co-management may be determined at any time during the member's care management. BMCHP and Beacon share a daily two-way referral file whereby BMCHP may refer a member to Beacon for coordination of behavioral health care services and Beacon may refer a member to BMCHP for care management.

BMCHP maintains these standards for all of its lines of business and programs. As a specific example, BMCHP participates in the Patient Centered Medical Home Initiative organized and overseen by the Massachusetts Executive Office of Health and Human

Services which promotes care coordination for MassHealth and Commonwealth Care members.

BMCHP and Beacon are also mindful of the sensitivity of the clinical information at issue for members with special needs, such as mental illness, substance use disorders, and human immunodeficiency virus (HIV). BMCHP takes the protection of protected health information and personally identifiable information very seriously. We maintain systems, policies, and procedures to comply with federal and state requirements (including HIPAA) pertaining to the security, privacy, and confidentiality of sensitive information. BMCHP and Beacon take heightened precautions regarding the transfer and sharing of sensitive data of members with special needs. BMCHP and Beacon have processes in place to maintain the confidentiality and privacy and protect against the unpermitted disclosure of such sensitive data. BMCHP and Beacon recognize that the protection and security of such information is critical to gaining members' trust and the ability to better manage their care.

While HIPAA allows an exception when disclosure of Protected Health Information (minimally necessary) for the purpose payment, treatment, or operations, BMCHP, for purposes of data sharing and integration to promote care coordination, currently aggregates, groups, and/or filters data in such a way as to prevent the identification or disclosure of sensitive health information. BMCHP takes heightened precaution pertaining to information/data regarding mental/behavioral health; substance abuse/chemical dependency; HIV/AIDS identification; and genetic information; as these categories of information are considered highly sensitive under federal and state law.

BMCHP would, therefore, maintain the necessary systems, policies, and procedures to protect the privacy and confidentiality of the health information of members of the New Hampshire Medicaid Care Management Program consistent and compliant with applicable federal and New Hampshire law, including laws pertaining to genetic testing; mental health care; HIV treatment; alcohol and other drug use treatment and; confidentiality of insurer records.

Q62. Describe your experience managing the listed disease states. Include empirical evidence of health outcomes your members have experienced through your chronic care management programs.

BMCHP currently manages members with diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, and coronary artery disease (CAD). Asthma and diabetes have high prevalence rates in our Medicaid population, while COPD and CAD are more prevalent in our Commonwealth Care population. Our care managers have expertise in all of these conditions and many of our members have many of these conditions as co-morbidities.

Depression is a frequently occurring co-morbid condition. All of our care management assessments have a depression screening embedded within them and our workflow is to send a referral to Beacon Health Strategies (Beacon) if the depression screen is positive. Beacon has a disease management program for depression and will enroll members with

these conditions into their depression disease management program or care management program.

Members with asthma or diabetes, the most common conditions affecting our current membership, are offered a three tiered intervention. There is a population educational intervention that includes information about how to stay healthy with asthma and/or diabetes. Members receive educational information, (e.g. calendar for diabetics with healthy recipes and reminders for routine tests). All asthmatics receive an Asthma Control Test and other educational materials.

Members with conditions not in good control are on our monthly registries and receive care management outreach. Those with multiple co-morbidities may be asked to enroll in our Complex Care Management Program. All members have access to on line educational material for many disease states. When working with a care manager these materials can be customized and mailed to the member. They are written for members with low health literacy and are easy to understand. They cover all of the disease conditions listed and many more.

Members with CHF may be offered a digital scale to monitor their weight (when coordinated with their PCP). Members may be offered pill boxes for any disease condition to increase medication compliance. Pharmacy staff is available to perform "brown bag" medication reconciliation when requested by care management staff to help members with these conditions better understand their medications and their interactions with over the counter medications or foods.

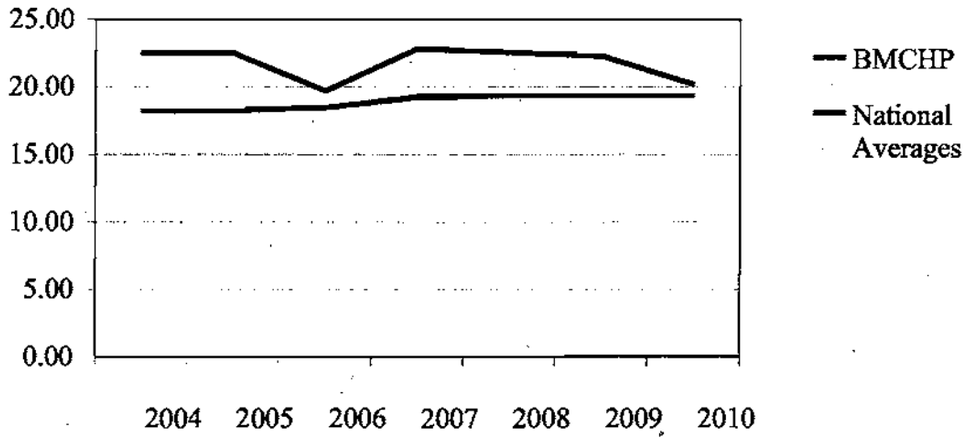
Members in need of home visits or environmental evaluations are identified and arrangements made as needed. For example, BMCHP will authorize a visiting nurse agency to perform an environmental evaluation to see if there are home triggers that might be alleviated for members discharged with a primary diagnosis of asthma or following an emergency room visit for asthma. We will authorize dust mite covers for mattresses and pillows. Small investments may prevent a costly hospitalization or emergency room visit. We have also made visits to members in their homes, shelters, clinics, or met members when face to face visits are indicated to better coordinate care.

As Massachusetts has experienced, disease management savings calculations are more a function of a vendor's trend assumption than of actual reduction in adverse events. At BMCHP, we apply a primary focus on the avoidance of adverse events, both in the near term, through the identification and contact with the highest risk members and longer term, through provider education and contract incentives. BMCHP identifies and generates a monthly registry of members with complex care management needs including members with rare diseases, AIDS/HIV, co-morbid conditions, skilled nursing facility discharges, complex newborns and high risk pregnancies. In addition, members with diabetes, asthma, cancer, CHF, CAD, frequent use of controlled substances, frequent ED utilization and or high DxCG risk score are included in the monthly registry.

As a result, we have improved the overall health of our members, using simple objective outcomes, cross-validated by our HEDIS scores. Calendar year 2010 performance has resulted in:

- An overall # 3 ranking among all Medicaid plans in the United States.
- An Excellent Accreditation Status for Year 3 of our current NCQA Accreditation (achieved approximately 87% of points available for HEDIS measures).
- Achieved approximately 94% of available accreditation points for HEDIS for Year 1 of next accreditation cycle.

As an example of BMCHP's experience in disease management, our asthma event rates per 1,000 (ICD-9 493 combined ER visits and inpatient stays vs. the national average for the TANF population, as compiled by the Disease Management Purchasing Consortium Inc.):



BMCHP has reduced its TANF asthma event rate by 8% and is now almost at the national average. To put our excellent performance in perspective, consider this article from the *Boston Globe*, independently confirmed by the Kaiser Family Foundation, showing that Massachusetts has the second-highest asthma prevalence in the country (http://www.statehealthfacts.org/comparemaptable) . Reducing asthma event rates to average while prevalence is high is an outcome that testifies to the effectiveness of our program. Our performances in asthma and four other common chronic conditions led to our inclusion by the *10th Annual (2011) Report on the Disease Management and Wellness Industries* as one of only two Medicaid plans to win recognition as a "best health plan in disease management." Further, ours is one of the only Medicaid plans whose outcomes have been audited, verified, and financially guaranteed by the Disease Management Purchasing Consortium.

Q63. Describe how you provide care management to children and youth involved in the child protection and/or juvenile justice systems as well as children in foster home/group home/residential placements.

Once an individual has been referred into or identified for a medical or behavioral health care management program, research is done through the medical and/or behavioral health management system. Over a year ago, BMCHP developed a Member Attribute Repository which enables us to identify those members involved with state agencies. Agency information received on the daily eligibility file from the state (Massachusetts) is identified and incorporated into the Member Attribute Repository. The Department of Children and Families (DCF) and the Department of Youth Services (DYS) are two such agencies identified and flagged in the member's record in our medical management system. Care managers can then quickly identify children involved with a state agency and make every effort to get them the services they need and coordinate with the case worker(s) involved in their care.

BMCHP's care management programs integrate physical and behavioral health services to help members regain optimum health or improved functional capability through focused support, coordination of care and services and evaluation of psychosocial needs. Our behavioral health partner provides members with in-home (family home, residential program, nursing home) crisis evaluation, assessment and ongoing therapeutic and training services.

The initial assessment may be done telephonically, face-to-face by a medical or behavioral health clinician or during a joint visit with a behavioral health and medical clinician to a foster home or group home if indicated. From this assessment, gaps in care are identified and an individualized care plan is created which addresses unique care needs, goals, preferences and desired involvement of the member and/or caregiver. Dependent upon the member's individual needs/situation, Beacon Health Strategies (Beacon) may be co-managing the child for behavioral health needs or take on the primary role in their Intensive Case Management program. They would have frequent contact with the member's caseworker, including face-to-face meetings. Appropriate consents are obtained to enable our clinicians to discuss the care plan with the foster parent/guardian. Based on the initial medical telephonic assessment, it is determined if a follow-up assessment needs to be done at the child's residence. If issues or problems are identified, the medical clinician will contact the DCF worker directly to resolve the issue and ensure coordination among providers. On occasion, when multiple agencies are involved, it is the BMCHP or Beacon care manager who coordinates the care between agencies and the primary healthcare provider. Since we integrate medical and behavioral health care management, there is enhanced care coordination and communication between the member, caseworker, guardian, community agencies, and providers.

Q64. Describe your proposed chronic care management program, including:

- **Any additional diseases you will target.**
- **Your risk stratification methodology.**
- **Your outreach strategies to members requiring disease management services.**
- **The interventions you will implement for members of each risk level.**
- **Your approach to telephonic interventions and face-to-face interventions.**
- **How you engage the member's primary care physician and other providers in developing and implementing a care plan.**
- **Your approach for managing members with multiple co-morbidities.**
- **How you will integrate your disease management programs with the member's primary care provider's care management responsibilities?**
- **Your approach to coordinating community resources for members in the disease management program.**
- **Describe your proposed approach to transitioning members who were receiving care management support from DHHS prior to enrollment in the MCO.**
- **Describe your approach for handling high-cost/high-risk individuals.**
- **Describe your organizational approach to the following: Aligning systems and management practices, including provider contracts, credentialing, training, and reimbursement policies; practice protocols; services authorization policies; benefit and non-MCO service coordination policies and protocols; and your quality assurance mechanisms, to promote care coordination of members with special needs, such as substance use disorders and HIV**
- **Children and youth in foster home/group home/residential placements**

In addition to the required chronic diseases BMCHP will target the following rare diseases: lupus, scleroderma, rheumatoid arthritis, hemophilia, sickle cell disease, multiple sclerosis, amyotrophic lateral sclerosis, advanced AIDS, complex newborns, high risk pregnancy, controlled substance use problems, select cancers and obesity.

BMCHP uses claims and predictive modeling tools to identify and stratify members in need of care management or disease management services with both behavioral health and physical health needs. A DxCG predictive modeling tool is used to identify members with high prospective risk scores. The members' diagnoses codes are used by the DxCG model to predict their expected resource use in the following year. This is used in combination with inpatient and outpatient utilization along with pharmacy data for stratification into the highest level of care management.

Members may move between three levels of care management depending on the severity of their condition, the intensity of care management needed and the level of education they may need about their condition. Level 1 is focused on general education and mailings. Level 2 is moderate severity requiring consistent care management (and social) interventions. Level 3 is complex care management requiring the most intensive and frequent interventions (social, medical and/or behavioral health). Level 3 members receive face-to-face visits as appropriate. Members are assessed monthly to determine if they continue to need care management through our sophisticated care management registry designs and provider referral or member/care giver referral process.

BMCHP's outreach strategies for disease management include population mailings or targeted phone calls for Level 1. Level 2 and Level 3 involve care management in addition to member mailings, care management outreach, and face-to-face visits. Care management staff conducts member outreach in many ways including by phone, mail, face-to-face visits when appropriate and provider site visits. Relevant health education materials are provided to members as the care managers follow up and communicate with them. Throughout the care management process, the care managers are routinely assessing the member's progress toward individual care plan (ICP) goals. They identify and address barriers, update the ICP as needed, and monitor outcomes of interventions toward completion of goals, and promote member self-management skills. Additionally, care managers work to promote the concept of the PCP as the primary care manager by working collaboratively with the PCP to support the adherence to his/her prescribed medical plan. Care managers also facilitate communication between the members and PCPs to prevent PCP reassignment whenever possible.

During the initial assessment process care managers identify members who could benefit from a face-to-face intervention or telephonic interventions. Telephonic interventions include ongoing assessment, education, advocacy and coordination of care. Members who have a face-to-face intervention have an assessment completed in person in shelters, group homes or anywhere in the community where the member is willing to meet their care manager. One of the benefits of our behavioral health partnership with Beacon Health Strategies (Beacon) is that a joint visit can be made when there are dual diagnosis issues. When appropriate, staff from other community agencies or services may be present to collaborate in the care plan. Member education is conducted during the visit promoting self-management strategies and interventions so the member can maintain and or improve their health status.

Members select a primary care provider of their choice. When members are engaged in care management we work in collaboration with the member to support their primary care provider's plan of care. One of the goals of care management is helping the member develop effective communication skills with their providers to promote self advocacy. However, with this population it is sometimes necessary to become the advocate until the members are able to advocate for themselves. Our care manager's training in motivational interviewing is key in facilitating member empowerment. BMCHP does however find it necessary to remind providers and members of evidence-

based interventions (e.g. overdue diabetic screenings or a need for a glucometer to better manage elevated blood sugars).

BMCHP's complex care management is not condition specific but rather member centric because the majority of our members have multiple co-morbidities and psychosocial issues. Our care management documentation system, CareEnhance® Clinical Management Software (CCMS), is designed to support complex care plans, interventions and tracking of outcomes.

BMCHP has experience with the patient centered medical home model in which both the practice and the plan each has a care manager who work together to best coordinate care. Additionally, BMCHP has worked with practice based care managers for the past seven years, supporting care management at the site of service for those practices able and willing to work with us to share the care management responsibilities for our members.

Members who are identified as needing community resources would work with our care coordinators to facilitate referrals to the appropriate agencies in New Hampshire. Part of our implementation plan will be to follow through to make sure the referral has been fulfilled and that services have been implemented and are meeting the member's needs. We have developed an extensive community resource guide for our staff and have the expertise to develop a similar resource guide for New Hampshire. Our care coordinators are experts in identifying, referring and following up on the outcome of the referral.

BMCHP has experience successfully transitioning new members into our plan even when the member is not familiar with managed care. When the current MassHealth contract became effective, we took the lead and coordinated a work group consisting of MassHealth and the other managed care organizations to smoothly transition members who were moving between MassHealth and the plans. The group developed and implemented a process to ensure that data and information related to members who were: pregnant, in care management, inpatient or who had open prior authorizations (including pharmacy) was transferred from the member's existing plan to their new plan. As a result, members' services were not disrupted. In addition, we participated in a Disability Advocate Forum with MassHealth and other plans to educate the participants in the benefits of managed care (who had not been in a managed care plan) and to respond to questions and concerns that were voiced. The forum also included a discussion of perceptions of disabled people as well as their need to retain control of their personal individualized care plan. This open dialogue was critical to the plans developing ongoing, productive relationships with their new members. BMCHP would be more than happy to participate in any similar forums that may help to make the transition to managed care smoother in New Hampshire.

BMCHP will work with DHHS care managers to obtain information regarding members who are receiving care management services and/or have existing authorizations and prior authorizations for services including durable medical equipment to ensure that services are not disrupted during the transition. We would

also request a meeting with DHHS care management staff to have a verbal report of the most at risk members as their care is transitioned. We would request a file listing all agencies that are involved in the member's care, and a list of current providers. We allow complex disabled members to request a specialist to be their primary care provider if the specialist is part our network and consents to be the primary care provider. For members transitioning into managed care for the first time this is a very important option. Our care managers would outreach to those members in need of coordination of care.

BMCHP has experience in managing high cost and high risk members in care management. Utilization management programs for both medical and behavioral health services focus on high volume and high cost services through various programs and initiatives, including reducing the average length of stay (ALOS), prior authorization of certain services (high end imaging, durable medical equipment, surgery, behavioral health outpatient visits) and concurrent review. This population receives intensive care management that involves frequent phone calls from our care managers who then facilitate coordination of care amongst multiple providers and community resources when needed.

As noted previously, members may choose a specialist as their PCP. BMCHP may authorize a specialist physician to serve as a member's PCP if the member has a life-threatening, degenerative, or disabling condition or disease that requires prolonged specialized care (e.g., HIV, end stage renal disease, or an oncology diagnosis) and BMCHP believes it will be in the best interest of the member to make this exception. A BMCHP care manager will review the request. Specialists acting in the capacity of a PCP must be, or must become, BMCHP participating physicians and must adhere to all BMCHP standards applicable to PCPs. Covering practitioners for the specialist-PCP must be credentialed by us.

If a member is receiving care from a specialist with whom BMCHP is not contracted, we will make every effort to recruit that specialist as a participating provider. If we are unable to bring this provider into our network, our staff implements our transition of care policy and will assist the member in transitioning to an appropriate network provider.

If we plan to utilize the services of a provider who does not plan to join our network, BMCHP will negotiate a specific rate for the services which that provider will deliver until the member can be transitioned to a participating provider. We will assign a contract manager to negotiate an "individual case rate". Contract management staff will assure that the appropriate documentation is sent to the provider so that the provider can be quickly enrolled through the Provider Enrollment Department as a non participating provider.

BMCHP strongly prefers not to disrupt care for our members with special needs, and will make every effort to assure these members' providers are within the network. If unable to recruit the provider into our network, BMCHP will accept and process requests from non participating providers via our email address and assure the non

participating provider's information is loaded into our claims system within one to two days. For our current providers, credentialing staff verify that the provider is not sanctioned by checking the Office of Inspector General website and the MassHealth Provider Disposition Report, which lists providers currently not participating in MassHealth due to a sanction, before the provider is enrolled in our system as a non participating provider. We would replicate this process for New Hampshire providers.

Our process for children in foster homes/group homes/residential placements is to work closely with Beacon and offer them co-management services. The child's guardian is contacted and arrangements are made for assessment by either a BMCHP or Beacon care manager. If appropriate a joint assessment would be completed.

The assessment includes questions regarding health status, including condition specific issues, clinical history, medications, activities of daily living, behavioral health status including cognitive function, evaluation of available benefits within the organization and community resources, life planning activities, cultural and linguistic needs, preferences or limitations. During this evaluation process the clinician may become aware of agency affiliations. BMCHP has a state agency liaison in our Care Management Department that any state agency worker may contact to get connected to the appropriate care manager or contact within BMCHP and facilitate coordination within our network.

Q65. Describe your organization's experience with managing the care of children in the child protection systems and/or juvenile justice system (e.g., foster care).

Please see our response to this question under Question 63 as set forth in the Official Response to Bidder's Question #300.

Q66. Describe your approach to providing care management to children and youth involved in the child protection and/or juvenile justice systems as well as children in foster home/group home/residential placement.

- **Identify children in the child welfare and child protection system.**
- **Initiate services and conduct a comprehensive health assessment**
- **Develop and monitor a care management plan in consultation with the child's primary DHHS case manager based on the health assessment and including all disease management or behavioral health needs.**
- **Assure continuation of care when the child/family leaves the child welfare/child protection system.**

BMCHP initially seeks to identify children and youth involved in the child protection and/or juvenile justice systems as well as foster home, group home and residential treatment. BMCHP currently receives a daily eligibility file including state agency affiliations from the state (Massachusetts) which are then entered into our Member Attribute Repository. CareEnhance® Clinical Management System (CCMS) software, our

medical management documentation system, flags those members with affiliations reported by the state. Some of the agencies identified in the Repository are Department of Children and Families, Department of Youth Services, Department of Mental Health, Massachusetts Commission for the Blind, and Department of Developmental Disabilities. We have systems in place to prevent unauthorized disclosure of information to third parties when administering coordination of benefits for members, such as those with protective orders and adopting children, who elect a MassHealth provision that the information not be disclosed. We would be able to put a similar process in place for New Hampshire.

Children are identified for care management at BMCHP using a predictive modeling tool and monthly care management registries, which include criteria for complex care management, complex newborns, pregnancy, high emergency department utilizers (medical), diabetes, asthma, HIV/AIDS, cancer, obesity, hypertension, and use of controlled substances. In addition to the predictive modeling and diagnosis-driven criteria, utilization criteria are integrated into the registry. Other identification methods for care management are the health risk assessments, referrals from medical and behavioral health concurrent reviewers, PCP referrals, and referrals for co-management from Beacon Health Strategies' care managers.

After a member is identified, a pre-assessment utilizing pharmacy reports and CCMS data is completed. If a member is identified and meets criteria for care management, the member is outreached telephonically (or face-to-face depending on the issues and situation) for an initial assessment which includes questions regarding health status, including condition specific issues, clinical history including medications, activities of daily living, behavioral health status including cognitive function, evaluation of available benefits within the organization and community resources, life planning activities, cultural and linguistic needs, preferences or limitations.

During this evaluation process the clinician may become aware of agency affiliations. The initial assessment may be done telephonically, face-to-face by a medical clinician or behavioral health clinician or during a joint visit with a behavioral health and medical clinician to a foster home or group home if indicated. BMCHP has a state agency liaison in the Care Management Department that any state agency worker may contact to get connected to the appropriate care manager or contact within BMCHP and facilitate coordination within our network. Any child with behavioral health issues may be referred to a network provider for an in-depth clinical assessment.

Throughout the ongoing care management process, and with each point of contact with the member/guardian, the ICP is continually reviewed and updated to reflect the member's progress. Evaluation of the care plan measures the member's response and effectiveness to the services, care, and interventions provided to the member. Progress towards goals is captured. Any time a change occurs in the member's needs or acuity, the member's level of care management may change and the ICP may be updated.

The clinician continually evaluates the progress made toward the achievement of the ICP goals and documents within CCMS not only the progress towards the goals, but also

barriers affecting or impacting outcomes, education, self-management, planned follow up dates, and overall outcomes. As barriers are identified, clinicians work with specialists to include all stakeholders in the member's success to best meet the goals. If issues or problems are identified, the clinician will contact the state worker(s) directly to resolve the issue(s) and ensure coordination among providers and behavioral health clinicians by maintaining their frequent contact with the state case worker.

BMCHP members remain in care management despite agency affiliation as long as they/their guardian agree, maximum goal achievement is met, and they remain eligible. If during the course of care management, the member is no longer affiliated with the agency and contact is lost due to an unreported address or phone number change, every attempt is made to get the correct information either from the agency or the member's provider.

Q67. Describe your approach to assuring the coordination with supporting community resources for children and families in child welfare and child protection system.

Linking members to and coordinating community resources is an integral part of the ICP and care management process at BMCHP. The integrated care management team will work together to refer and coordinate community resources to maintain the member's mental and physical health status and ensure activities to promote social development. A health resources assessment tool coupled with an EPSDT screening are critical to linking children in the care and custody of the state with community resources.

Coordination with supporting community resources may be done by a clinician or non-clinician depending on complexity. Currently, the medical non-clinicians coordinate the application for transportation to the state and provide education to the member on how to access the service once the application is approved. However, we will have the resources in place to facilitate the delivery of transportation if awarded the New Hampshire contract.

Coordination and referrals for food and formula through the Women, Infants and Children Nutrition Program is one of the more common resources. Working with agencies to find a wheelchair ramp, informing the parent/guardian about residential school programs and summer programs available through different associations are but a few of the community resources we coordinate and refer the member. After school programs, court systems, and schools are all important community resources to ensure members receive quality care. The care management team also assists the member through the application process for a personal care attendant but BMCHP would have the resources in place to provide this crucial service if awarded the contract. As part of the care management process, any referrals made to agencies are followed up on at the next contact with the member.

The availability of community resources changes frequently and from area to area. The staff at BMCHP update an internal electronic rolodex of resources from fuel assistance to child care as needed. The provider/member website also offers information on

community resources including housing and food, job training, legal assistance, and children's resources. If awarded the New Hampshire contract, staff at BMCHP would join committees made up of staff from community agencies and state agencies to ensure maximum coordination potential.

3.12.4 Performance Incentives

Q68. Describe your proposed Quality Management Program for your New Hampshire offering.

BMCHP was awarded Excellent Accreditation from the National Committee for Quality Assurance (NCQA) on June 1, 2009 based on the Medicaid Standards. We have maintained Excellent Accreditation each year since our original accreditation and have been ranked within NCQA's Top 5 Medicaid HMO Health Plans in the United States for the past 3 years (2009, 2010 and 2011), including as the #3 plan for 2011-2012.

The Quality Improvement Program (QIP) is the foundation upon which BMCHP bases all our efforts to continuously design, assess and improve the quality of medical and behavioral health care rendered to our members. Our comprehensive approach to improving the overall quality of clinical care recognizes the importance of ensuring the quality of administrative services rendered to members as well as to the provider network and other internal and external stakeholders. We are uniquely positioned to excel in these efforts because we are a provider-sponsored organization. Information regarding the QIP is communicated to members and providers through the Member and Provider Newsletters on an annual basis.

BMCHP is committed to improving the quality of clinical care provided by our participating providers and service delivered to our members. For this reason, the Board of Trustees (BoT) has formally adopted the 2011 Quality Improvement Program Plan, which is enclosed at Exhibit 6.5.E., and will review and update it at least annually. BMCHP's Chief Medical Officer (CMO) serves as the physician with substantial involvement in the QIP.

The QIP Plan establishes and describes in general terms the organization-wide corporate QIP. In particular, the QIP Plan describes an organizational structure, which identifies quality as a separate organizational function for which the BoT is accountable. The QIP Plan provides for oversight of the quality function by executive management and promotes the integration and coordination of quality with other BMCHP functions. The QIP Plan designates those resources, which are reasonably determined to be sufficient for the achievement of QIP goals and objectives.

Additionally, the QIP Plan identifies the individuals and committees responsible for QIP development, oversight and operations and it describes the primary QIP components. The QIP Plan directs that each year an Annual Work Plan setting forth specific goals, objectives and activities for the year be developed, implemented and evaluated. Finally, the QIP requires that an Annual Evaluation of the QIP be conducted and presented to the BoT.

The objectives of the QIP are to:

- Ensure that members receive medical and behavioral health care from qualified physicians, health care practitioners and organizational providers;
- Provide information, training and tools to staff and practitioners to support culturally competent and linguistically appropriate communication and services;
- Demonstrate meaningful improvement in clinical and non-clinical care and services experienced by members and providers;
- Provide the framework for the design, deployment and operation of the Utilization Management Program and to ensure coordination between quality improvement and care management activities;
- Reinforce the principles of continuous quality improvement through systematic monitoring of processes, analysis of data, design of interventions for process improvement and determination of actual effectiveness of interventions;
- Refine processes and standards for measuring, evaluating and improving the quality of care and services to members;
- Use multi-disciplinary teams to refine processes and standards that allow us to implement, evaluate and monitor process improvement;
- Demonstrate compliance with the quality management standards of external regulators and accrediting organizations;
- Serve members with complex needs and special health needs by coordinating care in a manner that takes their unique circumstances into consideration;
- Annually review all quality improvement activities. This includes evaluation of the QIP itself, of the Annual QIP Work Plan, of the accomplishments of the organization as a whole as well as implementation of updates to the QIP as appropriate; and
- Foster a supportive environment to help practitioners and providers improve the safety of their practices; through member and provider education and through the use of data, identify actual or potential opportunities to decrease medical errors and/or improve patient safety.

The QIP encompasses all aspects of quality improvement and management including, but not limited to, continuous quality improvement, member satisfaction (assessed through member surveys, appeals and grievances), patient safety, care management, disease management, delegation of NCQA standards, contracting of services, access and availability and clinical practice guidelines.

Although BMCHP delegates management of behavioral health (BEHAVIORAL HEALTH) services to Beacon Health Strategies (Beacon), an NCQA accredited Managed Behavioral Health Organization, Beacon is integrated with our QIP. There is a

Behavioral Health /QI Work Group that meets every two weeks to discuss QI initiatives and adverse incidents. Members of the work group include Beacon clinical and non-clinical staff as well as BMCHP clinical and non-clinical staff. The Behavioral Health/QI Work Group reports in to the QIC regularly. BMCHP's Behavioral Health Program Director is a member of QIC. Beacon staff are invited to attend QIC as needed to review initiatives and data. A Beacon Physician Advisor is a member of Q&CMC.

BMCHP has incorporated into contracts with our network providers requirements that they cooperate with us in quality related activities. For example, these requirements include the need for free and open communications between members and providers, accessibility of medical records by us for purposes of quality improvement and for providers to protect the confidentiality of member clinical records.

The QIP structure is designed to promote quality improvement as a distinct organizational function with accountability for this function residing at the highest levels of the organization. QIP activities are integrated and coordinated throughout the entire organizational structure to achieve optimal results. Established and approved by the BoT, the QIP includes an organizational structure, which identifies quality as a separate organizational function for which the BoT is accountable.

Senior management is responsible for the oversight of the quality function and the integration and coordination of quality improvement activities with other company functions. The Director of Quality Improvement chairs the Quality Improvement Committee (QIC) and reports to and works closely with the Chief Medical Officer (CMO) who chairs the Quality and Clinical Management Committee (Q&CMC). These are the two key quality committees in the organization. There is a QI Work Plan that is approved by the QIC, Q&CMC and BoT annually. The evaluation of the QIP Plan and QI Work Plan are approved by each of these bodies as well. The QI Work Plan is a dynamic document that describes the QI projects that we will work on during the calendar year based on the evaluation of measures from the previous year and other criteria. All levels of the organization are involved in the QI structure and ongoing QI work.

Q69. While DHHS will be choosing measures, describe how you would select measures to include in the QIP and offer recommendations of measures to include.

BMCHP considers several factors when selecting measures for the Quality Improvement Annual Work Plan. These include, but are not limited to, input from our constituents (e.g. members, providers, Commonwealth of Massachusetts), needs of our membership, objectivity of measure, standardization of measure specifications and availability of external benchmark data for comparison. Whenever possible, we use objective, standardized measures, such as HEDIS and CAHPS data. However if established measures are not available we will use our own internal data to assess progress toward goals over time. Ongoing evaluation of care and/or service is part of continuous quality improvement. Measures may be revised or identified if data analyses reveal opportunities for improvement. Many of our quality improvement efforts focus on

HEDIS and CAHPS results which did not meet the most recently published NCQA Medicaid HMO Quality Compass 90th percentile.
BMCHP recommends measuring performance in the domains of member satisfaction, clinical outcomes and access. Measures need to be objective, scientifically sound, useful, standardized and nationally accepted. Selected measures should be able to be: tracked over time, used for internal and external constituents, used to identify opportunities for improvement, used to prioritize improvement initiatives and used to compare health plans. Therefore it would make sense to use HEDIS and CAHPS measures. These have well defined specifications and are universally utilized by plans. Plans can be compared against each other and against national benchmarks. In order to ensure comparability, data should be audited by an external auditor to ensure that each plan is using the same methodology and specifications for each measure.

Q70. Describe how you recommend DHHS establish improvement goals.

We recommend that DHHS establish goals based on DHHS' assessment of current performance and needs of the New Hampshire Medicaid population. Conditions affecting a substantial portion of the population should be a priority particularly if there is variation in clinical practice and outcomes. There need to be scientifically based, standardized, validated and reliable measures to monitor performance. This will allow for meaningful comparison across plans, providers' geographic regions and against national Medicaid HMO benchmarks. Using established, vetted measures will decrease the resources that would be needed to develop and test new measures.

Q71. Please provide your strategy for improving the following measures in the first year of the contract and over the longer term. Four of the below measures will be chosen by DHHS prior to contract finalization as part of the quality incentive payment program for year 1. It is the intent of the Department to require member Satisfaction to be one of the four.

- **Member Satisfaction (overall plan, call abandonment/timeliness) from CAHPS**
- **Smoking Cessation Among Pregnant Women**
- **Coordination of Care for Children With Chronic Conditions Composite from CAHPS**
- **Shared Decision Making Composite from CAHPS**
- **Adolescent Well Care Visits**
- **Follow up after Hospitalization for mental illness (7 days and 30 days)**
- **Cholesterol Management for Patients with Cardiovascular Conditions**
- **Reduction in child & adult BMI**

BMCHP is committed to quality. We have been ranked as one of the top 5 Medicaid HMOs in the nation for the past 3 years (2009, 2010, and 2011) according to NCQA's Medicaid Health Insurance Plan Rankings. We were ranked #3 for 2011 – 2012. We have achieved Excellent NCQA Accreditation each year since our initial survey in 2009. For all of the HEDIS and CAHPS measures mentioned above, our HEDIS 2011 rates exceed the 2011 NCQA Medicaid HMO 75th percentiles. Many exceed the 2011 NCQA Medicaid HMO 90th percentiles (e.g. Rating of Health Plan, Call Abandonment, Call Answer Timeliness, Shared Decision Making, Rating of Health Plan, Adolescent Well Care Visits and 30 Day Follow Up After Hospitalization for Mental Illness). Our Customer Service CAHPS score was not reportable due to a small denominator and we did not do the Coordination of Care for Children With Chronic Conditions Composite.

BMCHP is committed to improving the quality of care provided to our members and either has or would implement quality initiatives for each of the topics identified above by DHHS. However, we are concerned about the possible selection of Reduction in Child and Adult BMI and Smoking Cessation Among Pregnant Women as measures for the quality incentive payment program. Reduction in Child and Adult BMIs are not HEDIS measures. The HEDIS measures related to BMI reflect the percentage of members with a BMI documented in their medical record. There are no standardized Reduction in BMI measures and therefore no nationally recognized benchmarks. Our experience is that this will make it extremely difficult to compare results across plans. Smoking Cessation Among Pregnant Women is also not a HEDIS or CAHPS measure. Again there would be no benchmark for comparison. Any measures developed by DHHS for the quality incentive payment program would need to have well defined methodology that is evidence-based and well vetted with the plans as well as with providers.

BMCHP has significant experience improving both HEDIS and CAHPS results. A description of our basic quality improvement structure is described below.
We believe that successful improvement efforts need to be comprehensive, company wide and include both member and provider focused interventions. Our strategy is to establish a multi-departmental committee with a medical director and representatives at all levels (frontline staff to senior directors) including the following departments: quality, care management, pharmacy, marketing, customer care, provider relations, business intelligence and clinical informatics.

For clinical improvement initiatives, the Chief Medical Officer is the executive sponsor and for non-clinical initiatives (e.g. improving member satisfaction with the call center), the Chief Operating Officer is the executive sponsor. Initially an assessment is done which includes data analysis of current performance and current interventions in place to address the topic. A target is established. The group then brainstorms about how to improve the rate. Everyone is encouraged to participate and group members meet with staff in their own areas to continue brainstorming. All ideas are then brought back to the committee for discussion. Through the discussion, interventions are formulated. Interventions are then prioritized. Implementation of interventions is coordinating across departments so that members, providers and staff are hearing the same message.

Strategies to improve member engagement include member outreach by non-clinicians and clinicians, if appropriate. Member incentives are created and implemented after approval by the state. Member education occurs through mailings, materials (e.g. diabetes calendar), member newsletters and our website. Ongoing evaluation of interventions takes place and interventions are revised, discontinued or implemented depending on their effectiveness. For example, during one initiative we determined that we were not reaching enough members during normal business hours. As a result, member outreach calls were made during evening hours and on Saturdays. The percentage of members reached increased significantly.

Data are analyzed by provider and/or provider group. Interventions are customized to address providers based on current performance. Low performing providers may receive outreach calls and/or visits from a medical director to discuss ways to improve performance, and identify and resolve barriers. High performing providers are contacted in order to identify best practices. Best practices are then shared with lower performing providers. Additionally, providers may receive reports of their current performance compared to overall network performance. Outreach to provider groups is also done by provider relations and quality staff. If possible, we collaborate with the provider in order to engage our members. For example, members may be more receptive to outreach from their provider than from BMCHP so we partnered with provider groups and sent a letter to members with our logo and the group's logo with the signatures of both medical directors.

Performance is monitored on a monthly basis to assess progress toward the goal. Depending on the data, interventions may be intensified and revised throughout the measurement period. If staff from other areas is needed, they are also involved in the initiatives. Subgroups may be formed to address specific issues or details regarding an intervention.

3.13 Early Periodic Screening, Diagnosis and Treatment

Q72. Describe your plan to meet the EPSDT requirements of this RFP.

BMCHP is experienced in the implementation of a variety of initiatives, targeted at both providers and members, to support compliance with EPSDT requirements for Medicaid members under the age of 21.

BMCHP endorses the evidence-based guideline for pediatric routine preventive care visits, which was developed by the Massachusetts Health Quality Partners and reflects EPSDT requirements. We use our provider newsletters to remind providers of EPSDT requirements and educate them regarding available resources to support them in meeting these requirements.

BMCHP sends targeted provider mailings to inform providers of their well child visit rate as compared to the network-wide rate. Included in these mailings are provider specific reports that include a list of the provider's BMCHP patients, by age category, who will be due for a well visit in the coming months. The lists also include children who are overdue for appointments; this would include children who have missed appointments. Providers have successfully used these reports to schedule timely well child visits and conduct the required screenings and labs during the visits. Provider outreach is conducted on an ongoing basis by our medical directors and Provider Relations representatives to support providers in meeting EPSDT requirements. In addition, member newsletters and member outreach calls have also been implemented to educate members and their guardians about EPSDT requirements and provide assistance to them in obtaining timely well child visits.

BMCHP uses a variety of tools to monitor EPSDT compliance including medical record audits, a behavioral health screening rate report and several HEDIS Effectiveness of Care measures including Childhood Immunization Status, Immunizations for Adolescents and Lead Screening in Children. In addition, BMCHP has a code that is used by providers to indicate that all EPSDT requirements were met according to the periodicity schedules. Improving behavioral health screening rates at well child visits continues to be a priority of BMCHP. Specific provider and member interventions have been implemented to improve this rate including the development of provider resources, ongoing provider outreach calls, co-sponsoring statewide forums for providers on behavioral health screening in primary care, and sharing with providers their behavioral health screening rates and best practices.

BMCHP will release for use by network providers child health tracking tools, periodicity schedules, risk assessments, guidelines and EPSDT medical record documentation standards. To ensure correct use of these materials they will be reviewed during provider office site visits. Internally BMCHP does not require health plan referrals for many of the services included within EPSDT. Providers are instructed to complete the needed clinical referrals to make certain the complete EPSDT requirements are addressed.

The Commonwealth of Massachusetts has not had a requirement for managed care organizations to track annual dental exam and referral completion. There are other states that have such requirements, and BMCHP proposes to work with DHHS to develop a tracking solution that meets the state's needs and does not significantly increase the documentation burden for providers. As an example, Pennsylvania has a requirement for managed care organizations to track EPSDT referrals. The managed care organizations largely do this through the claim adjudication process. Providers submit structured codes on claims to identify the referrals that they made. For example, providers are instructed on a standard 837 claim to populate NTE02 of the NTE segment of the 2300 Claim Information Loop with appropriate referral codes:

- YB – Behavioral
- YD – Dental
- YH – Hearing
- YM – Medical
- YV – Vision
- YO – Other

On paper claims this would be done using box 10d. For most service and waiting appropriate lag intervals, BMCHP will be able to track the provision of EPSDT referred services through analysis if claims data. If anticipated claims have not been received on schedule, a mailing to a child's parent or guardian could be triggered. A second stage can be follow up with the child's primary care.

For this process to work for dental services, since dental services are carved out of the DHHS contract, BMCHP would need to receive a file from DHHS that includes information about annual dental exams. BMCHP looks forward to working with DHHS to create this capability.

3.14 Utilization Management

Q73. Describe your approach to utilization management, including:

- **Lines of accountability for utilization policies and procedures and for individual medical necessity determinations;**
- **Data sources and processes used to determine which services require prior authorization and how often these requirements will be reevaluated;**
- **Process and resources to develop utilization review criteria, as well as specifically address how you use clinical evidence and comparative effectiveness research in the management of utilization and your approach when such evidence or research is insufficient or absent in the medial literature;**
- **Prior authorization processes for members requiring services from nonparticipating providers;**
- **Prior authorization processes for members who require expedited prior authorization review and determination due to conditions that threaten the member's life or health; and**
- **Processes to ensure consistent application of criteria by individual clinical reviewers.**

BMCHP considers utilization management (UM) to be the ongoing process of evaluating requests for coverage by determining the member's eligibility and the medical necessity, appropriateness, efficacy, and efficiency of the health care service under the terms of the applicable product. We conduct UM, where permissible, in accordance with contractual obligations, regulatory requirements and accreditation standards.

BMCHP employs a comprehensive, integrated, and multidisciplinary approach to manage the utilization of healthcare services. Our UM program is extensively detailed in the BMCHP UM Program Plan. The UM Program Plan describes the components that comprise the UM program, outlines the principles of UM as they apply to all levels of healthcare services and clarifies how we establish and maintain an integrated, comprehensive approach to monitoring the utilization of healthcare services and clinical effectiveness. Additionally, the UM Program Plan identifies the individuals and committees responsible for the development, evaluation and oversight of the various components of the UM Program. The UM program applies to all products, although the applicability of the policies and procedures may vary by product.

Lines of accountability for utilization policies and procedures and for individual medical necessity determinations

BMCHP's UM Program Plan is developed by our Senior UM Program Manager in collaboration with the Chief Medical Officer (CMO), senior medical directors, the senior directors of Clinical and Quality Management and of Prior Authorization, Provider Audit, and Other Party Liability, the Director of Quality Improvement, and other Office

of Clinical Affairs (OCA) leadership. All aspects of the Plan are consistent with regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards. Approval of the annual UM Program Plan resides with the Quality and Clinical Management Committee (Q&CMC). The Q&CMC, chaired by the CMO, is comprised of at least one Board Trustee member, two actively practicing physicians, members of our executive staff, clinical and leadership representatives from BMCHP and our parent organization, Boston Medical Center (BMC).

The Q&CMC delegates the responsibility for the oversight and operation of the UM program to the CMO, who is an executive staff member reporting directly to our Executive Director. Medical directors, OCA senior directors and directors have operational responsibility for the following functional areas that conduct UM:

- Prior Authorization (PA)
- Acute Care Coordination (ACC)
- Care Management (CM)
- UM Delegation Oversight
- Pharmacy
- Member Appeals

The CMO, medical directors, OCA senior directors and directors (including the Behavioral Health Program Director), and the Senior Utilization Management Program Manager oversee all key aspects of the UM process, including but not limited to:

- Policy and procedure development;
- Reviewing UM requests and rendering coverage decisions;
- Reviewing the application of clinical coverage criteria and the consistency of decisions;
- Compliance with all regulatory requirements, contractual obligations, and accreditation standards; and
- Oversight of delegated UM functions, as applicable.

The following committees provide additional support to the UM program:

- Quality Improvement Committee (QIC): develops, implements, and evaluates processes, programs, and measurement activities, including those related to member and provider satisfaction and member appeals and grievances.
- Utilization Management Committee (UMC): a sub-committee of the QIC, that:

- Reviews and evaluates utilization data and trends, including over- and under-utilization, high risk/high volume procedures and/or diagnoses, continued stay, length of stay, and/or readmission, emergency department utilization, etc.;
- Identifies and reviews UM related best practices;
- Reviews and approves proposed intervention recommendations;
- Evaluates utilization review criteria and decision support tools;
- Monitors prior authorization and utilization review activities;
- Reviews inter-rater reliability findings and recommends interventions;
- Approves the annual UM Program Plan and associated policies and procedures and any interim modifications; and
- Annually analyzes and evaluates the efficacy of the UM program.

- Medical Policy, Criteria and Technology Assessment Committee (MPCTAC): on a timely basis, reviews, discusses, and approves clinical policies, including those related to new medical technologies and new uses of existing technologies, as required to administer the UM program.
- Pharmacy and Therapeutics Committee (P&T): develops and manages BMCHP's drug formulary consistent with current evidence-based clinical practice and cost-effective use of pharmaceuticals and develops clinical coverage criteria (i.e., prior authorization, step-therapy, and quantity limitations) as required to administer the pharmacy UM program.
- Delegation Steering Committee: defines the parameters of the delegation program, including UM activities.

In addition to our internal BMCHP staff, BMCHP contracts with the following entities to perform the described functions on our behalf:

- *Beacon Health Strategies.* An NCQA accredited Managed Behavioral Health Organization (MBEHAVIORAL HEALTHO) to manage all behavioral health-related UM (initial determinations and appeals levels), quality improvement, care management and claims payment.
- *MedSolutions, Inc.* A URAC and NCQA accredited organization to manage high-end non-emergent outpatient radiology, including UM initial determination decisions, notification and clinical consultation to BMCHP regarding clinical appeals; and
- *Northwood, Inc.* A URAC accredited organization to manage the prior authorizations and claims payment of most durable medical equipment, orthotics, prosthetics and medical supplies (DMEPOS). BMCHP renders all medical necessity denial decisions and provides the required notifications.

The delegation of UM includes the delegation of criteria and reporting.

Adherence to BMCHP's requirements and standards are evaluated through our pre-delegation assessment, reports, audits, joint operating meetings and annual UM delegation oversight review. The vendors are required to maintain policies and procedures that are consistent with all applicable UM requirements and standards, as well as the delegation agreement. Designated staff is accountable for the oversight of specific vendors to allow for streamlined communication and ongoing feedback.

BMCHP has demonstrated our experience with successfully integrating subcontractors into our UM programs. Workflows are coordinated and there is ongoing evaluation with those subcontractors that have clinical interfaces. For example, there are monthly clinical operations meetings with our behavioral health partner, Beacon Health Strategies (Beacon), twice monthly quality improvement meetings, shared clinical rounds, and daily communication between UM staff. Staff from Beacon is co-located in our Boston and regional offices and sit among our Office of Clinical Affairs staff. Similarly we have shared UM/CM contact information with Northwood. All denial documentation is housed in our care management system so that the utilization management process is seamless to providers and members. Staff frequently communicates with Northwood staff to coordinate services and ensure that our members' needs are met.

Data sources and processes used to determine which services require prior authorization and how often these requirements will be reevaluated

BMCHP utilizes a variety of data sources to determine which services require management. Our Corporate Analytics Department utilizes processed claims and authorization data stored in a centralized data warehouse to conduct monthly and ad hoc analyses of utilization trends. The data files are updated daily ensuring that we have access to the most up-to-date information. Routinely conducted analyses highlight emerging utilization trends. Ad hoc analyses may be requested to quantify utilization of specific services that may have been identified through provider audits or fraud and abuse program reviews or Office of Inspector General (OIG) annual work plans. In the event that there is over or under utilization of a specific service, aberrant utilization patterns or a new service that is yielding high utilization or high costs, these services are referred for review by the UMC and MPCTAC for evaluation and appropriate intervention.

Process and resources to develop utilization review criteria. Specifically address how you use clinical evidence and comparative effectiveness research in the management of utilization and your approach when such evidence or research is insufficient or absent in the medial literature

BMCHP uses commercially purchased criteria and internally developed criteria to render utilization management decisions. These criteria are used by our UM staff to evaluate and determine that the healthcare services are medically necessary, are being provided in the most appropriate setting and level of care. BMCHP makes decisions that

consider the individual circumstances and local delivery system to allow for a clinically appropriate, cost effective and efficient use of services.

BMCHP's UM staff use InterQual®, McKesson's nationally recognized, evidence-based clinical decision support criteria. InterQual® criteria are developed by McKesson's clinical research staff, which includes physicians, registered nurses, and other healthcare professionals. BMCHP annually reviews the new and revised InterQual® criteria.

When InterQual® criteria are insufficient or unavailable for a specific service, our Medical Policy Manager develops a service-relevant internal medical policy by researching literature reviews, summaries, and technologies, including those provided by Hayes, Inc., a leader in health technology assessment, to develop clinical coverage criteria. The criteria are then reviewed by our medical directors and practicing primary care physicians and specialists and our contracted specialty consultant.

All of the criteria used by BMCHP are:

- Evidence-based and scientifically derived, if practicable;
- Developed with input from BMCHP practicing physicians, external specialty consultants, and advisory boards, as needed;
- Developed in accordance with government contracts, regulatory requirements, and/or the standards created and adopted by national accreditation bodies, when applicable; and
- Reviewed annually with input from appropriate practicing physicians and other providers and updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice.

Similarly, the pharmacy criteria are developed by a BMCHP clinical pharmacist working with the P&T and other practicing specialists, as needed.

When applying criteria, we consider the individual health care needs of the member, including:

- Member's age;
- Member's co-morbidities or complications;
- Progress of treatment;
- Member's home environment and/or psycho-social factors; and
- Availability of services in the local delivery system.

When approved criteria are not appropriate or a service does not meet medical necessity criteria, a medical director/licensed pharmacist will be consulted regarding the use of

additional utilization criteria. On occasion, they may consult a specialist in the field of practice during the decision-making process.

In the case of new technologies and new applications of existing technologies, including medical and behavioral health procedures, pharmaceuticals, and devices, the MPCTAC and P&T or delegated vendor designee utilize clinical evidence and comparative effectiveness research to determine if a service should be a covered. All criteria and new technology are brought to the MPCTAC for approval.

Committee members review information compiled from various sources, including Hayes, to determine the safely and efficacy of the technology using the following criteria:

- The technology must have final approval from the appropriate regulatory or other federal governmental body;
- The scientific evidence must support a positive conclusion on the effect of the technology on health outcomes;
- The technology must improve the net health outcome and should outweigh any harmful effect;
- The technology must be as beneficial as any established alternative; and
- The outcomes must be attainable outside the investigational setting.

Prior authorization processes for members requiring services from nonparticipating providers

BMCHP intends to have a far-reaching hospital and physician network in New Hampshire. However, in the rare event that there is a specific service or provider that is not available in our network, we have processes in place to manage non-participating provider requests.

The prior authorization process is typically initiated by a request from a member's PCP or rendering provider. Following confirmation that the member is eligible and the requested service is covered, a BMCHP staff member verifies whether the requested rendering provider is contracted (a participating provider) to provide services to the member. Our networks vary by BMCHP products. In the event that the rendering provider is not a participating provider, the Prior Authorization staff attempts to locate a minimum of two participating providers with similar expertise within the geographic access standards that are able to accommodate the member within the defined availability standards. All requests for services with a non-participating provider are reviewed by a BMCHP medical director to determine whether there is a need to allow services with a non-participating provider because the continuity of care requirements apply, or whether the participating provider has the appropriate clinical expertise and knowledge to treat the member's condition and is available within the applicable geographic and availability standards. Members and requesting providers are provided

with a medical necessity determination letter that includes any alternative providers within the network and the contact information.

Our UM staff then works with the designated contact in our Contracting Department to set up the provider in our system and determine how payment will be applied or to negotiate payment.

Prior authorization processes for members who require expedited prior authorization review and determination due to conditions that threaten the member's life or health

BMCHP processes require that utilization review decisions be made as expeditiously as the member's medical condition warrants. To that end, we maintain a Timeliness of Utilization Review Decisions Policy that defines the process and timelines for responding to urgent or expedited requests. Urgent or expedited requests are those for which the application of the time periods for making non-urgent care determination could either seriously jeopardize the life or health of the member, based on a prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain or injury that cannot be adequately managed without the care or treatment that is the subject of the request. Urgent or expedited authorization requests are identified during the request triage process, flagged as requiring immediate consideration, and escalated to the appropriate UM staff for review. Urgent or expedited decisions and notifications are completed in accordance with all federal, state, contractual, and NCQA requirements.

Processes to ensure consistent application of criteria by individual clinical reviewers.

BMCHP's Office of Clinical Affairs staff receive orientation and periodic training in the application of InterQual® criteria and internally developed medical policies for inpatient and outpatient services. As described above, staff from multiple BMCHP functional areas participate in the review of proposed internal medical policy clinical coverage criteria, thus ensuring an in-depth understanding of the intent of the policy and coverage conditions. The Prior Authorization and Acute Care Coordination departments conduct regularly scheduled meetings, attended by specialists and clinicians, during which individual criteria sets are discussed. In addition, the Medical Policy Manager reviews internal clinical criteria with medical directors. The Medical Policy Manager provides updates to all staff on any new or revised InterQual® or internal criteria as part of the annual review process.

BMCHP conducts annual monitoring of the application of clinical criteria by all licensed staff involved in the utilization review process, including medical directors and pharmacists. This monitoring, pursuant to the Inter-rater Review Policy, ensures the accurate and consistent application of criteria according to established policies and procedures.

The inter-rater reliability audit results are reported through the UMC meeting. Variance from the application of review criteria is utilized as an opportunity for improvement and appropriate interventions are put in place. Individual results are sent to managers and directors for any follow up that may be required.

Contracted vendors also have policies and procedures in place that are written in accordance with our requirements.

Q74. Describe how you identify provider utilization patterns to improve care and reduce costs.

Our Corporate Analytics Team regularly reviews medical cost and utilization trends by multiple dimensions, including but not limited to, level of care, geographic region, provider type, primary care provider groups, key population segments, and conditions. Standard monthly reporting is supplemented by timely ad-hoc analysis that allows for drill downs to quickly identify and understand drivers of trends. We have also worked directly with provider groups in our Clinical Innovation and Transformation Fund (CITF) to provide regular reporting in support of programs to decrease hospital readmissions, decrease ambulatory sensitive emergency room visits, and improve asthma medication management.

The BMCHP pharmacy team evaluates therapeutic class drug utilization to identify trends in prescribing and implements formulary policies and restrictions to help manage care and reduce costs.

Q75. Describe how under-utilization, over-utilization, and inappropriate utilization of services are detected and monitored, as well as processes to address opportunities for improvement.

In addition to the monitoring of utilization trends described above, BMCHP's Fraud and Abuse and Provider Audit Departments, supported as needed by Corporate Analytics, monitor utilization trends through a variety of mechanisms, including such avenues as data analysis, medical record review, and fraud and abuse hotline investigations. Typically focused on inappropriate and over-utilization, analysis of outliers may trigger improvement opportunities ranging from provider education to formal, system-wide utilization management by way of prior authorization. Recently, after increasingly expansive analysis and medical record review of claims associated with substance abuse-related urine drug testing, BMCHP instituted a policy detailing the circumstances under which we cover such services.

Our pharmacy department monitors therapeutic class drug utilization to identify under- and over-utilization as well as inappropriate prescribing. Our Controlled Substance Program identifies over-utilization of controlled substance drugs. Where necessary we utilize the results of this program to intervene to improve coordination of care for the member.

In addition to internal utilization monitoring, our contracted behavioral health vendor, Beacon, employs a quality management program (Psychotropic Drug Intervention Program) to identify claims-based, medication-related problems through analytics and clinical review. The program, which is designed to complement traditional PBM services, includes such behavioral health medication therapeutic class problem identification and management as non-adherence, poly-pharmacy, therapeutic duplication, unnecessary medication and sub-optimal dosing. Analytic activities result in remedial intervention, where necessary.

Q76. Describe the type of personnel responsible for each level of utilization management, including prior authorization and decision-making. Provide a narrative description of your prior authorization processes.

With fifteen years of managing the services of our Massachusetts Medicaid population, BMCHP's Office of Clinical Affairs (OCA) utilization management (UM) program's operational model has evolved to optimize the talents and skills of our team members in order to provide timely, accurate, and consistent responses to requests for coverage of services while maintaining a low administrative cost. The consistency with which we manage requests for authorization of services, including the application of clinical coverage criteria, is due to the expertise of our staff, well defined prior authorization (PA) policies, and prescribed procedures and workflows. The latter are progressive, with an increasing level of expertise required as requests move through the PA process.

We employ non-licensed staff to provide administrative support to the UM functional areas and to make prior authorization approval decisions that do not require clinical interpretation. The non-licensed staff receive direct supervision from licensed managers and/or directors. Senior OCA management, including the Chief Medical Officer (CMO), senior medical directors, medical directors, and senior directors are all licensed clinicians.

Registered nurses (RNs) are responsible for inpatient concurrent review, care management, and prior authorization of services requiring clinical interpretation and licensed pharmacists review pharmacy-related requests that require clinical interpretation. Qualified, licensed physicians or pharmacists, as permitted by the regulatory requirements and accreditation standards, make all UM decisions to deny coverage. For specialty services, every effort is made to assure that the physician reviewing a case has the appropriate clinical expertise to do so. When necessary, we consult with board-certified specialists during the decision-making process.

A BMHCP medical director is available to providers by phone to discuss determinations of medical necessity. In addition, as required by applicable law, providers may seek reconsideration of an initial or concurrent denial of coverage decision from an actively practicing, board-certified peer reviewer in the same or similar specialty as the medical condition, procedure or treatment under review. Members, or providers on behalf of members, may appeal coverage decisions. At each of the two internal levels of appeal an appeal is reviewed by a same/similar specialist who is a board certified practitioner in

the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment. A third level of review may be conducted by a board of hearings within the state Medicaid office.

Presently, staff performing UM related functions include:

- Prior Authorization function: licensed RNs and non-licensed staff;
- Acute Care Coordination function: licensed RNs and non-licensed staff;
- Care Management function: licensed RNs and non-licensed staff;
- Pharmacy function: licensed pharmacists and non-licensed staff;
- Member appeals: non-licensed staff supervised by a clinician; and
- UM delegation oversight: non-licensed staff, supervised by a clinician.

BMCHP's prior authorization process is interdisciplinary and begins with the provider faxing a completed prior authorization request form, available on our web page to the Prior Authorization Department. We utilize an electronic fax software product which allows for all submitted information to be electronically stored in our clinical documentation system. Of note, we are currently in the process of implementing on-line prior authorization.

BMCHP staff is responsible for the prior authorization decision-making process as described below. Throughout all phases of the process, information relevant to the process, including clinical notes, communication with providers, decisions, is documented in CareEnhance® Clinical Management Software (CCMS), our centralized care/utilization management data repository.

The non-licensed staff assigned to our triage function access the incoming fax mailbox and:

- Validate the eligibility of the member for whom a request is submitted;
- Triage, label, and save the request per department protocol and;
- Distribute the request to designated non-licensed staff for further evaluation and case set-up.

The receiving non-licensed staff:

- Further evaluate the request, including member eligibility verification, provider participation with BMCHP, and whether the requested service requires PA; and
- Utilizing CCMS, our clinical management software system, open a case and initiate detailed case record-keeping (e.g. documentation of PA requirements, provider communication, etc.); and

- Approve the request per defined criteria and create member and provider notification letters; or
- Having assured clinical information is available for review of a case requiring clinical interpretation, route the request to a licensed staff member.

The licensed staff member:

- Validates decision timeline based on product, determination type (prospective, concurrent or retrospective), and urgency of request;
- Reviews clinical information, outreaching to member's PCP or requesting provider for additional information, as required;
- Utilizes InterQual® or internal medical or pharmacy policy clinical coverage criteria to complete the medical necessity review; and
- Approves requests meeting criteria for coverage and creates member and provider notification letters; or
- If coverage criteria are not met, refers case to a medical director or licensed pharmacist for review and subsequently communicates the coverage determination to the member and the provider; and
- Collaborates with the medical director to schedule any requested peer-to-peer discussions caseload.

BMCHP's medical directors are responsible for conducting medical service medical necessity reviews, including consulting with specialists, when required, and any requested peer-to-peer reviews or re-determinations, for all authorization requests that do meet clinical coverage criteria.

Prior authorization of behavioral health services (Beacon Health Services/Beacon), certain defined non-emergent outpatient radiology (MedSolutions, Inc./MSI) and most durable medical equipment, orthotics, prosthetics and medical supplies (Northwood, Inc./Northwood) are delegated to our contracted vendors. Authorization approvals are managed by each vendor. Behavioral health and high end radiology medical necessity and benefit denials are managed by Beacon and MSI, Inc. respectively. Northwood manages all benefit denials and BMCHP currently retains the management of the DME medical necessity denials. The behavioral health appeals are delegated to Beacon and all other types of appeals are managed by BMCHP.

Q77. Describe your process for emergency department utilization review and identification of members with high utilization. What strategies to reduce high emergency utilization will you implement?

BMCHP has successfully implemented a comprehensive emergency utilization program to:

- Reduce inappropriate emergency department encounters
- Improve coordination of care through assignment to PCP and enrollment in care management
- Provide more effective cost care management through rendering services in a more appropriate level of care

Frequent emergency department use is also one of BMCHP's care management registry criteria. When appropriate, BMCHP tries to reduce unnecessary emergency room visits through member outreach efforts. Care management staff contact members to discuss why he or she went to the emergency department rather than call or access his or her PCP and discuss the member's PCP assignment. We especially look for members who visited the emergency department for an ambulatory care sensitive condition that could have been more appropriately treated in an office setting. We use the opportunity to educate the member. BMCHP periodically reminds members in our newsletters about the availability of their PCPs 24/7 coverage and remind our providers about their contractual responsibility to provide availability to their patient 24/7. We also validate PCP after-hours availability by calling offices after regular hours annually and follow-up with any office that does not provide telephone access to our members when the office is closed.

Generally, when a member is referred to care management and successfully engaged, an assessment is done with the member to determine the underlying cause of frequent emergency department visits. Members who might be controlled drug seeking are referred to our behavioral health partners or to our controlled substance program. For members who may be seeking pain management, the care manager will coordinate with the PCP regarding possible referral to a pain management program and the member will remain in care management.

BMCHP has also provided its members with 24-hour, 365 days per year access to a nurse advice line (NAL) since October 2005 through its program with McKesson. The NAL is an enhanced customer service offering that provides multi-lingual access to a clinician who can answer network and clinical questions, provide educational materials, refer to the Audio Health Library for members who have questions about accessing their PCP or related to their health diagnosis. Very often they can prevent a visit to an emergency department. BMCHP considers this a value added service to our members and an opportunity for identification of referrals to medical or behavioral healthcare management. BMCHP plans to offer this service to New Hampshire members.

Q78. Describe your methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with utilization management policies and procedures.

Clinical policies, guidelines and procedures govern all aspects of the Utilization Management (UM) Program for BMCHP members. The medical and behavioral health policies and procedures address the process for rendering coverage determinations including the overall timeliness and notification requirements for coverage determinations. Specific cases are expedited based on the medical need of the member or based on unique circumstances related to the case. These policies, along with other medical and behavioral health UM policies and procedures, work to assure the UM processes result in timely, reasonable, member and provider friendly, effective and efficient UM. Our behavioral health partner, Beacon Health Strategies' (Beacon's) evidence-based level of care guidelines are used and conducted at each concurrent review point which guide decision making, focusing on medical co-morbidities and social care needs. This ensures appropriateness of level of care, treatment, and disposition goals.

BMCHP utilizes nationally recognized commercially purchased UM criteria, McKesson's InterQual® Criteria, to determine the medical necessity of inpatient care. The McKesson InterQual®Criteria are clinical decision support tools developed by McKesson's clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content is annually reviewed, updated and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry through the United States. These criteria are reviewed and adopted annually by BMCHP clinical staff as McKesson updates and makes additions according to our clinical criteria policies and procedures. The InterQual®Criteria are used by our acute care coordination (ACC) staff for acute and sub-acute inpatient services, skilled nursing facility services, and rehabilitation inpatient services. InterQual®Criteria are the primary decision support tool for inpatient services and are used to assure the appropriateness of admissions and continued inpatient stays.

Since InterQual®Criteria are the primary support tool for inpatient services, all licensed staff, including medical directors receive ongoing and annual monitoring for consistency in decision making and application of criteria.

BMCHP's acute care coordination clinicians complete an initial assessment of the reported clinical findings taking into consideration the individual needs of the member. When medical necessity for continued stay is not demonstrated, based on InterQual®Criteria and the individual needs of the member, the acute care coordination clinician discusses the case with the medical director or may contact the PCP or the attending physician to discuss the medical management plan.

If a member no longer requires acute level of care and can receive care at a lower level of care, the acute care coordination clinician works collaboratively with the facility to arrange for discharge or transfer. If the attending physician disagrees with BMCHP that a lower level of care is appropriate, our medical director will discuss the member's situation with the attending physician.

Q79. Describe your management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospitalization and hospital readmissions. Describe your strategy moving forward to improve performance in this area.

BMCHP looks to capitalize on the health care value proposition. Value is quality divided by cost. We are always looking for ways to both decrease cost and improve quality. Decreasing 30 day readmissions and avoidable admissions is a national priority for CMS, for payment reform, for hospitals and for BMCHP. We believe BMCHP needs to partner with the medical groups to prevent avoidable admissions and readmissions. We have several programs targeted to prevent 30 day readmissions. Other programs are targeted to prevent avoidable admissions. Some are pilot programs, while others are ongoing and embedded within our culture and processes. This program includes:

- Sharing health plan data with primary care groups to keep members healthy, especially those with chronic conditions that need regular testing and check-up with their primary care providers. Through claims data we can share with PCPs, who do not yet have the infrastructure to produce these data, we can help identify members who need diabetic tests, need to be on controller medications for asthma, or have not had well child visits. Additionally, those providers who are in our Patient Centered Medical Home Initiative program (PCMHI) get daily reports of members discharged from an acute care inpatient stay so they can make sure these members have follow up care.
- Sharing aggregate data with large provider groups as it compares to BMCHP plan-wide data. These rates such as emergency room visits/thousand, inpatient use, readmissions rates (behavioral health and medical) are data that can change behavior.
- Our behavioral health partner, Beacon Health Strategies (Beacon), requires their behavioral health and substance abuse discharge plans to include a seven day follow-up visit. For substance abuse discharges in Massachusetts, hospitals do not get paid for the last day unless a follow up plan is included.
- Our complex newborn program establishes a relationship with the custodial parent while the premature newborn is still in the hospital so when the newborn is discharged, the relationship between the complex care manager and the custodial parent is well established and all services are set up to avoid re-hospitalization. Once the baby is home, the care manager follows the baby and guardian.

- Persistent asthmatic members not on controller medications get reminders about asking their physician about controller medications versus rescue medications.
- BMCHP has two pilot programs under evaluation to prevent 30 day readmissions.
  - Project RED (Re-engineered Discharge) currently at Boston Medical Center. BMCHP has on–site discharge nurse educators meeting with adult medical patients to conduct intensive discharge education and medication reconciliation to prevent readmission. BMCHP staff make all after hospital appointments and an "After Hospital Care Plan" is given to the member and faxed to the PCP with all appointments and discharge instructions in easy to read, bound, calendar format. One phone call is made once the patient is home by a nurse to make sure all instructions are understood. Early trends look positive, but it is too early to determine the outcome of this intervention.
  - Our Transitions to Home (TTH) Program is a telephonic program for medical patients discharged from other hospitals. Calls are made within 48 hours after discharge for key diagnoses to make sure the member understands discharge instructions and medications. It is too early to determine effectiveness of this intervention.
- Complex care management and care management are programs designed to help members learn to self manage their chronic conditions, know when to call their primary care giver, and avoid preventable hospitalizations. Our care managers are trained in motivational interviewing with the goal of engaging our members in working with our staff and their medical team to stay healthy. That goal is the best insurance against preventable hospitalizations for key diagnoses. Joint care management with Beacon is key in integrating medical and behavioral health for many of our dual diagnosis members.

Beacon also has programs to control avoidable behavioral health hospitalizations and hospital readmissions. Beacon provides a range of specialized services, especially for at-risk populations. Beacon has a history of working with community-based providers and social care agencies to build a continuum of community-based services designed to ensure extended community tenure and reduce avoidable hospitalizations. Specific services are designed in response to utilization analyses that highlight a need for a new service or intermediate level of care.

In partnership with interested providers, Beacon builds a multi-level continuum of care to support members who might otherwise be at increased risk for behavioral health inpatient care. Beacon works with providers to establish specific intensive community-based services designed to divert admissions from inpatient and other high-cost programs.

For example, Beacon's Home-Based Therapy Program (HBT) provides home-based therapy, medication management, and care coordination services to members unable to access traditional outpatient services. HBT also enables providers to assess patients'

living situations, compliance with medications, early signs of clinical deterioration, and to adjust treatment intensity to avoid further deterioration and possible hospitalization.

Beacon's Aftercare Program also reduces avoidable admissions and readmissions. This program is staffed by aftercare coordinators specifically trained on the plans and states to which they are assigned. Aftercare staff mail appointment reminder notices and make follow-up calls to members after their discharge from a facility. They then contact the outpatient provider to confirm that the appointment was kept. If not, Beacon staff contacts the member to help make another appointment. Aftercare coordinators work collaboratively with members to identify both practical and motivational barriers to treatment compliance.

Through implementing a multi-level continuum of care, which includes home-based services, mobile crisis and evaluation teams coupled with active care management and aftercare monitoring, Beacon has reduced and will continue to reduce avoidable hospitalizations and hospital readmissions.

In conjunction with Beacon, our plan to improve performance is to continually look for innovative ways to improve what we have in place, evaluate what is working and pilot new interventions. BMCHP evaluates its pilots and if they demonstrate a positive return on investment, we will look to expand those pilots.

3.15.1 Encounter Data

Q80. Provide relevant reports from at least two other states describing accuracy and timely submission of encounters.

BMCHP currently has business in a single state only, but does submit encounter data to two different agencies within Massachusetts as explained below.

The firs agency is the Executive Office of Health and Human Services, which administers the Massachusetts Medicaid program, MassHealth. We submit encounter data on a monthly basis. BMCHP has consistently submitted encounters on a timely basis with accurate information. As an example, the submission for the third quarter of contract year July 1, 2010 to September 30, 2011 was reported back to BMCHP as submitted on time, and with a pass rate of 98.95%.

BMCHP also submits encounter data to the Massachusetts Division of Healthcare Finance and Policy (DHCFP) for the Massachusetts All-Payer Claims Database, which is a requirement for HMOs licensed by the Massachusetts Division of Insurance. This is a comprehensive data submission with hundreds of data elements. BMCHP has been submitting monthly files since May 2011 and is up to date with submissions. All of our files have been accepted by DHCFP. Unlike MassHealth, DHCFP does not generate a single score for accuracy of encounters, but rather scores every field on every file, and BMCHP has met all of the requirements.

3.16 Grievances and Appeals

Q81. Describe your complaint and grievance process specifically addressing:

- **Compliance with State requirements**
- **Levels of review and timing**
- **Process for expedited review**
- **How complaints and grievances are tracked and trended and how you use the data to make changes to procedures and processes**

BMCHP complies with all Massachusetts state requirements and NCQA accreditation standards related to member appeals and member grievances including review, member and provider notification, timeframes for notification and resolution, notice content, tracking and reporting. BMCHP will comply with New Hampshire regulations regarding provider appeals and member grievances and appeals.

Provider appeals

BMCHP has an administrative provider appeals process for providers to appeal denied claims. Providers must submit a written request to BMCHP for reconsideration of a denied claim or retrospective review for authorization after services have been rendered. These claims are denied for an administrative reason rather than for medical necessity of services. The administrative appeal process is only applicable to claims that have already been processed and denied, for example:

- Claims received outside of the timely filing limit
- Claims denied for not following BMCHP authorization process
- Member eligibility limitation
- Coding or clinical edit denials

BMCHP offers two levels of internal administrative review to providers. All level two administrative appeals are reviewed automatically by the Administrative Appeals Committee.

Member appeals

BMCHP's Standard Internal Appeals Process is inclusive of a first and second level appeal and the process may not exceed more than 20 calendar days for each level of appeal (40 calendar days total) from the date we receive the member's or Authorized Appeal Representative's request for an appeal. If an appeal is upheld at the first or second level, members or Authorized Appeal Representatives are provided with instructions on filing an external review with the Board of Hearings (BOH) within the Executive Office of Health and Human Services Office of Medicaid. Providers may file

Member Appeals on behalf of members for prospective coverage of services, supplies or medications.

BMCHP's Expedited Internal Appeals Process consists of one-level of review only and will conclude no more than 72 hours from the time we received the member's or Authorized Appeal Representative's request for an expedited appeal. This one-level of review is considered the Final Internal Appeal.

Member appeals are categorized and tracked in BMCHP's Appeals Tracking System. We maintain reports of all Standard and Expedited Internal Appeals and BOH Appeals, which include but are not limited to the following information:

- Type and nature of Appeal
- Appeal outcome
- Provider(s) involved
- BMC HealthNet Plan Physician Reviewer
- Same/similar consulting Physician involved
- What, if any, corrective action taken

The above information is compiled and reported annually to the state for review and action as appropriate. Additionally, BMCHP reviews the Standard and Expedited Internal Appeals and BOH Appeal Policies annually.

Internally, member appeals data are reviewed at BMCHP's External Customers Work Group, which is part of the Quality Improvement Program structure and reports in to the Quality Improvement Committee (QIC). Members of the Work Group include representatives from the following departments: Appeals and Grievances, Quality Improvement, Clinical and Quality Management, Customer Care, Claims, Marketing, Provider Relations, Clinical Informatics, Pharmacy Services and Public Partnerships. Opportunities for improvement are identified and action plans are created and tracked.

Additionally, appeal overturn data are reviewed by the Medical Management Program Oversight Committee on a quarterly basis. This Committee includes representation from Office of Clinical Affairs (Chief Medical Officer), Appeals and Grievances, Quality Improvement, Clinical and Quality Management, Prior Authorization, Care Management, Acute Care Coordination, Pharmacy Services and Corporate Analytics. Opportunities for improvement and follow up actions are identified.

Member Grievances

Member grievances must be resolved and the resolution letter sent to the member or the member's Authorized Appeal Representative within 30 calendar days of receipt of the grievance by BMCHP. We consider expedited review of grievances if warranted.

Expedited grievances will be resolved as expeditiously as the issue warrants but not to exceed 30 calendar days. Grievances related to clinical care are reviewed by clinicians.

BMCHP tracks grievance information in our Grievance Tracking System for trending and analysis. The information includes:

- Member name & ID number
- Date of grievance (when the event occurred)
- Date grievance reported/received by BMCHP
- Type and nature of grievance
- Staff responsible for follow-up
- Date Appeal and Grievance Specialist was contacted
- How grievance was addressed
- Date of correspondence/communication with provider/practitioner
- Resolution
- Date resolution letter sent to member or Authorized Appeal Representative
- Corrective action taken, if any
- Grievance resolution date

Grievance data are analyzed, including turnaround times, patterns in the types of grievances received and/or the involved providers/practitioners. The Manager of Appeals and Grievances works with appropriate staff to ensure ongoing quality improvement. Reporting to internal and external stakeholders includes the following:

- Annual reports to the state
- Ongoing monitoring by our Credentialing Committee
- Semi-annual aggregate reporting to the External Customers Work Group
- Semi-annual reporting of access related grievances to our Access and Availability Workgroup which is part of the Quality Improvement Program structure and reports in to the QIC

3.17 Fraud and Abuse

Q82. Describe any front-end claims editing/auditing functionality that you are proposing.

BMCHP utilizes both automated and manual solutions for claims editing/auditing that integrate with our core claims processing system and eliminate erroneous payments. The capabilities of these key software and business solutions create a robust set of claim edits geared towards efficiency, low administrative cost, and pre-payment prevention of claim coding and billing errors. Each of these systems and processes are described below in more detail:

Trizetto Facets

Facets is used for core adjudication functions and provides BMCHP with basic code validity edits to ensure claims are submitted with only valid transaction code sets as required by HIPAA. These include HCPCS, place of service, bill type, ICD-9 diagnosis and procedure codes, occurrence codes, revenue codes, and the validation of all other required codes for proper and accurate claims payment.

In addition to basic code validation functionality, Facets' integrated adjudication/claim workflow capabilities allow for more subjective front-end claim editing efforts by automatically routing claims for adjudicator review before final processing. BMCHP has implemented these processes to increase the accuracy of first-pass claims processing and to ensure that specific Medicaid regulatory requirements are met. These front end review activities include:

- High dollar claim review for accuracy of charges submitted/service coding
- Confirmation of service approval and services billed when dates and/or services are inconsistently reported
- Review of claims that involve similar services on the same date, by the same provider for the same member but which don't represent an exact match – "possibly duplicate services"
- Review for improper unit value assignments to specific HCPCS codes involving surgical procedures, durable medical equipment and supplies, and other similar services with a high probability for billing errors
- Eligibility reviews based on variations between provided data, and system eligibility data
- Transplant case review, to avoid duplicate payment involving case rates
- Provider specific pre-payment auditing to manage situations involving suspected fraud/abuse or ongoing investigations

Trizetto NetworX Pricer

NetworX Pricer is a fully integrated pricing application used for assigning claims specific pricing and payment rules for each rendering provider. In addition to the basic function of administering a range of payment methods during adjudication, NetworX is also used to validate that the services rendered match a given provider's scope of service at a contract level – such as ensuring that a chiropractor is only rendering approved chiropractic services within the scope of their specialty. NetworX is also fully integrated with BMCHP's DRG grouping application to ensure the appropriate assignment of inpatient reimbursement based on the DRG resulting after other rules have been applied to claims processing, such as the application of Serious Reportable Events (or Never Events), as well as the elimination of other non-covered services from the DRG grouping process.

OptumInsight iCES

The OptumInsight iCES clinical editing system provides a pre-payment solution that checks each claim for errors, omissions, and questionable coding relationships by testing claim information against an expansive database containing all CMS and other industry based coding rules, regulations, and policies. Frequently leveraged edits include Medicare Outpatient Code Editor (OCE), Medicare Code Editor (MCE), National Correct Coding Initiative (NCCI) and custom edits derived from medical specialty society/association guidelines and clinical recommendations. Included in these edits are service reduction rules for bilateral procedures, multiple surgical/radiology/endoscopy reductions, as well as more advanced code validation rules for diagnosis coding that requires the 4,5th digit, age/gender editing, and medically unlikely edits.

Lastly, BMCHP has the flexibility to fully customize editing rules when required to fit the specific population of covered lives – often necessary when managing a Medicaid program that offers unique services not managed in commercial and the Medicare environment. This is particularly true for pediatric services which are less common in a Medicare environment. BMCHP's ability to customize these editing rules applies to all of the above solutions currently in use by BMCHP for other lines of business, including Massachusetts Medicaid, the Commonwealth Care program, and commercial product offerings.

Q83. Describe how you propose communicating suspected incidents of fraud to DHHS.

BMCHP has a comprehensive fraud and abuse program in place that we will modify, if necessary, to satisfy DHHS standards. Incidents would be reported to DHHS following an investigation and confirmation of the suspicion of fraud.

Upon receipt of a fraud concern, the Compliance Department staff is responsible for the initial investigation of cases received from employees, the compliance hotline or external leads. All cases are logged in the compliance database, researched and, if the lead rises to the level of a suspicion of fraud, the Compliance Department generates a written

referral to MassHealth or the Commonwealth Connector Authority. The referral is accompanied by documentation (e.g., medical or pharmacy claims history, hotline reports and any other pertinent documentation) in support of our suspicion. The referral also includes basic demographic information identifying the member or provider and a detailed description of the facts and circumstances that support the suspicion. The complete documentation package is sent by means of encrypted email to the relevant agency

Q84. Describe in detail, the fraud and abuse program that you will implement including:

- **Plan for compliance with the Exclusion Program of the United States Department of Health and Human Services Office of the Inspector General or any provider restrictions imposed by the State.**
- **Fraud detection methods that will be used**

BMCHP has a compliance plan that is designed to guard against fraud and abuse, to address other relevant compliance areas and to monitor BMCHP's compliance with all applicable contractual, legal and regulatory requirements. If awarded a contract in New Hampshire, we would apply the policies, procedures and features of the existing fraud detection program to the New Hampshire contract. The elements of the fraud and abuse program, including fraud detection methods that will be used, and our compliance plan with respect to the Exclusion Program of the United Stated Department of Health and Human Services Office of the Inspector General are discussed below.

BMCHP's fraud and abuse program includes a Code of Conduct that outlines employee responsibilities with respect to suspected fraud and that summarizes the applicable state and federal standards to which BMCHP is committed. We also have adopted a Fraud and Abuse policy specific to state and federal laws and the requirements of the MassHealth and the Commonwealth Care contracts regarding the detection and prevention of fraud and abuse. The policy is displayed on our website.

BMCHP's Compliance Department reports to the Chief Legal Officer. Our Director of Compliance also has a direct reporting relationship to the Executive Director and the Chair of the Audit and Compliance Committee of the BMCHP Board of Trustees. The Director of Compliance is responsible for fraud and abuse and chairs a Compliance Committee that includes as members the Executive Director, the Chief Financial Officer, the Chief Operating Officer, the Chief Legal Counsel, the Chief Medical Officer, and the Chief of Human Resources. At each meeting the director of compliance reports on all activities regarding allegations of potential fraud and abuse.

The Director of Compliance is a Certified Public Accountant and is a member of the Health Care Compliance Association and the National Health Care Anti-fraud and Abuse Association. He attends relevant compliance and fraud and abuse conferences as well as quarterly meetings with the Medicaid Fraud Division for the Commonwealth of Massachusetts.

BMCHP has a hotline telephone number service operated by an outside vendor that members, providers and employees can use to report any compliance concerns, including suspected fraud and abuse. Issues raised through this hotline are reviewed by the director of corporate compliance. Employees can also report any compliance concerns, including suspicions of fraud, directly to the compliance officer.

Our Fraud and Abuse program has been incorporated into the standard operating procedures across the organization and includes the following methods employed by BMCHP to detect fraud, abuse and waste:

Quality Assurance

The quality assurance team conducts routine audits of claims processed to ensure that claims are processed and paid in accordance with BMCHP policies and procedures and provides feedback on claims processing accuracy to all claim adjudicators. The focus of these activities is to measure and report accuracy rates for payment and processing of claims and to facilitate the planning of any corrective actions. The payment accuracy rate is based on the total number of claims with correct payments divided by the total number of claims reviewed within the claim sample. The processing accuracy measurement includes policy/procedural, financial and non-financial findings and is based on the total number of claims processed correctly divided by the total number of claims reviewed.

The goal of the quality assurance programs is to identify problem areas and trends. The program objectives are achieved through audits of random samples of claims, focused claims audits and categorization of audit results. Random sample claims audits are primarily designed to measure claims payment accuracy, processing accuracy and financial accuracy. Focused claims audits are primarily designed to identify duplicate payments, incorrect application of plan benefits and other potential claim payment errors. Both the random sample and focused audits are conducted on a weekly basis based on claims paid for that week to measure the results of the overall department and at the individual staff member level. The post-disbursement claim audit applies to all areas of the claim adjudication process including, including coding accuracy (data input), system processing logic, processor decisions, adjustments and claim turnaround time.

On a weekly basis, approximately two percent of all adjudicated claims are reviewed and used to evaluate the quality levels of claims adjustments, auto-adjudication, data entry and claims manual adjudication. Monthly calculations are based on the weekly quality review of claims. Each of these categories is further broken down into a summary of procedural and payment errors by category. A supervisor reviews these reports, and provides detailed feedback to the staff, in one-on-one feedback sessions, on the quality and accuracy of their claims work. Quality scores are also factored into annual performance evaluations and compensation of the claims staff. Trends identified for individuals as well as for the department are used to assess the need for additional or modified process documentation and remedial training.

Provider Audit and Other Party Liability

The audit arm of BMCHP is the Provider Audit and Other Party Liability (OPL) Department which utilizes a variety of strategies to audit claims, including external audits, internal system audits, and credit balance audits. Audits are conducted to determine the accuracy of provider billing practices and compliance with reimbursement methodologies, as specified in provider contracts. Through the course of an audit, any identified discrepancies impacting payment result in adjustments, as appropriate.

The Provider Audit Department works in collaboration with the Director of Corporate Compliance. Any suspicious activity or trends identified through external or internal audits are reported to the Director of Corporate Compliance.

External Audits

We also perform external audits that entail retrospective medical record reviews conducted to verify that paid services, documented in the medical record as having been provided, are billed according to industry and BMCHP-specific standards. These audits are performed in accordance with the National Health Care Billing Audit Guidelines by registered nurses with coding training. Typically, but not exclusively, external audits are focused on hospital billing; these reviews are conducted onsite at a provider's location. Claims are selected for review based on BMCHP internal criteria, including claim amount, services frequently billed inaccurately, and provider audit history.

Audits are pre-scheduled and conclude with an exit interview, the purpose of which is to review the findings with the designated provider representative. Providers are afforded a 30-day amendment period to submit additional information regarding any cited discrepancies. During this time providers may also submit late charge claims for services not previously billed or previously billed in insufficient quantity. Any discrepancies (either overpayment or underpayment) remaining after the amendment period are processed by BMCHP as payment adjustments. Final audit results are sent via secure e-mail to the providers.

System Audits

BMCHP performs system audits that involve internal reviews of previously paid claims to ensure accuracy of payment based on CPT coding guidelines, National Correct Coding Initiative standards, BMCHP billing guidelines, and individual provider contracts. Reviews are conducted by full-time auditors with coding training, utilizing Encoder Pro as a resource for coding questions or issues. Claims paid under any payment methodology (e.g. percent of charge, fee schedule, SPAD, and PAPE) are subject to review. Criteria delineating claims to be selected for audit are developed based on an annual review of claims by provider type (e.g. inpatient hospital, surgeon, community health center, anesthesiologist.)

Our Provider Audit Department has recurring initiatives that include reviews of:

- Criteria-specific physician and hospital claims for obstetrics/newborn services, including all physician claims nine months prior to delivery and six weeks post partum
- Suspected duplicate claims (more than one provider same date of service and same procedure/service)
- Overpayments due to member retro-terminations
- Hospital observation claims for appropriateness of billing
- Split SPADs, non-dental provider dental claims, non-emergent transportation, and anesthesia claims associated with labor and delivery

The Provider Audit Department's on-going on-site audit programs (approximately 2% of annual claim payments) include reviews of:

- Criteria-specific inpatient claims from universe of claims exceeding $20,000
- Criteria-specific outpatient claims from universe of claims exceeding $5,000
- Urine Drug Screening (mainly independent labs)
- Audit of Providers identified by the Medicaid Fraud Division

Claims are adjusted in the claims audit database and providers are notified via remittance advice. In addition, auditors may present educational materials to providers and may work with BMCHP departments to update policies and procedures, as appropriate.

Credit balance audits

Credit balance audits are conducted by dedicated internal BMCHP credit balance auditors. Internal credit balance activities consist of collaboration with providers that self-disclose credit balances to confirm the correct payment for a claim. External reviews are conducted onsite at a provider's location. For both internal and external credit balance activities, the reason for the credit balance is determined and cases are referred to BMCHP's OPL team, as appropriate. Claim adjustments or repayments are processed and posted accordingly.

When a field audit identifies systemic concerns, BMCHP requires a corrective action plan and establishes a schedule for follow up with the provider to ensure the action plan has been implemented. For example, in one case that was reported to MassHealth as suspected fraud, the BMCHP work plan required the provider to change its billing policy on inpatient drugs from a system that billed when the requisition was processed to one that billed when the drugs were administered. This corrective action plan required a commitment from the provider to replace its overall pharmacy billing system. During the

replacement process, BMCHP continued to audit this provider for pharmacy charges on inpatient cases.

Pharmacy system

In addition to point of sale (POS) prevention edits, BMCHP's Pharmacy Services team uses standard reports produced by the pharmacy benefit manager (PBM) to quickly identify potential prescribers, members and pharmacies who may warrant closer examination. After review, possible follow up actions include: (1) for pharmacies, referral to the PBM for a desk or on-site audit; (2) for members, referral to the Controlled Substance Management program; and (3) for prescribers, referral to the BMCHP's Compliance Department.

BMCHP's contract with our PBM requires the PBM to perform real-time and next-day audits and provide BMCHP with audit reports. The audits are comprised of both onsite and desktop audits in order to detect fraud and overpayments to pharmacies of reimbursements for covered services provided to members. The PBM performs onsite audits of at least 20% of network pharmacies that fill in excess of 20 claims per week and desktop audits on at least 20% of active network pharmacies. These audits include the top ten pharmacies with respect to annual prescription volume. The PBM also performs custom audits on any data or activity that is identified and requested by BMCHP. Under the terms of our agreement with the PBM, it is required to take appropriate action, including payment recoupment, in the event that a pharmacy audit discovers fraud or overpayments.

BMCHP also utilizes a pharmacy lock-in program for those members exhibiting patterns of using multiple pharmacies to fill controlled substances. This limitation is intended to support the organization in monitoring potential misuse of controlled substances.

Out of state addresses

Staff throughout BMCHP are required to report member information to the Enrollment Department if they observe a member with an out-of-state address. The Enrollment Department forwards this information to MassHealth and the Connector Authority on an ongoing basis and sends a copy of its monthly report to the fraud and abuse coordinator who investigates the matter to determine if the member is living out of state and utilizing benefits that should only be covered for eligible Massachusetts residence.

BMCHP's credentialing staff currently assures that we do not authorize any providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat members and we shall deny payment to such providers for services provided. For providers seeking entry into our provider network, we perform a check against the Office of Inspector General List of Excluded Individuals Entities (OIG) website and against the MassHealth Provider Disposition Report for all providers upon initial credentialing. BMCHP will fully comply with all exclusion requirements for the state of New Hampshire.

The OIG website and the MassHealth Provider Disposition Reports are checked for all full credentialed providers during the recredentialing process. Delegates to whom BMCHP has delegated credentialing also perform an OIG check for their providers upon recredentialing. BMCHP will comply with all New Hampshire reporting and exclusions verification requirements as we do for Massachusetts currently.

Currently, a monthly comparison is performed between all providers in Cactus, BMCHP's credentialing database, and the OIG database. When the monthly Provider Disposition Report is received, any new providers added to the report for that month are compared to all active network providers. Any newly identified providers from the OIG database check or on the MassHealth Disposition Report who are in the network are terminated per the practitioner termination policy. Throughout the month, if we are notified that a provider has been terminated by MassHealth, we terminate the provider immediately. BMCHP subcontractors managing the credentialing of providers on behalf of BMCHP follow these same processes. We plan to implement similar processes for New Hampshire.

For all providers, provider groups, and ancillaries that are newly contracted in Onyx, our provider database, an OIG database check is done. OIG checks are performed prior to inputting a non-participating provider into our system.

Q85. Describe your experience with fraud recovery collection. Provide any empirical evidence of your collection success rate when fraud is identified.

BMCHP's claims system has the ability to process recoveries against individual claims that have been paid and to establish lump sum settlements. In the case of recoveries against individual claims, the adjustment will appear on the explanation of payment (EOP) to the provider and reduces the total amount paid to the provider. An explanation of the adjustment also appears on the EOP. The claims payment system also has the ability to recover lump sum payments from a provider by deducting the amount of the settlement from the weekly claims payment process whereby legitimate claims to be paid are reduced by the specific lump sum amount. A full explanation of the recovery is included on the EOP to the provider. The balance of the lump sum settlement amount is carried over to future claim payments due the provider until the total lump sum settlement has been recovered. In addition, we also accept checks from the provider which we apply to our claims history.

Although we pursue all cases of overpayment identified in audits, we do not attribute these recoveries to fraud without a conclusion of an intent to deceive the organization by violating billing or other rules. Nonetheless, we generally recover 100% of negotiated settlements in field audits.

In a recent case, BMCHP estimated a total overpayment while negotiating a final settlement with a provider and utilized the lump sum recovery methodology mentioned above. This approach offset our estimated recovery against current claims that would have been paid. Since we also terminated our contract with the provider, we were able to

withhold (recover) $578,000 against current claims. The provider received EOPs for the currently payable claims and an explanation for the amount withhold.

In cases of suspected member fraud, we report these matters to MassHealth or the Connector Authority who, in turn, forward the cases to the state's Bureau of Special Investigations for investigation and prosecution if deemed appropriate.

Q86. Describe your experience administering provider and pharmacy lock-in programs. Include any empirical evidence on their effectiveness.

The Pharmacy Services Department at BMCHP offers a Controlled Substance Management Program (CSMP) that identifies a member population at risk for inappropriate use of controlled substances. CSMP incorporates various member and provider interventions targeted at educating members on the risks of over utilizing controlled substances, encouraging coordination of care among involved health care providers, and promoting appropriate utilization of other non-pharmacologic healthcare services.

Specific criteria have been developed that assist in identifying the most actionable members. Interventions associated with the CSMP include medical/behavioral health care management outreach, provider outreach, and pharmacy and/or physician restrictions.

Through the CSMP, members are encouraged to better understand their condition, seek alternative treatment options and utilize appropriate resources that do not rely solely on the use of controlled substances. The goal of BMCHP's CSMP is to improve coordination of care among health care providers, member and provider education, increase appropriate utilization of healthcare services, and satisfy state and/or federal regulatory and contractual obligations.

The program identification logic is incorporated into the care management registry. This provides a more comprehensive approach in that members identified may also trigger for other clinical conditions. The CSMP works in parallel with care management to better coordinate care. Additionally, members may also be enrolled in the program through provider referral, staff referral, or self-referral. Similar to BMCHP's care management programs, the CSMP is also tracked within CCMS® and is readily available to nurse case managers managing member cases.

A clinical pharmacist conducts the evaluation of medical and pharmacy claims data for trends and patterns in utilization. Members determined to be warranted in their treatment regimens are excluded from the program. Once evaluated, the clinical pharmacist determines which interventions are most appropriate based upon the member's history. The program incorporates a number of interventions that are aimed at addressing the specific risk identified. These include letter notifications and/or claims profiles to prescribing practitioners, provider lock-ins, pharmacy lock-ins, pharmacist consultations, medical director outreaches, referrals to fraud & abuse, and care

management referrals. The pharmacy lock-in process has been described in Section 3.3 Question 6.

With regard to provider lock-ins, similar processes apply. However, BMCHP requires provider agreement for the provider restriction and this is requested through an initial notification to the prescribing practitioner. Should a provider decline the request, we reevaluate the case and recommend other alternative interventions. When a provider accepts and agrees to the restriction, members are provided 30 days notice of the effective date and are required to receive all medication prescriptions from the sole prescriber.

Our experience in implementing this program has been positive and providers have welcomed our notifications and efforts to collaborate with them in managing member's care, which can often times be challenging. Due to the recent redesign of the program, there has not been sufficient data collected to fully evaluate program outcome measures and determine the impact of the program on member care and provider care coordination. BMCHP has developed outcome measures to be applied once sufficient data has been collected to evaluate program impact. Outcome measures will compare pre/post analyses versus a baseline eligible member population in tracking cost and utilization by service category. Additionally, the analysis will look into specific interventions and correlating outcomes.

BMCHP will work with DHHS to incorporate New Hampshire members into the CSMP and meet regulatory and contractual requirements.

Q87. Besides lock-in programs, describe other fraud and abuse prevention programs that you would propose to operate across the FFS program and the MMI.

BMCHP will employ its current prepayment programs, including the controls discussed below to identify fraud and abuse. In addition, at the time of this writing, we are evaluating fraud and abuse software for acquisition.

BMCHP utilizes clinical editing software on the front end of claims processing to identify and deny inappropriate or incomplete claims. The software identifies the following: member eligibility; services that require pre-authorization; primary care services rendered by someone other than the PCP or covering provider; exact duplicates; age and gender edits; experimental procedures; non covered benefits; cosmetic procedures; same day surgery edits, global surgical billings; necessity of assistant surgeon; CPT codes that are incidental to procedures; multiple surgery reductions; bundling and unbundling etc. If the claim fails these edits, the claim will be pended for review or denied.

All inpatient claims over $50,000 are reviewed by a claims supervisor prior to payment.

BMCHP utilizes the services of a PBM to administer pharmacy benefits to members. Potential fraud and abuse is monitored by both the BMCHP pharmacy services team and by the PBM. POS edits, triggered by the BMCHP's concurrent Drug Utilization

Evaluation policy, screen claims for a variety of clinical and financial parameters. Questionable use patterns are included in the screening process. Additionally, any claim above an established dollar amount requires review by either BMCPH's pharmacy services team or the PBM before authorization is granted to fill the prescription.

Q88. Describe any internal training programs that your MCO uses to train employees to recognize and report patterns of fraud and abuse.

Staff training is a key element of BMCHP's compliance program. All new employees receive mandatory training on fraud and abuse within the first two weeks of employment. Additionally, all employees receive mandatory fraud and abuse training annually. BMCHP conducts training by means of an on-line training tool that includes testing to ensure comprehension of content; a passing grade of 85% is required on all training.

The following BMCHP training modules inform employees of their responsibilities and BMCHP policies relative to fraud and abuse, protection of whistleblowers, and non-retaliation for reporting potential fraud, abuse or compliance issues:

- Compliance Overview
- Fraud and Abuse Awareness Training
- Code of Conduct
- Deficit Reduction Act of 2005 and The False Claims Act

In addition, the Compliance Department periodically issues "Compliance Tips" via email to all employees. These tips have been well received by employees, and have generated questions about operations and procedures and have prompted numerous reports of suspected member fraud relating to members residing out of state.

Q89. Describe how you engage members in preventing fraud and abuse.

Through periodic communications, BMCHP engages members in preventing fraud and abuse. Our member newsletters highlight the availability of the hotline to report suspected instances of fraud and abuse. We have also used this communication to instruct members against sharing their health insurance identification cards with others and urging members to use the hotline to report observations of card sharing.

3.18 Third Party Liability

BMCHP employs a Third Party Liability (TPL) Program to ensure that, in accordance with state and federal law, we are the payer of last resort. We cost avoid and "pay and chase" claims for which another insurance carrier is primary. The TPL Program conducts coordination of benefits (COB) when a member has other health insurance and when insurance exists due to motor vehicle accidents, workers' compensation, slip and fall, and general liability incidents. All TPL activities occur between BMCHP and the provider or other insurance carrier. At no time do we pursue recovery directly with members.

The information provided below outlines current BMCHP policies and procedures on TPL. These policies comply with all TPL-related data exchange and programmatic reporting requirements (including for MassHealth and Commonwealth Care). Subject to specifications detailed in the managed care organization contract, BMCHP will make our best effort to comply with DHHS program requirements.

Q90. Describe your TPL recovery experience. Provide empirical evidence of your collection percentage against TPL identification.

BMCHP accesses multiple avenues, including use of data-match vendors, to ensure that the maximum TPL identification. These include up-front claim identification and cost-avoidance and retroactive payment identification and recovery. In fiscal year 2011 we saved $13.6 million net of expenses through our TPL program – a 780% return on investment. Except in cases where another carrier identified as primary does not pay, we collect 100% of TPL.

Q91. Describe how you will maximize the identification and recovery of TPL.

BMCHP utilizes defined procedures to ensure that claims for members with other insurance are processed in accordance with Medicaid cost avoidance and recovery requirements. Such claims are identified through five main sources.

Data match process

We identify other insurance through a data match process with an external vendor, Health Management Systems (HMS). Monthly, HMS compares our eligibility and COB file data to the data of other insurance carriers. When other health insurance is identified and coverage is confirmed, HMS electronically transmits the specifics of that coverage to us. The information is uploaded into Facets, our claims processing system, and to the COB module and COB extension, customized electronic database. Any claims for the other carrier effective dates of service previously paid by BMCHP are automatically retracted and future associated claims are routed to COB Specialists to be cost-avoided.

HMS also handles our prescription drug-related recovery. By using information obtained during the data match process and pharmacy paid claims data to identify pharmacy claims for which another carrier is primary. Recoveries are sought through the primary carrier or their Pharmacy Benefit Manager (PBM).

Additionally, we conduct a data match program with ISO ClaimSearch (ISO), a vendor, to identify accident and trauma cases. ISO matches suspected accident and trauma liability information we provide them to data stored in their repository of liability claims filed by insurers. When a match is made the information is captured in Facets and in the OPL extension, an accident and trauma-specific electronic database. Any associated claims are retracted, cost-avoided, or subrogated, as applicable.

We use a data match program developed with the state Department of Industrial Accidents (DIA) to increase the identification of workers' compensation cases. A quarterly eligibility file is sent to the DIA. The DIA returns a file of our members who have filed a work related claim with the DIA. This information is downloaded into a report listing claims paid after the date of the workers' compensation claim for investigation by a TPL Specialist. Any associated claims are retracted, cost-avoided, or subrogated, as applicable.

Point of service (Customer Care Center, Claims Resolution Unit and Care Management) investigation

The Provider Audit and Other Party Liability Department collaborates with other BMCHP departments to identify, at the point of service, members who may have another primary insurance. Our Care Management Department refers all calls and authorization requests related to COB and inquiries for services related to accident and trauma cases to the Other Party Liability Department for investigation. The Customer Care Center and Claims Resolution Unit refer calls or inquiries from members and from providers related to COB and accident and trauma issues to the Other Party Liability Department.

Claims review

Facets, our claims processing system, is programmed to review claims submitted by providers for indications of other insurance carriers. Claims submitted with attachments, explanation of benefits from other insurers, and claim notations of other insurance are pended for review by the COB staff. Indications of other insurance are investigated and verified directly with the insurers. Verified information is input into the COB module and COB extension and claims are adjusted accordingly.

For accident and trauma-related services, claims submitted with "E" diagnosis codes that may indicate accident and trauma cases, with an automobile or workers' compensation letter, or with any attachment indicating liability involvement are pended in Facets. Once a member has been identified as having been injured as the result of accident and trauma (automobile accident, workers' compensation, slip and fall, general liability) any subsequent claims that are pended are reviewed by a TPL Specialist for potential cost-avoidance; the provider's remittance advice comment will contain

information regarding the liable insurance. Previously paid related claims are reviewed for potential recovery. If primary benefits (e.g., automobile insurance or workers' compensation benefits) are still available we retract the payments to the extent of primary benefit availability. The liable insurance is identified to the provider in a remittance advice comment. If primary benefits are not available we further investigate for subrogation rights and assert a statutory lien to recover any funds paid pursuant to a lawsuit, if applicable.

Department reports

We use various department reports to identify potential instances of other insurance. For example, we use an End Stage Renal Disease (ESRD) report to identify members with kidney failure who may be eligible for Medicare coverage. An "E" code report is used to identify claims containing diagnoses that may indicate a liability accident.

NEHEN

We use the New England Healthcare Exchange Network (NEHEN) system to verify the identity of other insurances. NEHEN is a consortium of regional payers and providers that has designed and implemented a secure health information exchange. Using NEHEN allows the COB Specialist to access eligibility information for Medicare and Medicaid, Harvard Pilgrim Healthcare, Aetna, Cigna, Tufts Health Plan, Neighborhood Health Plan, Network Health, United HealthCare and Blue Cross and Blue Shield.

Third Party Liability activities can be divided into two categories:

Cost avoidance

Claims submitted to BMCHP after a member has been identified as having other insurance are automatically pended for review by a COB Specialist. Upon confirmation that the other insurance is primary, the claim is cost-avoided and the provider is notified of the other insurance via a remittance advice. Any claim submitted indicating the presence of other health insurance of which we are not aware is pended and investigated. Upon confirmation that the other insurance is primary, the claim is cost-avoided and the provider is notified of the other insurance via the remittance advice. Accident and trauma claims submitted with an attachment from the auto or workers' compensation carrier are pended directly to TPL staff for review. Upon confirmation that the other insurance is liable and that the claim is still active, the pended claim is cost-avoided and the provider is notified of the liable carrier and claim number via the remittance advice.

Recovery/Retractions

When other insurance is associated with a member's claim, the member's claims history is reviewed and claims paid during the period of time the other insurance was primary are retracted. The adjustment reason and name of the other insurance are noted on the provider's remittance advice. For accident and trauma related services, payments we made for claims related to the incident (motor vehicle accident, workers' compensation,

etc.) are retracted. The adjustment reason and name of the other insurance are noted on the provider's remittance advice. If a liability accident is confirmed, we can assert subrogation rights by filing a lien to recover any claims paid, pending settlement of a claim.

BMCHP also has a credit balance program. Through this program, dedicated staff performs onsite audits of providers' aged trial balance reports and recover overpayments, including those identified to be TPL-related. Internal staff is also assigned to handling any TPL overpayments self-reported by providers.

Q92. Describe your method and process for capturing third-party resource and payment information from your claims system.

Our claims system pends claims with indications of third party liability. These claims are routed to a dedicated TPL team for handling. The triggers that are used to segregate TPL claims include claims with attachments, explanation of benefits from other insurers, and claim notations of other insurance. For accident related activity, claims submitted with "E" diagnosis codes that may indicate liability accidents or with any attachment indicating liability are pended to the TPL team.

We also send a monthly eligibility file to our vendor, HMS, who performs data matching against multiple commercial insurance eligibility files and transmits any COB matches back to us electronically.

Currently, all COB information is housed in the Facets claims processing system and all COB activities are carried out in the COB module and COB extension, which contains information on members' other insurances. When a member's file is flagged as containing another primary insurance, the Facets claims processing system will pend any claims submitted for that member. COB Specialists review the pended claims to confirm the existence of other insurance. Depending on the outcome of this review, claims are either paid or denied. The COB extension contains all information regarding the investigation of the case, including policy details such as eligibility, effective dates, and contact information, as well as investigation notes. Additionally, the COB extension allows for automated upload of data from our vendor, HMS. Our claims processing system includes automated batch-format retractions and repayments. All departmental reporting, including extensive regulatory reporting, is captured from data in the Facets claims module, COB module and COB extension.

All accident and trauma information is housed in the Facets claims processing system and all accident and trauma-related activities are carried out in the other party liability (OPL) database. The OPL database contains the history of an accident and trauma case, including automobile insurance and bodily injury information, lien letters, claims data assigned to the incident record, attorney information, and chronological comments, as well as automated claims processing. Additionally, the OPL database has work queue tasks that are automatically assigned to TPL specialists. These tasks include ISO updates, new claim submissions related to incident records, lien status reminders, and lien update reminders. ISO matches are automatically uploaded into the OPL database

for investigation. Although not used for current business, the OPL database can be programmed to send accident and trauma inquiry letters to members.
BMCHP's technology infrastructure is built to industry standards (e.g. Intel, Microsoft SQL, and Windows) and is designed with security and scalability as key attributes. Our COB extension and OPL database capture extensive data elements and are designed with reporting capabilities that can be customized as needed. Records are retained according to contractual and regulatory requirements.

Q93. Describe the process you use for retrospective post-payment recoveries of health-related insurance, as well as your process for adjudicating a claim involving an auto accident.

When commercial or Medicare coverage is identified retrospectively, we notify the provider with information on the other insurance, instruct them to bill the other carrier, and retract any claims that were paid in the previous two years in our claims system. If the other carrier does not reimburse the provider in full, the provider may submit the other carrier's explanation of benefits to us for payment consideration.

For claims that were paid in the previous 25 to 36 months, we use the services of our vendor, HMS, which bills the liable carrier directly, minimizing provider impact. Any reimbursement from the liable carrier is forwarded directly to BMCHP.

For benefits that were provided through our pharmacy benefit manager, we use HMS to bill the liable carrier directly and submit the recovery payments to BMCHP.

BMCHP has specific procedures for adjudicating claims involving an auto accident. Claims are denied for submission to the automobile insurance carrier if benefits are available through that carrier. If benefits are not available, we process the claims for payment but establish a lien against any potential future settlement that the member may receive. If claims were previously paid by BMCHP prior to the identification of the automobile carrier we will retract the claims if benefits are available with the primary carrier. If benefits are not available we establish a lien against any future settlement the member may receive.

Q94. Describe your collection rate of TPL when a third-party payer is identified.

When the third party payer is a commercial or Medicare carrier we collect on 100% of available benefits for claims that were paid in the previous two year period. The provider may rebill us for further consideration upon receipt of the primary carrier's explanation of payment and we may repay a portion or the entire claim depending upon the primary carrier's benefit determination.

When the third party payer is a carrier for automobile, workers' compensation or general liability coverage, we recover on 100% of available benefits for claims once it is determined that the primary carrier has accepted liability. If liability has not been clearly

established by the primary carrier we file a lien against future benefits or settlements and collect based on the outcome of benefit determination and/or settlement.

Q95. Describe your process for sharing TPL information with DHHS.

Data files will be made available to DHHS in a mutually agreeable format and frequency or as contractually required.

BMCHP currently provides Massachusetts Medicaid with a bi-weekly report containing detailed information on all newly identified members with commercial or Medicare coverage. This report includes the member's name, social security number, date of birth, other insurance certificate number and name, subscriber information, and effective and termination dates.

We exchange TPL information with Massachusetts Medicaid via an 834 exchange on a daily basis. Our systems have the capability to exchange information as necessary to suit program requirements.

We also provide detailed reports on all TPL activity at pre-determined reporting periods. For COB, these reports include claim-level detail of cost-avoided claims and recovered claims along with the name and certificate number of the other carrier. We provide the total recoveries by carrier as well as narratives that summarize key points and achievements during the reporting period.

For accident and trauma claims we provide claim-level detail of cost-avoided claims, recovered claims and lien reimbursements as well as narratives that summarize key points and achievements during the reporting period.

3.19.5 Claims Processing Accuracy

Q96. Describe your internal claims quality review program, including staffing, type and frequency of reviews, sampling methodologies, definitions of errors, performance measure calculations, and performance standards.

BMCHP's quality assurance program's focus is to measure and report accuracy rates for payment and processing of claims and to facilitate the planning of any corrective actions. We specifically identify problem areas and trends. The payment accuracy rate is based on the total number of claims without payment errors divided by the total number of claims reviewed. The processing accuracy measurement includes policy/procedural, financial and non-financial findings and is based on the total number of claims processed correctly divided by the total number of claims reviewed.

The quality assurance function within the Claims Department is staffed by a manager and four quality assurance specialists.

The program objectives are achieved through random sample claims audits, focused claims audits and categorization of audit results. Random sample claims audits are primarily designed to measure claims payment accuracy, processing accuracy and financial accuracy. Focused claims audits are primarily designed to identify duplicate payments, incorrect application of plan benefits and other potential claim payment errors.

BMCHP's Random Sample Claims Audit Process includes two components:

- Post-disbursement – conducted weekly on a random sample of claims
- Pre-disbursement – targeted at types of claims that represent high dollar claims or claims that have a high probability for errors

The post-disbursement claim audit applies to all areas of the claim adjudication process including, but not limited to, coding accuracy (data input), system processing logic, processor decisions, adjustments and claim turnaround time.

On a weekly basis two percent of all claims are reviewed and used to calculate the quality levels of claims adjustments, auto-adjudication, data entry and claims manual adjudication. Monthly calculations are based on weekly quality review of claims. Each of these categories is further broken down into a summary of procedural and payment errors by category.

Quality results as well as detailed feedback from the quality monitoring program are incorporated into routine one-on-one feedback between the supervisor and the staff member. Quality scores are also factored into annual performance evaluations and compensation.

Claims adjudicators are held to the following performance standards:

- 97% processing accuracy
- 97% payment accuracy

Q97. Provide the results of your internal claims quality review program for the past 12 months.

The internal claims quality review results for the past 12 months are as follows:

- Payment accuracy - 97.06%
- Procedural accuracy – 98.1%

Q98. Describe any failures to meet claims accuracy standards for any of your contracts over the last two years that resulted in not meeting your service level agreements with your customers. Describe the steps you took to correct these situations.

BMCHP has been successful in meeting all claims service level agreements over the last two years.

Q99. Describe any other administrative quality assurance monitoring conducted by your organization.

In addition to the claims quality assurance program, there are front-end edits built into Facets to increase the accuracy of claims processing and to ensure that specific Medicaid regulatory requirements are met. These include:

- The application of clinical editing software on the front end of claims processing to deny inappropriate or incomplete claims, which can include: member eligibility; services that require pre-authorization; primary care services rendered by someone other than the PCP or covering provider; exact duplicates; age and gender edits; experimental procedures; non-covered benefits; cosmetic procedures; same day surgery edits, global surgical billings; necessity of assistant surgeon; CPT codes that are incidental to procedures; multiple surgery reductions; and bundling and unbundling.
- The identification and review of all inpatient claims over $50,000 by a claims supervisor prior to payment.

Claim audits are also performed in the Provider Audit and Other Party Liability Department. These include external audits, internal system audits, and credit balance audits. Audits are conducted to determine the accuracy of provider billing practices and of BMCHP's compliance with reimbursement methodologies, as specified in provider

contracts. Through the course of an audit, discrepancies impacting payment are identified and payments are adjusted, as appropriate.

The Provider Audit Department works in collaboration with BMCHP's Internal Audit, Fraud and Abuse, Compliance, Health Services, and Claims Processing Departments. Any suspicious activity or trends identified through external or internal audits are reported to the Compliance Department.

External audits are retrospective medical record reviews conducted to verify that paid services are documented in the medical record as having been provided, and are billed according to industry and BMCHP-specific standards. Typically, but not exclusively, external audits are focused on hospital billing; these reviews are conducted onsite at a provider's location. Claims are selected for review based on BMCHP's internal criteria, including claim amount, services frequently billed inaccurately, and provider audit history.

System audits are internal reviews of previously paid claims to ensure accuracy of payment based on CPT coding guidelines, National Correct Coding Initiative standards, BMCHP billing guidelines, and individual provider contracts. Reviews are conducted by full-time auditors with coding training, utilizing Encoder Pro as a resource for coding questions or issues. Claims paid under any payment methodology (e.g. percent of charge, fee schedule, SPAD, and PAPE) are subject to review. Criteria delineating claims to be selected for audit are developed based on an annual review of claims by provider type (e.g. inpatient hospital, surgeon, community health center, and anesthesiologist).

Q100. Describe your processes and procedures to monitor claims payment timeliness, including operational monitoring reports and business practices employed to monitor and address aging claims.

All claims are received in BMCHP's claims processing system, Facets, via electronic 837I or 837P files. Files are generated via:

- The provider/facility systems which can communicate and send files electronically to BMCHP.
- EDI clearinghouses contracted with the providers to prepare and send the providers' claims via file.
- The 837 files prepared from paper claim submissions through BMCHP's outsourced vendor, Tela.

Claims adjudication is done as a batch process each night. The Facets overnight batch process checks member eligibility and whether the provider is on file in the Facets claims system. The overnight batch process checks whether procedure and diagnosis codes are valid, performs date validation functions (ensuring that future dates of service are not billed) and calculates line item totals.

BMCHP's experience shows that approximately 90% of claims adjudicate automatically. These claims flow through the validation and adjudication process with no additional manual intervention and are sent to the check batch process in Facets.

Those that do not auto adjudicate are pended and handled via Facets' workflow functionality. Approximately 10% of all claim receipts pend and receive further processing through Workflow, which is software within the Facets claims processing system that allows BMCHP to manage, prioritize, distribute and assign claim work items. It includes the ability to escalate claims on the basis of age, to ensure prompt payment.

Daily reports are generated within the Claims Department, showing the number and aging of each claim by role. These daily reports are reviewed by claims managers and adjudicators are assigned to specific roles to resolve claims. Role assignments are made by the expertise of the individual adjudicator.

Q101. Describe the current claims payment timeliness standards used within your organization.

BMCHP's current claims payment timeliness standards are as follows:

- 90% of all clean claims from providers are to be paid within 30 days from the date BMCHP receives the clean claim.
- 99% of all clean claims from providers are to be paid within 90 days from the date BMCHP receives the clean claim.

Q102. Provide your organization's actual performance for the last 12 months in relation to your claims payment timeliness standards.

BMCHP has had success in processing claims for payment within a timely manner. We have established, and consistently met, an internal standard of an average 12-day turnaround time for processing of claims. Average turnaround time for the most recent 12 month period has been 9.30 days. BMCHP has processed 98.4% of all claims within 30 days over the last 12 month period.

Q103. Describe the system you use to process claims.

BMCHP uses Facets from TriZetto, which is an industry leading, enterprise-wide software solution for health plan administration. Facets has the flexibility to support multiple lines of business; the system is scalable and can be integrated with third-party applications.

BMCHP processes subscriber/member enrollment and eligibility into Facets for use in claims payment, provider demographic and payment information and authorizations from CareEnhance® Clinical Management Software (CCMS®). All claims adjudication and payments are done within Facets.

Facets has capabilities for administering complex provider and facility contracts and has supported a high level of auto-adjudication for our Massachusetts Medicaid business. The system also has extensive integrated workflow management functionality for claims management. This workflow functionality includes the ability to route a claim for review or to escalate claims on the basis of age to ensure prompt payment. The system also has the ability to calculate and pay interest on claims as required. Facets is configured so that each adjudicator has dollar thresholds for release of claims the claim is automatically routed to the next level of approval required depending on the amount to be paid.

The system has edits and validations for member and provider information that are implemented upon data entry, or through batch processing. For example, claims missing key data items (i.e. unknown member ID, unknown provider) are rejected prior to additional adjudication. ICD-9 diagnosis codes, CPT codes, HCPCS and other medical coding standards are validated by the system using the date of service on the claim.

3.20 Delegation and Subcontractors

Q104. Describe your subcontracting plan, in detail, if you intend to subcontract with other entities to perform portions of the Scope of Work.

BMCHP currently delegates portions of our Quality Management (QM), Utilization Management (UM), Credentialing and Member Rights and Responsibilities (RR) functions, as defined by NCQA accreditation standards, to other entities with which we contract. Delegation is the formal process by which BMCHP gives another entity the authority to perform certain functions on our behalf. Although BMCHP delegates the authority to perform a function, we never delegate the responsibility for ensuring that the function is performed in accordance with our standards and those of our regulators and accrediting organizations.

BMCHP decides to delegate a function when we believe a subcontractor has significant experience, can demonstrate economies of scale, and can provide quality service to our membership. BMCHP's delegation and subcontracting philosophy is based on our understanding of value based healthcare principles. Value in healthcare is quality divided by cost. In the New England Journal of Medicine (Dec.23, 2010) article entitled "What is Value in Health Care," Michael E. Porter, Ph.D. of Harvard Business School states, "Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false 'savings' and potentially limiting effective care..." All subcontractor relationships are based on both quality and efficiency based metrics and continually strive to decrease cost while improving health outcomes or service to our members.

Prior to entering into any contractual relationship, BMCHP uses a standardized process for subcontractor selection. Our due diligence includes but is not limited to research of the industry, an RFI or RFP, subcontractor presentations, financial statement review, asking the subcontractor to analyze de-identified claims data to estimate cost savings, and reference checks. We check the subcontractor's fraud and abuse processes and we perform a check against the Office of Inspector General List of Excluded Individuals Entities (OIG) website. Once a subcontractor is selected, an executive sponsor, business owner and project owner are identified to begin planning for pre-assessment and planning for implementation.

Our subcontractor delegation and oversight process consists of a comprehensive pre-delegation assessment and evaluation that includes the following as applicable:

- QI or UM Program Description (depending on the scope of delegation)
- Applicable policies and procedures
- Staffing capacity to perform the functions BMCHP may delegate
- Ability to meet decision timeliness standards

- Denial process
- Ability to meet all BMCHP's requirements in accordance with applicable state, federal and accreditation standards
- Site visit
- File, contract, and network review
- Approval by the state, as required by regulation or contract

BMCHP assigns each delegate/subcontractor to an identified a subcontractor manager, who is a BMCHP staff person responsible for operational oversight of the delegated functions. The Delegation Steering Committee is responsible for overall oversight and approval of all QI, UM, Credentialing, and RR delegated functions. An internal BMC HealthNet Plan team with representation from relevant departments is designated by the Delegate Manager to assess the capacity of the potential delegate to perform all contracted services.

The team produces a written report of the pre-delegation initial evaluation. The Delegation Steering Committee and team evaluates the results of the review and determines if the subcontractor will be able to meet BMCHP's expectations and regulatory and accreditation requirements. A legally binding agreement that contains all requirements of regulatory and accreditation bodies is executed prior to the delegation of any function to a subcontractor.

BMCHP intends to utilize our subcontractor management experience, our current subcontractors as applicable, and will contract with additional subcontractors as needed in order to perform portions of the Scope of Work for this RFP.

Q105. List the names and addresses of the Subcontractors to be used, as well as their location(s).

Below please find BMCHP's list of subcontractors we intend to use:

Subcontractor name	*Address and Other Locations*
Accredo	1640 Century Center Pkwy. Memphis, TN 38134
Advanced Medical Reviews	10780 Santa Monica Blvd, Suite 333 Los Angeles, CA 90025
Ascend	53 Darling Avenue South Portland, ME 04106
Beacon Health Strategies	500 Unicorn Park Drive, Suite 401 Woburn, MA 01801
CDR Associates	307 International Circle Suite 300 Hunt Valley, MD 21030

Subcontractor name	*Address and Other Locations*
Enclarity	30 Enterprise Suite 220 Aliso Viejo, CA 92656
FIS	601 Riverside Avenue Jacksonville, FL 32204
Fiserv	5875 N. Lindbergh Hazelwood, MO 63042
Health Management Systems	401 Park Avenue South, New York, NY, 10016
InformedRx®	2441 Warrenville Road Suite 610 Lisle, Illinois 60532
McKesson Health Solutions	329 Interlocken Pkwy Broomfield, CO 80021
MedSolutions, Inc.	730 Cool Springs Boulevard, Suite 800 Franklin, TN 37067
Northwood, Inc	7277 Bernice Center Line, MI 48015
OptumInsight	950 Winter Street, Suite 3800 Waltham, MA 02541
Safeguard Records Management	75 Arlington St Boston, MA
Sirona Health	500 Southborough Drive South Portland, ME 04106
Tela/The Trizetto Group, Inc.	6061 South Willow Drive Greenwood Village, Colorado 80111
VSP-Vision Service Plan	3333 Quality Drive Rancho Cordova, CA 95670

Q106. Describe the services that the Subcontractor will provide and provide evidence of their experience providing those services.

Below please find descriptions of services each subcontractor will provide and evidence of their experience providing these services. Note that all listed subcontractors have entered into confidentiality agreements with BMCHP and follow HIPAA guidelines:

Accredo

Services provided: Specialty Medication Dispensing and Patient Consultative Services

Experience providing the services: Accredo has been providing specialty pharmaceutical serivces to BMCHP since 2004 and offers BMCHP members access to many specialty medications, including a number of medications that are only available in limited distribution and a select set of medications that have unique services and dispensing

requirements, such as local nursing support. Accredo provides BMCHP access to specialty pharmacy services that are aimed at providing patients with high-touch, ongoing consultative services to help promote compliance and persistency and prevent avoidable emergency room visits. Accredo holds pharmacy provider identification numbers for 48 state Medicaid programs and have been actively involved in the delivery of specialty products and services through their network of pharmacies and national distribution centers. Accredo has a comprehensive portfolio of services including inventory management, dose to assay matching, emergency room avoidance programs, managed care networking, electronic claims and data retrieval, comprehensive reporting packages, and customized therapy management plans for each BMCHP member serviced. Accredo understands that consistency and continuity of services are an essential component to promoting optimal therapeutic outcomes and is committed to providing BMCHP with high level of quality care that is expected for BMCHP members. BMCHP is satisfied with their performance.

Advanced Medical Reviews (AMR)

Services provided: Third party UM review and peer consultation

Experience providing the services: AMR provides independent medical reviews, peer reviews and comprehensive medical opinions. Actively practicing board-certified physicians and licensed healthcare professionals provide recommendations. AMR has full URAC accreditation as an Independent Review Organization. AMR renders professional, independent and unbiased case review to assist us with adjudication challenges or to provide an external source to comply with state regulations, contractual obligations and accreditation requirements. AMR reviews BMCHP cases prospectively, concurrently and retrospectively for medical necessity, appropriateness of treatment and to determine whether a particular treatment/procedure is experimental/investigational for initial determinations and all appeal levels. AMR provides recommendations only. Final decisions reside with a BMCHP Medical Director. All grievance and appeal rights are provided by BMCHP. AMR provides specialized reports, data mining and technology. AMR emphasizes continuous quality improvement, innovation and client satisfaction. BMCHP has worked with AMR since 2010 and we are satisfied with their performance.

Ascend SpecialtyRx, a division of SXC Health Solutions, Inc.

Services provided: Specialty Medication Dispensing and Patient Consultative Services

Experience providing the services: Ascend offers specialty pharmacy services to 16 state Medicaid programs including patient management for more than 20 different therapies. Ascend's specialty pharmacy program includes patient enrollment and counseling, dose optimization review, ongoing patient management, product shipping expertise and therapy management. Ascend offers BMCHP members access to a multitude of specialty medications, including medications with limited distribution. BMCHP members serviced by Ascend are offered ongoing consultative services including counseling and follow-up to promote compliance and ensure dose optimization. Ascend understands the needs of BMCHP's member population and has been successful in managing this

population through ongoing verbal contact with both the patient and the patient's physician. Ascend has been providing specialty services to BMCHP since 2006 and we are satisfied with their performance.

Beacon Health Strategies (Beacon)

Services provided: Management of BMCHP's behavioral health program including: utilization management; case management; network contracting and credentialing; claims payment and processing; quality management and improvement, member services for behavioral health, reporting and analytics for behavioral health.

Experience providing the services: Beacon Health Strategies is an organization fully focused on behavioral health, with a proven record of achieving high quality and efficient care. This subcontractor was organized and began operations in 1996 as an LLC under the laws of the Commonwealth of Massachusetts. Prior to partnering with BMCHP, Beacon had demonstrated its ability to comply with MassHealth, the Children's Behavioral Health Initiative (CBHI) and Connector Authority Requirements for other customers within the Commonwealth of Massachusetts. Beacon administers a system of care that focuses on ensuring the right intensity of care in the right setting for the right time. Appropriate pre-certification, aggressive continuing stay review, intensive case management including "feet on street", network profiling and development, psychotropic drug intervention, and co-location of behavioral health clinicians in primary care locations are just a few of the clinical and operational initiatives that permit Beacon to increase quality while reducing cost. BMCHP has partnered with Beacon Health Strategies March 2010 and we are satisfied with their performance.

CDR Associates

Services provided: Credit Balance Recovery

Experience providing the services: CDR Associates is a health care financial consulting firm founded in 1989 to assist health insurers in the identification and recovery of overpaid claims. CDR has established itself as the industry leader by completing thousands of onsite audits annually on behalf of Blue Cross and commercial payers a well as state Medicaid agencies across the country. CDR Associates has created CBAS – the Credit Balance Analysis System. This application allows providers to manage and resolve open credit balances using data from their practice management accounting systems. The system allows providers to determine the causes of credit balances (i.e., misapplied payments, over payments, duplicate allowances) and follow through to resolution. The system which is web-based, complies with HIPAA requirements and CMS 838 filing requirements. BMCHP has worked with CDR Associates since 2007 .

Enclarity

Services provided: Member Demographic Data Verification

Experience providing the services: Enclarity was incorporated on February 25, 2005 with a primary organizational goal to improve the data integrity of provider and member data within payers and managed care organizations. Increasing the accuracy and comprehensiveness of provider and member demographic data provides a higher level of service for both members and physicians through greater delivery success in written communications, improves the claim payment process, and, provides the most up-to-date information for provider directories. Enclarity has extensive experience working with other payors and managed care organizations to cleanse and augment provider and member demographic data to improve postal delivery, claims processing, and provider directory quality. In addition, a number of Enclarity's staff has experience working with various Medicaid/SCHIP programs and fiscal agents including First Health Services, Nevada Medicaid, Alaska Medicaid, NYC CHIPs, New Mexico Medicaid, and various other Medicaid Managed Care contractors. BMCHP has worked with Enclarity since 2008 and we are satisfied with their performance.

FIS

Services provided: Check Printing and Mailing

Experience providing the services: Founded in 1968, FIS is the world's largest global provider dedicated to banking and payments technologies. The company has operated as FIS since 2003, and has acquired many other companies over the years, including Metavante in 2009, which was formerly Adminisource. FIS serves more than 14,000 institutions in over 100 countries. First in financial technology, FIS is ranked third on the Barron's 500, 426 on the Fortune 500 and is a member of Standard & Poor's 500® Index. FIS has also been named the number one overall financial technology provider in the annual FinTech 100 rankings. FIS has been providing this service to BMCHP since 2005.

Fiserv Output Solutions

Services provided: Production and fulfillment of member enrollment materials, member health education information, and various other member communications

Experience providing the services: Fiserv Output Solutions has more than 25 years experience in communications fulfillment for the healthcare industry. It is a national organization with production and fulfillment facilities throughout the United States. Fiserv's automated processes help create efficiencies in costs, production turnaround times and quality. Fiserv processes daily files from BMCHP requesting member ID cards, member welcome kits with various components, health education information for members in our care management programs, and other member communications. Fiserv has been BMCHP's vendor partner since 2007 and we are satisfied with their performance.

Health Management Systems (HMS)

Services provided: Other Party Liability Verifications

Experience providing the services: HMS was incorporated in New York in 1974. Focused exclusively on the healthcare industry since its founding, HMS partnered with their first Medicaid agency client in 1984 to identify coverage that was primary to Medicaid. Since that time, over 40 additional Medicaid clients have engaged HMS to assist with their third party liability and overpayment recovery needs. Other government-sponsored healthcare concerns now rely on HMS to perform similar services, including managed care payers, SCHIPs, child support agencies, and CMS. HMS's mission is to protect the integrity of government-sponsored health and human services programs. HMS continually applies customer service, excellence, innovation, and integrity to achieve HMS's goals and help government-funded healthcare clients—including Medicaid managed care – achieve theirs. Currently HMS provides various cost containment solutions to 36 Medicaid programs, 80 Medicaid managed care plans, three SCHIPs, and 16 child support agencies nationwide. BMCHP has worked with HMS since 2007.

informedRx®

Services provided: Pharmacy Benefits Management (PBM)

Experience providing the services: informedRx® is a division of SXC Health Solutions, Inc. (SXC), which is a wholly owned subsidiary of SXC Health Solutions Corporation. Based in Lisle, Illinois, SXC employs 863 professionals who provide a broad range of pharmacy benefit and technology solutions to the payer, employer, PBM and provider markets. informedRx® systems are currently operational in 14 state Medicaid FFS programs and growing. Additionally, SXC processes pharmacy claims for eight Medicaid managed cared organizations covering more than 3.1 million recipients. informedRx® prides itself on their clinical innovations, mail service, and specialty pharmacy, consistent financial performance and provision of FFS services as well as carve-out pharmacy benefit services.

One of the principal strengths of informedRx® is the breadth of their experience. In fact over 100 million Americans' pharmacy needs are met by their services and systems. informedRx® has customers in virtually every segment of the pharmacy benefit market. informedRx®'s client list includes some of the nation's largest health care companies and spans organizations in the Health Maintenance Organization (HMO), Medicaid Fee-for-Service (FFS), Medicaid Managed Care Organizations (MCO), Third Party Administrators (TPA), Blue Cross Blue Shield (BCBS), and regional insurer markets. informedRx® has designed programs and systems to specifically accommodate these needs.

Formulary management is an area where they have developed population specific programs. The clinical department has developed a population specific formulary that focuses on therapeutic classes that account for the majority of cost while allowing the prescriber more flexibility in other areas. In addition to standard reporting that all managed care plans need to support disease management, case management, utilization management and financial initiatives, informedRx® has developed reporting to meet local, state and federal regulatory requirements. informedRx® also meets BMCHP's

needs related to submitting to MassHealth pharmacy utilization data that allows EOHHS to obtain maximum available pharmacy manufacturer rebates. BMCHP has worked with informedRx® since 2003 and we are satisfied with their performance.

McKesson Health Solutions

Services provided: 24 Hour Nurse Advice Line

Experience providing the services: Founded in 1833, McKesson Corporation is the fifth oldest continually operating company in the United States. McKesson is the largest healthcare supply management and information technology company in the world, #18 on the Fortune 500. They employ more than 32,900 people.

McKesson has provided telephonic 24x7 Nurse Advice Line services since 1986. The depth and breadth of the company's product and service offerings, coupled with the largest customer base in the healthcare industry, uniquely position McKesson to meet the needs of its customers including among others more than 1,800 healthcare payers. McKesson's mission is to advance the health of the healthcare system by advancing the success of its partners. McKesson currently has care management programs in California, Florida, Illinois, Montana, New Hampshire, Oregon, Pennsylvania and Texas. McKesson programs reduce avoidable hospital and emergency department utilization through the establishment of a medical home.

Their Nurse Advice Line (NAL) is an enhanced customer service offering that provides multi-lingual access to a Registered Nurse who can answer network and clinical questions, provide educational materials, and refer members to the Audio Health Library. Access to the Audio Health Library (AHL) is available in over 150 languages and for deaf and hard of hearing members. The automated audio health library available through McKesson has hundreds of topics including health education topics intended to promote healthy behaviors and lifestyle changes. Several of these topics are also available in Spanish. BMCHP has worked with McKesson in various programs since 2003.

MedSolutions, Inc.

Services provided: Utilization Management of high cost radiology studies

Experience providing the services: MedSolutions' business model originated from a multi-state imaging center business founded in 1992. The company has operated as MedSolutions since 1997. Recognizing the growing need of healthcare payers to control medical costs, MedSolutions sold the imaging centers to redirect their focus to managed care. MedSolutions' first radiology management program began in 1996, and has grown steadily since that time. Managed Medicaid care is fundamental to MedSolutions' mission of providing access to quality radiology care appropriately to all individuals. MedSolutions has a long history of experience with radiology management for managed Medicaid/SCHIP populations, commercially insured members and Medicare populations under capitated arrangements. MedSolutions assists more than 20 million

members throughout all 50 states in gaining access to needed imaging tests through our URAC-accredited, NCQA-certified UM program. MedSolutions' financial performance has been solid ever since their founding in 1992. BMCHP has worked with since 2008.

Northwood, Inc.

Services provided: Durable Medical Equipment Prosthetics and Orthotics Services and Medical Supplies

Experience providing the services: Northwood, Inc. has managed BMCHP's durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) supplied and billed by DMEPOS providers and most third party administrative functions related to DMEPOS since April 2011. Their responsibilities also include provider reimbursement, provider network contracting and management, credentialing, prior authorization, utilization management, member satisfaction and claims processing. The organization is URAC accredited for Health Utilization Management and Claims Processing. Northwood is also ISO 9001/2000 Certified. Northwood is an expert in the specialized field of DMEPOS benefit administration. The knowledge and experience of its team brings specific DMEPOS provider network, fee schedule, claims editing and utilization management expertise as well as product knowledge and claim adjudication procedures. Northwood presented a thoughtful return on investment (ROI) proposal including findings from their data analysis and BMCHP has confidence in their savings estimate. Northwood has been very responsive to all of BMCHP's requests.

OptumInsight

Services provided: Technical Support for Provider Look Up Function

Experience providing the services: OptumInsight is an information and technology company founded in 1996. OptumInsight was formed as a result of many acquisitions and mergers. They have been hosting BMCHP's online provider directory for the Massachusetts Medicaid program since 2003, and also provides this service for BMCHP's Commonwealth Care program (2006), and Commercial business (2011).

Safeguard Records Management

Services provided: Offsite Data Storage

Experience providing the services: BMCHP has used Safeguard for over seven years. Backup tapes rotated in and out of the facility on a routine basis in accordance to BMCHP's backup policies. Archived data is held at Safeguard until marked for destruction in accordance to the BMCHP data retention policy. Safeguard provides the documented data tape destruction services when authorized to do so by BMCHP.

SironaHealth

Services provided: Inbound Marketing Line

Experience providing the services: Headquartered in South Portland, Maine, SironaHealth was founded in March 2009 by the former management and operations teams of IntelliCare, Inc. a prominent medical contact center and technology company with over 13 years of telehealth experience. SironaHealth is accredited by URAC as a Health Call Center. SironaHealth provides services exclusively to the healthcare industry and has clients in 35 U.S. states, and serves patients in all 50 U.S. states. SironaHealth's client base includes: Hospitals and Health Systems, Private Health Plans, Medicaid and Medicare Plans, Employers, Health Management Companies, Colleges and Universities, Physician Practices and Groups, and Patient Centered Medical Homes as well as Nurse Advice Line, Decision Support, Preventive Care Reminders, Pre-Admission Services, Post Discharge Follow Up, Physician and Services Referral, Member and Patient Call Services, Custom Surveys, Health Risk Assessments, Health Management Outreach and Enrollment, and Automated Voice Services.

Currently, SironaHealth only provides BMCHP with phone services for prospective members. They answer all calls coming into BMCHP's marketing phone, which is the number printed on our marketing materials and included on the prospect (Need Insurance) section of BMCHP's website. The majority of the calls are from prospects looking to join BMCHP – both employers and individuals. SironaHealth's services include helping individuals determine which of BMCHP's three programs callers might qualify for; helping employers determine if they might qualify for our commercial program; explaining the MassHealth (Medicaid) and Commonwealth Care application processes; transferring calls to MassHealth, the Massachusetts Health Connector, and BMCHP, when dictated by scripts; faxing prospect information to BMCHP when callers would like to speak with members of our community outreach team about where to get help applying for MassHealth and Commonwealth Care or other questions and concerns related to these two programs; and provision of monthly reports to BMCHP documenting previous monthly call activity. BMCHP has worked with SironaHealth since 2007.

Tela/The Trizetto Group, Inc.

Services provided: Claims Administration Services

Experience providing the services: Tela provides BMCHP with Claims Administration Services – scanning claim images for retrieval on the BMCHP OnBase management system, Optical Character Resolution (OCR) data entry of BMCHP's keyable and non-keyable claims. Tela, headquartered in Baltimore, Maryland, provides processing, software development, and programming services to healthcare organizations including insurance carriers, HMOs, PPOs, TPAs, physician groups and other service providers. Tela offers these organizations proven methods to streamline processes, increase automation and reduce administrative costs to boost their profitability and competitive position. In March, 2011, Tela was acquired by The Trizetto Group, Inc. BMCHP has worked with Tela for several years and we are satisfied with their performance.

Vision Service Plan (VSP)

Services provided: Vision Services Provider

Experience providing the services: VSP provides a discount on certain vision lenses and frames for individuals enrolled in health plans offered by BMCHP. BMCHP members currently receive 20% discount on eye examinations, provided by a VSP network provider; 20% discount for a complete set of prescription glasses and lens options provided by a VSP network provider; 15% discount for fitting and evaluation services associated with prescription contact lenses provided by a VSP network provider. Founded in Oakland, California in 1955, VSP offered the first prepaid, not-for-profit vision benefit. In 2007, VSP expanded its company and network of doctors into Canada. VSP begins also offering a "direct to consumer" comprehensive eyecare plan to those who don't have access to vision coverage through an employer. As of 2010, the company has 55 million members and 26,000 participating doctors. BMCHP has worked with VSP since 2006 and is satisfied with their performance.

Q107. Describe how you will monitor the performance of your subcontractors to ensure all RFP and Sample Contract requirements are met. Provide sample reports showing any actions taken to improve performance and ensure positive results.

Each subcontractor contract currently contains explicit provisions addressing performance requirements, monitoring and reporting Annual Review/Audit requirements and sanctions or penalties. If BMCHP is selected as a successful bidder for this RFP, BMCHP will amend all applicable subcontractor contracts to list the additional requirements pertinent to this RFP and the proposed contract. BMCHP has the existing mechanisms to ensure that the subcontractor function(s) is appropriately implemented and professionally managed and is in accordance with applicable standards. BMCHP closely oversees, monitors, and continually evaluates each subcontractor to ensure such compliance. Per BMCHP's policy, the following are some of the current requirements that are regulated and monitored with subcontractors as applicable:

- The subcontractor provides its current QI and/or UM Program and evaluation of its previous QI and/or UM Program to BMCHP's Subcontractor Manager annually. The following is included:
  - A description of any updates or modifications to the Subcontractor's QI and/or UM Policies and Procedures, and
  - A description of any updates or modifications to the criteria used in the QI and/or UM services.
- Ascertain Subcontractor's ability to obtain NCQA accreditation, as applicable. Confirm continued accreditation for those Subcontractors currently accredited.
- If Subcontractor has received NCQA accreditation, the requirement for annual evaluation may be waived, although collection of the QI/UM program plans and semi-annual operational reporting and oversight are still required.

- Notify Subcontractor in writing, of annual oversight audit date.
- Review Subcontractor agency's QI and/or UM program using an approved tool based on scope of delegation.
- Conduct annual file audit (if Subcontractor performs functions included in NCQA file reviews). This may be waived if Subcontractor is NCQA accredited or certified.
- The Subcontractor Manager will submit a report to the Delegation Steering Committee. The Delegation Steering Committee will evaluate the content of the annual audit report, evaluation, and other documentation collected and determine if the Subcontractor's activities, including the QI and/or UM Program, continue to satisfy BMCHP's expectations and regulatory and accreditation requirements.
- The Subcontractor Manager notifies the Subcontractor in writing of continued services and obligations to BMCHP including any improvement action required
- The Delegation Steering Committee determines the need for an improvement plan based on the pre-delegation assessment, the semiannual reports, and/or annual review of the Subcontractor.
- A written improvement plan request is produced by the Subcontractor Manager detailing prescribed requirements and time frames for delegation agreement compliance, addressing any performance issues which are identified either prior to delegation or during the delegation period.
- The Delegation Steering Committee reviews submitted documentation addressing the improvement action needs.
- The Delegation Steering Committee continues to review all improvement plan documentation submitted by the Subcontractor until all standards have been adequately addressed.
- The Subcontractor Manager notifies the Subcontractor in writing of the results of all Delegation Steering Committee improvement plan reviews. Inability to achieve requirements established in the improvement plan may lead to revocation of part or all delegated functions.
- When all improvement plan requirements have been met, the Delegation Steering Committee continues standard review of semi-annual requirements and annual oversight review.
- BMCHP reserves the right to suspend or retract any activity previously delegated to a Subcontractor should improvement plans be ineffective in resolving identified areas of non-compliance.

BMCHP has attached at Exhibit 6.5.F. one of its reports relating to tracking performance and improvements with Beacon as a sample in response to this question.

Q108. Describe data you will transfer with your subcontractor(s) and how that data will be transferred.

The data expected to be exchanged with BMCHP's subcontractors are:

- Enrollment/eligibility data
- Member demographic data
- Provider data
- Payment data
- Authorization data
- Claim / encounter data

The subcontractors that will be used by BMCHP currently support other BMCHP business. The existing processes and file formats will be used for the New Hampshire Medicaid Program wherever possible.

All data is exchanged securely using Secure FTP, FTP with PGP Encrypted files or HTTPS.

Below is a grid summarizing the types of data transferred from or to BMCHP subcontractors, "to" shows where data is sent to the subcontractor, "from" shows where data is received from the subcontractor, and "both" indicates where data is exchanged in both directions.

Subcontractor	*Member eligibility*	*Member Demographic Data*	*Provider Data*	*Payment data*	*Auth data*	*Claim data*
FiServ		To				
FIS				To		
OptumInsight			To			
MSI	To	To	To		From	To
InformedRx®	To	To	From	From		From
Beacon Health	To	To	Both	From		Both
Northwood	To	To	Both	From		From
Enclarity		Both				
HMS	To	To	To			To
McKesson (NAL)	To	To				
Tela						From
VSP	To	To	From	From		From

Q109. Describe how subcontractors are integrated with your care management programs

BMCHP has experience with successfully integrating subcontractors into our care management programs. Workflows are coordinated as part of implementation and there is ongoing evaluation with those subcontractors that have clinical interfaces. For example; there are monthly clinical operations meetings with our behavioral health partner (Beacon Health Strategies) twice monthly quality improvement meetings, shared clinical rounds, and daily communication between utilization management and care management staff. Staff from Beacon Health Strategies are located in our Boston and regional offices and sit among our Office of Clinical Affairs staff.

Similarly, we have shared care management contact information with our durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) partner (Northwood). Care management staff frequently communicate with Northwood staff to coordinate services and ensure that our members' needs are met. Another example is the McKesson nurse advice line (NAL). On a daily basis we receive a report of members who have called the NAL in the previous 24 hours and this report is used by care management staff to determine which of those members would benefit from an outreach call by care management staff.

BMCHP will use our experience to seamlessly integrate our subcontractors into the management of the New Hampshire Medicaid population to ensure quality care is coordinated in the most efficient manner. We will replicate processes that have been successful in managing our MassHealth Medicaid population.

Q110. Describe how subcontractors are integrated with your TPL and fraud and abuse programs.

BMCHP's contracts with our behavioral health partner and durable medical equipment and services provider require the subcontractors to establish and maintain TPL and fraud and abuse programs and procedures, and to interact with BMCHP on the same. These subcontractors are required to support BMCHP in periodic reporting to MassHealth and Commonwealth Care by providing us with data relating to TPL and COB activities which is then incorporated into BMCHP's reports to these agencies.

Behavioral Health and Durable Medical Equipment Services Provider

BMCHP's agreements with Beacon and Northwood, specifically obligates each to perform coordination of benefits (COB) and TPL activities, including without limitation: requesting information from members regarding other payers that may have primary responsibility for covered services, using best efforts to pursue payment recoveries from such payers whenever possible, sending suppliers advance notice before retracting payments for COB, and reporting to BMCHP all payment received from other payers and deducting all such payments from claims costs.

These agreements also require Northwood and Beacon to develop and maintain a fraud and abuse program with the following obligations:

- Appoint a fraud and abuse prevention coordinator
- Investigate complaints or concerns of potential fraud, and report the matter in writing to BMCHP
- Recover improper payments of funds due
- Require corrective actions of or terminate providers as appropriate
- Certify in writing on an annual basis that after a diligent inquiry, to the best of its knowledge and belief
- Notify BMCHP of all overpayments above $75,000 or any voluntary supplier or provider disclosures resulting in receipt of overpayments in excess of $75,000 even if there is no suspicion of fraud
- Comply with all federal requirements for employee education about false claims laws

Pharmacy benefits manager

BMCHP's contract with InformedRx® requires the PBM to perform specific COB activities and ensure that BMCHP is the payer of last resort. We coordinate with our own TPL/COB vendor, Health Management Systems (HMS), to identify and recover pharmacy overpayments related to TPL.

The PBM contract also requires it to cooperate with BMCHP's fraud and abuse policies and initiatives and to implement corrective actions, and, potentially, be subject to financial penalties, if found to be out of compliance with such policies.

If awarded a contract from DHHS, BMCHP will be amending its agreements with the above referenced subcontractors to extend to the New Hampshire Medicaid program. At that time, we will require our subcontractors to be responsible for any new or additional requirements with respect to TPL and fraud and abuse required under the DHHS agreement. We also will amend our agreement with our vision services provided to support the New Hampshire program and to affirmatively establish responsibilities relative to integration of TPL and fraud and abuse activities with BMCHP's programs and procedures.

Q111. Describe any sanctions or penalties that apply if the subcontractor fails to perform up to the expectations of your organization. Attach sample performance monitoring reports.

As indicated in Question 107, each subcontractor contract currently contains explicit provisions addressing performance requirements, monitoring and reporting and sanctions or penalties. BMCHP reserves the right to suspend or retract any activity previously delegated to a subcontractor should improvement plans be ineffective in resolving identified areas of non-compliance. Therefore, in the event that BMCHP

concludes that a subcontractor is out of compliance with any provision of the subcontractor contract, BMCHP may require the subcontractor to develop and submit to BMCHP a corrective action plan (CAP) within a specific timeframe and for the subcontractor to implement provisions of the CAP as approved by BMCHP. If BMCHP determines that the CAP is not adequate to address the concerns raised by BMCHP, or if the implementation of the CAP is not satisfactorily achieved within the timeframes established therein, BMCHP may initiate any remedy available, including without limitation, withdrawal from the subcontractor of certain delegated functions or termination of the contract.

Please see attached at Exhibit 6.5.G. a sample performance monitoring report.

Exhibit 6.5.A

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

Exhibit 6.5.B

Harvard Pilgrim Health Care

December 14, 2011

[First Name] [Last Name]
[Title]
[Contract Entity Name]
[Street Addr1]
[Street Addr2]
[City, State Zip]

Important Update: New Hampshire Medicaid Care Management Program

Dear Provider:

I am writing to inform you of Harvard Pilgrim Health Care's intent to establish a strategic partnership with Boston Medical Center (BMC) HealthNet Plan relative to the New Hampshire Medicaid program.

As you may be aware, the New Hampshire Department of Health and Human Services is implementing a Medicaid managed care program, and BMC HealthNet Plan is responding to the State's request for proposals (RFP). Harvard Pilgrim is proud to collaborate with BMC HealthNet Plan in this effort. BMC HealthNet Plan is an experienced, non-profit Medicaid managed care organization (MCO), founded by Boston Medical Center in 1997. Like Harvard Pilgrim, which has been recognized by the National Committee for Quality Assurance (NCQA) as the number one private health plan in the U.S. for the past eight years*, BMC HealthNet Plan has been consistently recognized by NCQA for its quality and was recently ranked as one of the top three Medicaid health plans in the country.**

By partnering with BMC HealthNet, we aim to develop a statewide Medicaid provider network that is as robust and as quality-focused as our existing commercial network.

We will be contacting you in the next weeks to discuss our plans to support this important new program, effective July 1, 2012. Please also know that a listing of Harvard Pilgrim's existing New Hampshire provider network will be included in BMC HealthNet Plan's RFP responses for informational purposes only.

In the meantime, if you have any questions, please call your Contract Manager, [Contract Mgr Name] at xxx-xxx-xxxx.

Sincerely,

Beth Roberts
Vice President
New Hampshire and Emerging Markets

*HMO/POS. NCQA's Private Health Insurance Rankings, 2010-12 – Private. U.S.News/NCQA America's Best Health Insurance Plans 2005-2009 (annual). America's Best Health Insurance Plans is a trademark of U.S.News & World Report. NCQA The State of Health Care Quality 2004.

** NCQA's Medicare/Medicaid Private Health Insurance Rankings, 2011-12 – Medicaid.

Exhibit 6.5.C

Q: 33 ATTACHMENT A
Provi nder an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
FACILITY	Rehabilitation Hospital	Crotched Mountain Rehabilitation Center			1
	Skilled Nursing Facility	RANNIE WEBSTER FOUNDATION			1
		ROCHESTER MANOR LLC			1
FACILITY Total					3
HOSPITAL	General Hospital	Tufts Medical Center			1
		Boston Medical Center			1
		Children's Hospital - Boston			1
HOSPITAL Total					3
INPATIENT MH	General Hospital-Psychiatric	Hampstead Outlook Inc dba Hampstead Hospital			1
	Mental Hospital	Brattleboro Retreat			1
	MH Partial Hospitalization-Adult	Brattleboro Retreat			1
	MH Residential Treatment - Child and Adolescent	Brattleboro Retreat			1
	Residential Treatment Facility, Emotionally Disturbed (	Northern Human Services			1
INPATIENT MH Total					5
OTHER	Adult Day Care	Sarah Care Adult Dayservices			1
		The Homemakers Health Services			1
		VINTAGE GRACE			1
	Ambulance	Berlin EMS	NA	NA	1
	Customized Equipment	FULLER HAIR INC.	NA	NA	1
	Durable Medical Equipment & Medical Supplies	HUDSON HOME HEALTH CARE INC	NA	NA	1
		MINUTEMAN MEDICAL INC.	NA	NA	1
	Home Health	CITY OF BERLIN HEALTH DEPT	NA	NA	1
		Nurses PRN Inc	NA	NA	1
		The Homemakers Health Services			1
	Home Health Agency	Healthy At Home, Inc	NA	NA	1
		Interim Healthcare	NA	NA	6
		J and K Staffing Solutions	NA	NA	1
		Personal Touch Home Aider of Greater Portsmouth Inc	NA	NA	1
		Personal Touch Home Care of Greater Portsmouth Inc	NA	NA	1
		Valley Regional Hospital		NA	1
	Land Transport	CarePlus Ambulance Service Inc	NA	NA	1
	Medical Supplier (Medical Supplier, DME, & Prosthe	180 Medical Inc	NA	NA	1
		Herron & Smith Inc	NA	NA	1
		Next Step Orthotics & Prosthetics Inc	NA	NA	1
		Prentke Romich Company	NA	NA	1
		Renew Medical Services LLC	NA	NA	1
	Non-emergency Medical Transport (VAN)	SEACOAST CHAIR CAR SERVICE LLC	NA	NA	1
	Non-Hospital Connected Lab	Bio Reference Labs Inc & Subs			1
		Cytocheck Laboratory LLC	NA	NA	1
	Optician	Sunshine Eyeware LLC	Carleton	Sonja	1
		TREMAINE OPTICIANS			1
	Optometrist	Fields of Vision Eye Care Inc	FIELDS	CHRIS	1
		Theravision Eye Care	TAO	WENHONG	2

Q: 33 ATTACHMENT A
Providers under an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
		Windham Family Eye Care	SHANLEY	JENNIFER	1
	Optometry	James A Luccio	Gomez	Renee	1
			Luccio	JAMES	3
		Twin City Eye Inc	Russakovsky	Alex	1
	Pastoral	JOURNEYS A CENTER FOR PASTORAL PSYCHOTHERAPY & SPIRITUAL GROWTH			1
		Journeys Pastoral Counseling Center	SUNDELL	DAVID	1
		Pastoral Counseling Services	HERNDON	BAYARD	1
			KETZLER	PATRICIA	1
			O'DONNELL	JOHN	1
			REYNOLDS	DAVID	1
			WATTS	P.	1
	Personal Care Attendant	Granite State Independent Living	NA	NA	1
OTHER Total					49
OUTPATIENT MH	Addiction (Substance Use Disorder)	Pastoral Counseling Services	KOON	MARY	1
			YOST	MARY	1
		Wendy Quinn PsyD	QUINN	WENDY	1
	Clinical Social Worker	Family Guidance Center of Milford	BEDY	MICHELLE	1
			GODBOIS	PAMELA	1
		Granite State and Family Counseling PLLC	LOPILATO	LYNNE	1
		Judy Marie E Buteau LICSW	BUTEAU	JUDY MARIE	1
		Lisabeth Wotherspoon LICSW	WOTHERSPOON	LISABETH	1
		Mental Health Associates of Jackson LLC	ANDERSON	RICHARD	1
		Mount Washington Valley Psychological Services	WEATHERS	ROBERT	1
		New England Center for Comprehensive Counseling Services LLC	CORACCIO	CYNTHIA	1
		Pastoral Counseling Services	GENZEL	CALVIN	1
			Geoghegan	Emily	1
			KNIERIEM	CAROL	1
			WILLISTON	STEPHANIE	1
		Richard Danks LICSW	DANKS	RICHARD	1
		Solutions for Living	DREW-HENSON	SHARON	1
		Warren Street Family Counseling Svcs Inc	AKERS	SHERRY	1
			BENOIT	RONALD	1
			CROSBY	HERBERT	1
		Warren Street Family Counseling Svs Inc	HARBESON	ROSEMARY	1
			KAMMAN	SHERYL	1
			LeBeau	Colleen	1
			MOULTON	ELIZABETH	1
			OLSON	KIRKE	1
			THORINGTON	PAUL	1
			VANASKIE	MICHAEL	1
	Clinical Neuropsychologist	Neuroeducation Inc	Funk	Janice	2
		Psychological Resource Consultants	BREDE	TODD	2
	Clinical Social Worker	(blank)	VONSACKEN	SILVIA	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
FACILITY	Rehabilitation Hospital	Crotched Mountain Rehabilitation Center			1
	Skilled Nursing Facility	RANNIE WEBSTER FOUNDATION			1
		ROCHESTER MANOR LLC			1
FACILITY Total					3
HOSPITAL	General Hospital	Tufts Medical Center			1
		Boston Medical Center			1
		Children's Hospital - Boston			1
HOSPITAL Total					3
INPATIENT MH	General Hospital-Psychiatric	Hampstead Outlook Inc dba Hampstead Hospital			1
	Mental Hospital	Brattleboro Retreat			1
	MH Partial Hospitalization-Adult	Brattleboro Retreat			1
	MH Residential Treatment - Child and Adolescent	Brattleboro Retreat			1
	Residential Treatment Facility, Emotionally Disturbed	Northern Human Services			1
INPATIENT MH Total					5
OTHER	Adult Day Care	Sarah Care Adult Dayservices			1
		The Homemakers Health Services			1
		VINTAGE GRACE			1
	Ambulance	Berlin EMS	NA	NA	1
	Customized Equipment	FULLER HAIR INC.	NA	NA	1
	Durable Medical Equipment & Medical Supplies	HUDSON HOME HEALTH CARE INC	NA	NA	1
		MINUTEMAN MEDICAL INC.	NA	NA	1
	Home Health	CITY OF BERLIN HEALTH DEPT	NA	NA	1
		Nurses PRN Inc	NA	NA	1
		The Homemakers Health Services			1
	Home Health Agency	Healthy At Home, Inc	NA	NA	1
		Interim Healthcare	NA	NA	6
		J and K Staffing Solutions	NA	NA	1
		Personal Touch Home Aider of Greater Portsmouth Inc	NA	NA	1
		Personal Touch Home Care of Greater Portsmouth Inc	NA	NA	1
		Valley Regional Hospital		NA	1
	Land Transport	CarePlus Ambulance Service Inc	NA	NA	1
	Medical Supplier (Medical Supplier, DME, & Prosthe	180 Medical Inc	NA	NA	1
		Herron & Smith Inc	NA	NA	1
		Next Step Orthotics & Prosthetics Inc	NA	NA	1
		Prentke Romich Company	NA	NA	1
		Renew Medical Services LLC	NA	NA	1
	Non-emergency Medical Transport (VAN)	SEACOAST CHAIR CAR SERVICE LLC	NA	NA	1
	Non-Hospital Connected Lab	Bio Reference Labs Inc & Subs			1
		Cytocheck Laboratory LLC	NA	NA	1
	Optician	Sunshine Eyeware LLC	Carleton	Sonja	1
		TREMAINE OPTICIANS			1
	Optometrist	Fields of Vision Eye Care Inc	FIELDS	CHRIS	1
		Theravision Eye Care	TAO	WENHONG	2

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	CMHC	Behavioral Health & Dev Svcs of Strafford County dba Community Partners			5
		Center for Life Management	NA	NA	1
		Northern Human Services			1
		Riverbend Community Mental Health Inc			1
		Seacoast Mental Health Center, Inc.			1
		THE MENTAL HEALTH CENTER OF GREATER MANCHESTER			1
		West Central Behavioral Health			5
	Cognitive & Behavioral	Counseling Associates of New London PLLC	MORRELL	ROBERT	3
	Counselor	Pastoral Counseling Services	GOSS	LOIS	1
		Warren Street Family Counseling Svs Inc	FREESE	C	1
			TOWLE	SUSAN	1
	Developmental – Behavioral Pediatrics	Crotched Mountain Rehabilitation Center	COOLEY	WILLIAM	1
	Licensed Clinical Social Worker	Family Guidance Center of Milford	Barr	Donna	1
			Riemer	SUSAN	1
	Marriage & Family Therapist	Harmony Counseling PLLC	DUNN	MIRIAM	1
		Warren Street Family Counseling Svcs Inc	HATT	ROGER	1
		Warren Street Family Counseling Svs Inc	FITZGERALD	HELEN	1
			STROMBOM	TRACY	1
	Medical Services Clinic	DR SULS FAMILY & SPORTS MEDICINE	COSTIN	Kevin	1
		Habit Opco			2
		White Mountain Community Health Center			1
	Mental Health	Capital Valley Counseling Assoc Inc	MARK	THOMAS	1
		Counseling Associates of New London PLLC	Davis	Renee	3
			ESPOSITO	JIM	3
			HARRISON	BETSY	3
			Hayward	Lynn	3
			McClure	Martha	3
			MILLER	JAMIE	3
			Murray	Alexis	3
			Rossey	CHRISTOPHER	3
			Smeed	PRISCILLA	3
			Sweeney	JAMES	3
		Crotched Mountain Rehabilitation Center	JARZOMBEK	MICHAEL	1
		Donna Moore and Associates	MOORE	Donna	1
		Eileen Ross LCMHC	ROSS	EILEEN	1
		Families First Of The Greater Seacoast	Fifield	Peter	1
			Stout	JENNIFER	1
		Family Guidance Center of Milford	LEYTON VITIELLO	VALERIE	1
		Janet Cleary LCMHC	Cleary	Janet	1
		Life Choices Counseling	BOUTIN	MICHELLE	1
		Mariann Christ LCMHC	CHRIST	MARIANN	1
		Mount Washington Valley Psychological Services	ANDREWS	ERIC	1
			Horan	Mark	1

Q: 33 ATTACHMENT A
Providers under an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
		New England Pastoral Institute	HUFFORD	DAYL	2
		Pastoral Counseling Services	JOBIN	LISA	1
			ORZE	CAROL	1
			YOUKSTETTER	KATHY	1
		Phoenix Rising Counseling Services	RANDALL	PAULA	1
		Sara Lauren PhD	LAUREN	SARA	1
		Silverman and Associates	BONIFACE	DEBORA	2
			COLBY	LIZA	2
			FRIEDLER	DAVID	2
			SHIGO	ALBERT	2
		Warren Street Family Counseling Svcs Inc	LABOMBARD	JENNIFER	1
	Mental Health	THE MENTAL HEALTH CENTER OF GREATER MANCHESTER			1
	Mental Health Clinic	Northern Human Services			1
		Riverbend Community Mental Health Inc			1
		Seacoast Mental Health Center, Inc.			1
		THE MENTAL HEALTH CENTER OF GREATER MANCHESTER			1
		West Central Behavioral Health			1
	Mental Health Services	Northern Human Services			6
	MH-IOP	Brattleboro Retreat			1
	Physician Assistant	Behavioral Health and Developmental Services of Strafford County	BABATUNDE	IBIDUNNI	4
		Goodwin Community Health Center	BERNARD	DIANE	1
			GALLANT	KIMBERLY	1
			Martin	Maria	1
	Psychiatric Nurse Practitioner	Goodwin Community Health Center	Weston	Emily	1
	Psychiatric/Mental Health	Center for Life Management	BARNES	SUSAN	1
			DROUIN	CAROL	1
			Ebelacker	CYNTHIA	1
			ROSE	MARY	1
		Coos County Family Health Services	ELLIOTT	NORINE	1
		Pennie Kane APRN	KANE	PENNIE	1
		Warren Street Family Counseling Svs Inc	METCALF	AMY	1
	Psychiatric/Mental Health, Adult	Warren Street Family Counseling Svcs Inc	FIGUEROA	JUDY	1
	Psychiatric/Mental Health, Child & Adolescent	Goodwin Community Health Center	MOTE	Sandra	1
		Mary H Warren ARNP PLLC	WARREN	MARY	1
	Psychiatrist	Center for Life Management	Bostic	Jeff	1
	Psychiatry	Behavioral Health and Development Services of Strafford County	MAGUIRE	PAUL	4
			Wingate	Ted	4
		Behavioral Health and Developmental Services of Strafford County	ALLISTER	ROBERT	4
		Center for Life Management	BROWN	KENNETH	1
			DICESARE	Kevin	1
		Crotched Mountain Rehabilitation Center	KATRAGADDA	SREENIVAS	1
		Steven C Henricks MD PLLC	HENRICKS	Steven	1
	Psychiatry	Coos County Family Health Services	Annis	Chester	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	CMHC	Behavioral Health & Dev Svcs of Strafford County dba Community Partners			5
		Center for Life Management	NA	NA	1
		Northern Human Services			1
		Riverbend Community Mental Health Inc			1
		Seacoast Mental Health Center, Inc.			1
		THE MENTAL HEALTH CENTER OF GREATER MANCHESTER			1
		West Central Behavioral Health			1
	Cognitive & Behavioral	Counseling Associates of New London PLLC	MORRELL	ROBERT	5
	Counselor	Pastoral Counseling Services	GOSS	LOIS	3
		Warren Street Family Counseling Svs Inc	FREESE	C	1
			TOWLE	SUSAN	1
	Developmental – Behavioral Pediatrics	Crotched Mountain Rehabilitation Center	COOLEY	WILLIAM	1
	Licensed Clinical Social Worker	Family Guidance Center of Milford	Barr	Donna	1
			Riemer	SUSAN	1
	Marriage & Family Therapist	Harmony Counseling PLLC	DUNN	MIRIAM	1
		Warren Street Family Counseling Svcs Inc	HATT	ROGER	1
		Warren Street Family Counseling Svs Inc	FITZGERALD	HELEN	1
			STROMBOM	TRACY	1
	Medical Services Clinic	DR SULS FAMILY & SPORTS MEDICINE	COSTIN	Kevin	1
		Habit Opco			2
		White Mountain Community Health Center			1
	Mental Health	Capital Valley Counseling Assoc Inc	MARK	THOMAS	1
		Counseling Associates of New London PLLC	Davis	Renee	3
			ESPOSITO	JIM	3
			HARRISON	BETSY	3
			Hayward	Lynn	3
			McClure	Martha	3
			MILLER	JAMIE	3
			Murray	Alexis	3
			Rossey	CHRISTOPHER	3
			Smeed	PRISCILLA	3
			Sweeney	JAMES	3
		Crotched Mountain Rehabilitation Center	JARZOMBEK	MICHAEL	1
		Donna Moore and Associates	MOORE	Donna	1
		Eileen Ross LCMHC	ROSS	EILEEN	1
		Families First Of The Greater Seacoast	Fifield	Peter	1
			Stout	JENNIFER	1
		Family Guidance Center of Milford	LEYTON VITIELLO	VALERIE	1
		Janet Cleary LCMHC	Cleary	Janet	1
		Life Choices Counseling	BOUTIN	MICHELLE	1
		Mariann Christ LCMHC	CHRIST	MARIANN	1
		Mount Washington Valley Psychological Services	ANDREWS	ERIC	1
			Horan	Mark	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	Psychologist	April Weeks MA	Weeks	April	1
		Brian Jackson PhD	JACKSON	BRIAN	1
		Carignan, Edouard	Carignan	Edouard	1
		Counseling Associates of New London PLLC	BORCHERT	SUSAN	3
		Crotched Mountain Rehabilitation Center	FRYE	THOMAS	1
		Family Guidance Center of Milford			1
		Goodwin Community Health Center	ROSE	Sandra	1
		Manchester Psychological Associates	KELLY	LAURENCE	1
		Michaud, Ronald L	Michaud	Ron	1
		Mount Washington Valley Psychological Services	ANDREWS	ERIC	1
		Silverman and Associates	SILVERMAN	RICKEY	2
		udy Wilbur Albertson LCSW	WILBUR-ALBERTSON	JUDY	1
	Social Worker	Family Guidance Center of Milford	ALLEN	LAURENE	1
			LODDENGAARD	NANCY	1
		Warren Street Family Counseling Svs Inc	POTTER	KENNETH	1
OUTPATIENT MH Total					189
PCP	Adult Health	White Mountain Community Health Center	COTE	GLORIA	1
			NAGEL	MARY FRANCES	1
			RIFORGIATO	MARGARET MARY	1
	Adult Medicine	Crotched Mountain Rehabilitation Center	RODD	CAREY	1
	Family Medicine	Clinic Sans Frontiers	AVERY	JOHN	1
		Coos County Family Health Services	Benckendorf	Sandra	1
			BERTIN	SHANA	1
			BOURBEAU	JOSEE	1
			CARDENAS	JAVIER	1
			EATON	RAINA	1
			KERNAN	DONALD	1
			LAKE	CHRISTOPHER	1
			LANG	KENNETH	1
			MCDOWELL	JOHN	1
			MCLANE	ALICE	1
			ROSS	ELLEN	1
			SHUTE	KEITH	1
				PATRICIA	1
			SULLIVAN	MITCHELL	1
			TEMME	THOMAS	1
			TRACY	SHERRILL	1
		Coos County Family Health Services Inc	DONOVAN	KATHLEEN	1
		Deborah Glazer MD	GLAZER	DEBORAH	1
		Families First of the Greater Seacoast	KOOP	JENNIFER	1
			KRISTL	VIRGINIA	1
		Families First Of The Greater Seacoast	SLOCUM	ROBERT	1
		Goodwin Community Health Center	MACDONALD	HUGH	1

Q: 33 ATTACHMENT A
Providers under an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
			Molnar-Gabor	Steven	1
			THOMPSON	MICHAEL	1
			Zent	Kevin	1
		Health First Family Care Center	Wehbi	Fadi	1
			YOUNGS	Steven	1
		LAMPREY HEALTH CARE INC	BERGERON-KILLOUGH	KATRIN	1
			Bonafede	Katherine	1
			BUJNO	LISA	1
			CORRIGAN	KATHLEEN	1
			CRUSBERG	HEIDI	1
			FRIEDRICHS	PAUL	1
			HEATHERTON	CHRISTOPHER	1
			JAMES	JEREMY	1
			JANEWAY	Barbara	1
			JOHNSON	MARY	1
			JONES	Steven	1
			LACEY	ANNE	1
			MANNING	CAROL	2
			MERRILL	PRISCILLA	1
			NAGARAJ	VASUKI	1
			NICHOLS	SUSAN	1
			SCULLY	EDWARD	1
			SHARMA	AJAY	1
			SMITH	ROSEMARY	1
			TILTON	COLETTE	1
			WOOD-FRIEND	AMANDA	1
			ZACHOS	SARAH	1
		LATHAM, BRUCE DO	LATHAM	BRUCE	1
		Linwood Medical Associates	FELGATE	RODNEY	1
		Montague Family Medicine PLLC	MONTAGUE	LAURIE	1
		White Mountain Community Health Center	DARGIS	BRIGITTE	1
			WHELLEY	SARAH	1
	Family Nurse Practitioner	Families First Of The Greater Seacoast	Hasselbrack	Kerry	1
			SMITH	VIRGINIA	1
		Health First Family Care Center	RIDINGER	ELIZABETH	1
			SMITH	TODD	1
	Family Planning Center	Avis Goodwin Community Health Center			1
	Family Practice Nurse Practitioner	Families First Of The Greater Seacoast	HENNING	LYNNE	1
	Family Nurse Practitioner	Goodwin Community Health Center	Cox	Martha	1
	FQHC	Avis Goodwin Community Health Center			1
	Internal Medicine	Coos County Family Health Services	PERRY	DEBRA	1
		Falyaz Hakim MD	Hakim	Falyaz	1
		Internal Medicine of Milfor	BOWER	GEORGE	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	Psychologist	April Weeks MA	Weeks	April	1
		Brian Jackson PhD	JACKSON	BRIAN	1
		Carignan, Edouard	Carignan	Edouard	1
		Counseling Associates of New London PLLC	BORCHERT	SUSAN	3
		Crotched Mountain Rehabilitation Center	FRYE	THOMAS	1
		Family Guidance Center of Milford			1
		Goodwin Community Health Center	ROSE	Sandra	1
		Manchester Psychological Associates	KELLY	LAURENCE	1
		Michaud, Ronald L	Michaud	Ron	1
		Mount Washington Valley Psychological Services	ANDREWS	ERIC	1
		Silverman and Associates	SILVERMAN	RICKEY	2
		udy Wilbur Albertson LCSW	WILBUR-ALBERTSON	JUDY	1
	Social Worker	Family Guidance Center of Milford	ALLEN	LAURENE	1
			LODDENGAARD	NANCY	1
		Warren Street Family Counseling Svs Inc	POTTER	KENNETH	1
OUTPATIENT MH Total					189
PCP	Adult Health	White Mountain Community Health Center	COTE	GLORIA	1
			NAGEL	MARY FRANCES	1
			RIFORGIATO	MARGARET MARY	1
	Adult Medicine	Crotched Mountain Rehabilitation Center	RODD	CAREY	1
	Family Medicine	Clinic Sans Frontiers	AVERY	JOHN	1
		Coos County Family Health Services	Benckendorf	Sandra	1
			BERTIN	SHANA	1
			BOURBEAU	JOSEE	1
			CARDENAS	JAVIER	1
			EATON	RAINA	1
			KERNAN	DONALD	1
			LAKE	CHRISTOPHER	1
			LANG	KENNETH	1
			MCDOWELL	JOHN	1
			MCLANE	ALICE	1
			ROSS	ELLEN	1
			SHUTE	KEITH	1
				PATRICIA	1
			SULLIVAN	MITCHELL	1
			TEMME	THOMAS	1
			TRACY	SHERRILL	1
		Coos County Family Health Services Inc	DONOVAN	KATHLEEN	1
		Deborah Glazer MD	GLAZER	DEBORAH	1
		Families First of the Greater Seacoast	KOOP	JENNIFER	1
			KRISTL	VIRGINIA	1
		Families First Of The Greater Seacoast	SLOCUM	ROBERT	1
		Goodwin Community Health Center	MACDONALD	HUGH	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	Nurse Practitioner	Warren Street Family Counseling Svs Inc	MOULTON	ELIZABETH	1
	Obstetrics & Gynecology	Coos County Family Health Services	BURLESON	NANCY	1
			KULL	STEPHEN	1
			PLOCIENNIK	KRSZYZTOFF	1
		Families First of the Greater Seacoast	CHAG	Mark	1
			KINGSTON	MARGOT	1
			LANTINEN	ALBERT	1
		Goodwin Community Health Center	ARNOLD	COLENE	1
		John P Sauter MD	SAUTER	JOHN	1
		LAMPREY HEALTH CARE INC	PRUNA	SIRONA	2
		Manchester OBGYN Associates	CHALIFOUR	ANN	1
			CLARK	NANCY	1
			DIORIO	ANGELA	1
			DONOFRIO	JENNIFER	1
			GOLDNER	WAYNE	1
			MEINZ	HEIDI	1
			SANBORN	BRENDA	1
			WASSERMAN	GARY	1
	Osteopath, Individual	Buzzell, Keith A DO	Buzzell	KEITH	1
		Candelore, AJ	Candelore	A	1
		Stephen R Brennan DO PA	Brennan	STEPHEN	1
	Pediatric Nurse Practitioner	Families First Of The Greater Seacoast	Spuler	Charae	1
	Pediatrics	Coos County Family Health Services	BEALS	BRIAN	1
			CHAREST	JEANNE	1
		Crotched Mountain Rehabilitation Center	MCGONAGLE	JAN	1
		Crotched Mountain Rehabilitation Center	MCCARTIE	JOHN	1
		Deepak Sharma MD	SHARMA	DEEPAK	1
		LAMPREY HEALTH CARE INC	OXNARD	SARAH	1
		Swing for the Stars	JONES	JAMIE	1
		We Care Pediatrics, Inc.	ARORA	PRIYANKA	1
			FENDER	TRACEY	1
			ROTH	CATHERINE	1
		White Mountain Community Health Center	FLANAGAN-ROGERS	SHARYN	1
	Planned Parenthood Clinic	Ammonoosuc Community Health Services Inc			1
		Ammonoosuc Family Hlth Inc			1
		Coos County Family Health Services, Inc			1
	Primary Care	DR SULS FAMILY & SPORTS MEDICINE	FAHEY	MARY LYNN	1
	Primary Care Nurse Practitioner	Health First Family Care Center	ZAKORCHEMNY	LAURA	1
	Rural Health Clinic	Ammonoosuc Community Health Services Inc			1
		Avis Goodwin Community Health Center			1
		Coos County Family Health Services Inc			1
		Families First Of The Greater Seacoast			2
		Health First Family Care Center			2

Q: 33 ATTACHMENT A
Providers under an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
		Lamprey Health Care at Healthy Connections			1
		LAMPREY HEALTH CARE INC			3
	Womens Health	Coos County Family Health Services	CHEVARIE	Janet	1
PCP Total					122
PHARMACY	Community/Retail Pharmacy	The Medicine Store Pharmacy	NA	NA	1
	Community/Retail Pharmacy	The Medicine Store Pharmacy	DONOVAN	MARTIN	1
	Pharmacy	Accredo Health Groupinc			1
		CARE PHARMACY INC	NA	NA	3
		CARE PHARMACY OF DOVER INC	NA	NA	1
		Critical Care Systems			1
		Northeast Pharmacy Services Llc			1
		Walgreens-Bedford			1
		Walgreens-Concord			1
		Walgreens-Derry			1
		Walgreens-Dover			1
		Walgreens-East Hampstead			1
		Walgreens-Epping			1
		Walgreens-Exeter			1
		Walgreens-Hampton			1
		Walgreens-Hooksett			1
		Walgreens-Hudson			1
		Walgreens-Keene			1
		Walgreens-Laconia			1
		Walgreens-Lee			1
		Walgreens-Littleton			1
		Walgreens-Londonderry			1
		Walgreens-Manchester			2
		Walgreens-Merrimack			1
		Walgreens-Milford			1
		Walgreens-Nashua			3
		Walgreens-North Conway			1
		Walgreens-Pelham			1
		Walgreens-Raymond			1
		Walgreens-Rochester			1
		Walgreens-Salem			1
		Walgreens-Tilton			1
		Walgreens-Walpole			1
		Walgreens-West Lebanon			1
PHARMACY Total					39
SPECIALIST	Advanced Practice Midwife	Goodwin Community Health Center	NIKKEL	MONTE	1
		LAMPREY HEALTH CARE INC	ROWLSON	MARISA	1
	Anesthesiology	Anesthesia Care Group PC	BOGURSKY	STEPHEN	1
			CORMACK	JAMES	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
	Nurse Practitioner	Warren Street Family Counseling Svs Inc	MOULTON	ELIZABETH	1
	Obstetrics & Gynecology	Coos County Family Health Services	BURLESON	NANCY	1
			KULL	STEPHEN	1
			PLOCIENNIK	KRSZYZTOFF	1
		Families First of the Greater Seacoast	CHAG	Mark	1
			KINGSTON	MARGOT	1
			LANTINEN	ALBERT	1
		Goodwin Community Health Center	ARNOLD	COLENE	1
		John P Sauter MD	SAUTER	JOHN	1
		LAMPREY HEALTH CARE INC	PRUNA	SIRONA	2
		Manchester OBGYN Associates	CHALIFOUR	ANN	1
			CLARK	NANCY	1
			DIORIO	ANGELA	1
			DONOFRIO	JENNIFER	1
			GOLDNER	WAYNE	1
			MEINZ	HEIDI	1
			SANBORN	BRENDA	1
			WASSERMAN	GARY	1
	Osteopath, Individual	Buzzell, Keith A DO	Buzzell	KEITH	1
		Candelore, Al	Candelore	A	1
		Stephen R Brennan DO PA	Brennan	STEPHEN	1
	Pediatric Nurse Practitioner	Families First Of The Greater Seacoast	Spuler	Charae	1
	Pediatrics	Coos County Family Health Services	BEALS	BRIAN	1
			CHAREST	JEANNE	1
		Crotched Mountain Rehabilitation Center	MCGONAGLE	JAN	1
		Crotched Mountain Rehabilitation Center	MCCARTIE	JOHN	1
		Deepak Sharma MD	SHARMA	DEEPAK	1
		LAMPREY HEALTH CARE INC	OXNARD	SARAH	1
		Swing for the Stars	JONES	JAMIE	1
		We Care Pediatrics, Inc.	ARORA	PRIYANKA	1
			FENDER	TRACEY	1
			ROTH	CATHERINE	1
		White Mountain Community Health Center	FLANAGAN-ROGERS	SHARYN	1
	Planned Parenthood Clinic	Ammonoosuc Community Health Services Inc			1
		Ammonoosuc Family Hlth Inc			1
		Coos County Family Health Services, Inc			1
	Primary Care	DR SULS FAMILY & SPORTS MEDICINE	FAHEY	MARY LYNN	1
	Primary Care Nurse Practitioner	Health First Family Care Center	ZAKORCHEMNY	LAURA	1
	Rural Health Clinic	Ammonoosuc Community Health Services Inc			1
		Avis Goodwin Community Health Center			1
		Coos County Family Health Services Inc			1
		Families First Of The Greater Seacoast			2
		Health First Family Care Center			2

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
			DANA	JAMES	1
			DEL GIUDICE	PAUL	1
			FAZZONE	ANTHONY	1
			KELLY	DENNIS	1
			NA	NA	1
			POUTRE	TIMOTHY	1
			STEEVES	GLEN	1
			WAGNER	DAVID	1
	Asthma / Allergy	Families First of the Greater Seacoast	Duelle	Barbara	1
	Audiologist	Fodero, Sally	Fodero	Sally	1
	Birthing	BIRTH COTTAGE OF MILFORD			1
	Case Management	CROTCHED MOUNTAIN COMMUNITY CARE			1
		Northern Human Services			1
	Certified Midwife (Non-Nurse)	BIRTH COTTAGE OF MILFORD	BOWMAN	TRACEY	1
			Feldhusen	Adrian	1
			Vergo	Autumn	1
	Chap Clinic	Ammonoosuc Community Health Services Inc			1
		Ammonoosuc Family Hlth Inc			1
		Coos County Family Health Services Inc			1
		Families First Of The Greater Seacoast			1
		White Mountain Community Health Center			1
	Child & Adolescent Psychiatry	Behavioral Health and Developmental Services of Strafford County	FECTEAU	JAMES	4
	Chiropractor	Bard Chiropractic	BARD	AARON	1
		Family Chiropractic Center	KWASNIEWSKI	DIANE	1
	Dental	Avis Goodwin Community Health Center			2
		White Mountain Community Health Center			1
	Dentist	Goodwin Community Health Center	GOODE	WHITNEY	1
			SLAUGHTER	LISA	1
	Dermatology	Families First of the Greater Seacoast	SISTO	JOAN	1
	Dietitian, Registered	Nutrition Matters	ENGLE	SUSAN	1
		Patricia Murray Derr RD	MURRAY-DERR	PATRICIA	2
	General Surgery	Paul J Harper MD PA	HARPER	PAUL	1
	Hematology & Oncology	Drs Paul and Sonneborn PA	PAUL	Steven	2
			SONNEBORN	HENRY	2
	Midwife	(blank)	WHITE	LUCY	1
	Multi-Specialty	Families First Of The Greater Seacoast			1
	Neuromusculoskeletal Medicine & OMM	T MURRAY WELLNESS CENTER INC	Murray	PATRICIA	2
	Occupational Therapist	Healthy At Home, Inc	Recke	Suzanne	1
		Kids Therapy Company	HERRHOLZ	LISA	1
		Strafford Health Alliance	LAPIERRE	JEFFREY	1
			Miles	MARY	1
			RIGOR DA EVA	Donna	1
			WILSON	KRISTIN	1

Q: 33 ATTACHMENT A
Providers under an LOI

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
		Swing for the Stars	Christiansen	Cedra	1
			HEATH	JODELLE	1
			Thunberg	Megan	1
	Occupational Therapy	Swing for the Stars	BURTON	LAURIE	1
	Occupational Therapy	Swing for the Stars	MORAN	HEATHER	1
	Orthodontics and Dentofacial Orthopedics	Fred W Salvatoriello DMD	SALVATORIELLO	FRED	3
	Orthopedic	Strafford Health Alliance	GORAYEB	KAREN	1
	Parenteral & Enteral Nutrition	PHARMERICA INSTITUTIONAL PHARMACY SERVICES LLC			1
	Physical Medicine & Rehabilitation	Crotched Mountain Rehabilitation Center	CHIAPPINI	ROCCO	1
	Physical Therapist	Adams Physical Therapy and Sports Rehabilitation	ADAMS	ERIC	1
				TRACY	1
		Diane Kleist PT	KLEIST	DIANE	1
		Healthy At Home, Inc	Hendrickson	KAREN	1
			Hinton	BRIAN	1
		New Boston Physical Therapy LLC	EBERHARDT	ANTHONY	1
		ProEx Physical Therapy	COMPAGNONE	GINO	1
			KEYSER	SARAH	1
			MARTYN	HEATHER	1
			MCMANUS	JESSICA	1
				NICOLE	1
			THOMAS	DAN	1
					1
		Scaccia Physical Therapy and Sports Conditioning LLC	Marotta	Emily	1
			SCACCIA	ROBERT	1
		Strafford Health Alliance	ABBETT	DAVID	1
			BOURN	C.	1
			FERNALD	DEBORAH	1
			Gagne	Melissa	1
			Henry	Julia	1
			KOH	ROBERT	1
			LAUZE	JOHN	1
			Lawson	JAMES	1
			MCAVOY	RICHARD	1
			NA	NA	1
			PLANTE	NICOLE	1
			PORTER	CYNTHIA	1
			QUINT	DAVID	1
			ROWLEY	KRISTIE	1
			SLOVENSKI	GEOFFREY	1
			TOWLE	DEBORAH	1
		Universal Physical Therapy	CHERRY	Sandra	1
			Couitt	AMANDA	1
			KOUMRIAN	SHANE	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
			DANA	JAMES	1
			DEL GIUDICE	PAUL	1
			FAZZONE	ANTHONY	1
			KELLY	DENNIS	1
			NA	NA	1
			POUTRE	TIMOTHY	1
			STEEVES	GLEN	1
			WAGNER	DAVID	1
	Asthma / Allergy	Families First of the Greater Seacoast	Duelle	Barbara	1
	Audiologist	Fodero, Sally	Fodero	Sally	1
	Birthing	BIRTH COTTAGE OF MILFORD			1
	Case Management	CROTCHED MOUNTAIN COMMUNITY CARE			1
		Northern Human Services			1
	Certified Midwife (Non-Nurse)	BIRTH COTTAGE OF MILFORD	BOWMAN	TRACEY	1
			Feldhusen	Adrian	1
			Vergo	Autumn	1
	Chap Clinic	Ammonoosuc Community Health Services Inc			1
		Ammonoosuc Family Hlth Inc			1
		Coos County Family Health Services Inc			1
		Families First Of The Greater Seacoast			1
		White Mountain Community Health Center			1
	Child & Adolescent Psychiatry	Behavioral Health and Developmental Services of Strafford County	FECTEAU	JAMES	4
	Chiropractor	Bard Chiropractic	BARD	AARON	1
		Family Chiropractic Center	KWASNIEWSKI	DIANE	1
	Dental	Avis Goodwin Community Health Center			2
		White Mountain Community Health Center			1
	Dentist	Goodwin Community Health Center	GOODE	WHITNEY	1
			SLAUGHTER	LISA	1
	Dermatology	Families First of the Greater Seacoast	SISTO	JOAN	1
	Dietitian, Registered	Nutrition Matters	ENGLE	SUSAN	1
		Patricia Murray Derr RD	MURRAY-DERR	PATRICIA	2
	General Surgery	Paul J Harper MD PA	HARPER	PAUL	1
	Hematology & Oncology	Drs Paul and Sonneborn PA	PAUL	Steven	2
			SONNEBORN	HENRY	2
	Midwife	(blank)	WHITE	LUCY	1
	Multi-Specialty	Families First Of The Greater Seacoast			1
	Neuromusculoskeletal Medicine & OMM	T MURRAY WELLNESS CENTER INC	Murray	PATRICIA	2
	Occupational Therapist	Healthy At Home, Inc	Recke	Suzanne	1
		Kids Therapy Company	HERRHOLZ	LISA	1
		Strafford Health Alliance	LAPIERRE	JEFFREY	1
			Miles	MARY	1
			RIGOR DA EVA	Donna	1
			WILSON	KRISTIN	1

PROVIDERS UNDER A BMCHP LOI

PROV TYPE	Specialty	Legal Entity	P Last	P FIRST	Total
			SHERMAN	AIMEE	1
	Physical Therapy	ProEx Physical Therapy			1
	Podiatrist	Ankle and Foot Center	BONENBERGER	HOWARD	1
		Coos County Family Health Services	BEDARD-RYAN	MADELEINE	1
	Preventive Medicine/Occupational Environmental Me	Strafford Health Alliance	MILOSAVLJJEVIC	TATJANA	1
	Speech Therapist	Swing for the Stars	Chadwick	Tiffany	1
			Neal	NICOLE	1
			Pelletier	Emily	1
	Sports Medicine	DR SULS FAMILY & SPORTS MEDICINE			1
SPECIALIST Total					109
Grand Total					519

Exhibit 6.5.D

Q 33: ACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
General Hospital	Alice Peck Day Memorial Hospital			1
	Androscoggin Memorial Hospital			1
	Concord Hospital			1
	Cottage Hospital			1
	Dartmouth Hitchcock Regional Medical Center			1
	ELLIOT HOSPITAL			1
	Franklin Regional Hospital			1
	Huggins Hospital			1
	Lakes Regional Hospital			1
	Mary Hitchcock Memorial Hospital			1
	Monadnock Community Hospital			1
	New London Hospital			1
	SOUTHERN NEW HAMPSHIRE MEDICAL CENTER			1
	ST. JOSEPH HOSPITAL			1
	Tufts Medical Center			1
	UPPER CONNECTICUT VALLEY HOSPITAL			1
	Valley Regional Hospital			1
	WEEKS MEDICAL CENTER			1
Addiction (Substance Use	Concord Hospital	MARTIN	KATHLEEN	1
Adolescent Medicine	ROCHESTER PEDIATRICS	DUTTON	PATRICIA	1
Adult Day Care	Easter Seals Nh Ad Medical			1
Adult Day Care	ELLIOT ADULT DAY CARE			1
Adult Health				1
Adult Health		HORDIS	CAROL	1
Adult Health		COOPER-PIELA	REBECCA	1
Adult Reconstructive Ort	FOUR SEASONS ORTHOPEDIC CENTER, PA	BATISSA LENAHAN	GAIL	1
Advanced Practice Midwife		HOGAN	KATHLEEN	1
Advanced Practice Midwife		MURPHY-FITCH	KAREN	1
Allergy		COUYOU	DEBRA	1
Allergy & Immunology	Dartmouth Hitchcock Clinic	VORE	JON	1
Ambulance	CITY OF CONCORD			1
Ambulance	FRISBIE MEMORIAL HOSPITAL			1
Ambulance Service/Whe	Trilogy Wheelchair Transport & Eldercare			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Ambulance Service/Whe	Laconia Fire Department			1
Ambulance Service/Whe	Easter Seal Society of NH			1
Ambulatory Surgical	LRGHEALTHCARE			1
Ambulatory Surgical	DARTMOUTH-HITCHCOCK CLINIC			1
Ambulatory Surgical	DARTMOUTH HITCHCOCK CLINIC			1
Ambulatory Surgical	ELLIOT 1 DAY SURGERY CENTER			1
Ambulatory Surgical	LRGHEALTHCARE			1
Ambulatory Surgical Cen	Sjh Surgicenter Llc			1
Anatomic Pathology & Cl	Concord Hospital			1
Anatomic Pathology & Cl	Concord Hospital	TRANSUE	SARAH	1
Anesthesiology	LRGHealthcare			1
Athletic Trainer		MEYER	ERIC	1
Audiologist	ENT Associates of NH	LABORE	LINDSAY	1
Audiologist	ENT ASSOCIATES OF NH	DAGNON	CHERYL	1
Cardiovascular Disease	Dartmouth Hitchcock Clinic	MCARDLE	SHAUN	1
Cardiovascular Disease		MONOSON	PETER	1
Cardiovascular Disease		O'ROURKE	DANIEL	1
Cardiovascular Disease		ENDO	YUKA	1
Cardiovascular Disease		CARDEIRO	WENDI	1
Cardiovascular Disease	CATHOLIC MEDICAL CENTER PPA	SCHWARTZ	STEVEN	1
Child & Adolescent Psych	Easter Seals New Hampshire			1
Clinical	Easter Seals New Hampshire	WINGATE	WALTER	1
Clinical Neurophysiology		SEIFERT	BERNADETTE	1
Clinical Nurse Specialist	LRGHealthcare	LESSER	EUGENE	1
Colon & Rectal Surgery		ROWLEY	JANICE	1
Community/Retail Pharm	MARY HITCHCOCK MEMORIAL HOSPITAL	FRIEL	JOHN	1
Counselor				1
Critical Access	FRANKLIN REGIONAL HOSPITAL	DAHL	SHEILA	1
Critical Access	MONADNOCK COMMUNITY HOSPITAL			1
Critical Access	WEEKS MEDICAL CENTER			1
Critical Access	COTTAGE HOSPITAL INC			1
Critical Access	COTTAGE HOSPITAL ICTT			1
Critical Access	COTTAGE HOSPITAL			1

Q 33[redacted]CHMENT A
Provide[redacted]s Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
General Hospital	Alice Peck Day Memorial Hospital			1
	Androscoggin Memorial Hospital			1
	Concord Hospital			1
	Cottage Hospital			1
	Dartmouth Hitchcock Regional Medical Center			1
	ELLIOT HOSPITAL			1
	Franklin Regional Hospital			1
	Huggins Hospital			1
	Lakes Regional Hospital			1
	Mary Hitchcock Memorial Hospital			1
	Monadnock Community Hospital			1
	New London Hospital			1
	SOUTHERN NEW HAMPSHIRE MEDICAL CENTER			1
	ST. JOSEPH HOSPITAL			1
	Tufts Medical Center			1
	UPPER CONNECTICUT VALLEY HOSPITAL			1
	Valley Regional Hospital			1
	WEEKS MEDICAL CENTER			1
Addiction (Substance Use	Concord Hospital	MARTIN	KATHLEEN	1
Adolescent Medicine	ROCHESTER PEDIATRICS	DUTTON	PATRICIA	1
Adult Day Care	Easter Seals Nh Ad Medical			1
Adult Day Care	ELLIOT ADULT DAY CARE			1
Adult Health				1
Adult Health		HORDIS	CAROL	1
Adult Health		COOPER-PIELA	REBECCA	1
Adult Reconstructive Ort	FOUR SEASONS ORTHOPEDIC CENTER, PA	BATISSA LENAHAN	GAIL	1
Advanced Practice Midwife		HOGAN	KATHLEEN	1
Advanced Practice Midwife		MURPHY-FITCH	KAREN	1
Allergy		COUYOU	DEBRA	1
Allergy & Immunology	Dartmouth Hitchcock Clinic	VORE	JON	1
Ambulance	CITY OF CONCORD			1
Ambulance	FRISBIE MEMORIAL HOSPITAL			1
Ambulance Service/Whe	Trilogy Wheelchair Transport & Eldercare			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Critical Access	HUGGINS HOSPITAL			1
Critical Access	ALICE PECK DAY MEMORIAL HOSPITAL			1
Critical Care Medicine				1
Critical Care Medicine	ELLIOT PROFESSIONAL SERVICES	DAIGLE	CHRISTOPHER	1
Critical Care Medicine				1
Critical Care Medicine		CURLEY	MATTHEW	1
Dermatology	LRGHealthcare	HOU	JOSEPH	1
Dermatology		WATERSON	K	1
Dermatology		POSNICK	ROBERT	1
Dermatology		LICHTER	MICHAEL	1
Diagnostic Radiology	ORTHOPEDIC PROFESSIONAL ASSOCIATION	GORDON	ROBERT	1
Diagnostic Radiology	LAKES REGION RADIOLOGY PA			1
Diagnostic Radiology	ELLIOT PROFESSIONAL SERVICES			1
Dietitian, Registered	Dartmouth Hitchcock Clinic			1
Dietitian, Registered	Londonderry Family Practice and Derry Medical Center	LAYTON	TINA	1
Distinct Part Unit - Rehab	Valley Regional Hospital 0 0 0	MULLER	LORI	1
Distinct Part Unit - Rehab	St Joseph Hospital			1
Distinct Part Unit - Rehab	Mary Hitchcock Memorial Hospital			1
Distinct Part Unit - Rehab	Lakes Region Generalhospital			1
Distinct Part Unit - Rehab	Dartmouth-Hitchcock			1
Distinct Part Unit - Rehab	Concord Hospital Inc			1
Durable Medical Equipm	LRGHEALTHCARE			1
Durable Medical Equipm	CORE HEALTH SERVICES INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	ELLIOT HOSPITA			1
Durable Medical Equipm	FOUNDTION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS			1
Durable Medical Equipm	LRGHEALTHCARE			1
Durable Medical Equipm	ANDROSCOGGIN VALLEY HOSPITAL			1
Emergency Care	Elliot Health Systems			1
Emergency Medical Servi	GREATER NASHUA EMERGENCY PHYSICIANS PC			1
Emergency Medical Servi	GREATER NASHUA EMERGENCY PHYSICIANS PC	HOFFMAN	ERIC	1
Emergency Medical Servi	GREATER NASHUA EMERGENCY PHYSICIANS PC	ROW	PETER	1
Emergency Medical Servi	GREATER NASHUA EMERGENCY PHYSICIANS PC	KRUPP	CHRISTOPHER	1
Emergency Medical Servi	EMERGENCY PHYSICIANS OF DERRY PLLC			1
Emergency Medical Servi	EMERGENCY PHYSICIANS OF DERRY PLLC	JORDAN	RACHEL	1
Emergency Medicine	Elliot Health Systems			1
Emergency Medicine		THOMAS	MICHAEL	1
Emergency Medicine		WU	MELISSA	1
Emergency Medicine	St. Joseph Hospital	STAHL	SIMONNE	1
Emergency Medicine	Elliot Health Systems	YOUNG	HARRIET	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	SMALL	ANDREW	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	SWEENEY	BRIAN	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	GILSTON	RICHARD	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	KOSSAYDA	NORMAN	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	MUDAN	PUSHPA	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	RUSESKI	PETER	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	LOVERRO	WILLIAM	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	GOULD	PETER	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	MARTIN	JAMES	1
Emergency Medicine	GREATER NASHUA EMERGENCY PHYSICIANS PC	LOHNES	BRIAN	1
Emergency Medicine	Elliot Health Systems	SWEENY	ANGELA	1
Emergency Medicine	Elliot Health Systems	DIRITO-HERBERT	NICOLA	1
Emergency Medicine	Elliot Health Systems	SETNIK	LON	1
Emergency Medicine	Elliot Health Systems	ELDER	NATHAN	1
Emergency Medicine	Elliot Health Systems	KING	RICHARD	1

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Critical Access	HUGGINS HOSPITAL			1
Critical Access	ALICE PECK DAY MEMORIAL HOSPITAL			1
Critical Care Medicine				1
Critical Care Medicine	ELLIOT PROFESSIONAL SERVICES	DAIGLE	CHRISTOPHER	1
Critical Care Medicine				1
Critical Care Medicine		CURLEY	MATTHEW	1
Dermatology	LRGHealthcare	HOU	JOSEPH	1
Dermatology		WATERSON	K	1
Dermatology		POSNICK	ROBERT	1
Dermatology		LICHTER	MICHAEL	1
Diagnostic Radiology	ORTHOPEDIC PROFESSIONAL ASSOCIATION	GORDON	ROBERT	1
Diagnostic Radiology	LAKES REGION RADIOLOGY PA			1
Diagnostic Radiology	ELLIOT PROFESSIONAL SERVICES			1
Dietitian, Registered	Dartmouth Hitchcock Clinic			1
Dietitian, Registered	Londonderry Family Practice and Derry Medical Center	LAYTON	TINA	1
Distinct Part Unit - Rehab	Valley Regional Hospital 0 0 0	MULLER	LORI	1
Distinct Part Unit - Rehab	St Joseph Hospital			1
Distinct Part Unit - Rehab	Mary Hitchcock Memorial Hospital			1
Distinct Part Unit - Rehab	Lakes Region Generalhospital			1
Distinct Part Unit - Rehab	Dartmouth-Hitchcock			1
Distinct Part Unit - Rehab	Concord Hospital Inc			1
Durable Medical Equipm	LRGHEALTHCARE			1
Durable Medical Equipm	CORE HEALTH SERVICES INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	ELLIOT HOSPITA			1
Durable Medical Equipm	FOUNDTION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1
Durable Medical Equipm	FOUNDATION MEDICAL PARTNERS INC			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Emergency Medicine	Elliot Health Systems	DAPRIX	THOMAS	1
Emergency Medicine	Elliot Health Systems	WEINER	MARC	1
Emergency Medicine	Elliot Health Systems	HEFFERNAN	THOMAS	1
Emergency Medicine	Elliot Health Systems	GUARNACCIA	JOSEPH	1
Emergency Medicine	Elliot Health Systems	SEIDNER	JOHN	1
Emergency Medicine	Elliot Health Systems	MARCUCCI	RICHARD	1
Emergency Medicine	Elliot Health Systems	HIGH	JAMES	1
Emergency Medicine	Elliot Health Systems	BAXTER	WILLIAM	1
Emergency Medicine	ELLIOT PROFESSIONAL SERVICES			1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC			1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DWYER	PATRICIA	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DURCAN	MARK	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	WAGNER	HENRY	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	SCOTT	THOMAS	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DELORIE	AMY	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	LE	DA	1
Emergency Medicine	CONCORD HOSPITAL	CERUNDOLO	AIDA	1
Endocrinology, Diabetes	St. Joseph Hospital			1
Endocrinology, Diabetes & Metabolism		SPATOLA	ELIZABETH JANE	1
Endocrinology, Diabetes & Metabolism		SILVER	ROBERT	1
Endocrinology, Diabetes & Metabolism		GUSEVA	NINA	1
Endoscopy	CONCORD ENDOSCOPY CENTER LLC	CHUANG	ELLIE	1
Family				1
Family	Concord Hospital	GUST	SUSAN	1
Family	Dartmouth Hitchcock Clinic	BUCKLEY	SUSAN	1
Family	Dartmouth Hitchcock Clinic	PRESNELL	MELANIE	1
Family		COMPAGNA	ROBERTA	1
Family		GEBHARDT	DEBORAH	1
Family		FORTIN	CELINE	1
Family		BANGHART	ANNE	1
Family	Elliot Health Systems	GREBUS	COLLEEN	1
Family		FERNALD	ERIN	1
Family		DORAN	DOROTHY	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Family	Concord Hospital	PORFIDO-BELLISLE	MARTHA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	BEAUDET	LINDA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MURAI	SARAH	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	WHEELER	JOHN	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	KILROY	JONATHAN	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	LYNCH	GREGORY	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	BROOKS	THEODORE	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	DALEY	JOHN	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MACKINNON	DIANE	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	HAND	CHRISTINE	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	NORTHCUTT	ALBERT	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	WELTER	JOHN	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	RORK	DENNIS	1
Family Medicine		EGENOLF	CRISTI	1
Family Medicine		THYNG	DARLA	1
Family Medicine		ZIELINSKA	ANNA	1
Family Medicine		ZINNES	ROBERT	1
Family Medicine		VORE	JON MICHAEL	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	LURVEY	GABRIEL	1
Family Medicine		LIU	SHUWEI	1
Family Medicine		MARGOLIS	DEBRA	1
Family Medicine		HENEGHAN	HELEN	1
Family Medicine		GUIRY	COLLEEN	1
Family Medicine		BUCHANAN	JOHN	1
Family Medicine		DUXBURY	MELISSA	1
Family Medicine		KRAMER	RYAN	1
Family Medicine		BUENO	ELEANOR	1
Family Medicine		SIXON	JONATHAN	1
Family Medicine	Catholic Medical Center	DAGOSTINO	ROBERT	1
Family Medicine	ELLIOT PHYSICIANS NETWORK	ONG	MARICHI	1
Family Medicine	ELLIOT PHYSICIANS NETWORK			1
Family Medicine				1
Family Medicine		JACOB	ABRAHAM	1

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Emergency Medicine	Elliot Health Systems	DAPRIX	THOMAS	1
Emergency Medicine	Elliot Health Systems	WEINER	MARC	1
Emergency Medicine	Elliot Health Systems	HEFFERNAN	THOMAS	1
Emergency Medicine	Elliot Health Systems	GUARNACCIA	JOSEPH	1
Emergency Medicine	Elliot Health Systems	SEIDNER	JOHN	1
Emergency Medicine	Elliot Health Systems	MARCUCCI	RICHARD	1
Emergency Medicine	Elliot Health Systems	HIGH	JAMES	1
Emergency Medicine	Elliot Health Systems	BAXTER	WILLIAM	1
Emergency Medicine	ELLIOT PROFESSIONAL SERVICES			1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC			1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DWYER	PATRICIA	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DURCAN	MARK	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	WAGNER	HENRY	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	SCOTT	THOMAS	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	DELORIE	AMY	1
Emergency Medicine	EMERGENCY PHYSICIANS OF DERRY PLLC	LE	DA	1
Emergency Medicine	CONCORD HOSPITAL	CERUNDOLO	AIDA	1
Endocrinology, Diabetes	St. Joseph Hospital			1
Endocrinology, Diabetes & Metabolism		SPATOLA	ELIZABETH JANE	1
Endocrinology, Diabetes & Metabolism		SILVER	ROBERT	1
Endocrinology, Diabetes & Metabolism		GUSEVA	NINA	1
Endoscopy	CONCORD ENDOSCOPY CENTER LLC	CHUANG	ELLIE	1
Family				1
Family	Concord Hospital	GUST	SUSAN	1
Family	Dartmouth Hitchcock Clinic	BUCKLEY	SUSAN	1
Family	Dartmouth Hitchcock Clinic	PRESNELL	MELANIE	1
Family		COMPAGNA	ROBERTA	1
Family		GEBHARDT	DEBORAH	1
Family		FORTIN	CELINE	1
Family		BANGHART	ANNE	1
Family	Elliot Health Systems	GREBUS	COLLEEN	1
Family		FERNALD	ERIN	1
Family		DORAN	DOROTHY	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Family Medicine		DILONE-ARELLANO	HELING	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MCCLURE	LYDIA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MERCURO	ELISA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	KRASNOF	REBECCA	1
Family Medicine	ELLIOT PHYSICIANS NETWORK	WASZKOWSKI	DANIEL	1
Family Medicine	ELLIOT PHYSICIANS NETWORK			1
Family Medicine	ELLIOT PHYSICIANS NETWORK			1
Family Medicine				1
Family Medicine		NGUYEN	PATRICK	1
Family Medicine		GARLIN	DEBRA	1
Family Medicine		BYRNE	THOMAS	1
Family Medicine	ELLIOT PHYSICIANS NETWORK	BOULE	JUDITH	1
Foot Surgery				1
Gastroenterology	Dartmouth Hitchcock Clinic	ITENBERG	ILANA	1
Gastroenterology		MEYER	TRINH	1
Gastroenterology		ELVANIDES	HARRY	1
Gastroenterology		LEUNG	CHRISTOPHER	1
General Acute Care Hosp	SOUTHERN NEW HAMPSHIRE MEDICAL CENTER	MITZ	HOWARD	1
General Acute Care Hosp	ST. JOSEPH HOSPITAL			1
General Acute Care Hosp	ELLIOT HOSPITAL			1
General Acute Care Hosp	CATHOLIC MEDICAL CENTER			1
General Acute Care Hosp	ELLIOT HOSPITAL OF THE CITY OF MANCHESTER			1
General Hospital	Upper Connecticut Valley Hospital			1
General Hospital	New London Hospital			1
General Hospital	Lakes Region General Hospital			1
General Hospital	Cottage Hospital			1
General Practice	CONCORD HOSPITAL			1
Hematology & Oncology				1
Home Health	VISITING NURSE AND HOSPICE CARE SERVICES OF NORTHE	HAKIMIAN	ROGER	1
Home Health	CARROLL COUNTY HEALTH AND HOME CARE SERVICES			1
Home Health Agency	Vna Hospice Of Southern			1
Home Infusion Therapy P	ELLIOT HOSPITAL			1
Hospice and Palliative M	ELLIOT PROFESSIONAL SERVICES			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Hospice Care, Communit	VISITING NURSE AND HOSPICE CARE SERVICES OF NORTHERN CARROLL COUNTY			1
Hospital Based Rural Hea	Westside Health Careservices			1
Hospital Based Rural Hea	Newfound Family Practice			1
Hospitalist				1
Infectious Disease		POPELKA	ANDREW	1
Infectious Disease		GRANOK	ALEXANDER	1
Infectious Disease		SHARMA	GEETIKA	1
Infectious Disease		STRAMPFER	MICHAEL	1
Internal Medicine	CATHOLIC MEDICAL CENTER	CLARK	ELIZABETH	1
Internal Medicine				1
Internal Medicine		KUMAR	ANITA	1
Internal Medicine		GORECKI	NATALIA	1
Internal Medicine	LRGHealthcare	KAMMILA	SUNEETHA	1
Internal Medicine	LRGHealthcare	DIPRE	MICHAEL	1
Internal Medicine	LRGHealthcare	MAHARAJ	ADORA	1
Internal Medicine	LRGHealthcare	MARKERT	CRAIG	1
Internal Medicine	LRGHealthcare	CHAPIN	BARRETT	1
Internal Medicine	LRGHealthcare	MILCHEV	VALENTIN	1
Internal Medicine	Concord Hospital	GUTNER	ROGER	1
Internal Medicine		RZEPKA	ROBERT	1
Internal Medicine	Foundation Medical Partners	TRANCHEMONTAGNE	TERESA	1
Internal Medicine		BRIER	MATTHEW	1
Internal Medicine	Dartmouth Hitchcock Clinc Bedford	KAUPP	GREGORY	1
Internal Medicine	Dartmouth Hitchcock Clinic	LOVINSKI	PAULA	1
Internal Medicine	Dartmouth Hitchcock Clinic	POLIYEDATH	ANUPAMA	1
Internal Medicine		UPADRASTA	VIJAYA	1
Internal Medicine	MARY HITCHCOCK MEMORIAL HOSPITAL	PRASAD	ANIL	1
Internal Medicine				1
Internal Medicine		RICCIO	CHRISTOPHER	1
Internal Medicine		GANEM	DEBORAH	1
Internal Medicine		LEVINE	STEVEN	1
Internal Medicine		LUNDQUIST	PETER	1
Internal Medicine		PARNELL	JEANNE	1

Q 33: [redacted]CHMENT A
Provide[redacted]s Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Family Medicine		DILONE-ARELLANO	HELING	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MCCLURE	LYDIA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	MERCURO	ELISA	1
Family Medicine	Londonderry Family Practice and Derry Medical Center	KRASNOF	REBECCA	1
Family Medicine	ELLIOT PHYSICIANS NETWORK	WASZKOWSKI	DANIEL	1
Family Medicine	ELLIOT PHYSICIANS NETWORK			1
Family Medicine	ELLIOT PHYSICIANS NETWORK			1
Family Medicine				1
Family Medicine		NGUYEN	PATRICK	1
Family Medicine		GARLIN	DEBRA	1
Family Medicine		BYRNE	THOMAS	1
Family Medicine	ELLIOT PHYSICIANS NETWORK	BOULE	JUDITH	1
Foot Surgery				1
Gastroenterology	Dartmouth Hitchcock Clinic	ITENBERG	ILANA	1
Gastroenterology		MEYER	TRINH	1
Gastroenterology		ELVANIDES	HARRY	1
Gastroenterology		LEUNG	CHRISTOPHER	1
General Acute Care Hosp	SOUTHERN NEW HAMPSHIRE MEDICAL CENTER	MITZ	HOWARD	1
General Acute Care Hosp	ST. JOSEPH HOSPITAL			1
General Acute Care Hosp	ELLIOT HOSPITAL			1
General Acute Care Hosp	CATHOLIC MEDICAL CENTER			1
General Acute Care Hosp	ELLIOT HOSPITAL OF THE CITY OF MANCHESTER			1
General Hospital	Upper Connecticut Valley Hospital			1
General Hospital	New London Hospital			1
General Hospital	Lakes Region General Hospital			1
General Hospital	Cottage Hospital			1
General Practice	CONCORD HOSPITAL			1
Hematology & Oncology				1
Home Health	VISITING NURSE AND HOSPICE CARE SERVICES OF NORTHE	HAKIMIAN	ROGER	1
Home Health	CARROLL COUNTY HEALTH AND HOME CARE SERVICES			1
Home Health Agency	Vna Hospice Of Southern			1
Home Infusion Therapy P	ELLIOT HOSPITAL			1
Hospice and Palliative M	ELLIOT PROFESSIONAL SERVICES			1

Q 33: ACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Internal Medicine		WASILESKI	HEATHER	1
Internal Medicine		SCHEIB	LISA	1
Internal Medicine		PAINE	JUDITH	1
Internal Medicine		JAMPANI	SUSHAMA	1
Internal Medicine		MEYER	KEVIN	1
Internal Medicine	Dartmouth Hitchcock Clinic	MELENDEZ YOUNG	JILL	1
Internal Medicine	Dartmouth Hitchcock Clinic	JONES	JENNIFER	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	SONG	LIJUN	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine				1
Internal Medicine		MELAMED	YAIR	1
Internal Medicine		TANZER	MARY	1
Internal Medicine		DZEN	JEREMY	1
Internal Medicine		DECHIRICO	CORIN	1
Internal Medicine		SMIRNOV	MAXIM	1
Internal Medicine		MAHGOUB	MOHAMED	1
Internal Medicine		HANDA	ASHIMA	1
Internal Medicine		YOO	CHUNG-MOK	1
Internal Medicine		O'SHEA	DANA	1
Internal Medicine		BOBOCEA	MANUELA	1
Internal Medicine		HILBURN	SUSAN	1
Internal Medicine		JARAMILLO	MARTHA	1
Internal Medicine		VELLA	SALVATORE	1
Internal Medicine		BUNDSCHUH	ALEXIS-ANN	1
Internal Medicine		DASARI	SANDHYA	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	KUMAR	AMIT	1
Internal Medicine	LRGHEALTHCARE			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	RUSH	LAWRENCE	1
Internal Medicine	Concord Hospital			1
Interventional Cardiology		GITTZUS	JENNIFER	1
Medical	Elliot Health Systems	BOFFETTI	PAUL	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Medical	GREATER NASHUA EMERGENCY PHYSICIANS PC	OZKAN	SUSAN	1
Medical	FOUR SEASONS ORTHOPEDIC CENTER, PA	HOWARD	SARAH	1
Medical	FOUR SEASONS ORTHOPEDIC CENTER, PA	CLOUTIER	DAGAN	1
Medical	Elliot Health Systems	JOHNSTON	ALAN	1
Medical		CLARK	STACEY	1
Medical		LEWIS	GEORGE	1
Medical		FILION	STACY	1
Medical		LOCKWOOD	SHARON	1
Medical	EMERGENCY PHYSICIANS OF DERRY PLLC	GILLIS	KELLEY	1
Medical	EMERGENCY PHYSICIANS OF DERRY PLLC	SMITH	JANET	1
Medical	EMERGENCY PHYSICIANS OF DERRY PLLC	SHANAVER	ERIN	1
Medical	EMERGENCY PHYSICIANS OF DERRY PLLC	BRYSON	DAVID	1
Medical Genetics, Ph.D.	DOVER PEDIATRICS PLLC	GRAHAM	JULIANNE	1
Medical Oncology	Home Medical Equipment & Infusion Services.	SOARES	EUGENE	1
Mental Health		GERKEN	MADELINE	1
Mental Health		FRIEDMAN	MERRILL	1
Mental Health		BENDER	DIANE	1
Multi-Specialty	LRG HEALTHCARE	KANTNER	BARBARA	1
Multi-Specialty	FOUNDATION MEDICAL PARTNERS INC			1
Nephrology				1
Nephrology		KERT	CHARLES	1
Nephrology		RAJUR	KRUPA	1
Neurological Surgery		FITZPATRICK	SEAN	1
Neurology	LRGHealthcare	NGUYEN	TUNG	1
Neurology	Dartmouth Hitchcock Clinic	SURANYI	LESLIE	1
Neurology		INDORF	GERALD	1
Neurology with Special C	Dartmouth Hitchcock Clinic	NABIOULLINA	TATIANA	1
Neuromusculoskeletal Medicine, Sports Medicine		WOODS	ANNE	1
Non-Hospital Connected	Mgh Chelsea Imagingcenter	LEWIS	DAVID	1
Nurse Practitioner	ENT Associates of NH			1
Nurse Practitioner	Londonderry Family Practice and Derry Medical Center	SHAMEL	KATHERINE	1
Nurse Practitioner		ENGLAND	LYNNE	1
Nurse Practitioner		PACIULAN	PAULA	1

Q 33 ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Internal Medicine		WASILESKI	HEATHER	1
Internal Medicine		SCHEIB	LISA	1
Internal Medicine		PAINE	JUDITH	1
Internal Medicine		JAMPANI	SUSHAMA	1
Internal Medicine		MEYER	KEVIN	1
Internal Medicine	Dartmouth Hitchcock Clinic	MELENDEZ YOUNG	JILL	1
Internal Medicine	Dartmouth Hitchcock Clinic	JONES	JENNIFER	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	SONG	LIJUN	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK			1
Internal Medicine				1
Internal Medicine		MELAMED	YAIR	1
Internal Medicine		TANZER	MARY	1
Internal Medicine		DZEN	JEREMY	1
Internal Medicine		DECHIRICO	CORIN	1
Internal Medicine		SMIRNOV	MAXIM	1
Internal Medicine		MAHGOUB	MOHAMED	1
Internal Medicine		HANDA	ASHIMA	1
Internal Medicine		YOO	CHUNG-MOK	1
Internal Medicine		O'SHEA	DANA	1
Internal Medicine		BOBOCEA	MANUELA	1
Internal Medicine		HILBURN	SUSAN	1
Internal Medicine		JARAMILLO	MARTHA	1
Internal Medicine		VELLA	SALVATORE	1
Internal Medicine		BUNDSCHUH	ALEXIS-ANN	1
Internal Medicine		DASARI	SANDHYA	1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	KUMAR	AMIT	1
Internal Medicine	LRGHEALTHCARE			1
Internal Medicine	ELLIOT PHYSICIANS NETWORK	RUSH	LAWRENCE	1
Internal Medicine	Concord Hospital			1
Interventional Cardiology		GITTZUS	JENNIFER	1
Medical	Elliot Health Systems	BOFFETTI	PAUL	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Nurse Practitioner	ELLIOT PHYSICIANS NETWORK	CAWLEY	DOREEN	1
Nurse Practitioner	Elliot Health Systems	FERRERI	CHRISTINA	1
Nurse Practitioner		MCCONVILLE	RAMONA	1
Nurse Practitioner		WRIGHT DEVINE	CYNTHIA	1
Obstetrics	MONADNOCK OBGYN ASSOCIATES	HARRIS	JASON	1
Obstetrics				1
Obstetrics & Gynecology	LRGHealthcare	WITT	KARIN	1
Obstetrics & Gynecology	Dartmouth Hitchcock Clinic	TOVELL	WILLIAM	1
Obstetrics & Gynecology		BARBER	COLLEEN	1
Obstetrics & Gynecology		MCHUGH	DENISE	1
Obstetrics & Gynecology		KANTER	ALYSE	1
Obstetrics & Gynecology		MARTINEZ-ADORNO	MELISSA	1
Obstetrics & Gynecology		MAYNARD	KAREN	1
Obstetrics & Gynecology	CARING PARTNERS OBGYN	BISSON	MONELLE	1
Occupational Therapist	Easter Seals New Hampshire			1
Occupational Therapist	Easter Seals New Hampshire	MERRILL	KRISTEN	1
Occupational Therapist	Easter Seals New Hampshire	POLLOCK	ANN-MARIE	1
Occupational Therapist	Easter Seals New Hampshire	BUCHANAN	SARA	1
Occupational Therapist	Easter Seals New Hampshire	PSALEDAS	LAURA	1
Occupational Therapist	Easter Seals New Hampshire	GAFFNEY LARKIN	BRENDA	1
Occupational Therapist	Easter Seals New Hampshire	FAVREAU	ELISE	1
Occupational Therapist	Easter Seals New Hampshire	LANDRIGAN	VIRGINIA	1
Occupational Therapist	Easter Seals New Hampshire	BORR	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	BENJAMIN	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	ZENGA	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	PARIS	JAMIE	1
Occupational Therapy As	Easter Seals New Hampshire	STOCKBRIDGE CLIFFORD	KRISTIN	1
Ophthalmology		FORTIN	ANITA	1
Ophthalmology	SAMUEL C GOLD MD PA	GOLD	SAMUEL	1
Ophthalmology				1
Ophthalmology	NUTFIELD OPHTHALMOLOGY PC	LAMY	FRANCIS	1
Optician				1
Optometrist		IRVING	CLAYTON	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Optometrist		TUTHILL	EMILY	1
Optometrist		FRANGOS	JAMES	1
Optometrist		UDINA	CHRISTOPHER	1
Orthopaedic Surgery	LRGHealthcare	PATEL	NISHA	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER, PA	MILLER	ARNOLD	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER, PA	KILLIE	HEATHER	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER, PA	SINKOV	VLADIMIR	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	EVANS	SCOTT	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	VAILAS	JAMES	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	STRAPKO	STEFAN	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	JOSEPH	DOUGLAS	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	HEAPS	ROBERT	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	LYNN	JOHN	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	MARINO	ANTHONY	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	PRICE	WILLIAM	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	MACEY	LANCE	1
Orthopaedic Surgery	FOUR SEASONS ORTHOPEDIC CENTER. PA	CANDITO	LOUIS	1
Orthopaedic Surgery of the Spine		BOUVIER	DANIEL	1
Osteopath, Group	Lewis Physical Medicine Pa	FLEISCHER	GARY	1
Osteopath, Group	Huggins Hospital Dbatamworth Family Medicine			1
Osteopath, Group	Family Care Of Somersworth			1
Osteopath, Individual	Martino, Christopher J			1
Otolaryngic Allergy	ENT Associates of NH			1
Otolaryngology	Dartmouth Hitchcock Clinic	KELLY	MARK	1
Otolaryngology	ENT Associates of NH	WILSON	DONALD	1
Otolaryngology	ENT Associates of NH	SCANNELL	RYAN	1
Otolaryngology	ENT Associates of NH	MURRAY	JAMES	1
Otolaryngology		STARK	JAMES	1
Pediatrics	Elliot Physican Network	YOON	MICHELLE	1
Pediatrics	LRGHealthcare	KAVATHEKAR	POORNIMA	1
Pediatrics	Dartmouth Hitchcock Clinic	PETTERSON	JEAN	1
Pediatrics		HUNTER	CONVERSE	1
Pediatrics	Dartmouth Hitchcock Clinic	MILLS	CARA	1

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Nurse Practitioner	ELLIOT PHYSICIANS NETWORK	CAWLEY	DOREEN	1
Nurse Practitioner	Elliot Health Systems	FERRERI	CHRISTINA	1
Nurse Practitioner		MCCONVILLE	RAMONA	1
Nurse Practitioner		WRIGHT DEVINE	CYNTHIA	1
Obstetrics	MONADNOCK OBGYN ASSOCIATES	HARRIS	JASON	1
Obstetrics				1
Obstetrics & Gynecology	LRGHealthcare	WITT	KARIN	1
Obstetrics & Gynecology	Dartmouth Hitchcock Clinic	TOVELL	WILLIAM	1
Obstetrics & Gynecology		BARBER	COLLEEN	1
Obstetrics & Gynecology		MCHUGH	DENISE	1
Obstetrics & Gynecology		KANTER	ALYSE	1
Obstetrics & Gynecology		MARTINEZ-ADORNO	MELISSA	1
Obstetrics & Gynecology		MAYNARD	KAREN	1
Obstetrics & Gynecology	CARING PARTNERS OBGYN	BISSON	MONELLE	1
Occupational Therapist	Easter Seals New Hampshire			1
Occupational Therapist	Easter Seals New Hampshire	MERRILL	KRISTEN	1
Occupational Therapist	Easter Seals New Hampshire	POLLOCK	ANN-MARIE	1
Occupational Therapist	Easter Seals New Hampshire	BUCHANAN	SARA	1
Occupational Therapist	Easter Seals New Hampshire	PSALEDAS	LAURA	1
Occupational Therapist	Easter Seals New Hampshire	GAFFNEY LARKIN	BRENDA	1
Occupational Therapist	Easter Seals New Hampshire	FAVREAU	ELISE	1
Occupational Therapist	Easter Seals New Hampshire	LANDRIGAN	VIRGINIA	1
Occupational Therapist	Easter Seals New Hampshire	BORR	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	BENJAMIN	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	ZENGA	JENNIFER	1
Occupational Therapist	Easter Seals New Hampshire	PARIS	JAMIE	1
Occupational Therapy As	Easter Seals New Hampshire	STOCKBRIDGE CLIFFORD	KRISTIN	1
Ophthalmology		FORTIN	ANITA	1
Ophthalmology	SAMUEL C GOLD MD PA	GOLD	SAMUEL	1
Ophthalmology				1
Ophthalmology	NUTFIELD OPHTHALMOLOGY PC	LAMY	FRANCIS	1
Optician				1
Optometrist		IRVING	CLAYTON	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Pediatrics		GLATZ	JENIFER	1
Pediatrics		DANDEKAR	RANJAN	1
Pediatrics		MONAHAN	LILA	1
Pediatrics		GLIDDEN	JANE	1
Pediatrics		KAUPP	CARA	1
Pediatrics		DAS	ANINDITA	1
Pediatrics	DOVER PEDIATRICS PLLC	WILLIAMS	LINDA	1
Pediatrics	DOVER PEDIATRICS PLLC	LALLY	TERRI	1
Pediatrics	DOVER PEDIATRICS PLLC	LARAMEE	RACHEL	1
Pediatrics	DOVER PEDIATRICS PLLC	BUTTERFIELD	REBECCA	1
Pediatrics	DOVER PEDIATRICS PLLC	SMALL	LEONARD	1
Pediatrics	DOVER PEDIATRICS PLLC	VANDERZANDEN	ANDRE	1
Pediatrics	ELLIOT PHYSICIANS NETWORK			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	MYERS	MARK	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	FERRUCCI	FERNANDO	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	PULASKI	MARY	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	NEEFE	HOLLY	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	CAYER	PATRICIA	1
Pediatrics	ELLIOT PHYSICIANS NETWORK			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	SALVATORE	DONALD	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	REIMER	ALEXIS	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	TRUEBE	SANDRA	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	FRIEDEN	ROGER	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	NACKMAN	LOUIS	1
Pediatrics	Elliot Health Systems			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	ZAJANO	EMILY	1
Pediatrics				1
Pediatrics		LEBLANC	SUSANN	1
Pediatrics		MCNAMEE	SUSAN	1
Pediatrics		LERO	WILLIAM	1
Pediatrics		FETTER	SUZANNE	1
Pediatrics		ATKINS	VALERIE	1
Pediatrics	Dartmouth Hitchcock Clinic	HERMANSEN	MARCUS	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Pediatrics	LRGHEALTHCARE	CUNIS	DAVID	1
Pediatrics		GROENKE	MICHAEL	1
Pediatrics	Concord Hospital	TOMANEK	TOMAS	1
Pharmacist	Concord Health	RADWAN	SARAH	1
Pharmacy	Home Medical Equipment And Infusion Services 180,746 1	TRIPP	RICHARD	1
Pharmacy	Dartmouth Hitchcockpharmacy 278,098 309,678 986,189			1
Physical Medicine & Reh	LEWIS PHYSICIAL MEDICINE ASSOCIATES PA			1
Physical Therapist	Weegar, Kathryn A 3,699 8,461 18,043			1
Physical Therapist	Mountain Center Physical Therapy			1
Physical Therapist	LRGHealthcare	DONOVAN	BETSY	1
Physical Therapist	Easter Seals New Hampshire	NICHOLS	SHELLEY	1
Physical Therapist	Easter Seals New Hampshire	LORD	ERIN	1
Physical Therapist	Easter Seals New Hampshire	DEMARCO	CHARLENE	1
Physical Therapist	Easter Seals New Hampshire	MCALLISTER	SUSANNE	1
Physical Therapist	Easter Seals New Hampshire	THOMAS	LYNNE	1
Physical Therapist	Mountain Center Physical Therapy	HUSSEY	ANN	1
Physical Therapist	Mountain Center Physical Therapy	LANE	KAREN	1
Physical Therapist	Mountain Center Physical Therapy	HOOPER	WENDY	1
Physical Therapist	Mountain Center Physical Therapy	EMERY	VICKI	1
Physical Therapist	Mountain Center Physical Therapy	WEEGAR	KATHRYN	1
Physical Therapist	Mountain Center Physical Therapy	MORGAN	SUSAN	1
Physical Therapist	Mountain Center Physical Therapy	HANSON	JEFFREY	1
Physical Therapist	Mountain Center Physical Therapy	LOCKE	KELLY	1
Physical Therapist	Easter Seals New Hampshire	WIGGIN	BENJAMIN	1
Physical Therapist	Concord Hospital	REEVES	KELLY	1
Physical Therapist	Easter Seals New Hampshire	LANCASTER	DAVID	1
Physical Therapist	Easter Seals New Hampshire	SLAVIN	BEATRICE	1
Physical Therapist	Mountain Center Physical Therapy	NELSON	LORENE	1
Physical Therapy	MOUNTAIN CENTER PHYSICAL THERAPY	MARTIN	RYAN	1
Physical Therapy Assistar	Concord Hospital			1
Physician Assistant	LRGHealthcare	LEHOULLIER	JANET	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	KREIENSIECK	CHARLENE	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	MURRAY	AIMEE	1

Q 33: [redacted]CHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Pediatrics		GLATZ	JENIFER	1
Pediatrics		DANDEKAR	RANJAN	1
Pediatrics		MONAHAN	LILA	1
Pediatrics		GLIDDEN	JANE	1
Pediatrics		KAUPP	CARA	1
Pediatrics		DAS	ANINDITA	1
Pediatrics	DOVER PEDIATRICS PLLC	WILLIAMS	LINDA	1
Pediatrics	DOVER PEDIATRICS PLLC	LALLY	TERRI	1
Pediatrics	DOVER PEDIATRICS PLLC	LARAMEE	RACHEL	1
Pediatrics	DOVER PEDIATRICS PLLC	BUTTERFIELD	REBECCA	1
Pediatrics	DOVER PEDIATRICS PLLC	SMALL	LEONARD	1
Pediatrics	DOVER PEDIATRICS PLLC	VANDERZANDEN	ANDRE	1
Pediatrics	ELLIOT PHYSICIANS NETWORK			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	MYERS	MARK	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	FERRUCCI	FERNANDO	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	PULASKI	MARY	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	NEEFE	HOLLY	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	CAYER	PATRICIA	1
Pediatrics	ELLIOT PHYSICIANS NETWORK			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	SALVATORE	DONALD	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	REIMER	ALEXIS	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	TRUEBE	SANDRA	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	FRIEDEN	ROGER	1
Pediatrics	ELLIOT PHYSICIANS NETWORK	NACKMAN	LOUIS	1
Pediatrics	Elliot Health Systems			1
Pediatrics	ELLIOT PHYSICIANS NETWORK	ZAJANO	EMILY	1
Pediatrics				1
Pediatrics		LEBLANC	SUSANN	1
Pediatrics		MCNAMEE	SUSAN	1
Pediatrics		LERO	WILLIAM	1
Pediatrics		FETTER	SUZANNE	1
Pediatrics		ATKINS	VALERIE	1
Pediatrics	Dartmouth Hitchcock Clinic	HERMANSEN	MARCUS	1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Physician Assistant	Londonderry Family Practice and Derry Medical Center	RULE	TANYA	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	MCGINNIS	JULIE	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	UNDERWOOD	AMANDA	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	JORDAN	JULIE	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	LESSARD	ROBERT	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	CAVANAUGH	RENEE	1
Physician Assistant		VANDER MARK	JULIE	1
Physician Assistant		GIBSON	JILLIAN	1
Physician Assistant	GREATER NASHUA EMERGENCY PHYSICIANS PC	CONWAY-CLANCY	NANCY	1
Physician Assistant		DIAS	PETER	1
Physician Assistant		URBAN	SARAH	1
Physician Assistant	Elliot Health Systems	KRASOVIC	JENNIFER	1
Physician Assistant	Elliot Health Systems	GLENNON	NIKKI	1
Physician Assistant	Elliot Health Systems	PLANTE	ANTHONY	1
Physician Assistant	EMERGENCY PHYSICIANS OF DERRY PLLC	WEBB	LISA	1
Physician, Group (MD)	Sj Physician Svcs Npmil 75,237 92,969 108,284	RATTA	JON	1
Physician, Group (MD)	Sj Physician Svcs Mvp 88,947 106,712 113,161			1
Physician, Group (MD)	Barrington Walk In Care 12,606 108,973 115,237			1
Physician, Group (MD)	Concord Obgyn 0 47,584 126,082			1
Physician, Group (MD)	Elliot Primary Care 94,116 116,029 134,835			1
Physician, Group (MD)	Rochester Hill Family Practice 111,649 134,709 142,412			1
Physician, Group (MD)	Concord Pediatrics 133,526 143,062 149,813			1
Physician, Group (MD)	Elliot Behavioral Health 198,473 203,271 161,342			1
Physician, Group (MD)	Catholic Medical Center Dba New Englandheart 124,014 160,927 170,784			1
Physician, Group (MD)	Huggins Hospital Dbawolfeboro Pediatrics 174,724 210,105 183,527			1
Physician, Group (MD)	Dart Hitchcock Psychassoc 108,552 149,697 189,219			1
Physician, Group (MD)	Rochester Obgyn 147,909 175,452 199,806			1
Physician, Group (MD)	Wentw Douglass Physcorp Wdpc Hospitalistgrp 76,864 74,318 202,539			1
Physician, Group (MD)	Mass General Physicians			1
Physician, Group (MD)	Caring For Women			1
Physician, Group (MD)	Lrh Physicians Group			1
Physician, Group (MD)	Lakes Region Generalhospital			1
Podiatrist	LRGHealthcare			1

Q 33: ATTACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Primary Care	DARTMOUTH HITCHCOCK CLINIC	LIMBURG	KENNETH	1
Primary Care	COTTAGE HOSPITAL HEALTH PRACTICES			1
Primary Care	COTTAGE HOSPITAL			1
Psychiatric Unit	ST. JOSEPH HOSPITAL			1
Psychiatric Unit	ELLIOT HOSPITAL OF THE CITY OF MANCHESTER			1
Psychiatric Unit	CONCORD HOSPITAL			1
Psychiatric/Mental Health				1
Psychologist	Family Medicine Center	MONA	LAURETTA	1
Psychologist		BALLOU	MARY	1
Pulmonary Disease		SLATOFF	JACK	1
Pulmonary Disease		BUDNITZ	ALBEE	1
Radiology	DERRY MEDICAL CENTER	WOLF-ROSENBLUM	STEPHANIE	1
Radiology	Londonderry Family Practice and Derry Medical Center			1
Registered Nurse				1
Registered Nurse		JACOBSON	CHRISTOPHER	1
Rehabilitation Unit	ST. JOSEPH HOSPITAL	MAHONEY	DANIELLE	1
Rheumatology				1
Rheumatology		GOVINDARAJU	KALYANI	1
Rheumatology	LRGHEALTHCARE	GORMAN	JOHN	1
Rural Health	WESTSIDE HEALTHCARE	QUINONES	LUCHI	1
Rural Health	Newfound Family Practice			1
Rural Health Clinic	Dartmouth-Hitchcockclinic			1
Social Worker				1
Specialist	FOUR SEASONS ORTHOPEDIC CENTER. PA	D'URSO	TAMMY-SUE	1
Specialist	ENT ASSOCIATES OF NH			1
Specialist	ENT ASSOCIATES OF NH	SIDARI	JOSEPH	1
Speech-Language Pathol	Easter Seals New Hampshire			1
Speech-Language Pathol	Easter Seals New Hampshire	HERMAN	SCOTT	1
Speech-Language Pathol	Easter Seals New Hampshire	MCLAUGHLIN	TRACEY	1
Speech-Language Pathol	Easter Seals New Hampshire	BLAKE	TARA	1
Speech-Language Pathol	Easter Seals New Hampshire	SPELTZ	JOHANNAH	1
Speech-Language Pathol	Easter Seals New Hampshire	MCKENNA	LISA	1
Speech-Language Pathol	Easter Seals New Hampshire	HAWES	NANCY	1

Q 33: CHMENT A
Provide.. Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Physician Assistant	Londonderry Family Practice and Derry Medical Center	RULE	TANYA	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	MCGINNIS	JULIE	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	UNDERWOOD	AMANDA	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	JORDAN	JULIE	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	LESSARD	ROBERT	1
Physician Assistant	Londonderry Family Practice and Derry Medical Center	CAVANAUGH	RENEE	1
Physician Assistant		VANDER MARK	JULIE	1
Physician Assistant		GIBSON	JILLIAN	1
Physician Assistant	GREATER NASHUA EMERGENCY PHYSICIANS PC	CONWAY-CLANCY	NANCY	1
Physician Assistant		DIAS	PETER	1
Physician Assistant		URBAN	SARAH	1
Physician Assistant	Elliot Health Systems	KRASOVIC	JENNIFER	1
Physician Assistant	Elliot Health Systems	GLENNON	NIKKI	1
Physician Assistant	Elliot Health Systems	PLANTE	ANTHONY	1
Physician Assistant	EMERGENCY PHYSICIANS OF DERRY PLLC	WEBB	LISA	1
Physician, Group (MD)	Sj Physician Svcs Npmil 75,237 92,969 108,284	RATTA	JON	1
Physician, Group (MD)	Sj Physician Svcs Mvp 88,947 106,712 113,161			1
Physician, Group (MD)	Barrington Walk In Care 12,606 108,973 115,237			1
Physician, Group (MD)	Concord Obgyn 0 47,584 126,082			1
Physician, Group (MD)	Elliot Primary Care 94,116 116,029 134,835			1
Physician, Group (MD)	Rochester Hill Family Practice 111,649 134,709 142,412			1
Physician, Group (MD)	Concord Pediatrics 133,526 143,062 149,813			1
Physician, Group (MD)	Elliot Behavioral Health 198,473 203,271 161,342			1
Physician, Group (MD)	Catholic Medical Center Dba New Englandheart 124,014 160,927 170,784			1
Physician, Group (MD)	Huggins Hospital Dbawolfeboro Pediatrics 174,724 210,105 183,527			1
Physician, Group (MD)	Dart Hitchcock Psychassoc 108,552 149,697 189,219			1
Physician, Group (MD)	Rochester Obgyn 147,909 175,452 199,806			1
Physician, Group (MD)	Wentw Douglass Physcorp Wdpc Hospitalistgrp 76,864 74,318 202,539			1
Physician, Group (MD)	Mass General Physicians			1
Physician, Group (MD)	Caring For Women			1
Physician, Group (MD)	Lrh Physicians Group			1
Physician, Group (MD)	Lakes Region Generalhospital			1
Podiatrist	LRGHealthcare			1

Q 33: ACHMENT A
Providers Expected to Contract

OTHER PROVIDERS WHO HAVE SAID CONTACT POST RFP AWARD TO CONTRACT

Specialty	Legal Entity	P Last	P FIRST	Total
Speech-Language Pathol	Easter Seals New Hampshire	PELLERIN	AMY	1
Speech-Language Pathol	Easter Seals New Hampshire	RAYMOND	ALLISON	1
Speech-Language Pathol	Easter Seals New Hampshire	PHELPS	JENNIFER	1
Speech-Language Pathol	Easter Seals New Hampshire	CHOUINARD	LYNDA	1
Speech-Language Pathol	Easter Seals New Hampshire	CLARK	CHERYL	1
Sports Medicine		BABCOCK	KATHLEEN	1
Student in an Organized	Dartmouth Hitchcock Clinic	COUTURE	CHRISTOPHER	1
Surgery		ALMODOVAR SUAREZ	JORGE	1
Surgery	LRGHealthcare	FLICKINGER	EDWARD	1
Surgery		AWRICH	ALAN	1
Surgery		HOWE	KENNETH	1
Surgical		JIMENEZ	LUIS	1
Surgical	Dartmouth Hitchcock Clinic	DETLEFSEN	KRISTIN	1
Surgical		KNEPP	MAUREEN	1
Urology	LRGHealthcare	PLUMLEY	ERIC	1
Urology	Concord Hospital	FERNHOLZ	FREDERIC	1
Urology	CORE HEALTH SERVICES INC	JACKSON	THOMAS	1
Urology				1
Vascular Surgery		DUNETZ	GARY	1
Vascular Surgery		YOUNG	LAURENCE	1
Womens Health		RODRIGUEZ	CHRISTIAN	1
Family Medicine	DH FAMILY MEDICINE NASHUA INC	FLAHERTY	KAREN	1
Home Health	VNA PERSONAL SERVICES INC			1
Home Health	VNA HOME HEALTH & HOSPICE SERVICES INC			1
Home Health	VNA HOME HEALTH & HOSPICE SERVICES INC			1
			TOTAL	553

Exhibit 6.5.E

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

Exhibit 6.5.F

Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

From: November 2010 Through: October 2011

Performance Targets:

90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

BOSTON MEDICAL CENTER HealthNet Plan — Get more.℠

BEACON HEALTH STRATEGIES

[redacted]

November 2010

Member	704	4	0.57%	6.96	93%
Provider	4,158	50	1.20%	4.17	97%

[redacted]

December 2010

Member	668	9	1.35%	4.42	92%
Provider	4,328	65	1.50%	2.91	94%

[redacted]

January 2011

Member	619	1	0.16%	4.13	96%
Provider	4,230	50	1.18%	2.96	97%

[redacted]

February 2011

Member	627	9	1.44%	5.25	93%
Provider	3,816	56	1.47%	2.88	97%

[redacted]

March 2011

Member	779	20	2.57%	7.45	90%
Provider	4,635	49	1.06%	4.31	95%

Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

From: November 2010 Through: October 2011

Performance Targets:

90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

BOSTON MEDICAL CENTER HealthNet Plan — Get more.℠

BEACON HEALTH STRATEGIES

[redacted]

April 2011

Member	649	16	2.47%	6.78	91%
Provider	3,700	39	1.05%	3.36	96%

[redacted]

May 2011

Member	621	8	1.29%	5.18	91%
Provider	3,676	59	1.61%	4.00	95%

[redacted]

June 2011

Member	627	16	2.55%	6.19	90%
Provider	3,817	62	1.62%	3.83	95%

[redacted]

July 2011

Member	483	0	0.00%	3.21	97%
Provider	3,379	12	0.36%	7.40	93%

[redacted]

August 2011

Provider	3,338	27	0.82%	6.93	94%

Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

From: November 2010 Through: October 2011

Performance Targets:

90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

BOSTON MEDICAL CENTER HealthNet Plan — Get more.

BEACON HEALTH STRATEGIES

[redacted]

November 2010

Member	704	4	0.57%	6.96	93%
Provider	4,158	50	1.20%	4.17	97%

[redacted]

December 2010

Member	688	9	1.35%	4.42	92%
Provider	4,328	65	1.50%	2.91	94%

[redacted]

January 2011

Member	619	1	0.16%	4.13	96%
Provider	4,230	50	1.18%	2.96	97%

[redacted]

February 2011

Member	627	9	1.44%	5.25	93%
Provider	3,818	56	1.47%	2.88	97%

[redacted]

March 2011

Member	779	20	2.57%	7.45	90%
Provider	4,635	49	1.06%	4.31	95%

Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

[redacted]om: November 2010 Through: October 2011

Performance Targets:

90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

BOSTON MEDICAL CENTER HealthNet Plan — Get more.℠

BEACON HEALTH STRATEGIES

	Member	601	1	0.17%	6.14	95%

[redacted]

September 2011

	Provider	3,456	21	0.61%	9.97	91%
	Member	548	5	0.95%	8.86	92%

[redacted]

October 2011

	Member	566	2	0.35%	6.04	94%
	Provider	3,200	29	0.92%	8.29	92%

[redacted]

Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

From: November 2010 Through: October 2011

Performance Targets:

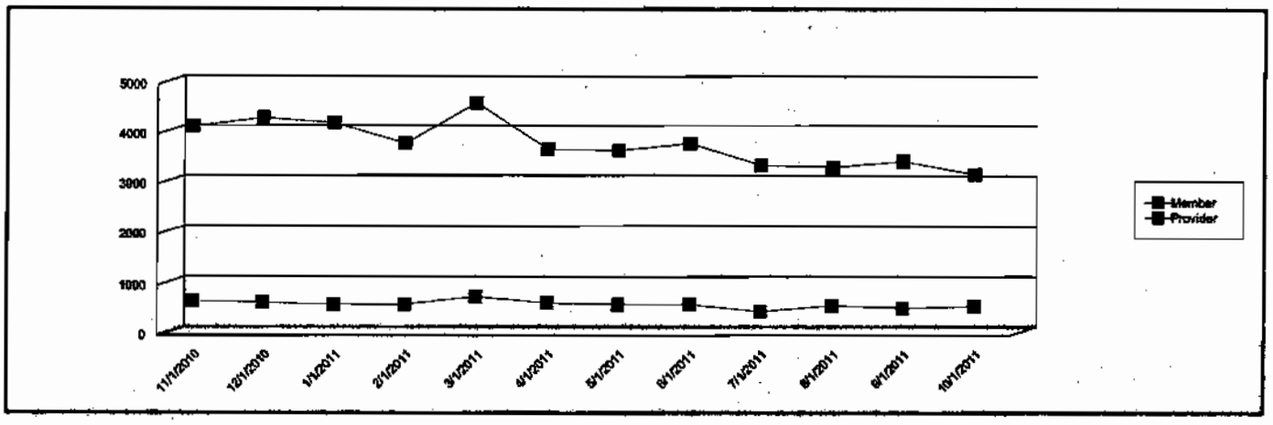
90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

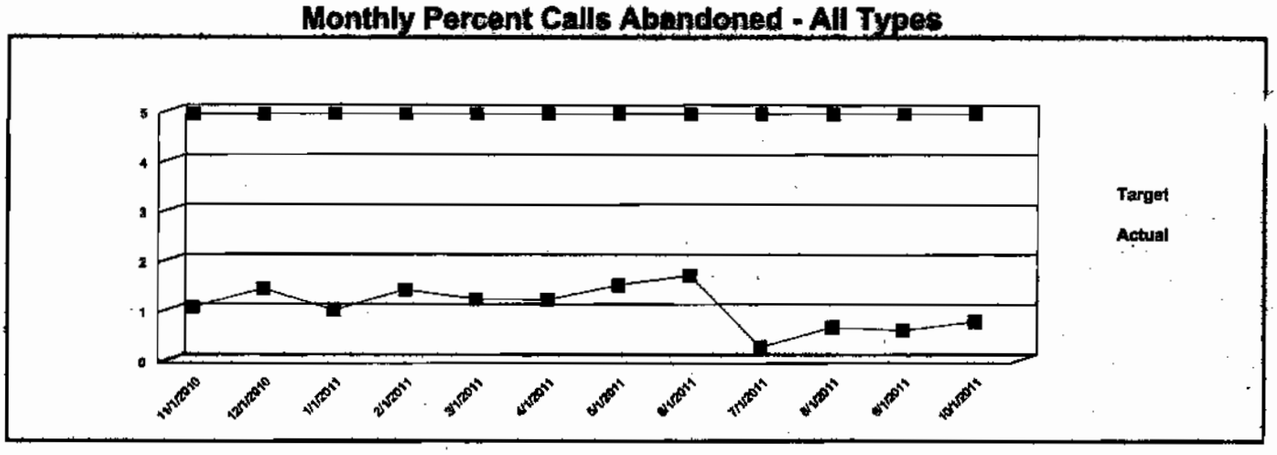
BOSTON MEDICAL CENTER HealthNet Plan — Get more.℠

BEACON HEALTH STRATEGIES

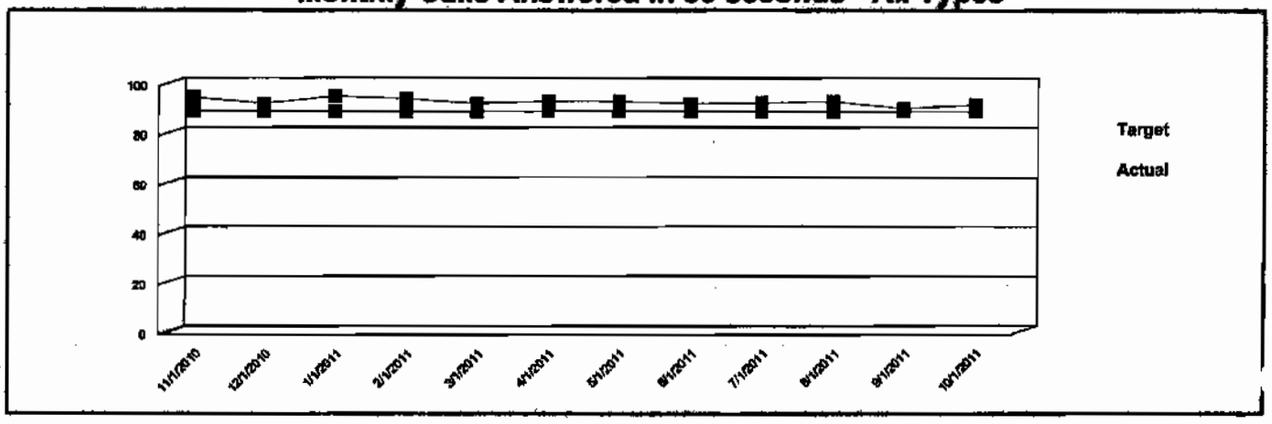
Total Monthly Calls Incoming



Monthly Percent Calls Abandoned - All Types



Monthly Calls Answered in 30 seconds - All Types



Beacon Health Strategies, LLC

Boston Medical Center HealthNet Plan - MassHealth

Monthly Report - Telephone Access Summary

From: November 2010 Through: October 2011

Performance Targets:

90.00% Calls Answered Within 30.00 Seconds

Fewer Than 5.00% Calls Abandoned

BOSTON MEDICAL CENTER HealthNet Plan — Get more.℠

BEACON HEALTH STRATEGIES

Member	601	1	0.17%	6.14	95%

[redacted]

September 2011

Provider	3,456	21	0.61%	9.97	91%
Member	548	5	0.95%	8.86	92%

[redacted]

October 2011

Member	586	2	0.35%	6.04	94%
Provider	3,200	29	0.92%	8.29	92%

[redacted]

Exhibit 6.5.G

BMCHP/Bylaon BH Contract Reporting Deliverables			
Deliverable	**Notes/Report Reference/Title**		**BMCHP Feedback**
June 2011 Deliverables			
Regulatory Reports			
Monthly			
BH CARD Report	**Heather emailed Kim Alexander on 6/1**	[redacted]	**Delivered on time, no comments at this time**
CBHI Reports			
* CBHI Authorizations	Title: bmchp_cbhi_auth_may11		
* CBHI Cost Utilization	Title: BMCHP_CBHI_COSTANDUTILIZATION_MAR11		
* CANS Month Year	Title: BMCHP_CANS_MAR11		
* ICC Key Indicators Month Year	Title: BMCHP_ICC_KEY_INDICATORS_MAR11		
Management Reports			
Monthly			
Commonwealth Care Reports			
* Cost Avoidance Report	[redacted]	[redacted]	[redacted]
* Recovery Report			
* TPL Accident and Trauma Report	Title: BMCHPRegRpts_CWC_31MAY2011_w summary		
Mass Health Reports			
* Cost Avoidance Report	[redacted]	[redacted]	[redacted]
* Recovery Report			
* TPL Accident and Trauma Report	Title: BMCHPRegRpts_MH_31MAY2011_w summary		
Utilization Dashboard Performance Summary Report	Title: bmc_q5a_dashboardcharts_utilizationandcalicr		
Service Utilization Report Detail	[redacted]	[redacted]	[redacted]
* Cost and Util - All LOC - PMPM			
* Cost and Util - All LOC - Penetration Rates			
* Cost and Util - Diversionary - PMPM			
* Cost and Util - Diversionary - Penetration Rates			
* Cost and Util - Inpatient - PMPM			
* Cost and Util - Inpatient - Penetration Rates			
* Cost and Util - Outpatient - PMPM			
* Cost and Util - Outpatient - Penetration Rates			
*ALOS Acute MH			
*ALOS Acute SA	Title: admin4_plandollarsandunitspaidsummary_xtab_bmchp		Delivered on time, no comments at this time
Telephone Responsiveness Report			
* Call Abandonment Rates	[redacted]	[redacted]	[redacted]
* Average Speed to Answer			
* % Calls Answered in 30 seconds	Titles: m1_2_phoneanswerperformancegraphs_bmc_1; m1_2_phoneanswerperformancegraphs_bmc_2		
* Number of Incoming Calls			
Claims Performance			
* 30 Day Claims Processing Recap	Title: bmchp_q1_30claimsprocess	[redacted]	[redacted]
* Claims Quality Report	Title: BMCHP_M_ClaimsQualityMonitor_2011-06-06-12-25-26		
Credentialing			
* Adverse Terminations	[redacted]	[redacted]	[redacted]
Case Management			
* Intensive Case Management Activity	Title: ICM_ActivitySummary_June 2011	[redacted]	[redacted]
* Care Coordination Activity	Title: Care_Coordination_ActivitySummary_June 2011		
* Case Consultation Activity	Title: Case_Consultation_ActivitySummary_June 2011		
Adverse Incidents Report			

BMCHP/Beacon BH Contract Reporting Deliverables			
[redacted]	Notes/Report Reference Title	[redacted]	[redacted]
June 2011 Deliverables			
* Commonwealth Care	**Title: BMCHP CWC Adverse Incidents Report_May 2011**	[redacted]	[redacted]
* MassHealth	**Title: BMCHP Medicaid Adverse Incidents Report_May 2011**	[redacted]	[redacted]
Clinical Operations			
* Acute Care - 7 day continuing care percentages	**Title: Quality_AftercareHybrid_BMC**	[redacted]	[redacted]
* Acute Care - 30 day continuing care percentages		[redacted]	[redacted]

BMCHP/Beacon BH Contract Reporting Deliverables			
Deliverable	Notes/Report Reference File	[redacted]	[redacted]
June 2011 Deliverables			
Regulatory Reports			
Monthly			
BH CARD Report	Heather emailed Kim Alexander on 6/1	[redacted]	[redacted]
CBHI Reports			
* CBHI Authorizations	Title: bmchp_cbhi_auth_may11	[redacted]	[redacted]
* CBHI Cost Utilization	Title: BMCHP_CBHI_COSTANDUTILIZATION_MAR11	[redacted]	[redacted]
* CANS Month Year	Title: BMCHP_CANS_MAR11	[redacted]	[redacted]
* ICC Key Indicators Month Year	Title: BMCHP_ICC_KEY_INDICATORS_MAR11	[redacted]	[redacted]
Management Reports			
Monthly			
Commonwealth Care Reports			
* Cost Avoidance Report * Recovery Report * TPL Accident and Trauma Report	Title: BMCHPRegRpts_CWC_31MAY2011_ w summary	[redacted]	[redacted]
Mass Health Reports			
* Cost Avoidance Report * Recovery Report * TPL Accident and Trauma Report	Title: BMCHPRegRpts_MH_31MAY2011_w summary	[redacted]	[redacted]
Utilization Dashboard Performance Summary Report	Title: bmc_q5a_dashboardcharts_utilizationandcallctr		
Service Utilization Report Detail * Cost and Util - All LOC - PMPM * Cost and Util - All LOC - Penetration Rates * Cost and Util - Diversionary - PMPM * Cost and Util - Diversionary - Penetration Rates * Cost and Util - Inpatient - PMPM * Cost and Util - Inpatient - Penetration Rates * Cost and Util - Outpatient - PMPM * Cost and Util - Outpatient - Penetration Rates *ALOS Acute MH *ALOS Acute SA	Title: admin4_plandollarsandunitspaidsummary_xtab_bmchp		
Telephone Responsiveness Report			
* Call Abandonment Rates * Average Speed to Answer * % Calls Answered in 30 seconds * Number of Incoming Calls	Titles: m1_2_phoneanswerperformancegraphs_bmc_1; m1_2_phoneanswerperformancegraphs_bmc_2	[redacted]	[redacted]
Claims Performance			
* 30 Day Claims Processing Recap	Title: bmchp_q1_30claimsprocess	[redacted]	[redacted]
* Claims Quality Report	Title: BMCHP_M_ClaimsQualityMonitor_2011-06-06-12-25-26		
Credentialing			
* Adverse Terminations	Title: bmc_m11_credentialingappactivity	[redacted]	[redacted]
Case Management			
* Intensive Case Management Activity	Title: ICM_ActivitySummary_June 2011	[redacted]	[redacted]
* Care Coordination Activity	Title: Care_Coordination_ActivitySummary_June 2011		
* Case Consultation Activity	Title: Case_Consultation_ActivitySummary_June 2011		
Adverse Incidents Report			

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.6 Description of Organization

6.6 Description of Organization

Please note that the following information also responds to the requirements of Section 2.5 of the RFP.

Company experience and lines of business

BMC HealthNet Plan (BMCHP) is well positioned to successfully manage care for New Hampshire's Medicaid population. BMCHP brings nearly 15 years of experience in managing care for people who qualify for government-subsidized insurance. Our primary line of business is Medicaid. We serve nearly 240,000 members in Massachusetts (as of fiscal year ending 10/31/11), 83% of whom are on MassHealth (Medicaid managed care in Massachusetts), making BMCHP the largest Medicaid HMO in the state.

BMCHP is a not for profit, 501(c)(3) organization licensed as a health maintenance organization in Massachusetts. Founded in 1997 by Boston Medical Center (BMC), the largest "safety net" hospital in New England, BMCHP operates as an affiliate of BMC, which is the sole corporate member of BMCHP. Our mission is to "assist and support BMC in providing and enhancing access to efficient, effective medical care among low income, underserved, disabled, elderly and other vulnerable residents," as stated in our bylaws.

To better serve our members and our Massachusetts provider network, BMCHP maintains offices in Boston (our headquarters), New Bedford and Springfield. BMCHP employs 400 individuals across these three offices. Our goal is to ensure local support in all regions where we provide coverage. Collectively, our executives at the chief level alone bring more than 125 years of managed care experience not only with BMCHP but with other Medicaid and commercial carriers across New England and the U.S.

In addition to MassHealth, BMCHP's other major government client is the Massachusetts Commonwealth Health Insurance Connector Authority, which oversees two key programs in which BMCHP participates. The first is Commonwealth Care, which provides partially or fully subsidized insurance for adults who meet income and other eligibility requirements. BMCHP serves nearly 40,000 Commonwealth Care members across Massachusetts. The other Connector program through which BMCHP is offered is Commonwealth Choice, which is insurance purchased by individuals and small businesses through the Connector's shopping exchange. BMCHP also began selling directly to small groups under our Employer Choice Plan on November 1, 2011.

Other than its commitment to the lines of business described above, BMCHP does not have any current project commitments related to new products.

Focus on efficiency

BMCHP aggressively works to achieve administrative cost efficiency. For the fiscal year ended September 30, 2011, our administrative cost ratio was among the top 25% most efficient Medicaid HMO plans in the nation. For the current fiscal year we forecast an administrative expense efficiency ratio of less than seven percent.

Operationally, BMCHP processes over 300,000 claims per month, 98% of which are paid within 30 days. Average turnaround time is 9.4 days. Our customer care calls center answers over 90% of all member and provider calls within 30 seconds, with average speed of answer at less then 15 seconds and a call abandonment rate of less than one percent.

Successful commitment to quality

New Hampshire Medicaid members will benefit from BMCHP's experience managing care for individuals who face not only the challenge of limited income but other social barriers to good health. BMCHP is ranked #3 in America for quality for our Medicaid plan, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Rankings, 2011–2012. We have earned NCQA Excellent Accreditation (Medicaid) four times in row.

BMC HealthNet Plan's performance is in the top 10% of all Medicaid HMO plans on the following measures included in the Healthcare Effectiveness Data and Information Set (HEDIS®), based on data submitted by over 130 Medicaid HMO plans to NCQA and published in the NCQA HEDIS 2011 Quality Compass:

- Breast and cervical cancer screening rates
- Chlamydia screening rate
- Lead screening rates in children
- Appropriate treatment for children with upper respiratory infection
- Controlling high blood pressure
- Comprehensive Diabetes Care: HbA1c, eye exam and nephropathy screening
- Initiation and continuation of ADHD medications
- 30 day follow-up after hospitalization for mental illness
- Timeliness of prenatal care
- Well care visits among children and adolescents
- Child access (ages 2-19) to primary care

BMCHP's care management and disease management programs for members who are at high risk for medical and/or behavioral health complications contribute to our successful management of clinical quality. Our nurses and other clinical support staff actively reach

out to educate and engage pregnant members in our 'Sunny Start" pre-natal and post-partum care management program. Members with diabetes, asthma and several other chronic conditions are targeted for participation in programs to assist them in managing their conditions and educating them on self management.

We are committed to continuous improvement in our clinical quality. For example, targeted interventions (e.g., member and/or provider outreach and incentives) for clinical opportunities for improvement resulted in the following:

- Post partum follow up increased 12.17% from 63.99% (HEDIS 2008) to 71.78% (HEDIS 2011)
- 7 day follow up after hospitalization for mental illness increased 21.71% from 53.9% (HEDIS 2008) to 65.6% (HEDIS 2011)
- 30 day follow up after hospitalization for mental illness increased 8.12% from 76.4% (HEDIS 2008) to 82.6% (HEDIS 2011)
- Diabetic eye exam increased 6.23% from 67.4% (HEDIS 2009) to 71.6% (HEDIS 2011)

Partnering with providers

We collaborate with our participating providers to deliver clinical excellence for the low-income individuals and families who are BMCHP members. Our Massachusetts provider network for MassHealth and Commonwealth Care includes 58 acute care hospitals, 3,400 primary care physicians, nearly 12,000 specialists and ancillary providers, and 1,000 pharmacies.

We are partnering and actively working with Harvard Pilgrim Health Care (HPHC) to contract with a comprehensive provider network for our Medicaid members in New Hampshire. Working together specifically on this key element of the New Hampshire Medicaid managed care program, BMCHP and HPHC aim to develop a statewide Medicaid provider network that is as robust and as quality-focused as HPHC's existing commercial network.

BMCHP strives to coordinate the care of our members closely with our providers. Our approach to provider servicing involves the assignment of a provider relations representative to every contracted provider, who receives assistance with BMCHP policies, procedures and expectations. We will bring this same approach to our provider relations in New Hampshire.

In addition to our own network, BMCHP selectively partners with several vendors to provide behavioral health, durable medical equipment and pharmacy benefit management. We anticipate having these same vendors in place for our New Hampshire Medicaid members. These arrangements enable BMCHP to effectively manage quality and control both medical and administrative costs. Beacon Health Strategies administers

our behavioral health program. Northwood, Inc., manages the provider network for and the delivery of durable medical equipment, prosthetics, orthotics and medical supplies. informedRx administers our prescription drug benefit through a comprehensive network of retail pharmacies (mail order is also available) and offers clinical support to members regarding medications.

We will seek to reach the best outcomes for the New Hampshire Medicaid population by integrating BMCHP's traditional and innovative managed care best practices with local practice initiatives and programs. This requires engaging physicians in collaborative management, which may include shared savings models and quality incentives targeted at their specific patterns of care. BMCHP has had some early successes on pilot projects with provider groups to decrease hospital readmissions, decrease ambulatory sensitive emergency room visits and improve diabetes screening rates. We believe that as a provider-sponsored health plan, we have the experience, culture, trust and credibility to engage physicians in new and innovative care management strategies that improve care for low income individuals and families.

With respect to the remaining requirements under Section 2.5, Ownership and Control Statement, BMCHP offers the following information:

- BMCHP holds a Certificate of Good Standing with New Hampshire Secretary of State's Office. (A copy is enclosed at Section 6.13.) BMCHP is in the process of applying for a license to operate as a health maintenance organization in New Hampshire and will have a license secured by the required March 8, 2012 deadline as required by the RFP.
- BMCHP confirms that no individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to, any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts.
- BMCHP does not and will not knowingly employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities.
- Please find following this page BMCHP's written assurance from our General Counsel that BMCHP is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

BOSTON MEDICAL CENTER
HealthNet Plan

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES
Section 6.6

December 16, 2011

On behalf of Boston Medical Center Health Plan, Inc., d/b/a Boston Medical Center HealthNet Plan (BMCHP), I, Susan M. Coakley, as Clerk and General Counsel, hereby provide this written assurance that BMCHP is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract for the above-referenced RFP.

Susan M. Coakley, Esq.
Clerk and General Counsel

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.7 References

6.7 Bidder's References

In response to Section 6.7, BMCHP has enclosed the following references and testimonials that include relevant information about contracts awarded to us as well as provider network references and client testimonials. One or more of these references or testimonials also illustrate our previous contractual experience with government agencies and administrative data sets. The references and testimonials are from the following:

- The Massachusetts Executive Office of Health and Human Services Medicaid Office
- The Commonwealth Health Insurance Connector Authority
- Signature Healthcare
- The East Boston Neighborhood Health Center
- The National Committee for Quality Assurance (NCQA)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
MassHealth Office of Acute and Ambulatory Care
100 Hancock Street, 6th Floor
Quincy, MA 02171

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

JULIAN J. HARRIS, M.D.
Medicaid Director

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
617-573-1770
www.mass.gov/eohhs/gov/departments/masshealth/

To Whom It May Concern:

BMC HealthNet Plan has requested a reference in support of its response as a bidder to the above-referenced RFP.

The Massachusetts Executive Office of Health and Human Services (EOHHS) operates the Commonwealth of Massachusetts' Medicaid program, known as MassHealth. We generally do not provide written references on behalf of contractors, but will be happy to provide your agency an oral reference concerning BMC HealthNet Plan upon request.

Sincerely,

Sharon Hanson
Director, Provider and Plans
MassHealth Program
617-847-3493
sharon.hanson@state.ma.us
www.mass.gov/eohhs/gov/departments/masshealth/

Cc: Dr. Julian Harris

The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

DEVAL PATRICK
Governor

TIM MURRAY
Lieutenant Governor

JAY GONZALEZ
Board Chair

GLEN SHOR
Executive Director

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108
617-933-3030
www.mahealthconnector.org

In connection with the response of BMC HealthNet Plan (BMCHP) to the above-referenced RFP, I am writing on behalf of the Massachusetts Commonwealth Health Insurance Connector Authority (the Health Connector) to offer a reference for BMCHP.

The Health Connector oversees the State's Commonwealth Care and Commonwealth Choice programs, which offer subsidized and unsubsidized coverage, respectively, to individuals age 19 and older and small businesses in Massachusetts. These programs were established as part of the state's health care reform efforts. The Health Connector contracts with managed care organizations (MCOs) to provide health insurance coverage, including subsidized coverage for individuals with incomes up to 300% of the federal poverty level under the Commonwealth Care program.

Since November 2006, BMCHP has been a valued MCO partner by offering coverage to members enrolled in the Commonwealth Care program. Along with several other MCOs, BMCHP was offered exclusive participation rights in the Commonwealth Care program through 2009, subject to its satisfaction of certain membership targets, which were exceeded during the first year of the program. The Health Connector has subsequently negotiated renewals of the contract with BMCHP. In addition, BMCHP has recently entered the Commonwealth Choice program under which it will offer unsubsidized coverage to individuals and small businesses through the Health Connector.

BMCHP has been an excellent partner in providing coverage to Commonwealth Care members and in administering innovative solutions to meet their complex healthcare needs. For example, BMCHP currently participates in our Patient-Centered Medical Home Care Initiative in an effort to improve primary care for our members through BMCHP's network community health centers. As an MCO in the State's Medicaid program, BMCHP has also helped to provide continuity of care to MassHealth members who lose eligibility under Medicaid and who then become eligible for Commonwealth Care by offering many of the same providers under both programs.

Throughout its participation in Commonwealth Care, BMCHP has exhibited a strong ability to maintain and provide data sets and reports from its clinical management, authorization, claims, provider network, and financial systems in accordance with the Health Connector's specifications and

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
MassHealth Office of Acute and Ambulatory Care
100 Hancock Street, 6th Floor
Quincy, MA 02171

JUDYANN BIGBY, M.D.
Secretary

JULIAN J. HARRIS, M.D.
Medicaid Director

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
617-573-1770
www.mass.gov/eohhs/gov/departments/masshealth/

To Whom It May Concern:

BMC HealthNet Plan has requested a reference in support of its response as a bidder to the above-referenced RFP.

The Massachusetts Executive Office of Health and Human Services (EOHHS) operates the Commonwealth of Massachusetts' Medicaid program, known as MassHealth. We generally do not provide written references on behalf of contractors, but will be happy to provide your agency an oral reference concerning BMC HealthNet Plan upon request.

Sincerely,

Sharon Hanson
Director, Provider and Plans
MassHealth Program
617-847-3493
sharon.hanson@state.ma.us
www.mass.gov/eohhs/gov/departments/masshealth/

Cc: Dr. Julian Harris

deadlines. In particular, BMCHP has successfully demonstrated the HIPAA-compliant exchange of member enrollment data, interfaced with Connector required systems, and met other reporting requirements involving encounter data sets, geographic access mapping, copayment cap accumulators, and third party liability carrier codes among others. BMCHP is also currently involved in the Commonwealth Care Program Performance and Oversight Initiative under which it has provided all required data and reports. BMCHP delivers over 55 unique reports to the Health Connector.

Based on the Connector's partnership with BMCHP over the years, we are pleased to offer this reference for BMCHP.

Sincerely,

Glen M. Shor
Executive Director
(617) 933-3060
glen.shor@state.ma.us
www.mahealthconnector.org

SIGNATURE HEALTHCARE
Brockton Hospital

680 Centre Street
Brockton, MA 02302-3395

Phone: 508.941.7000
www.signature-healthcare.org

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

On behalf of Signature Healthcare, I am pleased to offer this testimonial in support of BMC HealthNet Plan (BMCHP) in connection with the above-referenced RFP.

Signature Healthcare (Signature) is a healthcare provider headquartered in Brockton, Massachusetts and is compromised of Brockton Hospital, Brockton Hospital School of Nursing and Signature Medical Group with over 150 physicians and other healthcare providers. Established in 1896, Brockton Hospital is a 253-bed, community-based, non-profit teaching hospital providing a full range of clinical services. We maintain a major teaching affiliation with Tufts Medical Center and are fully accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Signature has partnered with BMCHP as a keystone network provider since 1998, notably as one of its first regional community hospitals. Signature has been a provider to BMCHP's MassHealth members since 1998 and its Commonwealth Care members since 2006. Through Brockton Hospital and/or Signature Medical Group, Signature has contracted with BMCHP under a number of financial methodologies, including those involving a combination of fee for service, percent of charges and risk sharing arrangements. We currently operate under a physician hospital organization (PHO) contract with BMCHP that renews annually. In total, we serve approximately 7,000 of BMCHP's MassHealth and Commonwealth Care members.

Over the course of our partnership, BMCHP has been a collaborative and innovative plan that seeks to promote the health of our members. Through the recent establishment of an accountable care risk sharing arrangement with us, BMCHP has worked to develop a number of quality metrics to further promote healthcare outcomes for our members. In addition, BMHCP has created a regularly updated registry of members with chronic illnesses to assist in the management of their care by us. Signature has a deep commitment to the community and specific populations that we serve. We believe that BMCHP acts as an important partner advancing the health and wellness of our mutual members through these and other clinical and quality improvement initiatives.

Signature is again pleased to offer this enthusiastic testimonial in support of BMCHP and its response to the above RFP.

Sincerely,

Kim Hollon

Kim Hollon, President and CEO
508-941-7004
khollon@signature-healthcare.org

deadlines. In particular, BMCHP has successfully demonstrated the HIPAA-compliant exchange of member enrollment data, interfaced with Connector required systems, and met other reporting requirements involving encounter data sets, geographic access mapping, copayment cap accumulators, and third party liability carrier codes among others. BMCHP is also currently involved in the Commonwealth Care Program Performance and Oversight Initiative under which it has provided all required data and reports. BMCHP delivers over 55 unique reports to the Health Connector.

Based on the Connector's partnership with BMCHP over the years, we are pleased to offer this reference for BMCHP.

Sincerely,

Glen M. Shor
Executive Director
(617) 933-3060
glen.shor@state.ma.us
www.mahealthconnector.org

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

East Boston Neighborhood Health Center
10 Gove Street, East Boston, MA 02128
(617) 569-5800
http://www.ebnhc.org/

East Boston Neighborhood Health Center (EBNHC) is pleased to offer this testimonial in support of BMC Health Net Plan (BMCHP) and its response to the above-referenced RFP.

EBNHC is among the largest community health centers in the country, having been a vital part of the community for 40 years. We provide personalized, multidisciplinary and accessible primary and specialty care 24/7/365, including emergency care and pharmacy services. Our patients represent an ethnic and cultural cross section of the population, and we have created a variety of programs and services to serve special needs patients, including those with HIV/AIDS and other chronic diseases, children with multiple disabilities, and childhood obesity. We are one of 15 community health centers working in affiliation with Boston Medical Center and Boston University School of Medicine.

We were among the first community health centers to begin caring for BMCHP members when BMCHP began in July 1997. EBNHC specifically provides care to BMCHP's MassHealth and Commonwealth Care members. Through the years EBNHC and BMCHP have collaborated on a variety of innovative payment structures, including a capitation arrangement, which included significant provider engagement opportunities, and a fee-for-service arrangement. BMCHP also introduced a pay-for-performance arrangement focusing on diabetes and well-child care as well as the Clinical Innovations Transformations Fund which addressed members with poorly controlled asthma. In 2011, EBNHC entered into an accountable care risk arrangement with BMCHP that moves us away from the traditional-fee-for-service structure and into a value-based payment system.

As a long-standing provider partner, we are struck with BMCHP's dedication to diverse, underserved populations, which represent the majority of patients being served at EBNHC. For example, under the accountable care arrangement, BMCHP has created a mechanism to identify the members with chronic illnesses to ensure that EBNHP engages those members in medical management programs. As illustrated by these types of forward-thinking arrangements and combined with BMCHP's transparency and collaborative approach, we believe that our organizations have established a 'healthcare solidarity' in the Boston area where quality health care is the norm and not the exception.

We strongly recommend BMCHP in its effort to bring its experience and innovation to New Hampshire.

Sincerely,

Jim Rogers

Timothy Rogers
Executive Vice President
East Boston Neighborhood Health Center
(617) 568-4570
rogerst@ebnhc.org

NCQA
Measuring quality.
Improving health care.

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) #12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

On behalf of the National Committee for Quality Assurance (NCQA), in connection with the response of Boston Medical Center HealthNet Plan (BMCHP) to establish and provide managed care coverage for the New Hampshire Medicaid population, in response to the above-referenced RFP.

In my role at NCQA, I have worked with key members of BMCHP's Quality department for four years, and also have had the pleasure of knowing some of these individuals for longer than that. My experience is that BMCHP is demonstrably committed to demonstrating health care quality and accountability. This is evidenced by BMCHP having continuously earned – since 2008 – Excellent Accreditation, NCQA's highest possible accreditation status, for its Medicaid plan. BMCHP also earned the #3 rank in the nation among Medicaid plans in NCQA's Medicaid Health Insurance Rankings, 2011-2012. It is also important to note that BMCHP is an active participant in NCQA's Health Plan Advisory Committee.

Sincerely,

Dayna S. McKnight

Dayna McKnight
Assistant Vice President, Accreditation
202.955.5148
mcknight@ncqa.org
www.ncqa.org

BIDDER'S REFERENCE

REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01
FOR MEDICAID CARE MANAGEMENT SERVICES

East Boston Neighborhood Health Center
10 Gove Street, East Boston, MA 02128
(617) 569-5800
http://www.ebnhc.org/

East Boston Neighborhood Health Center (EBNHC) is pleased to offer this testimonial in support of BMC Health Net Plan (BMCHP) and its response to the above-referenced RFP.

EBNHC is among the largest community health centers in the country, having been a vital part of the community for 40 years. We provide personalized, multidisciplinary and accessible primary and specialty care 24/7/365, including emergency care and pharmacy services. Our patients represent an ethnic and cultural cross section of the population, and we have created a variety of programs and services to serve special needs patients, including those with HIV/AIDS and other chronic diseases, children with multiple disabilities, and childhood obesity. We are one of 15 community health centers working in affiliation with Boston Medical Center and Boston University School of Medicine.

We were among the first community health centers to begin caring for BMCHP members when BMCHP began in July 1997. EBNHC specifically provides care to BMCHP's MassHealth and Commonwealth Care members. Through the years EBNHC and BMCHP have collaborated on a variety of innovative payment structures, including a capitation arrangement, which included significant provider engagement opportunities, and a fee-for-service arrangement. BMCHP also introduced a pay-for-performance arrangement focusing on diabetes and well-child care as well as the Clinical Innovations Transformations Fund which addressed members with poorly controlled asthma. In 2011, EBNHC entered into an accountable care risk arrangement with BMCHP that moves us away from the traditional-fee-for-service structure and into a value-based payment system.

As a long-standing provider partner, we are struck with BMCHP's dedication to diverse, underserved populations, which represent the majority of patients being served at EBNHC. For example, under the accountable care arrangement, BMCHP has created a mechanism to identify the members with chronic illnesses to ensure that EBNHP engages those members in medical management programs. As illustrated by these types of forward-thinking arrangements and combined with BMCHP's transparency and collaborative approach, we believe that our organizations have established a 'healthcare solidarity' in the Boston area where quality health care is the norm and not the exception.

We strongly recommend BMCHP in its effort to bring its experience and innovation to New Hampshire.

Sincerely,

Tim Rogers

Timothy Rogers
Executive Vice President
East Boston Neighborhood Health Center
(617) 568-4570
rogerst@ebnhc.org

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.8 Financial Condition

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.9 Performance Bond and Insurance

6.9 Performance Bond and Insurance

BMCHP confirms that, at the time of contract award, we will meet all New Hampshire Department of Insurance requirements to operate as an HMO in the State of New Hampshire as required by RSA 420-B and any other relevant New Hampshire laws and regulations, including but not limited to any performance bond and insurance level requirements.

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.10 Staffing and Resumes

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

BOSTON MEDICAL CENTER
HEALTH*NET* PLAN

6.11 Subcontractor LOC

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that INGENIX will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by INGENIX for BMC HealthNet Plan under an existing agreement between the parties.

INGENIX commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

INGENIX understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

INGENIX will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Michael Schrader

Title: Chief Operating Officer

Date: 12-14-11

Subcontractor: Optum Insight

Signature: [signature]

Printed Name: Gina L. Johnson

Title: Manager, Applicatin Implementation

Date: 12-14-2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Northwood, Inc. will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Northwood, Inc. for BMC HealthNet Plan under an existing agreement between the parties.

Northwood, Inc. commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Northwood, Inc. understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Northwood, Inc. will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: _____

Printed Name: Scott O'Gorman

Title: Executive Director

Date: 12·13·11

Subcontractor: Northwood, Inc.

Signature: _____

Printed Name: Kenneth G. Fasse

Title: President

Date: 12/9/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) #12-DHHS-CM-01
Medicaid Care Management Services

December 12, 2011

We the undersigned agree that MedSolutions, Inc. will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by MedSolutions, Inc. for BMC HealthNet Plan under an existing agreement between the parties, to be amended to cover the specific services referenced herein.

MedSolutions, Inc. commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

MedSolutions, Inc. understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

MedSolutions, Inc. will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC HealthNet Plan

Signature: _____

Printed Name: Scott O'Gorman

Title: Executive Director

Date: 12·13·11

Subcontractor: MedSolutions, Inc.

Signature: _____

Printed Name: David S. Bassin

Title: Chief Financial Officer

Date: 12·12·11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that McKesson Health Solutions will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by McKesson Health Solutions for BMC HealthNet Plan under an existing agreement between the parties.

McKesson Health Solutions commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

McKesson Health Solutions understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

McKesson Health Solutions will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: Richard Kuter

Printed Name: Richard Kuter

Title: Interim Chief Medical Officer

Date: 12/6/11

Subcontractor: McKesson Health Solutions LLC

Signature: Renee M. Gobeille

Printed Name: Renee M. Gobeille

Title: CFO & VP of Finance

Date: 12/06/2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Vision Service Plan, Inc. will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Vision Service Plan, Inc. for BMC HealthNet Plan under an existing agreement between the parties.

Vision Service Plan, Inc. commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Vision Service Plan Inc. understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Vision Service Plan, Inc. will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Michael Schrader

Title: COO

Date: 12-07-11

Subcontractor: Vision Service Plan, Inc

Signature: [signature]

Printed Name: AL SCHUBERT

Title: Vice President, Managed Care & Health Policy

Date: 12/5/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Health Management Systems, Inc. will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Health Management Systems, Inc for BMC HealthNet Plan under an existing agreement between the parties.

Health Management Systems, Inc commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Health Management Systems, Inc understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Health Management Systems, Inc will hold any applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC HealthNet Plan

Signature: [signature]

Printed Name: Richard Kyle

Title: Chief Medical Officer

Date: 12/12/11

Subcontractor: Health Management Systems, Inc

Signature: [signature]

Printed Name: Ron Singh

Title: CVP

Date: 12-6-2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that CDR Associates will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.6 of the RFP. The referenced services and responsibilities will be provided by CDR Associates for BMC HealthNet Plan under an existing agreement between the parties.

CDR Associates commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

CDR Associates understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

CDR Associates will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Richard Kalish

Title: Chief Medical Officer

Date: 12/12/11

Subcontractor: CDR Associates

Signature: [signature]

Printed Name: Scott F. Baker

Title: Director, Audit Operations

Date: December 5, 2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Advanced Medical Reviews will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Advanced Medical Reviews for BMC HealthNet Plan under an existing agreement between the parties.

Advanced Medical Reviews commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Advanced Medical Reviews understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Advanced Medical Reviews will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: _____

Printed Name: Scott O'Gorman

Title: Executive Director

Date: 12/9/11

Subcontractor: Advanced Medical Reviews

Signature: _____

Printed Name: Ed. Bodde

Title: Vice President, Business Development

Date: 12-7-11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Beacon Health Strategies, LLC will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Beacon Health Strategies, LLC for BMC HealthNet Plan under an existing agreement between the parties.

Beacon Health Strategies, LLC commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Beacon Health Strategies, LLC understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Beacon Health Strategies, LLC will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Richard Kash

Title: Interim Chief Medical Officer

Date: 12/6/11

Subcontractor: Beacon Health Strategies, LLC

Signature: [signature]

Printed Name: James E Spink

Title: Chief Client Officer

Date: 5 Dec 2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Fiserv Solutions, Inc. will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Fiserv Solutions, Inc. or BMC HealthNet Plan under an existing agreement between the parties.

Fiserv Solutions, Inc. commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Fiserv Solutions, Inc. understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Fiserv Solutions, Inc. will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: Susan Coakley

Printed Name: Susan Coakley

Title: Chief Legal Officer

Date: 12/

Subcontractor: Fiserv Solutions, Inc.

Signature: Ken Brown

Printed Name: Ken Brown

Title: SVP

Date: 12/4/2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that informedRx® will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by informedRx® for BMC HealthNet Plan under an existing agreement between the parties.

informedRx® commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

informedRx® understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

informedRx® will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC HealthNet Plan

Signature: _____

Printed Name: Richard Kalish

Title: Chief Medical Officer

Date: 12/6/11

Subcontractor: informedRx, Inc.

Signature: _____

Printed Name: Jeff Park

Title: EVP & CFO

Date: 12/5/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

The undersigned agrees that Accredo Health Group, Inc. for itself and its affiliated entities (including but not limited to, its wholly owned subsidiary Critical Care Systems, Inc.) herein after collectively referred to as "Accredo" will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by Accredo for BMC HealthNet Plan under an existing agreement between the parties.

Accredo commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Accredo understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Accredo will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC HealthNet Plan

Signature: [signature]

Printed Name: Richard Kalish

Title: Chief Medical Officer

Date: 12/9/11

Subcontractor: Accredo Health Group, Inc.

Signature: [signature]

Printed Name: Elizabeth A. Holloway

Title: Vice President, Legal Counsel

Date: December 8, 2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that SironaHealth will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by SironaHealthfor BMC HealthNet Plan under an existing agreement between the parties.

SironaHealth commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

SironaHealth understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

SironaHealth will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: Susan Coakley

Printed Name: Susan Conkey

Title: Chief Legal Officer

Date: 12/12/11

SironaHealth: _____

Signature: _____

Printed Name: Jeff Forbes

Title: President

Date: 12/12/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that Enclarity will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 6.5 of the RFP. The referenced services and responsibilities will be provided by Enclarity for BMC HealthNet Plan under an existing agreement between the parties.

Enclarity commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

Enclarity understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

Enclarity will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Michael Schrader

Title: Chief Operating Officer

Date: 12-12-2011

Subcontractor: ENCLARITY

Signature: [signature]

Printed Name: WARREN GOOK

Title: CFO

Date: DEC. 12, 2011

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that FIS will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by FIS for BMC HealthNet Plan under an existing agreement between the parties.

FIS commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

FIS understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

FIS will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: [signature]

Printed Name: Michael Schrader

Title: Chief Operating Officer

Date: 12-12-11

Subcontractor: FIS

Signature: [signature]

Printed Name: Tonya Rogers

Title: Relationship Manager

Date: 12/12/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that ~~(Subcontractor)~~ SafeGuard Records will be ready to begin performance of the services and responsibilities described in the above-referenced RFP, explicitly subcontracted by BMC HealthNet Plan to us by the date listed in Section 5.5 of the RFP. The referenced services and responsibilities will be provided by ~~(Subcontractor)~~ SafeGuard Records for BMC HealthNet Plan under an existing agreement between the parties.

~~(Subcontractor)~~ SafeGuard Records commits that its responsibilities will be performed for the entire contract period unless a change is approved by the State of New Hampshire.

~~(Subcontractor)~~ SafeGuard Records understands that the State of New Hampshire reserves the right to approve or reject subcontractors for this project and that BMC HealthNet Plan is required to replace subcontractors found by the State to be unacceptable.

~~(Subcontractor)~~ SafeGuard Records will hold all applicable licenses or registrations necessary to provide the services being subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: Michael Schrader

Printed Name: Michael Schrader

Title: Chief Operating Officer

Date: 12-12-11

Subcontractor: Safeguard Records Mgmt.

Signature:

Printed Name: SEAN KELLY

Title: General Manager

Date: 12/9/11

BMC HealthNet Plan

Subcontractor Letter of Commitment

State of New Hampshire
Department of Health and Human Services
Request for Proposal (RFP) # 12-DHHS-CM-01
Medicaid Care Management Services

December 1, 2011

We the undersigned agree that The TriZetto Group, Inc. ("TriZetto") will be ready to begin performance of the services provided under the existing agreement between the parties that are requested by the above-referenced RFP, and explicitly subcontracted by BMC HealthNet Plan as set forth in an appropriate amendment to the existing agreement. Any services and responsibilities subcontracted by BMC HealthNet Plan to TriZetto as a result of the RFP will be provided by TriZetto solely under the terms and conditions of the existing agreement between the parties. Any additional terms and conditions or requirements of the RFP which are outside of the scope of the current agreement will be subject to negotiation between the parties at the time of award and will be reflected in a an appropriate amendment to the existing agreement. Notwithstanding anything the contrary, this letter in no way modifies, supplements, or amends the services or other terms or obligations of the parties under the existing agreement. TriZetto understands that the State of New Hampshire reserves the right to approve or reject proposed subcontractors for this project. Furthermore, the parties understand that this letter is not a guarantee of subsequent award or future contract for services.

TriZetto will hold applicable licenses or registrations necessary to provide the services under the existing agreement between the parties which may be subcontracted by BMC HealthNet Plan in connection with the RFP.

Bidder: BMC Health Net Plan

Signature: Scott F. O'Brien

Printed Name: Scott F. O'Brien

Title: Executive Director

Date: 12/15/11

Subcontractor: The TriZetto Group, Inc.

Signature: Thomas C Rekart

Printed Name: Thomas C. Rekart

Title: SVP Business Mgmt Services TriZetto

Date: 12/15/2011

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.12 Addenda to Technical Proposal

This section is omitted as Confidential/Proprietary not subject to RSA 91-A

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.13 Licenses, Certificates and Permits

6.13 License, Certificate and Permits as Required

Prior to the award of a contract pursuant to the RFP, BMCHP has or will have all applicable certificates and licenses to operate as an HMO in New Hampshire.

BMCHP currently holds a Certificate of Good Standing from the New Hampshire Office of the Secretary of State. A copy of the Certificate is enclosed herein.

BMCHP also currently holds a license to operate as an HMO in our state of domicile, Massachusetts. Copies of our 2011 and 2012-2013 licenses are enclosed herein.

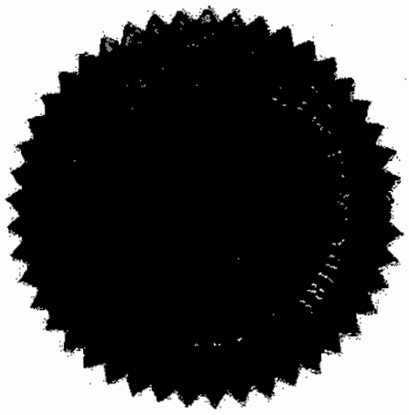
BMCHP further offers this written assurance that we will obtain a license to operate as an HMO from the New Hampshire Insurance Department as required by RSA 420-B and any other relevant New Hampshire laws and regulations prior to the award of any contract.

By way of further information, BMCHP has met with the Insurance Department concerning its impending application, which we are presently preparing. BMCHP intends to have our HMO license in advance of the contract award date.

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Boston Medical Center Health Plan, Inc., a(n) Massachusetts nonprofit corporation, registered to do business in New Hampshire on December 8, 2011. I further certify that it is in good standing as far as this office is concerned, having paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 8th day of December, A.D. 2011

William M. Gardner
Secretary of State

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street Boston MA 02118-6200
(617) 521-7794 • http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

Serial #: 2011- 03
NAIC #: 13203
Licensed: November 09, 2010

COMPANY LICENSE

THIS IS TO CERTIFY THAT

Boston Medical Center Health Plan, Inc.

is recognized as a

HEALTH MAINTENANCE ORGANIZATION

and is authorized to do business as such under the authority of

M.G.L. Chapter 176 G and 211 CMR 43.00 et.seq.

for the period of January 1, 2011 to December 31, 2011

unless such authority is amended or revoked in accordance with law.

Joseph G. Murphy

Joseph G. Murphy
Commissioner of Insurance

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street• Boston, MA 02118-6200
(617) 521-7794 • http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

Serial #: 2012- 03
NAIC #: 13203
Licensed: November 22, 2011

COMPANY LICENSE

THIS IS TO CERTIFY THAT

Boston Medical Center Health Plan, Inc.

is recognized as a

HEALTH MAINTENANCE ORGANIZATION

and is authorized to do business as such under the authority of

M.G.L. Chapter 176 G and 211 CMR 43.00 et.seq.

for the period of January 1, 2012 to December 31, 2013

unless such authority is amended or revoked in accordance with law.

Joseph G. Murphy
Commissioner of Insurance

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.14 Cost Bid Requirements

6.14 Cost Bid Requirements

Please find BMCHP's cost proposal in response to the RFP in a separate binder titled, "New Hampshire Care Management Cost Proposal and Agenda."

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.15 Conflict of Interests

6.15 Affiliations – Conflicts of Interest

BMCHP hereby states that there are no affiliations between our organization and others, including hospitals or physician organizations, that might result in a conflict of interest in the performance of the terms and conditions of the RFP.

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.16 Appendix A (GIS Reports)

APPENDIX A

BMCHP GIS Comments and Assumptions

Note: The following referenced files referenced in the GIS instructions were not available in the RFP Library.

- Member Census file
- Rural, Urban, Suburban definition in a Network Access Standard Table
- Regional Definitions for Mapping

Using data that was available in the RFP library, BMCHP has utilized best efforts to meet the intent of APPENDIX A GIS REPORTING INSTRUCTIONS.

BMCHP has submitted maps based upon the following categories and distance requirements:

PCPS

- Urban: 2 within 8 min/8 mile
- Rural: 2 within 45 min/45 mile

Comments:

- Urban PCP access will be resolved with the hospital affiliated physicians contracted after RFP award.
- Rural PCP access will be expanded post award to cover any remaining coverage deficiencies.

SPECIALISTS

- Urban: 1 within 30 min/30 mile
- Rural: 1 within 60 min/60 mile

Comments:

- The Urban and Rural Specialty files are a compilation of all specialists under LOI.

HOSPITALS

- Urban: 1 within 30 min/30 mile
- Rural: 1 within 60 min/60 mile

Comments:

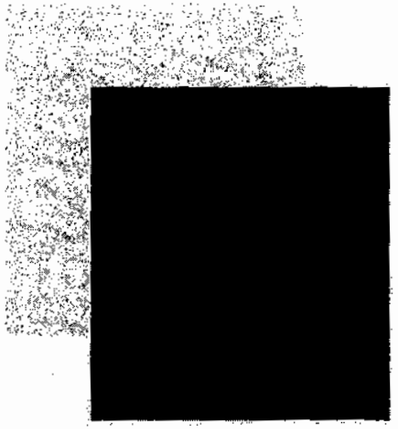
- 17 New Hampshire Hospitals have either agreed verbally or in writing to enter into discussions if BMCHP is selected by the State of New Hampshire. These Hospitals have not signed either a Letter of Intent or Contract.
- 3 Massachusetts hospitals have signed and submitted an LOI.

MENTAL HEALTH

INPATIENT
- Urban: 1 within 30 min/30 mile
- Rural: 1 within 60 min/60 mile

OUTPATIENT
- Urban: 1 within 30 min/30 mile
- Rural: 1 within 60 min/60 mile

Comments:
- BMCHP has initiated a collaborative relationship with the Community Mental Health Centers and has secured LOI from 8 of the 10 CMHC; the remaining two are in process but not received as of the RFP preparation.



Network Access Analysis - PCP

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 14, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan
Created by...
HEOPS

Report Contents

URBAN by Minutes

Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5

RURAL by Minutes

Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

Access Overview

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

Access Map
Member locations...

- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.

- 1st closest provider
- 2nd closest provider

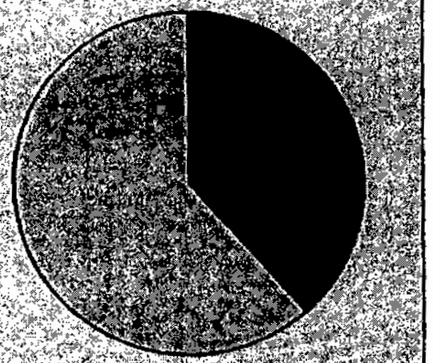
[1] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

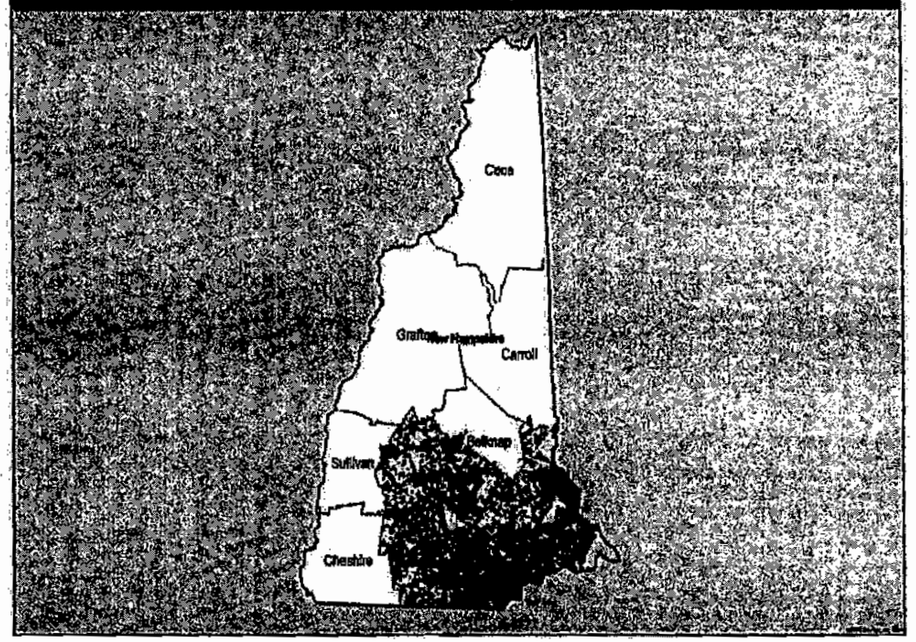
Overall Access[1]

75,897 membership
114 providers at 33 locations

29,167 (38.4%) membership with access
46,730 (61.6%) membership without access



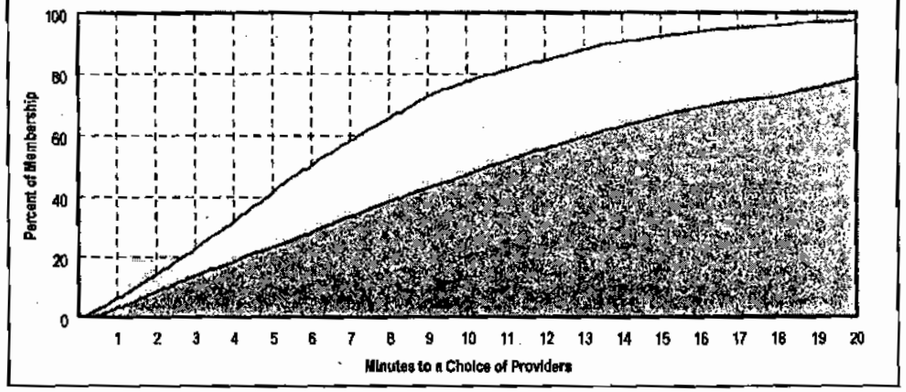
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	7.0 minutes
Average driving time to 2nd closest provider	11.8 minutes

Access Standard Comparison



©2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	75,897 membership [1] 29,167 (38.4%) membership with access 46,730 (61.6%) membership without access		114 unique providers at 39 unique locations (121 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access [1] #	With Access [1] %	Without Access [1] #	Without Access [1] %	Average Time to Providers [2] 1	Average Time to Providers [2] 2
With Access	Hillsborough County, NH	14	35,670	9,774	27.4	25,896	72.6	3.6	4.3
	Rockingham County, NH	36	15,666	6,645	42.4	9,021	57.6	3.8	4.1
	Strafford County, NH	9	11,505	6,523	56.7	4,982	43.3	6.1	6.1
	Merrimack County, NH	6	13,056	6,225	47.7	6,831	52.3	2.7	3.3
	Totals	65	75,897	29,167	38.4	46,730	61.6	3.8	4.2
Without Access	Hillsborough County, NH	14	35,670	9,774	27.4	25,896	72.6	6.1	10.1
	Rockingham County, NH	36	15,666	6,645	42.4	9,021	57.6	12.0	12.7
	Merrimack County, NH	6	13,056	6,225	47.7	6,831	52.3	12.9	14.2
	Strafford County, NH	9	11,505	6,523	56.7	4,982	43.3	13.9	13.9
	Totals	65	75,897	29,167	38.4	46,730	61.6	9.1	10.6

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
Hillsborough County, NH	14	35,070	0.00	9,774	27.4	25,996	72.6	5.4	15.0
Merrimack County, NH	6	13,056	0.00	6,225	47.7	6,831	52.3	8.1	9.0
Rockingham County, NH	36	15,666	0.00	6,645	42.4	9,021	57.6	8.5	9.1
Strafford County, NH	9	11,505	0.00	6,523	56.7	4,982	43.3	8.9	8.9
Grand Totals	**65**	**75,897**	**0.00**	**29,167**	**38.4**	**46,730**	**61.6**	**7.0**	**11.8**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban

New Hampshire

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Urban

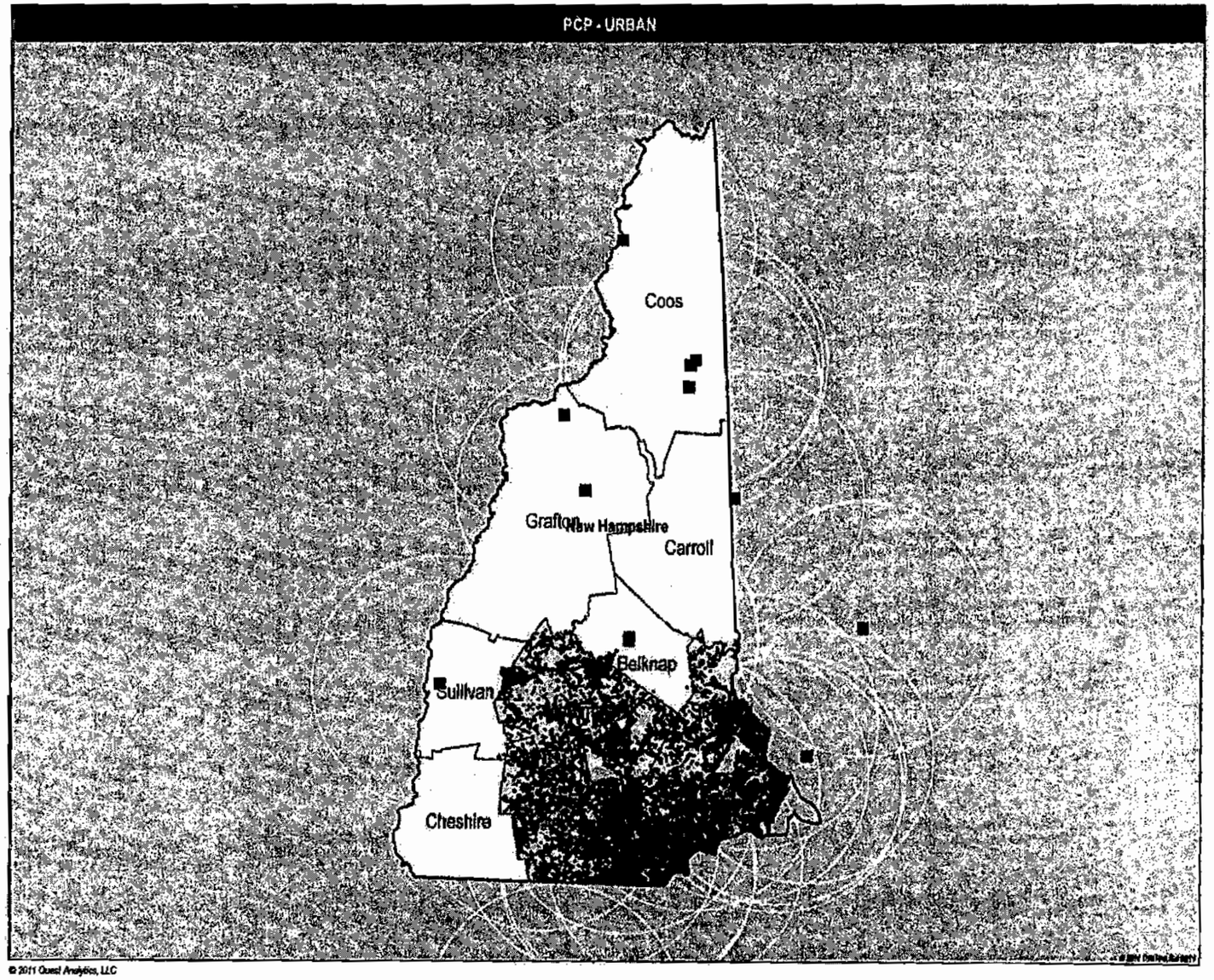
75,897 member locations
2 within 8
PCP
- Membership with Access (29,167)
- Membership without Access (46,730)

PCP

114 providers at 35 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

Access Overview

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

Access Map
Member locations...

- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.

- 1st closest provider
- 2nd closest provider

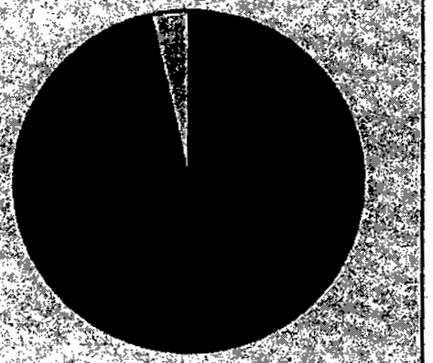
[1] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

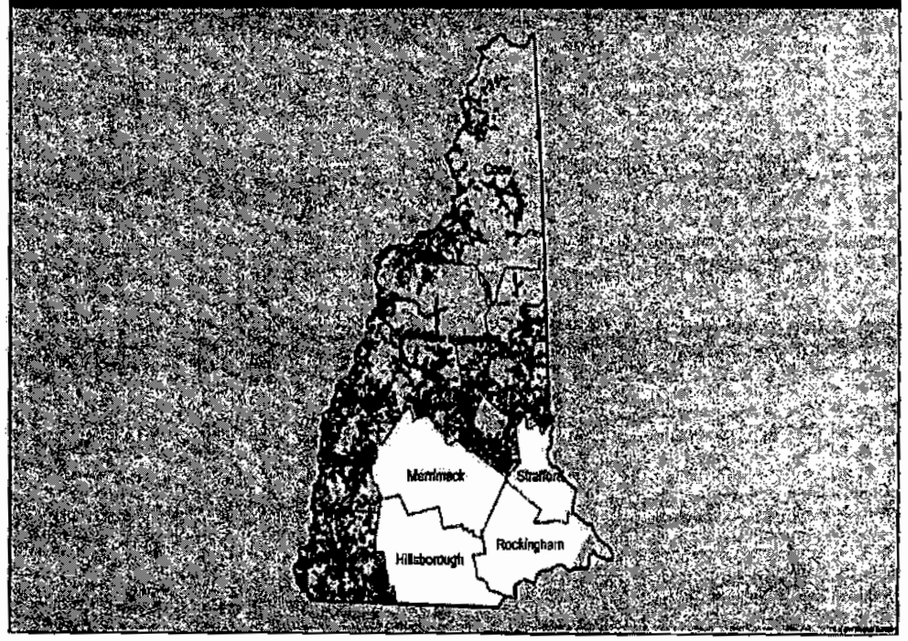
Overall Access[1]

34,187 membership.
114 providers at 35 locations

32,963 (96.4%) membership with access
1,224 (3.6%) membership without access



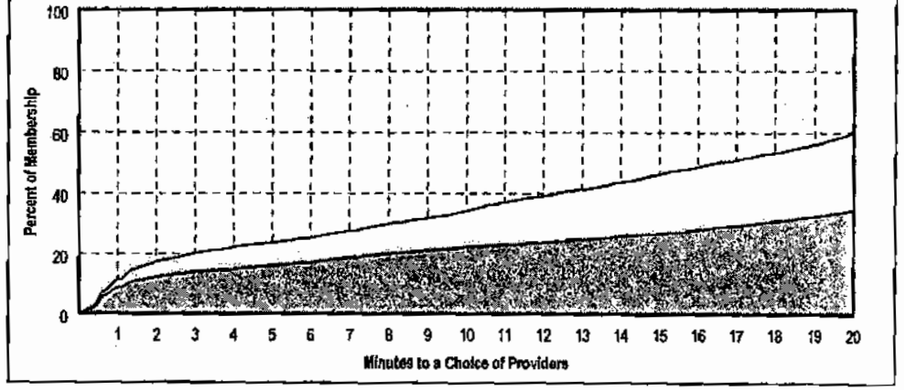
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	15.7 minutes
Average driving time to 2nd closest provider	24.0 minutes

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	34,187 membership 32,963 (96.4%) membership with access 1,224 (3.6%) membership without access		114 unique providers at 35 unique locations (121 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Cheshire County, NH	4	6,873	6,873	100.0	0	0.0	27.2	28.0
	Grafton County, NH	4	7,236	6,435	88.9	801	11.1	18.4	25.1
	Belknap County, NH	3	6,208	6,208	100.0	0	0.0	7.4	7.7
	Carroll County, NH	0	4,827	4,827	100.0	0	0.0	18.3	28.8
	Sullivan County, NH	1	4,766	4,498	94.4	268	5.6	8.1	37.0
	Coos County, NH	26	4,277	4,122	96.4	155	3.6	8.6	12.5
	Totals	34	34,187	32,963	96.4	1,224	3.6	15.5	23.1
Without Access	Grafton County, NH	4	7,236	6,435	88.9	801	11.1	25.3	47.1
	Sullivan County, NH	1	4,766	4,498	94.4	268	5.6	11.0	45.6
	Coos County, NH	26	4,277	4,122	96.4	155	3.6	16.1	48.0
	Totals	31	16,279	15,055	92.5	1,224	7.5	21.2	46.9

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburuban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
Belknap County, NH	4	6,206	0.00	6,206	100.0	0	0.0	7.4	7.7
Carroll County, NH	0	4,827	0.00	4,827	100.0	0	0.0	18.3	28.8
Cheshire County, NH	0	6,873	0.00	6,873	100.0	0	0.0	27.2	28.0
Coos County, NH	26	4,277	0.01	4,122	96.4	155	3.6	8.9	13.8
Grafton County, NH	4	7,256	0.00	6,435	88.9	801	11.1	19.2	27.5
Sullivan County, NH	1	4,766	0.00	4,498	94.4	268	5.6	8.3	38.2
Grand Totals	**34**	**34,187**	**0.00**	**32,963**	**96.4**	**1,224**	**3.6**	**15.7**	**24.0**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Rural

New Hampshire

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Rural

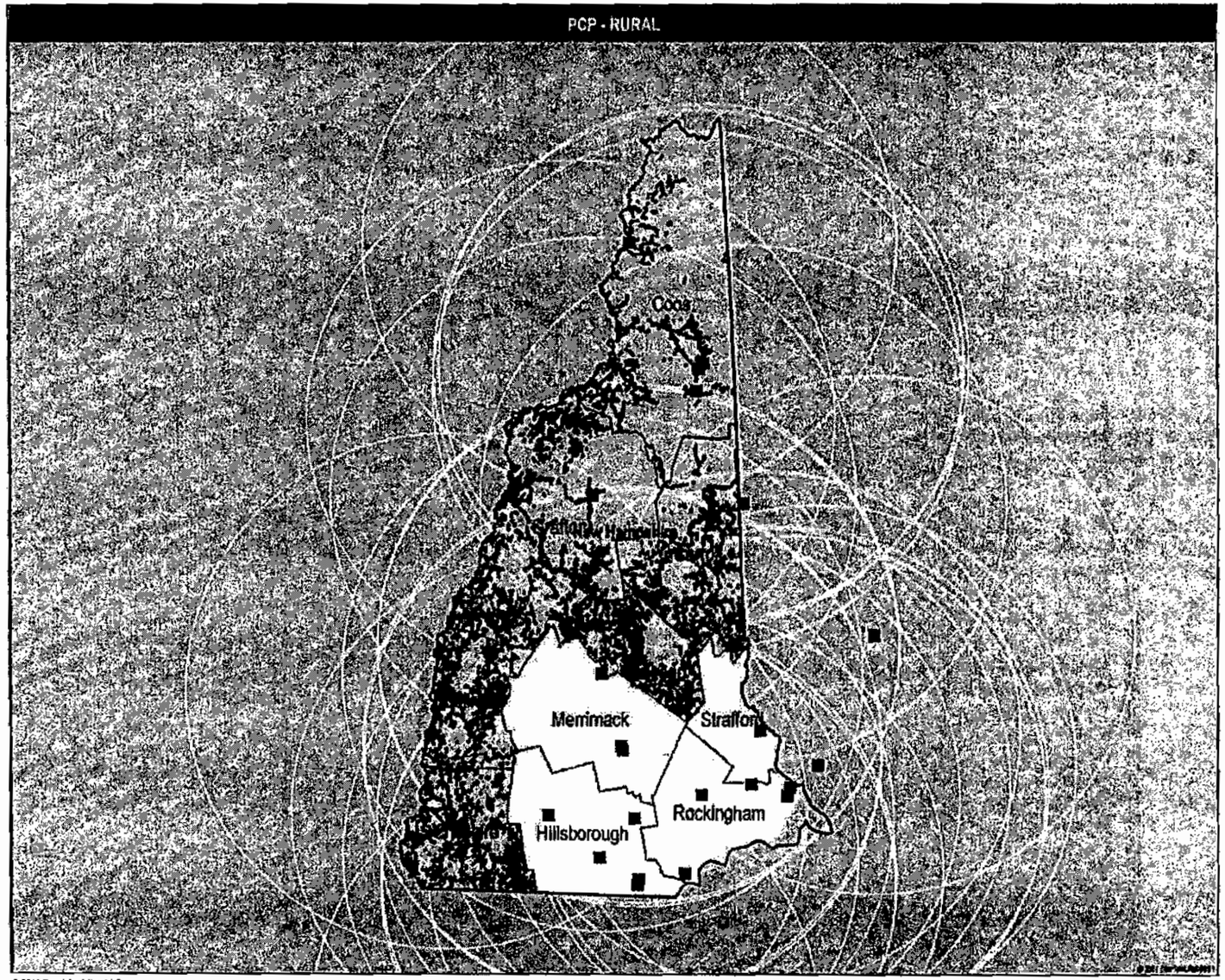
34,187 member locations
2 within 45
PCP
- Membership with Access (32,963)
- Membership without Access (1,224)

PCP

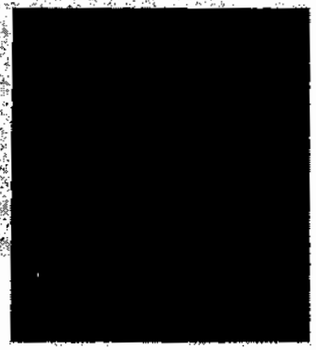
114 providers at 35 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC



Network Access Analysis - PCP

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 14, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Mileage

Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5

RURAL by Mileage

Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

URBAN by Mileage

Access Overview

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

Access Map
Member locations...

- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over miles.

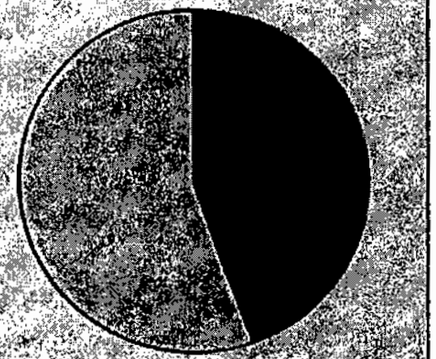
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 miles

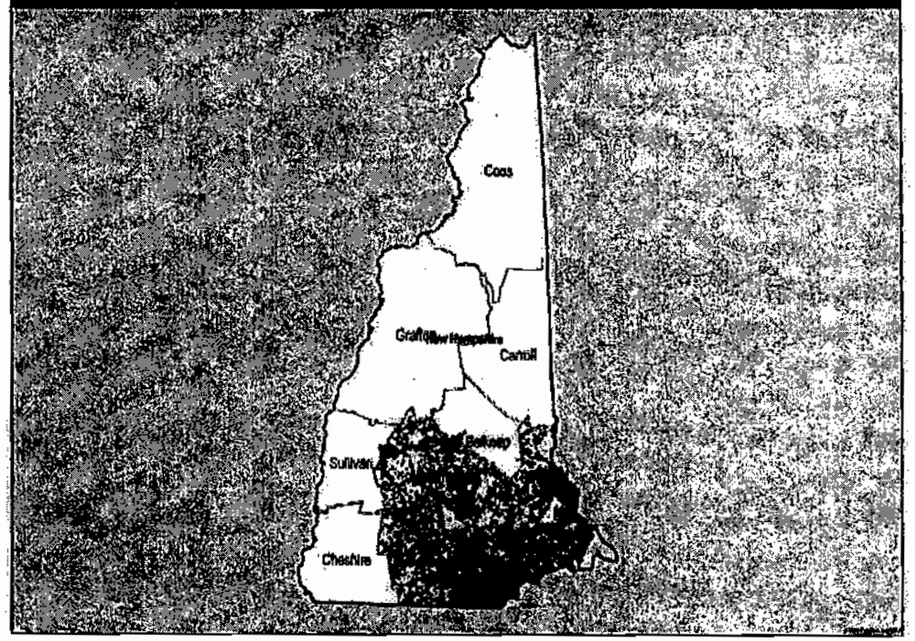
Overall Access [1]

75,897 membership
114 providers at 39 locations

33,810 (44.5%) membership with access
42,087 (55.5%) membership without access



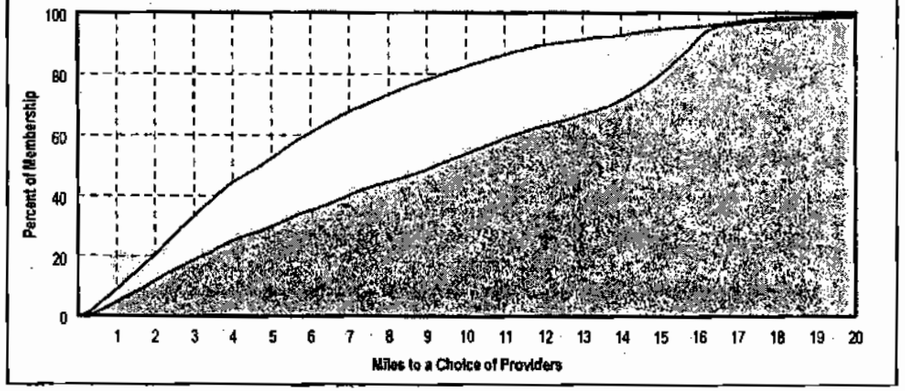
All Membership



Average Distances

Average distance to 1st closest provider	5.9 miles
Average distance to 2nd closest provider	9.2 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 miles

Summary Information

Member Group		Provider Group	
	75,897 membership 33,810 (44.5%) membership with access 42,087 (55.5%) membership without access		114 unique providers at 38 unique locations (121 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Hillsborough County, NH	14	35,670	11,653	32.7	24,017	67.3	2.8	3.3
	Strafford County, NH	9	11,505	8,136	70.7	3,369	29.3	4.8	4.8
	Rockingham County, NH	36	15,656	7,515	48.0	8,151	52.0	3.6	4.1
	Merrimack County, NH	6	13,066	6,506	49.8	6,550	50.2	2.7	3.3
	Totals	65	75,897	33,810	44.5	42,087	55.5	3.5	3.9
Without Access	Hillsborough County, NH	14	35,670	11,653	32.7	24,017	67.3	4.8	14.2
	Rockingham County, NH	36	15,656	7,515	48.0	8,151	52.0	10.9	11.3
	Merrimack County, NH	6	13,066	6,506	49.8	6,550	50.2	12.1	13.3
	Strafford County, NH	9	11,505	8,136	70.7	3,369	29.3	13.8	13.9
	Totals	65	75,897	33,810	44.5	42,087	55.5	7.8	13.5

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 8

Provider Group
PCP

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 2 (PCP) Providers within 8.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	14	36,670	0.00	11,823	32.2	24,847	67.8	4.2	10.7
Merrimack County, NH	6	13,056	0.00	6,506	49.8	6,550	50.2	7.4	8.3
Rockingham County, NH	36	15,666	0.00	7,505	48.0	8,161	52.0	7.5	7.9
Strafford County, NH	9	11,505	0.00	8,136	70.7	3,369	29.3	7.5	7.5
Grand Totals	**65**	**75,897**	**0.00**	**33,810**	**44.5**	**42,087**	**55.5**	**5.9**	**9.2**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban

New Hampshire

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Urban

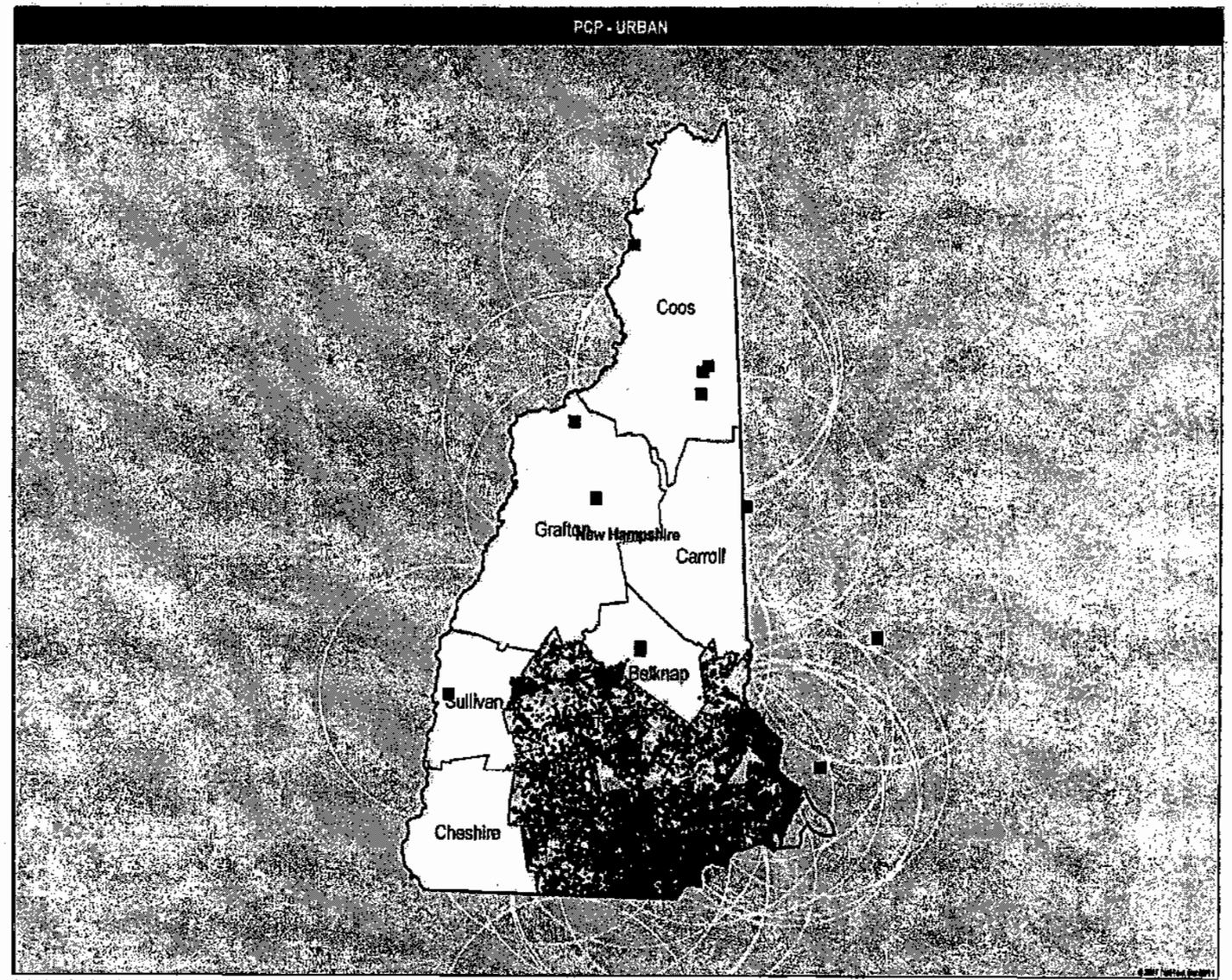
75,897 member locations
2 within 8
PCP
- Membership with Access (33,810)
- Membership without Access (42,087)

PCP

114 providers at 35 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 In. = 33.33 miles



© 2011 Quest Analytics, LLC

RURAL by Mileage

Access Overview

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

Access Map
Member locations...

- ◆ Membership with Access
- ● Membership without Access
- ☐ Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over miles.

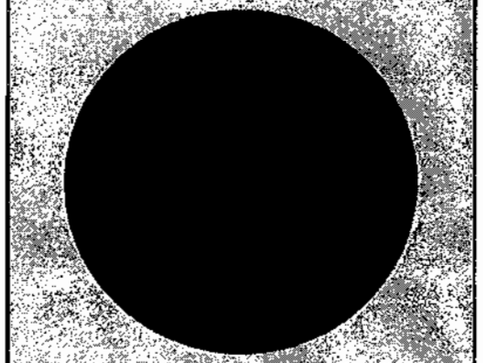
- ☐ 1st closest provider
- ☐ 2nd closest provider

[1] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 miles

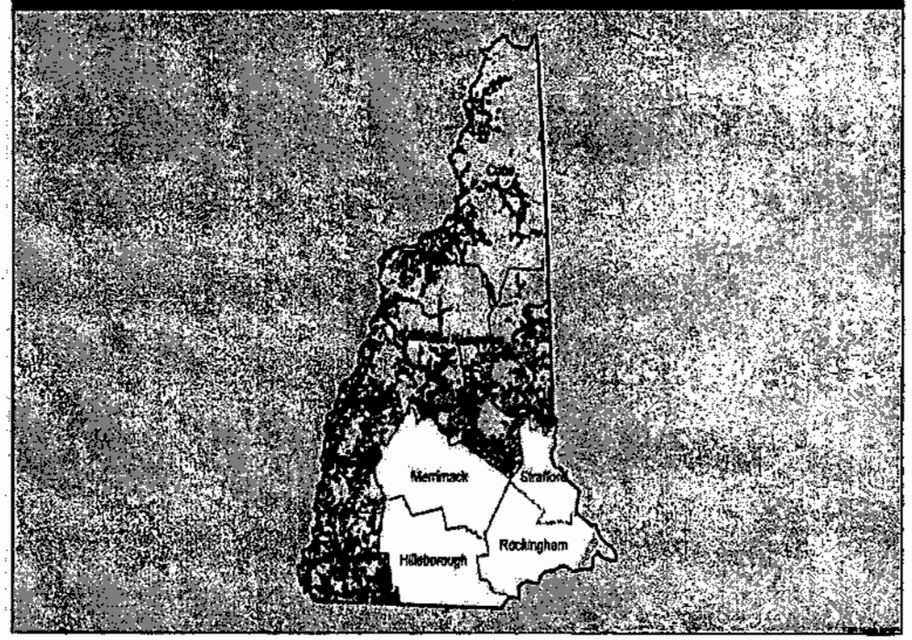
Overall Access [1]

34,187 membership
114 providers at 39 locations

34,164 (99.9%) membership with access
23 (0.1%) membership without access



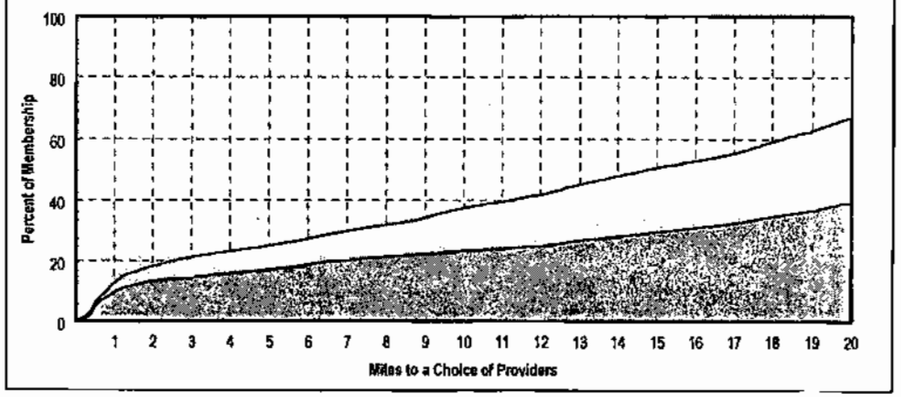
All Membership



Average Distances

Average distance to 1st closest provider	14.2 miles
Average distance to 2nd closest provider	21.7 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 miles

Summary Information

Member Group	Provider Group
34,187 members 34,164 (99.9%) members with access 23 (0.1%) members without access	114 unique providers at 35 unique locations (121 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Grafton County, NH	4	7,236	7,236	100.0	0	0.0	17.8	25.2
	Cheshire County, NH	0	6,873	6,873	100.0	0	0.0	24.9	25.7
	Belknap County, NH	3	6,206	6,206	100.0	0	0.0	8.2	8.4
	Carroll County, NH	0	4,827	4,827	100.0	0	0.0	16.1	25.2
	Sullivan County, NH	1	4,705	4,705	100.0	0	0.0	7.7	35.1
	Coos County, NH	26	4,277	4,254	99.5	23	0.5	8.2	12.5
	Totals	34	34,187	34,164	99.9	23	0.1	14.2	21.2
Without Access	Coos County, NH	26	4,277	4,254	99.5	23	0.5	18.7	48.0
	Totals	26	4,277	4,254	99.5	23	0.5	18.7	48.0

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
2 within 45

Provider Group
PCP

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 2 (PCP) Providers within 45.0 miles

County	All Membership								
	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	2	6,208	0.00	6,208	100.0	0	0.0	6.2	6.4
Carroll County, NH	0	4,827	0.00	4,827	100.0	0	0.0	16.1	25.2
Cheshire County, NH	0	6,573	0.00	6,573	100.0	0	0.0	24.9	25.7
Coos County, NH	26	4,277	0.01	4,254	99.5	23	0.5	8.2	12.7
Grafton County, NH	4	7,236	0.00	7,236	100.0	0	0.0	17.6	25.2
Sullivan County, NH	1	4,766	0.00	4,766	100.0	0	0.0	7.7	35.1
Grand Totals	**34**	**34,187**	**0.00**	**34,164**	**99.9**	**23**	**0.1**	**14.2**	**21.7**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Rural

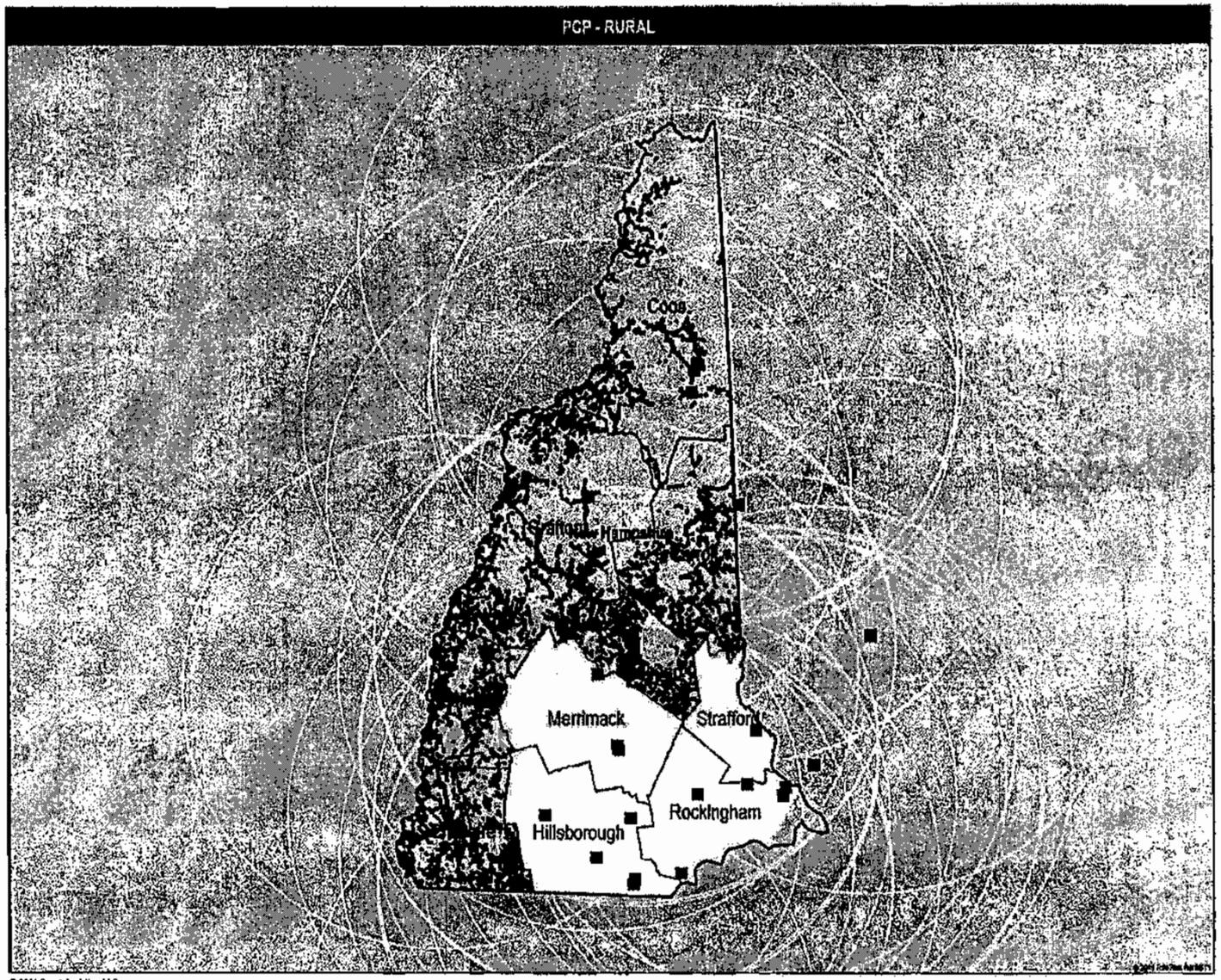
34,187 member locations
2 within 45
PCP
- Membership with Access (34,164)
- Membership without Access (23)

PCP

114 providers at 35 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 In. = 33.33 miles



© 2011 Quest Analytics, LLC

[redacted]

Network Access Analysis - SPECIALIST

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Members hip
New Hampshire
December 13, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Report Contents

URBAN by Minutes
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Minutes
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

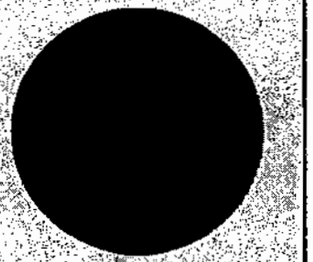
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

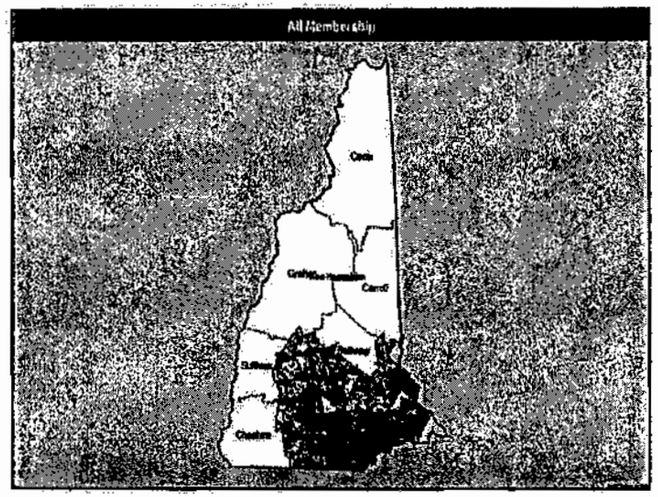
Overall Access[1]

75,697 membership
82 providers at 42 locations

75,697 (100.0%) members with access
0 (0.0%) members without access



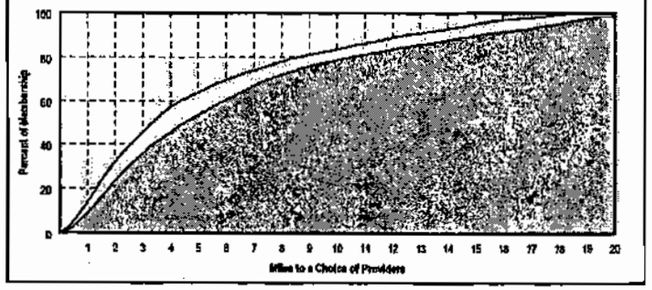
All Membership



Average Distances

Average distance to 1st closest provider	5.1 miles
Average distance to 2nd closest provider	6.3 miles

Access Standard Comparison



© 2011 Open Analytics, LLC

Access Summary by County

NH Medicaid Urban
Urban Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

Summary Information

Member Group	Provider Group
75,697 membership 75,697 (100.0%) membership with access 0 (0.0%) membership without access	92 unique providers at 97 unique locations (103 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Hillsborough County, NH	39	38,670	38,670	100.0	0	0.0	3.9	4.8
	Rockingham County, NH	20	15,666	15,666	100.0	0	0.0	6.6	7.6
	Strafford County, NH	10	11,000	11,000	100.0	0	0.0	8.6	10.2
	Stafford County, NH	31	11,505	11,505	100.0	0	0.0	4.1	5.5
	Totals	91	75,697	75,697	100.0	0	0.0	6.1	6.9
Without Access	No records meet the criteria								

©2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	20	35,970	0.00	35,970	100.0	0	0.0	3.5	4.3
Merrimack County, NH	10	13,056	0.00	13,056	100.0	0	0.0	8.4	10.2
Rockingham County, NH	20	15,008	0.00	15,008	100.0	0	0.0	6.5	7.9
Strafford County, NH	31	11,505	0.00	11,505	100.0	0	0.0	4.1	6.6
Grand Totals	**81**	**75,897**	**0.00**	**75,897**	**100.0**	**0**	**0.0**	**5.1**	**6.3**

© 2011 Quest Analytics LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

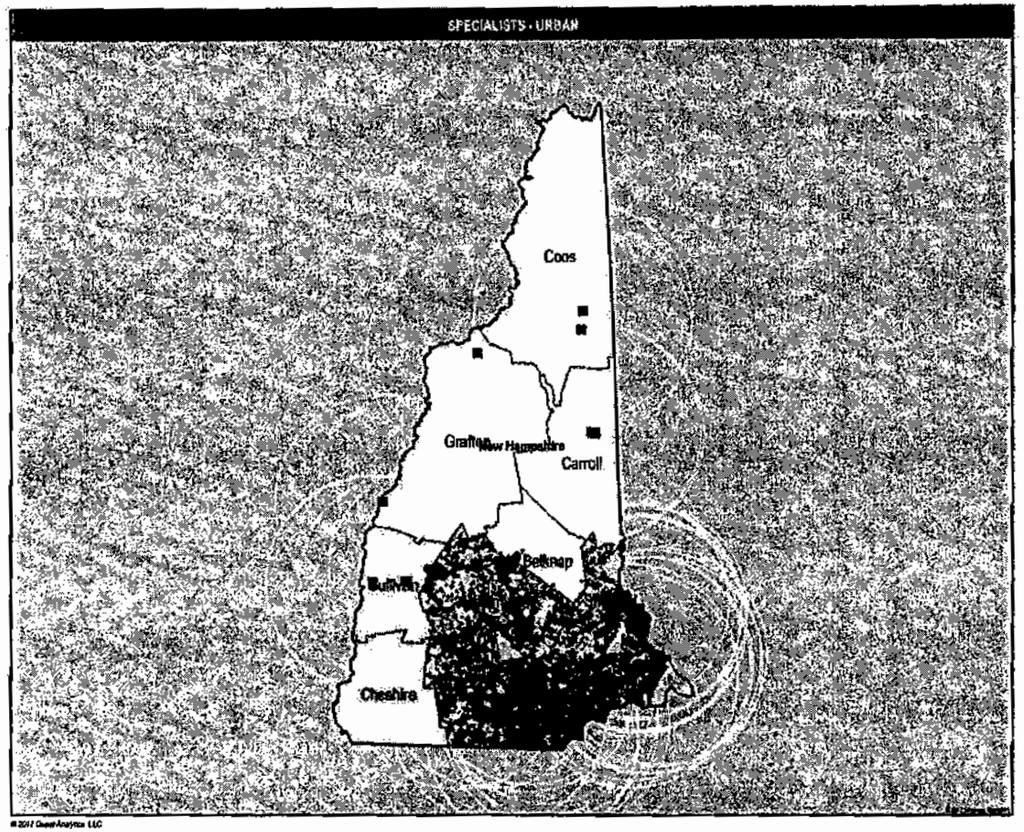
Created by...
HEOPS

NH Medicaid Urban
75,897 member locations
1 within 30
SPECIALISTS
- Membership with Access (75,897)
- Membership without Access (0)

SPECIALISTS
92 providers at 47 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



© 2011 GeoAnalytics LLC

Access Overview

NH Medicaid Rural
Rural Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
SPECIALISTS

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

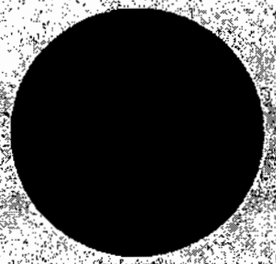
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 60.0 miles

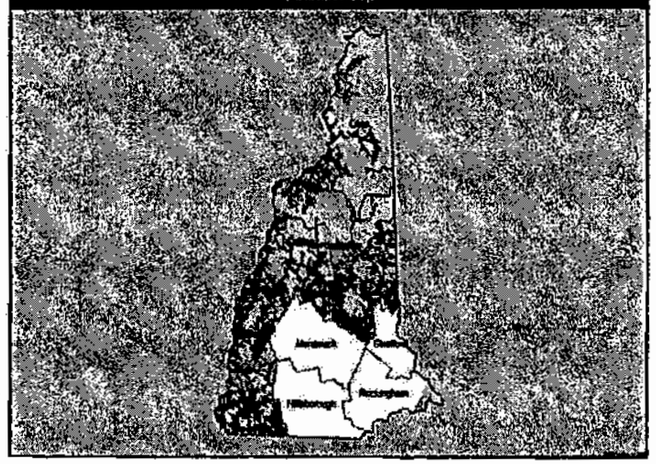
Overall Access

34,197 membership
52 providers at 47 locations

34,197 (100.0%) membership with access
0 (0.0%) membership without access



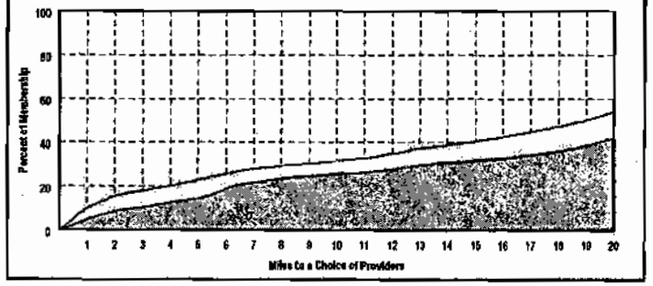
All Membership



Average Distances

Average distance to 1st closest provider	16.7 miles
Average distance to 2nd closest provider	20.0 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 50

Provider Group
SPECIALISTS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 50.0 miles

Summary Information

Member Group		Provider Group	
	34,167 membership 34,167 (100.0%) membership with access 0 (0.0%) membership without access		22 unique providers at 47 unique locations (103 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Grafton County, NH	3	7,230	7,230	100.0	0	0.0	15.5	21.8
	Cheshire County, NH	0	6,873	6,873	100.0	0	0.0	24.8	29.4
	Sullivan County, NH	0	6,266	6,266	100.0	0	0.0	22.3	28.5
	Carroll County, NH	3	4,827	4,827	100.0	0	0.0	14.7	15.4
	Sullivan County, NH	5	4,766	4,766	100.0	0	0.0	4.7	5.6
	Coos County, NH	2	4,277	4,277	100.0	0	0.0	12.9	15.7
	Totals	13	34,167	34,167	100.0	0	0.0	16.7	20.0
Without Access	No records meet the criteria								

© 2011 Quest Analytics LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
SPECIALISTS

[1] Provider To Membership ratio

[2] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 60.0 miles

All Membership								
County	Provider Locations	Total Memberships	Ratio [1]	With Access [2] #	With Access [2] %	Without Access [2] #	Without Access [2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	6	6,208	0.00	6,208	100.0	0	0.0	23.2	35.3
Carroll County, NH	3	4,827	0.00	4,827	100.0	0	0.0	14.7	15.4
Cheshire County, NH	6	6,973	0.00	6,973	100.0	0	0.0	24.3	31.6
Coos County, NH	2	4,277	0.00	4,277	100.0	0	0.0	12.0	16.7
Grafton County, NH	5	7,296	0.00	7,296	100.0	0	0.0	18.9	31.8
Sullivan County, NH	5	4,766	0.00	4,766	100.0	0	0.0	4.7	5.0
	Grand Totals	33	34,197	0.96	34,997	100.0	0	18.7	20.9

© 2011 Quest Analytics LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

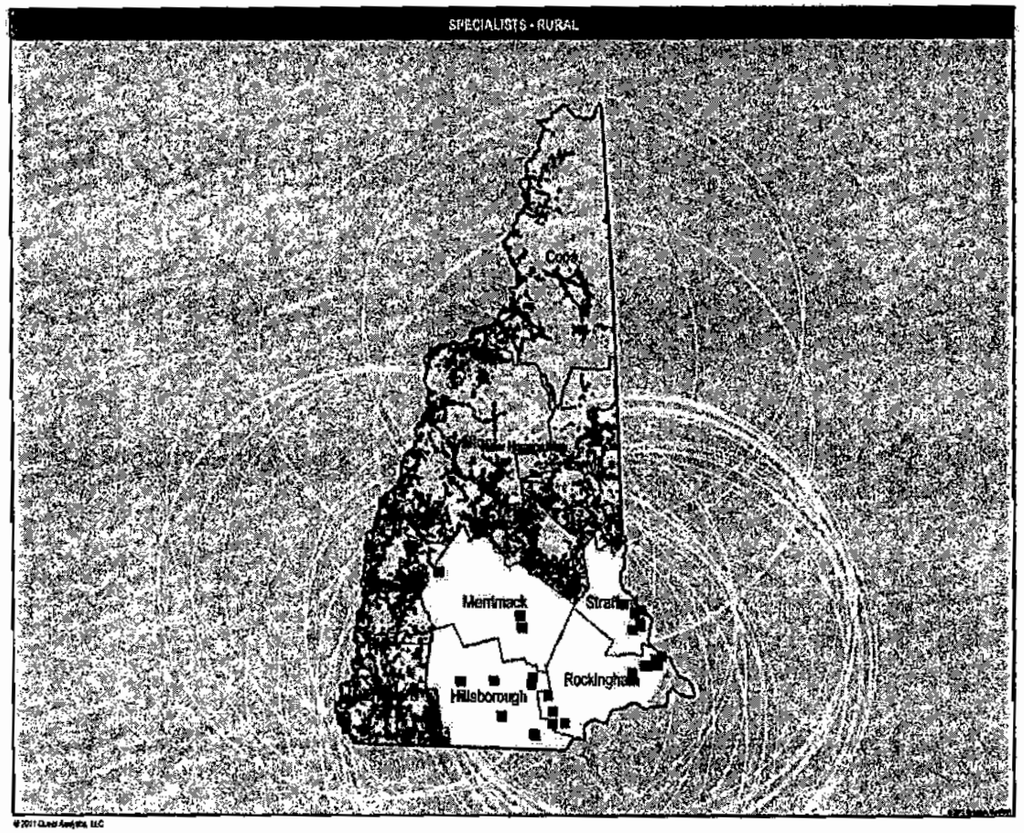
Created by...
HEOPS

NH Medicaid Rural
34,167 member locations
1 within 60
SPECIALISTS
Membership with Access (34,167)
Membership without Access (0)

SPECIALISTS
92 providers at 47 locations
All Providers
60 mile radius

Service Areas
Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

Network Access Analysis - SPECIALIST

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Mileage
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Mileage
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

URBAN by Mileage

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEDPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

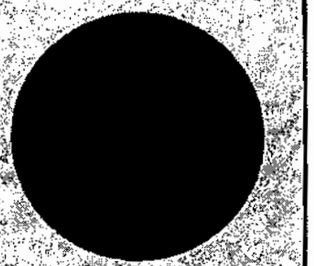
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

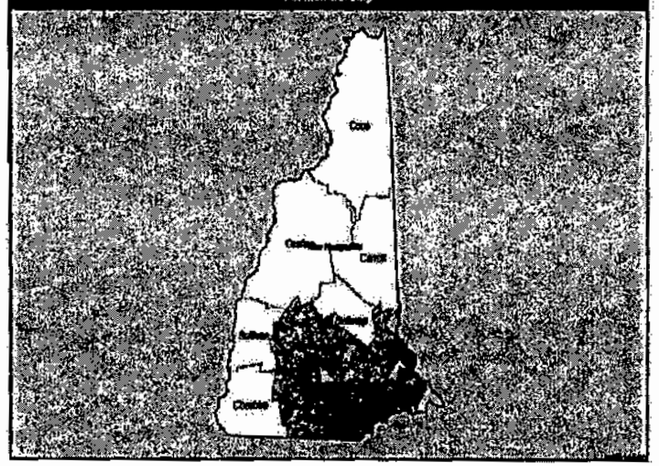
Overall Access [1]

75,897 membership
92 providers at 47 locations

75,897 (100.0%) membership with access
0 (0.0%) membership without access



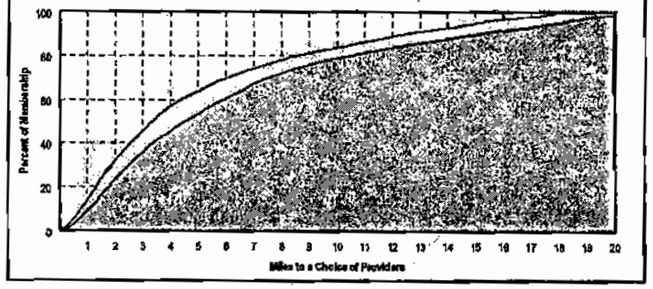
All Membership



Average Distances

Average distance to 1st closest provider	5.1 miles
Average distance to 2nd closest provider	6.3 miles

Access Standard Comparison



©2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

Summary Information

Member Group		Provider Group	
	79,997 memberships 79,997 (100.0%) memberships with access 0 (0.0%) memberships without access		92 unique providers at 87 service locations 100 total access points

Key Geographic Areas

With Access

County	Provider Locations	Total Membership	#	%	Without Access #	Without Access %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	29	36,676	36,676	100.0	0	0.0	3.5	4.2
Rockingham County, NH	20	15,966	15,966	100.0	0	0.0	6.8	7.6
Merrimack County, NH	20	13,854	13,854	100.0	0	0.0	6.4	10.3
Strafford County, NH	31	11,505	11,505	100.0	0	0.0	4.1	6.8
Totals	87	79,997	79,997	100.0	0	0.0	5.5	6.5

Without Access

County	Provider Locations	Total Membership	#	%	Without Access #	Without Access %	Average Distance to Providers 1	Average Distance to Providers 2
No records meet the criteria.								

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
SPECIALISTS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 30.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	20	35,879	0.00	35,879	100.0	0	0.0	3.5	4.2
Merrimack County, NH	10	13,056	0.00	13,056	100.0	0	0.0	8.4	10.2
Rockingham County, NH	20	13,056	0.00	13,056	100.0	0	0.0	6.9	7.8
Strafford County, NH	31	11,505	0.00	11,505	100.0	0	0.0	4.1	6.8
Grand Totals	81	73,497	0.00	73,497	100.0	0	0.0	5.1	6.3

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban

New Hampshire

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Urban

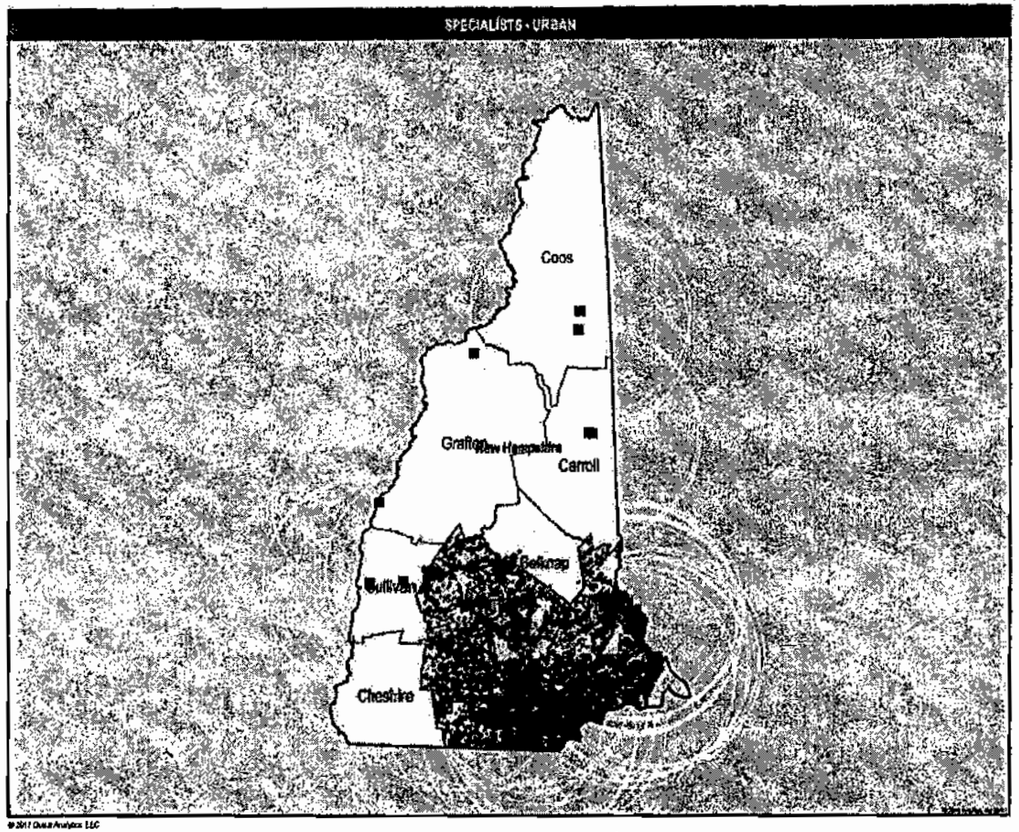
75,097 member locations
1 within 30
SPECIALISTS
- Membership with Access (75,057)
- Membership without Access (0)

SPECIALISTS

92 providers at 47 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 20.33 miles



© 2011 Quest Analytics LLC

RURAL by Mileage

Access Overview

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

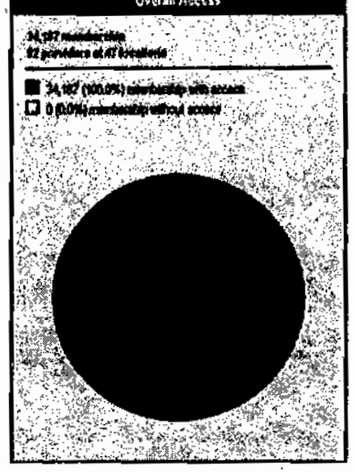
Provider Group
SPECIALISTS

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

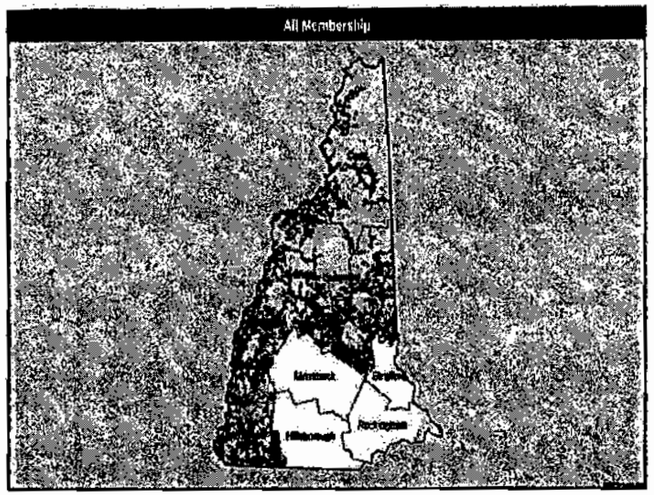
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 60.0 miles

Overall Access[1]



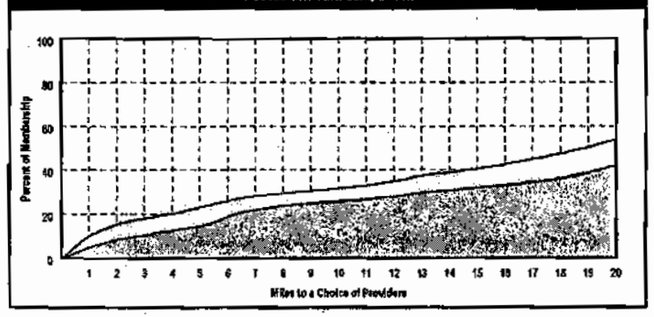
All Membership



Average Distances

Average distance to 1st closest provider	16.7 miles
Average distance to 2nd closest provider	20.0 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural

Rural Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEDPS

Access Standard
1 within 60

Provider Group
SPECIALISTS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 60.0 miles

Summary Information

Member Group	Provider Group
34,167 membership 34,167 (100.0%) membership with access 0 (0.0%) membership without access	92 unique providers at 47 unique locations (103 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access #	With Access %	Without Access #	Without Access %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Grafton County, NH	31	7,290	7,290	100.0	0	0.0	18.5	21.8
	Cheshire County, NH	0	6,873	6,873	100.0	0	0.0	24.8	29.4
	Belknap County, NH	0	6,208	6,208	100.0	0	0.0	22.3	26.1
	Carroll County, NH	3	4,827	4,827	100.0	0	0.0	14.7	15.4
	Sullivan County, NH	0	4,796	4,796	100.0	0	0.0	9.7	9.8
	Coos County, NH	2	4,277	4,277	100.0	0	0.0	12.8	16.7
	Total	11	34,167	34,167	100.0	0	0.0	16.2	20.0
Without Access	No records meet this criteria.								

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
MEOP9

Access Standard
1 within 60

Provider Group
SPECIALISTS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (SPECIALISTS) Provider within 60.0 miles

	All Membership								
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	0	6,206	0.00	6,206	100.0	0	0.0	23.5	25.3
Carroll County, NH	3	4,827	0.00	4,827	100.0	0	0.0	14.7	16.4
Cheshire County, NH	0	8,873	0.00	8,873	100.0	0	0.0	24.3	25.4
Coos County, NH	2	4,277	0.00	4,277	100.0	0	0.0	12.9	16.7
Grafton County, NH	1	7,236	0.00	7,236	100.0	0	0.0	15.8	21.5
Sullivan County, NH	5	4,766	0.00	4,766	100.0	0	0.0	4.7	5.0
Grand Totals	**13**	**34,167**	**0.00**	**34,167**	**100.0**	**0**	**0.0**	**16.7**	**20.8**

©2011 Geoa Analytics LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Rural
34,167 member locations
1 within 60
SPECIALISTS
- Membership with Access (34,167)
- Membership without Access (0)

SPECIALISTS
92 providers at 47 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles

© 2011 Quest Analytics, LLC

Network Access Analysis-ACUTE HOSPITAL

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 14, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Minutes
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Minutes
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

Access Overview

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

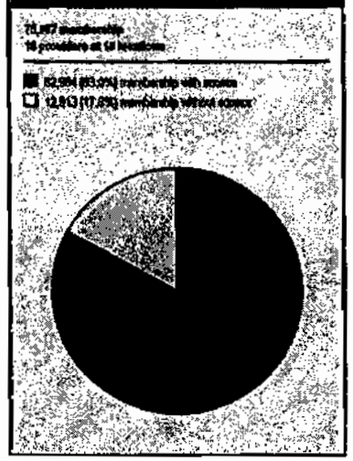
Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.
- 1st closest provider
- 2nd closest provider

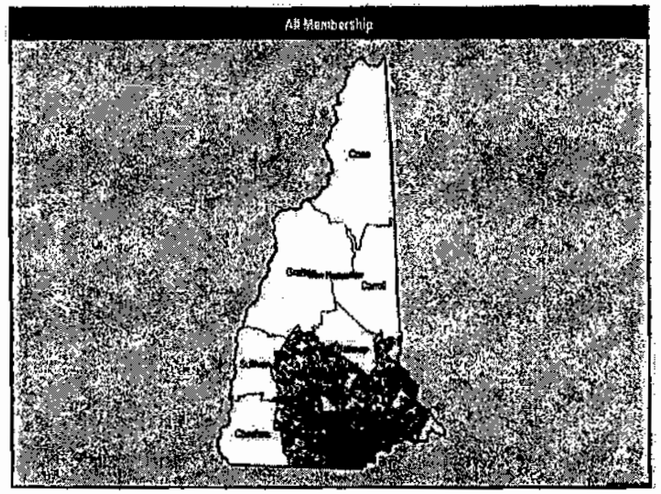
[1] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 30.0 minutes

[2] Driving Times estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Overall Access[1]



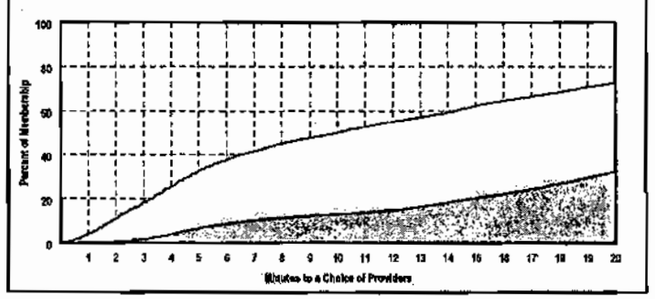
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	14.4 minutes
Average driving time to 2nd closest provider	24.5 minutes

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 30.0 miles

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	75,887 memberships 62,964 (82.9%) memberships with access 12,913 (17.0%) memberships without access		18 unique providers at 18 unique locations (18 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Hillsborough County, NH	4	35,670	35,670	100.0	0	0.0	6.4	16.5
	Merrimack County, NH	3	13,056	13,056	100.0	0	0.0	7.4	18.5
	Rockingham County, NH	0	15,658	10,492	67.0	5,174	33.0	19.6	37.4
	Strafford County, NH	0	11,505	3,746	32.7	7,739	67.3	23.9	32.8
	Totals	7	75,887	62,964	83.0	12,913	17.0	9.6	20.9
Without Access	Strafford County, NH	0	11,505	3,766	32.7	7,739	67.3	38.5	38.4
	Rockingham County, NH	0	15,658	10,492	67.0	5,174	33.0	39.4	46.7
	Totals	0	27,163	14,258	52.5	12,913	47.5	37.2	43.3

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 30.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
Hillsborough County, NH	4	25,670	0.00	25,670	100.0	0	0.0	5.4	18.5
Merrimack County, NH	3	13,056	0.00	13,056	100.0	0	0.0	7.4	18.5
Rockingham County, NH	6	12,506	0.00	10,432	67.0	5,174	33.0	25.4	33.8
Strafford County, NH	0	11,505	0.00	3,766	32.7	7,739	67.3	32.3	37.2
Grand Totals	7	75,897	0.00	62,984	83.0	12,913	17.0	14.4	24.5

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

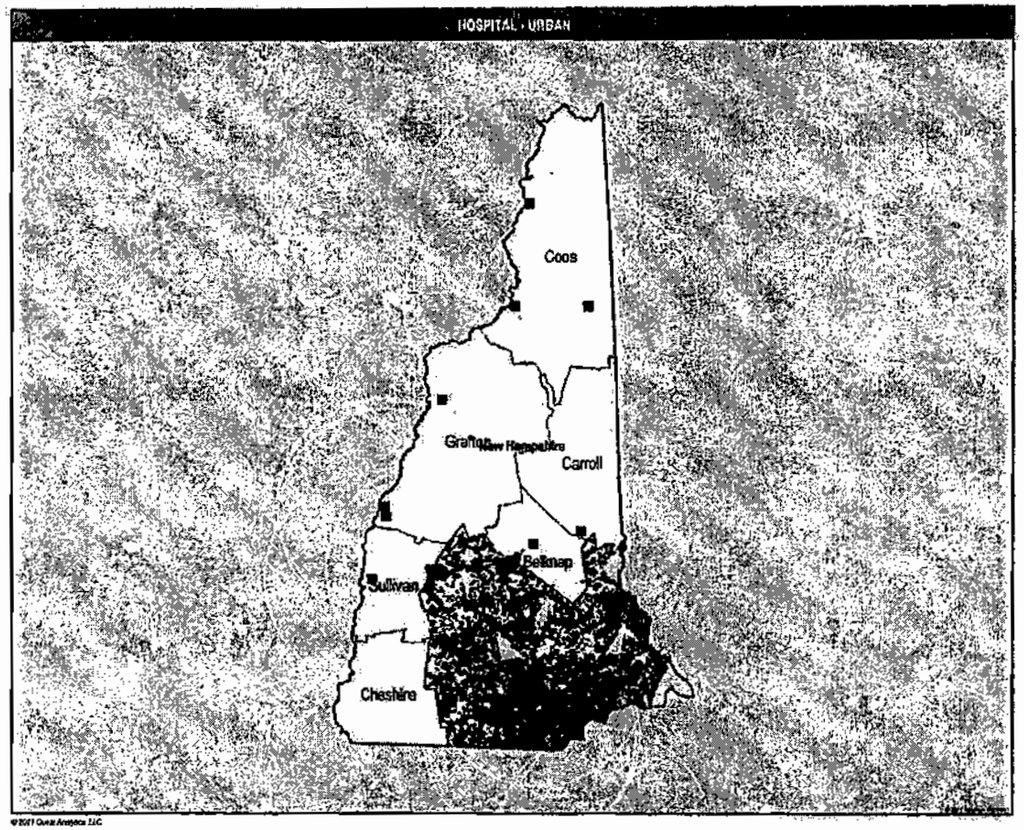
Created by...
HEOPS

NH Medicaid Urban
75,897 member locations
1 within 30
HOSPITALS
- Membership with Access (62,984)
- Membership without Access (12,913)

HOSPITALS
18 providers at 18 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



© 2011 Quest Analytics LLC

Access Overview

NH Medicaid Rural
Rural Counties
December 14, 2011

Created for...
Boston Medical Center Healthfiet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
HOSPITALS

Access Map
Member locations...

- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.

- 1st closest provider
- 2nd closest provider

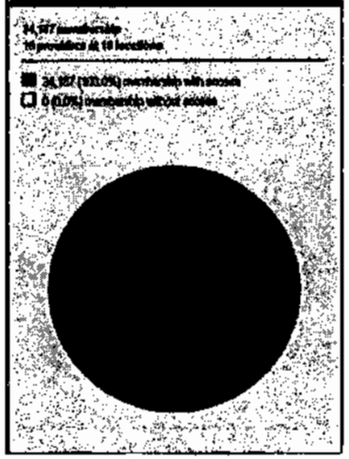
1 The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 minutes

2 Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

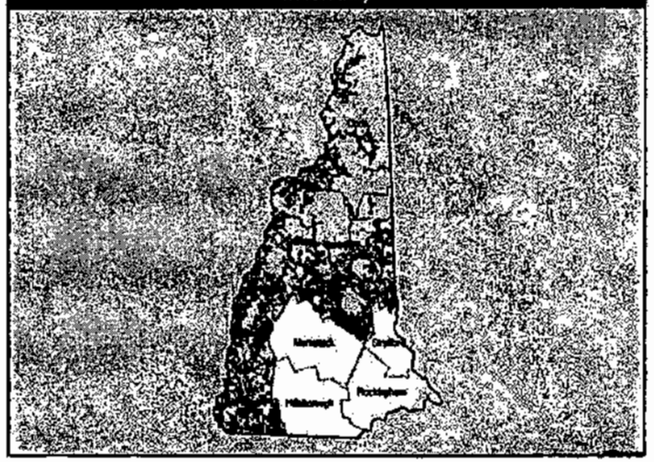
Overall Access[1]

34,187 membership
16 providers at 16 locations

- 34,187 (100.0%) membership with access
- 0 (0.0%) membership without access



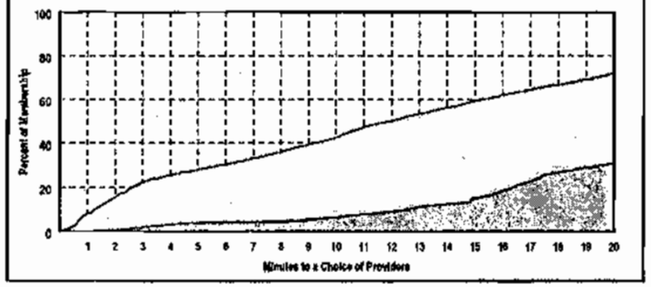
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	13.4 minutes
Average driving time to 2nd closest provider	26.3 minutes

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
HOSPITALS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	34,187 membership 34,187 (100.0%) membership with access 0 (0.0%) membership without access		18 unique providers at 18 unique locations (18 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Grafton County, NH	4	7,230	7,230	100.0	0	0.0	14.1	22.3
	Cheshire County, NH	0	6,673	6,673	100.0	0	0.0	21.7	39.8
	Sullivan County, NH	1	6,208	6,208	100.0	0	0.0	8.8	18.3
	Carroll County, NH	1	4,827	4,827	100.0	0	0.0	21.4	33.8
	Sullivan County, NH	1	4,768	4,768	100.0	0	0.0	7.8	20.0
	Coos County, NH	3	4,277	4,277	100.0	0	0.0	6.7	24.8
	Totals	10	34,187	34,187	100.0	0	0.0	12.4	26.3
Without Access	No records meet the criteria								

© 2011 Ocean Analytics, LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
HOSPITALS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

County	All Membership								
	Provider Locations	Total Membership	Ratio [1]	With Access [2] #	With Access [2] %	Without Access [2] #	Without Access [2] %	Average Time to Providers [3] 1	Average Time to Providers [3] 2
Belknap County, NH	1	8,208	0.00	8,208	100.0	0	0.0	6.6	16.3
Carroll County, NH	1	4,827	0.00	4,827	100.0	0	0.0	21.4	33.8
Cheshire County, NH	0	8,873	0.00	8,873	100.0	0	0.0	21.7	32.6
Coos County, NH	3	4,277	0.00	4,277	100.0	0	0.0	6.7	24.8
Grafton County, NH	4	7,235	0.00	7,235	100.0	0	0.0	14.1	23.5
Sullivan County, NH	1	4,765	0.00	4,765	100.0	0	0.0	7.2	20.0
Grand Totals	10	34,187	0.00	34,187	100.0	0	0.0	13.4	25.3

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 14, 2011

Created for...
Dartmouth Medical Center HealthNet Plan

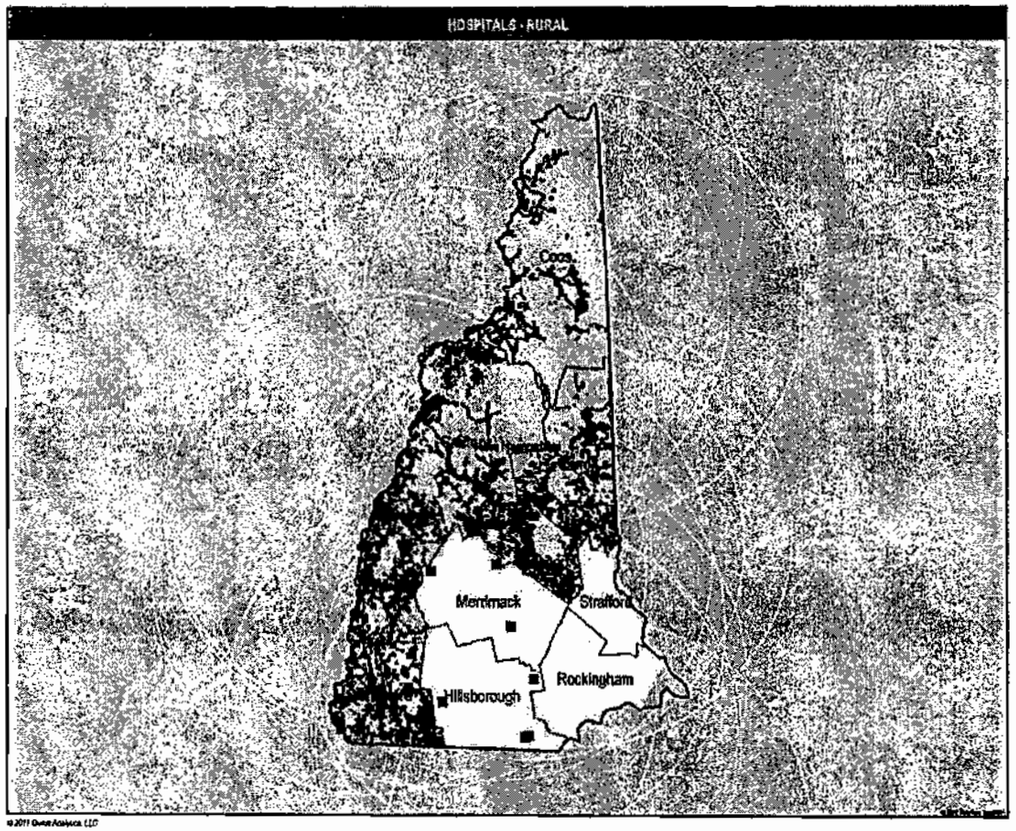
Created by...
HEOPS

NH Medicaid Rural
34,187 member locations
1 within 60
HOSPITALS
- Membership with Access (34,187)
- Membership without Access (0)

HOSPITALS
18 providers at 18 locations
- All Providers
- 60 mi radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

[redacted]

Network Access Analysis-ACUTE HOSPITAL

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 14, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan
Created by...
HEOPS

Report Contents

URBAN by Mileage
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Mileage
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

URBAN by Mileage

Access Overview

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

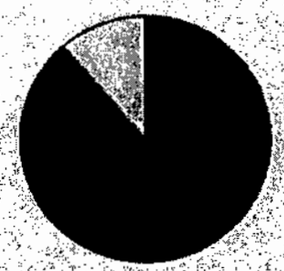
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 30.0 miles

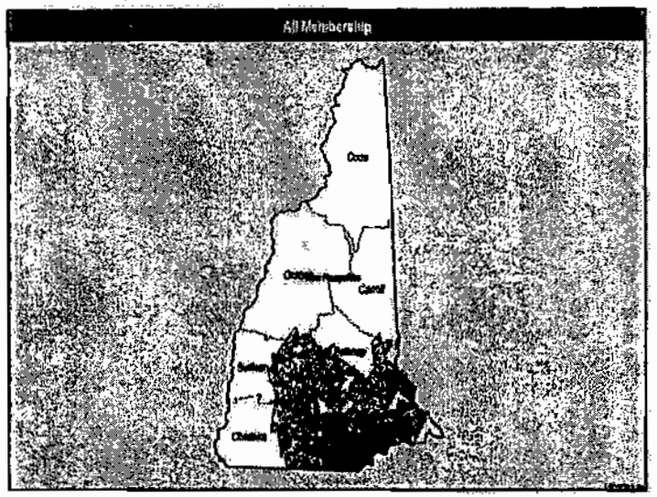
Overall Access

[illegible] membership
[illegible] providers at [illegible] locations

- [illegible] (88.6%) membership with access
- 8,631 (11.4%) membership without access



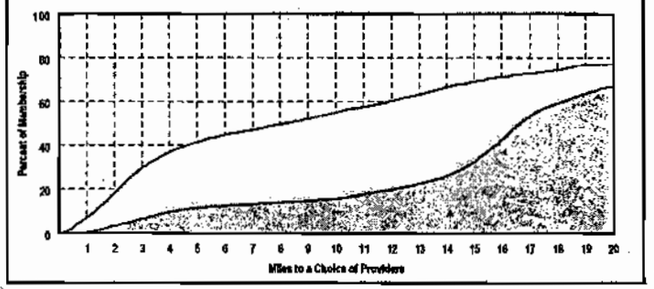
All Membership



Average Distances

Average distance to 1st closest provider	12.0 miles
Average distance to 2nd closest provider	19.1 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 [HOSPITALS] Provider within 30.0 miles

Summary Information

Member Group	Provider Group
75,907 membership 67,266 (88.6%) membership with access 8,631 (11.4%) membership without access	18 unique providers at 18 unique locations (18 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] p	With Access[1] %	Without Access[1] p	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Hillsborough County, NH	1	25,670	25,670	100.0	0	0.0	6.7	12.6
	Merrimack County, NH	3	13,056	13,056	100.0	0	0.0	6.7	18.3
	Rockingham County, NH	0	15,665	12,293	78.5	3,373	21.5	10.8	22.8
	Strafford County, NH	0	11,505	6,247	54.3	5,258	45.7	24.6	30.4
	Totals	7	75,897	67,266	88.6	8,631	11.4	8.1	16.7
Without Access	Strafford County, NH	0	11,505	6,247	54.3	5,258	45.7	24.6	35.2
	Rockingham County, NH	0	15,665	12,293	78.5	3,373	21.5	33.7	40.1
	Totals	0	27,171	18,540	68.2	8,631	31.8	34.1	37.8

© 2011 Dean Analytics LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
HOSPITALS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 30.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	4	35,670	0.00	35,670	100.0	0	0.0	4.7	12.4
Merrimack County, NH	3	13,058	0.00	13,058	100.0	0	0.0	6.7	16.3
Rockingham County, NH	0	15,659	0.00	12,293	78.5	3,273	21.5	20.5	26.0
Strafford County, NH	0	11,505	0.00	6,247	54.3	5,268	45.7	29.0	32.8
Grand Totals	7	75,897	0.00	67,266	88.6	8,631	11.4	12.8	19.1

© 2012 Quest Analytics, LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 14, 2011

Created for...
Boston Medical Center Health Net Plan

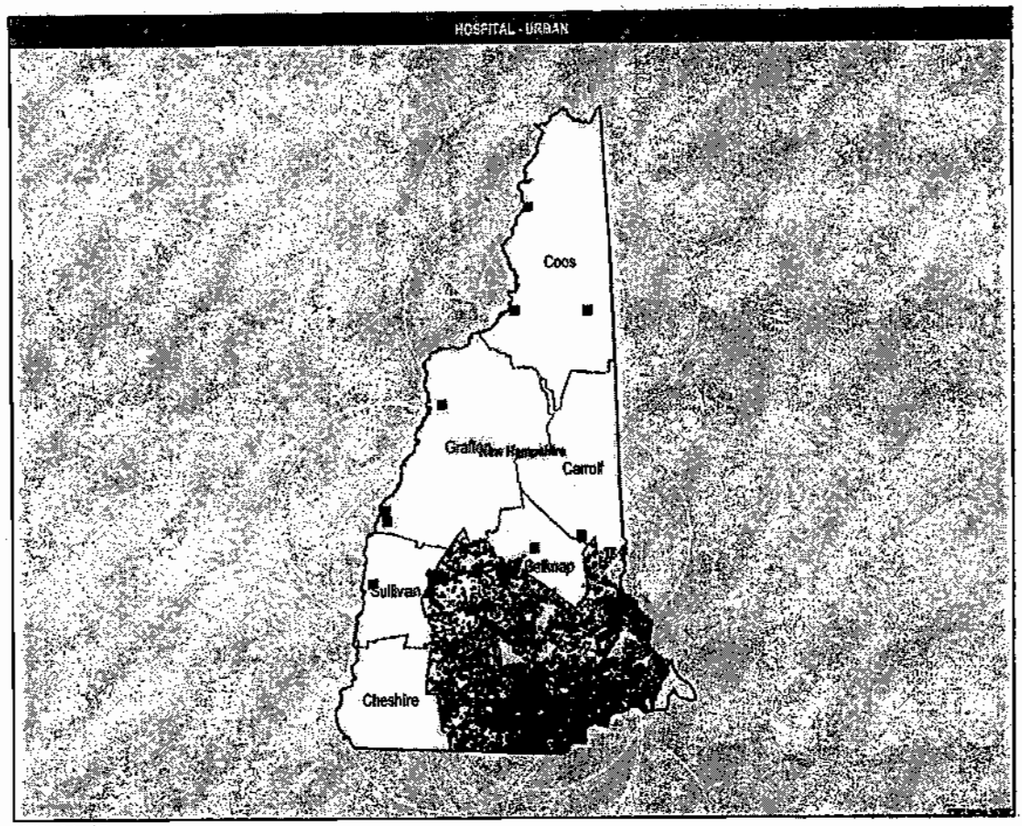
Created by...
NEOPS

NH Medicaid Urban
75,897 member locations
1 within 30
HOSPITALS
- Membership with Access (57,266)
- Membership without Access (18,631)

HOSPITALS
18 providers at 18 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



©2011 Quest Analytics, LLC

RURAL by Mileage

Access Overview

NH Medicaid Rural

Rural Counties

December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
HOSPITALS

Access Map
Member locations...

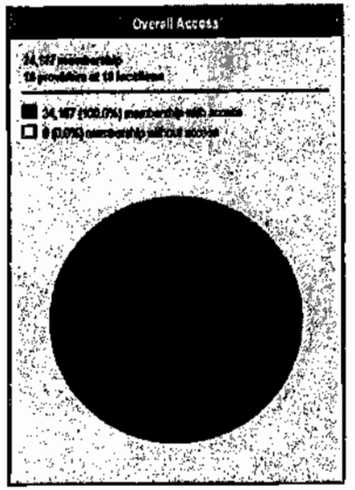
- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over miles.

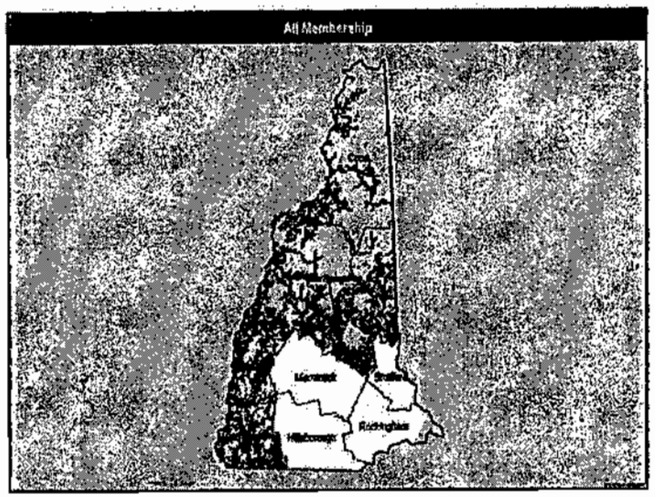
- 1st closest provider
- 2nd closest provider

1 The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 miles

Overall Access



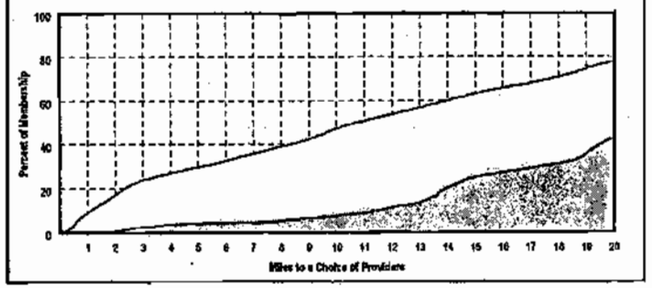
All Membership



Average Distances

Average distance to 1st closest provider	12.2 miles
Average distance to 2nd closest provider	23.3 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
HOSPITALS

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access

[1] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 miles

Summary Information

Member Group		Provider Group	
	34,197 membership 34,197 (100.0%) membership with access 0 (0.0%) membership without access		18 (unique providers at 18 unique locations *18 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] a	a%	Without Access[1] b	b%	Average Distance to Providers t	z
With Access	Grafton County, NH	4	7,230	7,230	100.0	0	0.0	12.8	30.0
	Cheshire County, NH	0	6,873	6,873	100.0	0	0.0	20.0	34.4
	Belknap County, NH	1	6,296	6,296	100.0	0	0.0	5.7	14.3
	Carroll County, NH	1	4,927	4,927	100.0	0	0.0	19.5	29.7
	Sullivan County, NH	1	4,394	4,394	100.0	0	0.0	6.6	18.4
	Coos County, NH	3	4,277	4,277	100.0	0	0.0	6.2	22.8
	Totals	10	34,197	34,197	100.0	0	0.0	11.2	23.3
Without Access	No records meet this criteria.								

© 2011 Cuna Analytics, LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEDPS

Access Standard
1 within 60

Provider Group
HOSPITALS

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (HOSPITALS) Provider within 60.0 miles

County	All Membership								
	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	1	8,298	0.00	8,298	100.0	0	0.0	9.7	44.2
Carroll County, NH	1	4,627	0.00	4,627	100.0	0	0.0	19.5	29.7
Cheshire County, NH	2	8,373	0.00	8,373	100.0	0	0.0	20.0	34.4
Coos County, NH	3	4,277	0.00	4,277	100.0	0	0.0	9.2	22.6
Grafton County, NH	4	7,258	0.00	7,258	100.0	0	0.0	12.8	20.0
Sullivan County, NH	1	4,766	0.00	4,766	100.0	0	0.0	8.5	18.4
Grand Totals	**16**	**34,597**	**0.00**	**34,597**	**100.0**	**0**	**0.0**	**12.2**	**23.3**

© 2011 Geo Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 14, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Rural

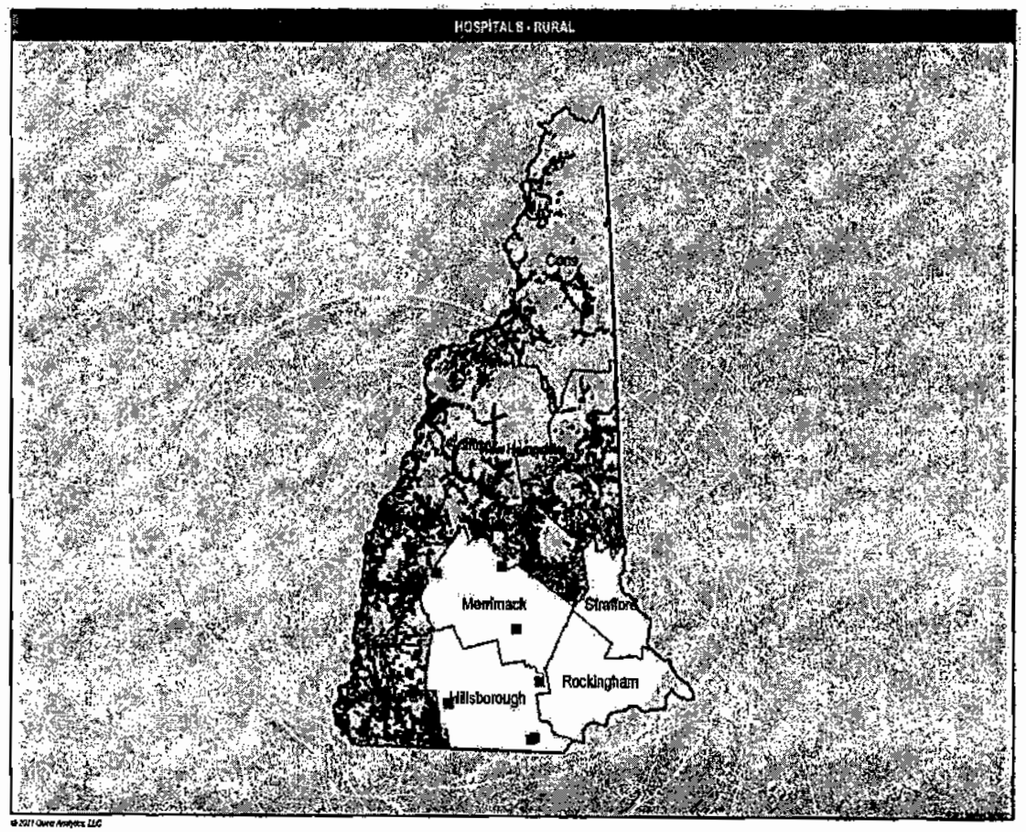
34,157 member locations
1 within 60
HOSPITALS
- Membership with Access (34,157)
- Membership without Access (0)

HOSPITALS

16 providers at 16 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Claire Analytics, LLC

Network Access Analysis - MH INPATIENT

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Minutes
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Minutes
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.
- 1st closest provider
- 2nd closest provider

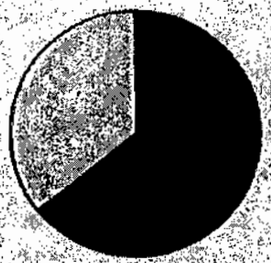
[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

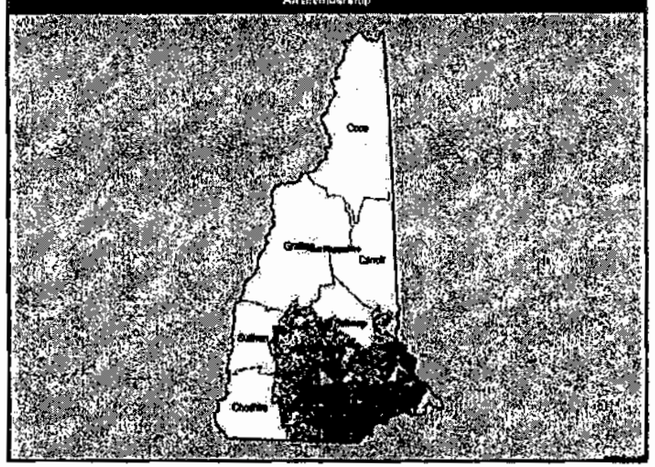
Overall Access[1]

[illegible] membership
2 providers at 2 locations

[illegible] (74.7%) membership with access
[illegible] (35.7%) membership without access



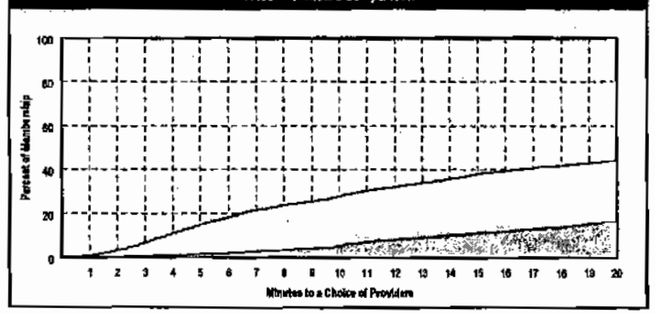
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	22.8 minutes
Average driving time to 2nd closest provider	31.5 minutes

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group	Provider Group
[illegible] membership [illegible] (94.3%) membership with access 27,080 (35.7%) membership without access	[illegible] unique providers at 2 unique locations (3 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Hillsborough County, NH	1	35,670	27,560	77.3	8,110	22.7	11.6	29.0
	Rockingham County, NH	2	15,666	14,376	91.8	1,290	8.2	14.1	14.4
	Merrimack County, NH	0	13,030	6,002	46.0	7,054	54.0	28.3	37.7
	Stratford County, NH	0	11,505	669	7.6	10,836	92.4	28.3	28.3
	Totals	3	75,897	48,607	64.3	27,290	35.7	13.9	23.0
Without Access	Stratford County, NH	0	11,505	669	7.6	10,836	92.4	35.7	36.7
	Hillsborough County, NH	1	35,670	27,560	77.3	8,110	22.7	34.1	36.1
	Merrimack County, NH	0	13,030	6,002	46.0	7,054	54.0	45.7	54.0
	Rockingham County, NH	2	15,666	14,376	91.8	1,290	8.2	33.3	33.3
	Totals	3	75,897	48,607	64.3	27,290	35.7	38.9	41.6

© 2011 Quest Analytics LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburuban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
Hillsborough County, NH	1	35,675	0.00	27,980	77.3	8,119	22.7	16.6	30.6
Merrimack County, NH	0	13,055	0.00	6,002	46.0	7,054	54.0	34.0	46.9
Rockingham County, NH	2	15,906	0.00	14,376	91.0	1,290	8.2	15.7	15.9
Strafford County, NH	0	11,505	0.00	669	7.6	10,638	92.4	37.9	37.9
Grand Totals	3	75,697	0.00	49,067	64.8	27,098	35.7	22.6	31.5

© 2011 Quest Analysis, LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plus

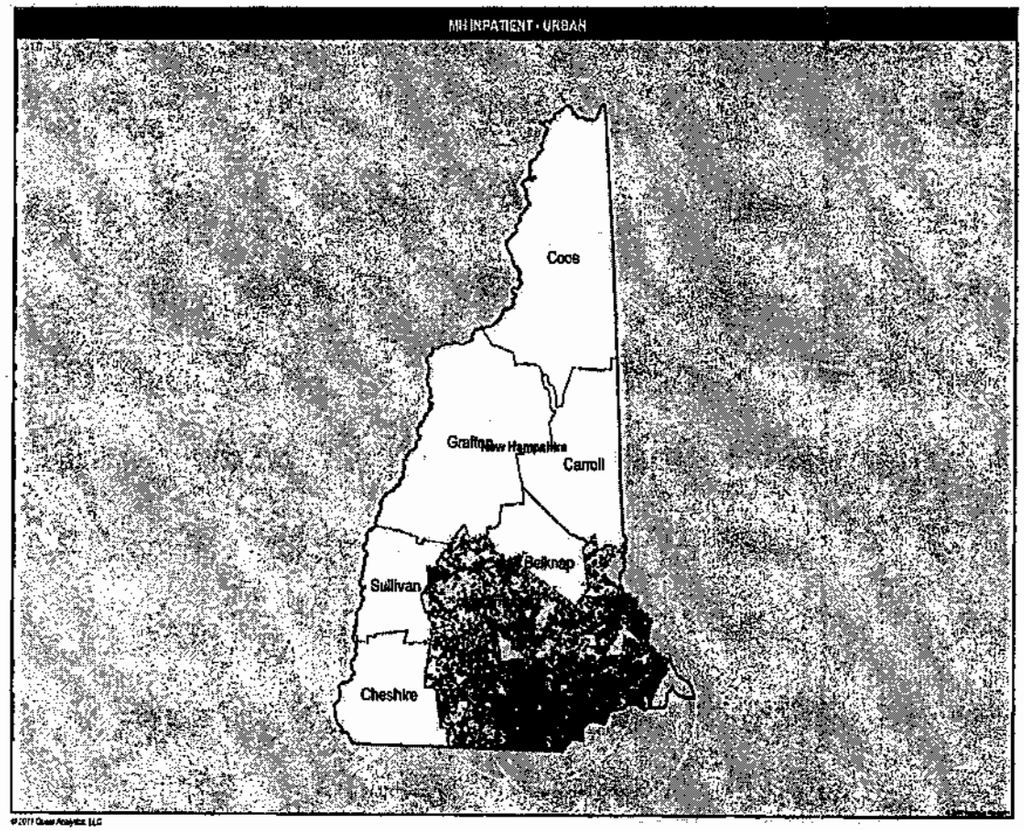
Created by...
HEOPS

NH Medicaid Urban
75,897 member locations
1 within 30
MH INPATIENT
- Membership with Access (48,807)
- Membership without Access (27,090)

MH INPATIENT
2 providers at 2 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

Access Overview

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plus

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH INPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.
- 1st closest provider
- 2nd closest provider

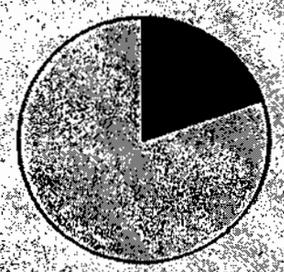
[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburuban areas and 55 MPH for rural areas.

Overall Access[1]

34,167 membership
2 providers at 2 locations

- 6,743 (19.7%) membership with access
- 27,444 (80.3%) membership without access

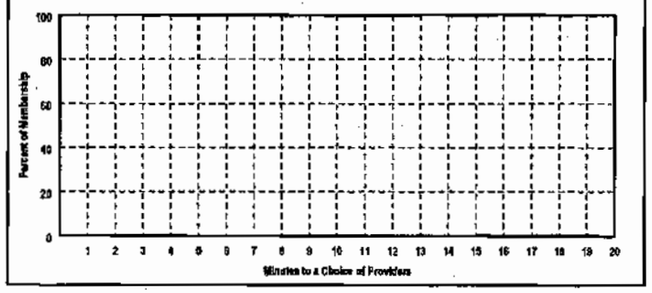


All Membership

Average Driving Time[2]

Average driving time to 1st closest provider	80.4 minutes
Average driving time to 2nd closest provider	81.2 minutes

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural

Rural Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 50

Provider Group
MH INPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 65 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	[illegible] membership [illegible] (19.7%) membership with access [illegible] (80.3%) membership without access		[illegible] providers at [illegible] locations [illegible] access points

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access #	With Access %	Without Access #	Without Access %	Average Time to Providers[1] 1	Average Time to Providers[1] 2
With Access	Belknap County, NH	0	[illegible]	[illegible]	[illegible]	3,201	[illegible]	[illegible]	[illegible]
	Cheshire County, NH	0	6,873	2,698	39.3	4,175	60.7	53.8	55.7
	Carroll County, NH	0	4,627	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Sullivan County, NH	0	4,766	70	1.5	4,696	98.5	53.6	61.3
	Totals	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Without Access	Grafton County, NH	0	[illegible]	0	0.0	[illegible]	[illegible]	[illegible]	[illegible]
	Sullivan County, NH	0	4,766	70	1.5	4,696	98.5	79.4	80.1
	Coos County, NH	0	4,277	0	0.0	4,277	[illegible]	[illegible]	[illegible]
	Cheshire County, NH	0	6,873	2,698	39.3	4,175	60.7	67.2	68.9
	Carroll County, NH	0	4,627	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Belknap County, NH	0	6,208	3,007	48.4	3,201	51.6	63.6	64.0
	Totals	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH INPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Carroll County, NH	0	4,827	0.00	956	20.1	3,859	79.9	74.1	74.1
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Coos County, NH	0	4,277	0.00	0	0.0	4,277	100.0	126.9	126.9
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sullivan County, NH	0	4,758	0.00	70	1.5	4,696	98.5	79.0	79.0
Grand Totals	**8**	**34,187**	**0.00**	**6,743**	**19.7**	**27,444**	**80.3**	**69.4**	**91.2**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

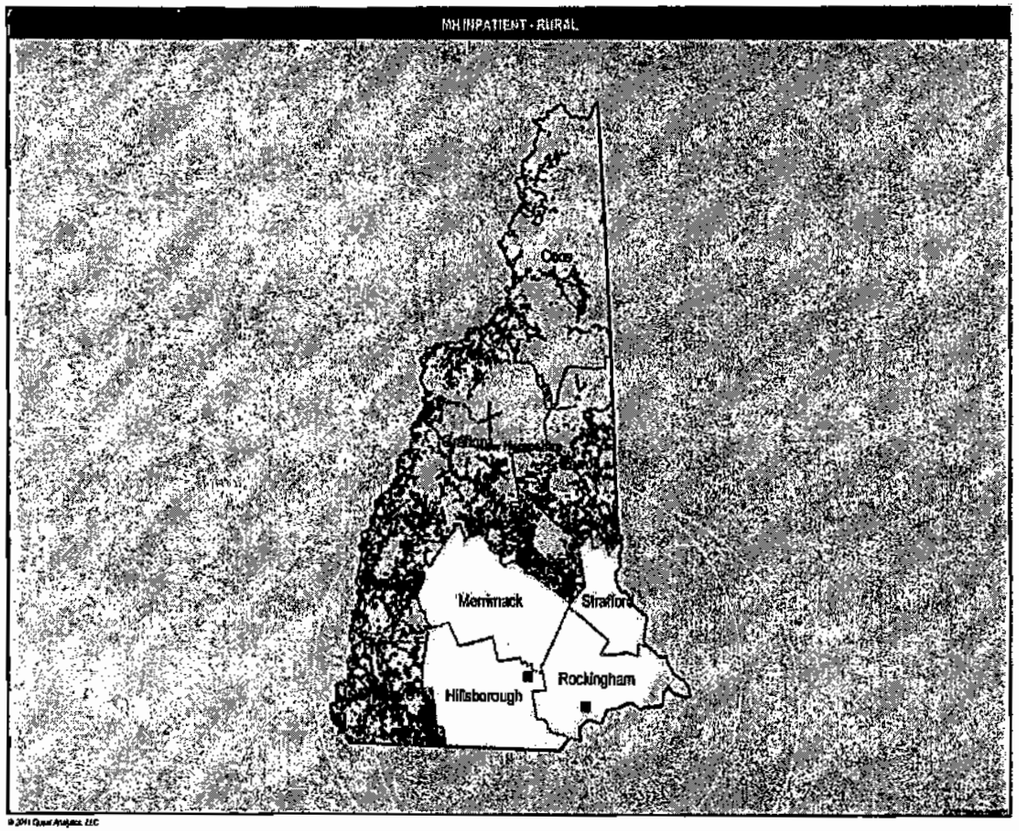
Created by...
HEDPS

NH Medicaid Rural
34,187 member locations
1 within 60
MH INPATIENT
- Membership with Access (6,743)
- Membership without Access (27,444)

MH INPATIENT
2 providers at 2 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

[redacted]

Network Access Analysis - MH INPATIENT

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Mileage
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Mileage
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

URBAN by Mileage

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
MEOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

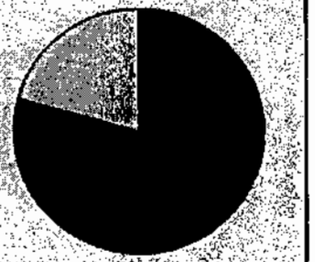
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 miles

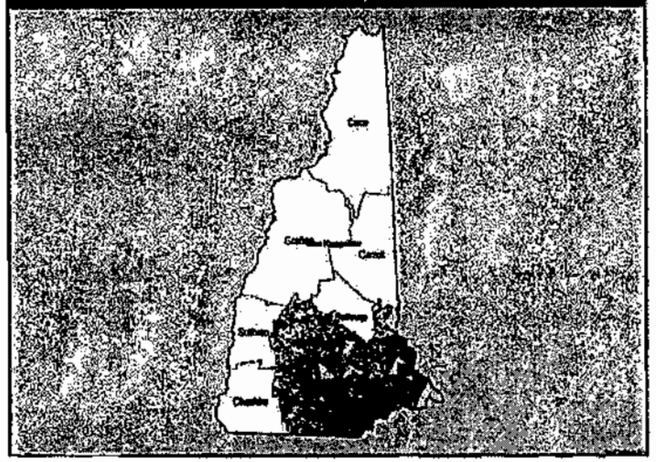
Overall Access [1]

[redacted] members
[redacted] providers at [redacted] locations

[redacted] members (79.3%) membership with access
15,731 (20.7%) membership without access



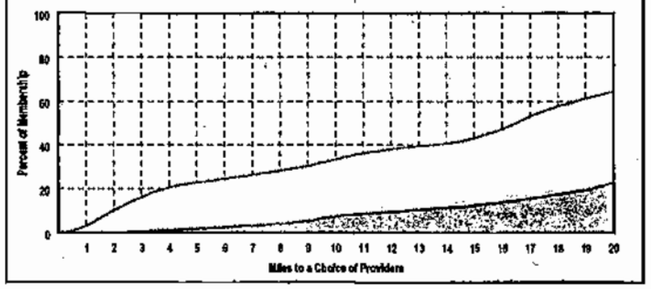
All Membership



Average Distances

Average distance to 1st closest provider	17.3 miles
Average distance to 2nd closest provider	26.9 miles

Access Standard Comparison



© 2011 Geo Analytics, LLC

Access Summary by County

NH Medicaid Urban
Urban Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HSOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 miles

Summary Information

Member Group		Provider Group	
[redacted]	[redacted]	[redacted]	[redacted]

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access #	With Access %	Without Access #	Without Access %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Rockingham County, NH	2	15,668	14,786	94.4	880	5.6	13.1	13.5
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Strafford County, NH	0	11,506	1,389	12.1	10,116	87.9	26.9	26.9
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Without Access	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Merrimack County, NH	0	13,056	9,245	70.8	3,811	29.2	38.1	57.0
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Rockingham County, NH	2	15,668	14,788	94.4	880	5.6	31.0	31.0
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

© 2011 Quest Analytics LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH INPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 30.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	1	35,670	0.00	34,746	97.4	924	2.6	10.8	34.1
Merrimack County, NH	0	13,056	0.00	9,245	70.8	3,811	29.2	23.9	43.1
Rockingham County, NH	2	16,959	0.00	14,785	94.4	880	5.6	14.1	14.9
Strafford County, NH	0	11,505	0.00	1,389	12.1	10,119	87.9	34.3	34.3
Grand Totals	3	75,897	0.00	60,166	79.3	15,731	20.7	17.3	28.9

© 2011 Quest Analytics LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

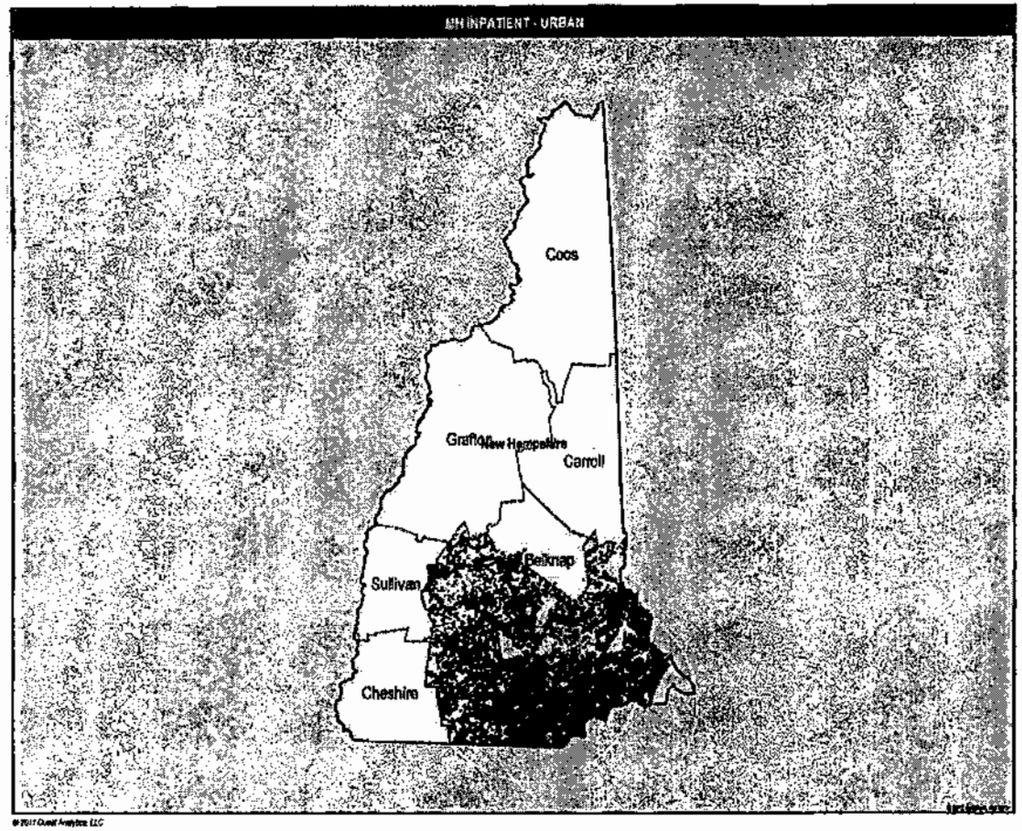
Created by...
HEOPS

NH Medicaid Urban
75,697 member locations
1 within 30
MH INPATIENT
- Membership with Access (60,166)
- Membership without Access (15,731)

MH INPATIENT
2 providers at 2 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 30.33 miles



© 2011 Quest Analytics, LLC

RURAL by Mileage

Access Overview

NH Medicaid Rural
Rural Counties
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

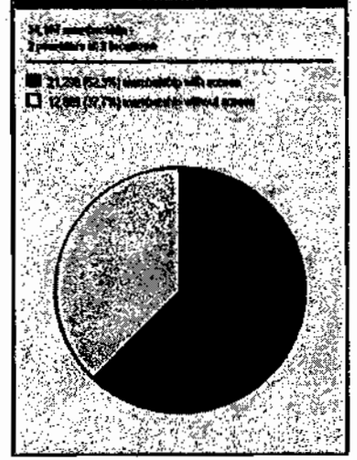
Provider Group
MH INPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

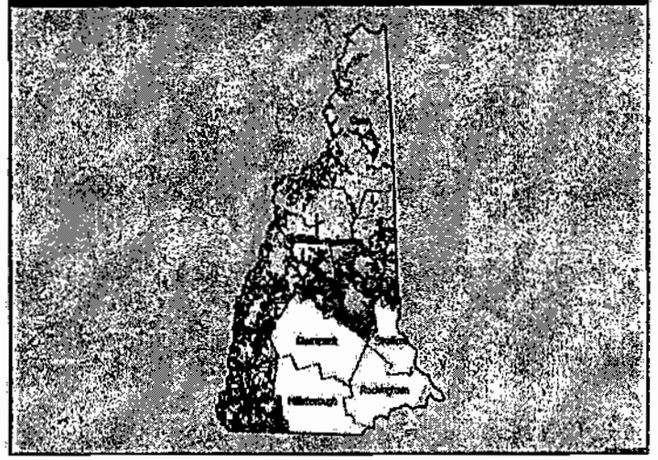
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 miles

Overall Access[1]



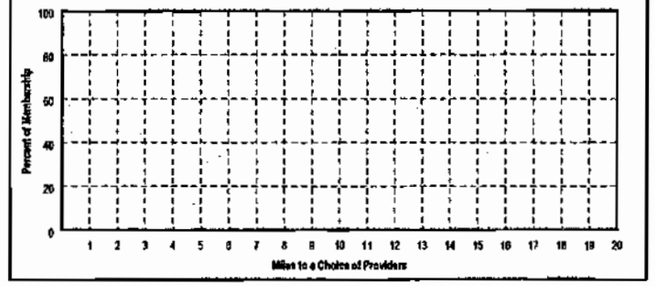
All Membership



Average Distances

Average distance to 1st closest provider	61.5 miles
Average distance to 2nd closest provider	74.1 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center Healthfist Plan

Created by...
HEDPS

Access Standard
1 within 60

Provider Group
MH INPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 miles

Summary Information

Member Group	Provider Group
14,187 membership [illegible] (83.3%) membership with access [illegible] (37.7%) membership without access	2 unique providers at 2 unique locations (3 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Cheshire County, NH	0	6,873	6,873	100.0	0	0.0	44.3	50.4
	Belknap County, NH	0	6,208	6,208	100.0	0	0.0	38.4	50.8
	Sullivan County, NH	0	4,766	4,187	87.9	579	12.1	54.9	72.2
	Carroll County, NH	0	4,827	2,294	47.5	2,533	52.5	52.5	66.7
	Grafton County, NH	0	7,236	1,736	24.0	5,500	76.0	63.6	70.0
	Totals	0	29,910	21,298	71.2	8,612	28.8	48.3	59.7
Without Access	Grafton County, NH	0	7,236	1,736	24.0	5,500	76.0	77.7	93.1
	Coos County, NH	0	4,277	0	0.0	4,277	100.0	109.4	116.2
	Carroll County, NH	0	4,827	2,294	47.5	2,533	52.5	72.7	78.2
	Sullivan County, NH	0	4,766	4,187	87.9	579	12.1	63.7	88.2
	Totals	0	21,106	8,217	38.9	12,889	61.1	68.6	97.0

© 2011 Quest Analytics LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH INPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH INPATIENT) Provider within 60.0 miles

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	0	5,209	0.00	6,525	100.0	0	0.0	38.4	58.8
Carroll County, NH	0	4,627	0.00	2,294	47.5	2,533	52.5	63.1	68.0
Cheshire County, NH	0	5,673	0.00	5,673	100.0	0	0.0	44.3	58.4
Coos County, NH	0	4,277	0.00	0	0.0	4,277	100.0	109.4	116.2
Grafton County, NH	0	2,236	0.00	1,736	24.0	5,500	76.0	71.8	87.5
Sullivan County, NH	0	4,766	0.00	4,187	87.9	579	12.1	56.0	73.2
Grand Totals	0	34,187	0.00	21,293	62.3	12,889	37.7	61.3	74.1

© 2011 Quality Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

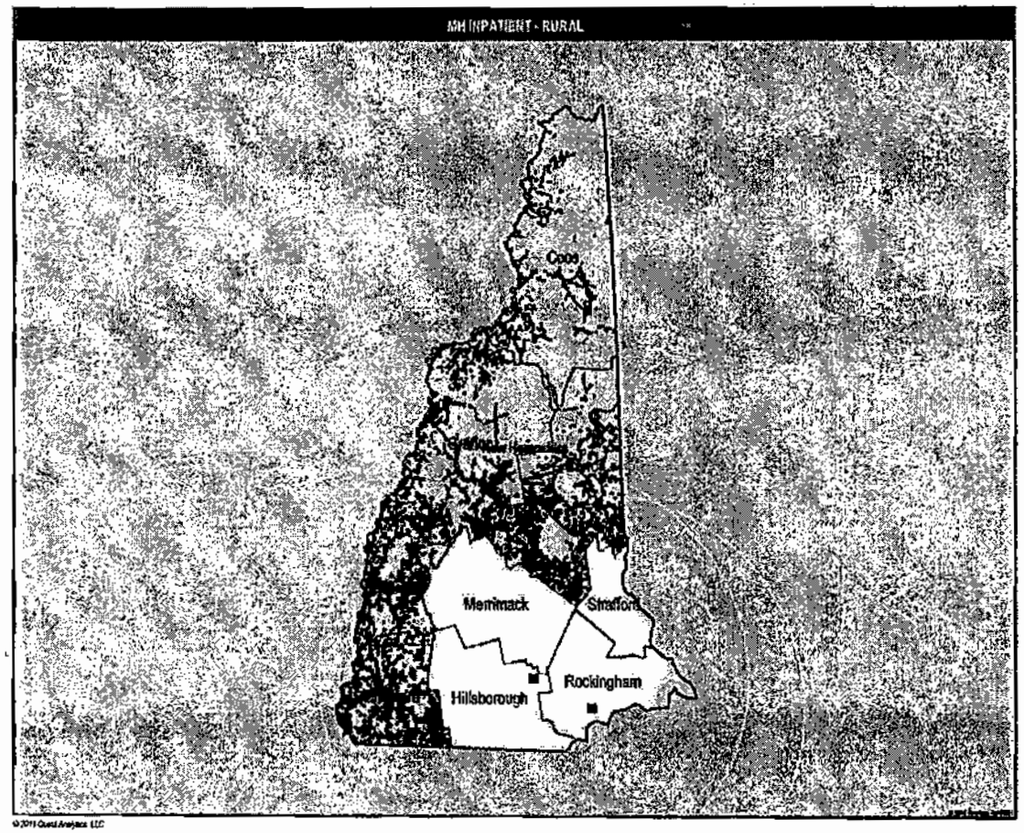
Created by...
HEOPS

NH Medicaid Rural
34,187 member locations
1 within 60
MH INPATIENT
- Membership with Access (21,298)
- Membership without Access (12,889)

MH INPATIENT
2 providers at 2 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

[redacted]

Network Access Analysis - MH OUTPATIENT

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 13, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEGPS

Report Contents

URBAN by Minutes
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Minutes
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

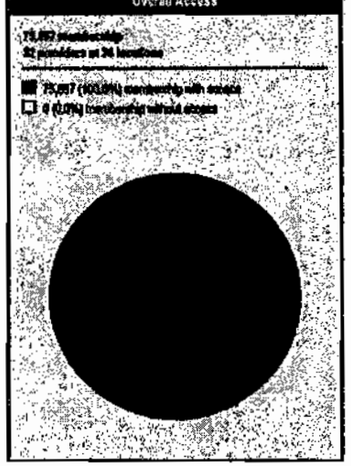
Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

Comparison Graph
Percent of membership with access to a choice of providers over minutes.
- 1st closest provider
- 2nd closest provider

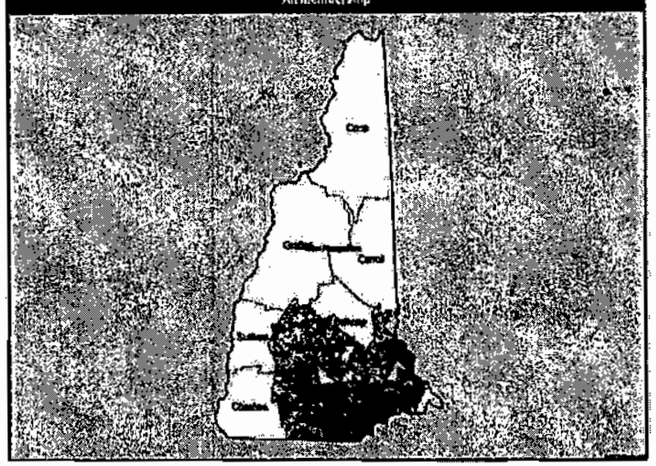
[1] The Access Standard is defined as having 1 (MH OUTPATIENT) Provider within 30.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Overall Access[1]



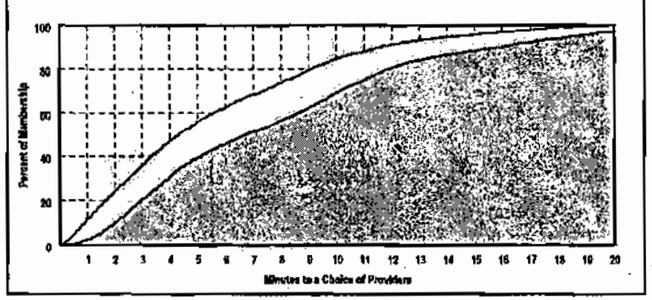
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	5.6 minutes
Average driving time to 2nd closest provider	7.9 minutes

Access Standard Comparison



©MH Quest Analysis, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

1 The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 30.0 minutes

2 Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	75,887 membership 75,887 (100.0%) membership with access 0 (0.0%) membership without access		22 unique providers at 30 unique locations (41 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Hillsborough County, NH	15	35,679	35,679	100.0	0	0.0	4.7	6.9
	Rockingham County, NH	13	15,668	15,668	100.0	0	0.0	6.2	9.0
	Merrimack County, NH	5	13,054	13,054	100.0	0	0.0	9.5	11.8
	Strafford County, NH	2	11,505	11,505	100.0	0	0.0	6.4	9.2
	Totals	25	75,887	75,887	100.0	0	0.0	5.6	7.9
Without Access	No records meet the criteria								

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 30.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

All Membership									
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Merrimack County, NH	5	13,056	0.00	13,056	100.0	0	0.0	6.5	11.0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Strafford County, NH	2	11,505	0.00	11,505	100.0	0	0.0	6.4	9.2
Grand Totals	**35**	**75,897**	**0.00**	**75,897**	**100.0**	**0**	**0.0**	**5.6**	**7.9**

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

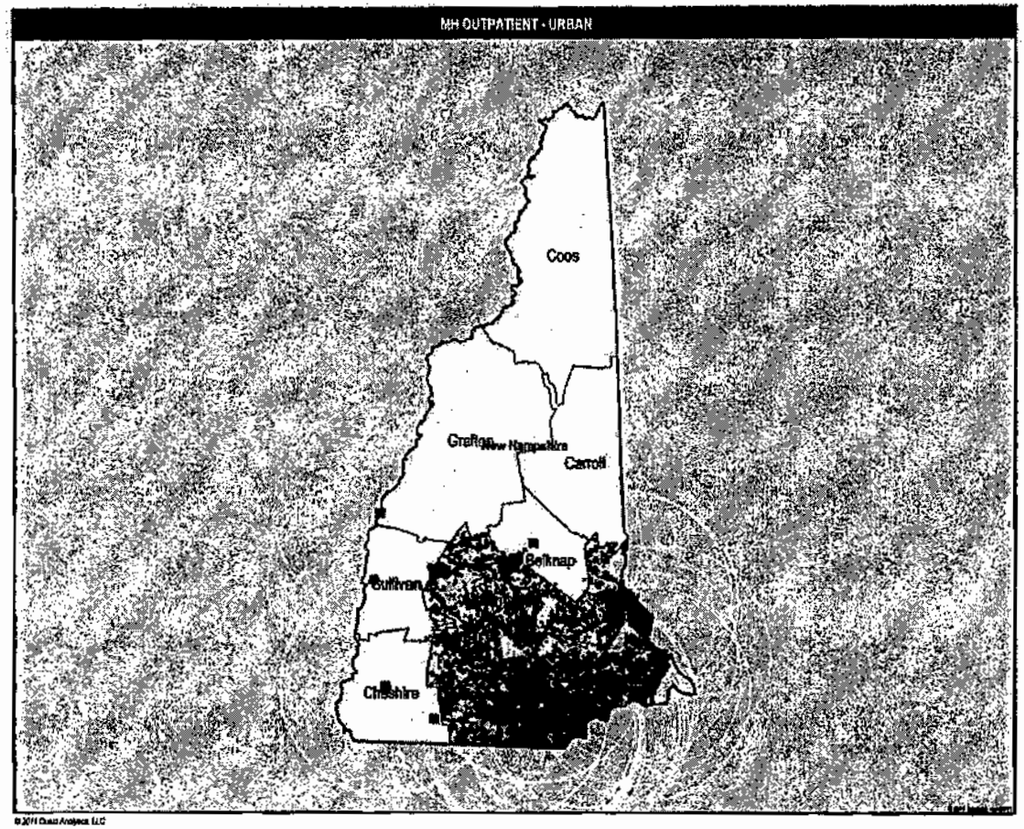
Created by...
HEOPS

NH Medicaid Urban
75,897 member locations
1 within 30
MH OUTPATIENT
- Membership with Access (75,897)
- Membership without Access (0)

MH OUTPATIENT
32 providers at 36 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Cocaltte

1 in. = 33.33 miles



©2011 Data Analysis, LLC

Access Overview

NH Medicaid Rural

Rural Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH OUTPATIENT

Access Map
Member locations...

- Membership with Access
- Membership without Access
- Network Service Area

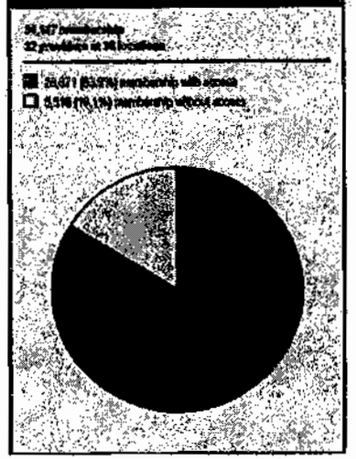
Comparison Graph
Percent of membership with access to a choice of providers over minutes.

- 1st closest provider
- 2nd closest provider

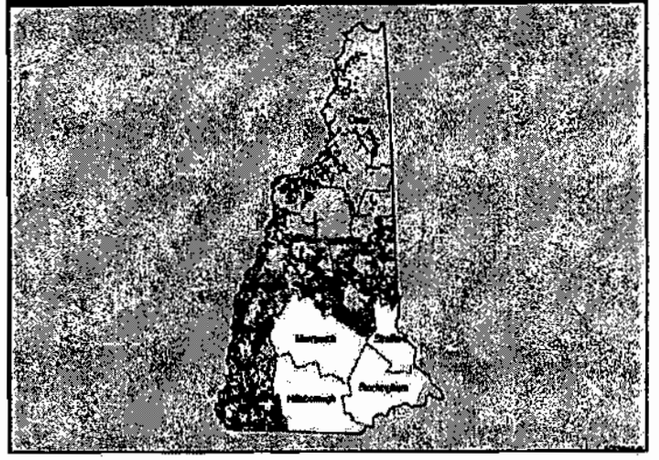
[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

Overall Access[1]



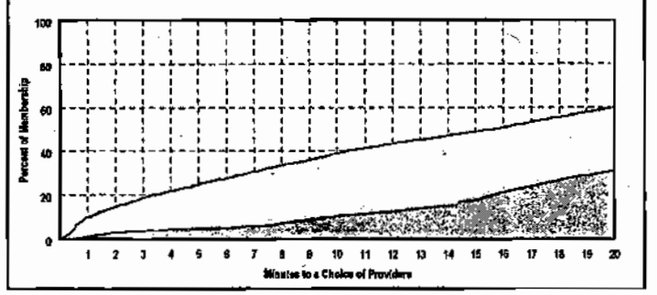
All Membership



Average Driving Time[2]

Average driving time to 1st closest provider	26.4 minutes
Average driving time to 2nd closest provider	34.1 minutes

Access Standard Comparison



© 2011 Client Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH OUTPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 minutes

[2] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 65 MPH for rural areas.

Summary Information

Member Group		Provider Group	
	34,167 membership 28,671 (83.9%) membership with access 5,516 (16.1%) membership without access		32 unique providers at 38 unique locations (41 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Time to Providers[2] 1	Average Time to Providers[2] 2
With Access	Cheshire County, NH	1	6,673	6,673	100.0	0	0.0	9.8	12.5
	Belknap County, NH	1	6,206	6,206	100.0	0	0.0	7.3	16.7
	Grafton County, NH	1	7,236	6,180	85.4	1,056	14.6	22.6	35.4
	Sullivan County, NH	1	4,766	4,766	100.0	0	0.0	7.7	23.0
	Carroll County, NH	0	4,827	4,444	96.2	183	3.8	17.6	41.8
	Totals	6	28,910	28,671	85.9	1,239	4.1	16.0	24.8
Without Access	Coos County, NH	0	4,277	0	0.0	4,277	100.0	63.4	80.9
	Grafton County, NH	1	7,236	6,180	85.4	1,056	14.6	64.5	67.2
	Carroll County, NH	0	4,827	4,444	96.2	183	3.8	64.0	83.8
	Totals	1	16,340	10,824	66.2	5,516	33.8	60.7	82.4

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural

Rural Counties

December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Access Standard
1 within 60

Provider Group
MH OUTPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 minutes

[3] Driving Time estimated using 30 MPH for urban areas, 45 MPH for suburban areas and 55 MPH for rural areas.

County	All Membership								
	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time to Providers[3] 1	Average Time to Providers[3] 2
Belknap County, NH	1	4,298	0.00	4,298	100.0	0	0.0	7.8	18.2
Carroll County, NH	0	4,827	0.00	4,644	96.2	183	3.8	28.1	42.7
Cheshire County, NH	3	8,473	0.00	8,473	100.0	0	0.0	8.6	13.5
Coos County, NH	0	4,277	0.00	0	0.0	4,277	100.0	85.4	86.9
Grafton County, NH	1	7,258	0.00	6,140	85.4	1,005	14.8	29.0	36.8
Sullivan County, NH	1	4,766	0.00	4,766	100.0	0	0.0	7.7	23.0
Grand Totals	6	34,187	0.00	28,675	83.9	5,516	16.1	29.4	34.9

©2011 Quest Analytics LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

NH Medicaid Rural

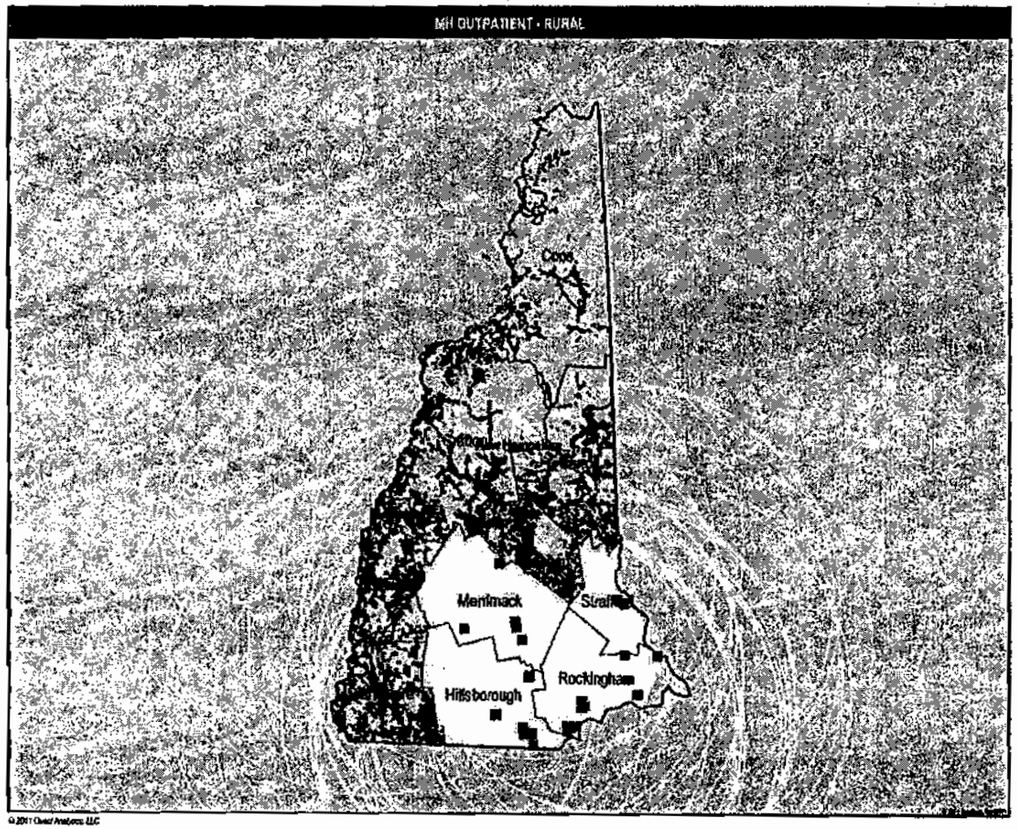
34,187 member locations
1 within 60
MH OUTPATIENT
- Membership with Access (28,671)
- Membership without Access (5,516)

MH OUTPATIENT

32 providers at 39 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

[redacted]

Network Access Analysis - MH OUTPATIENT

All New Hampshire Membership

New Hampshire

Created for...

Boston Medical Center HealthNet Plan

Created by...

HEOPS

December 15, 2011

Created with the Quest Analytics Suite
Copyright © 2003-11 Quest Analytics, L.L.C.

Contents

All New Hampshire Membership
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Report Contents

URBAN by Mileage
Access Overview - All Members 2
Access Summary by County - All Members 3
Access Detail by County - All Members 4
Universal Map - All Members 5
RURAL by Mileage
Access Overview - All Members 6
Access Summary by County - All Members 7
Access Detail by County - All Members 8
Universal Map - All Members 9

URBAN by Mileage

Access Overview

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center Health Net Plan

Created by...
NEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

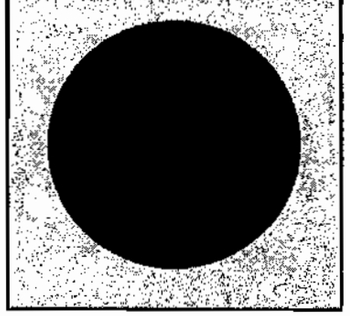
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 30.0 miles.

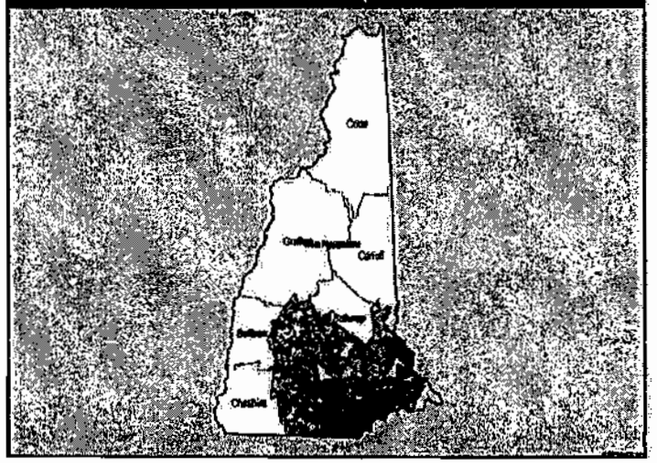
Overall Access[1]

75,887 membership
22 providers at 36 locations

- 75,887 (100.0%) membership with access
- 0 (0.0%) membership without access



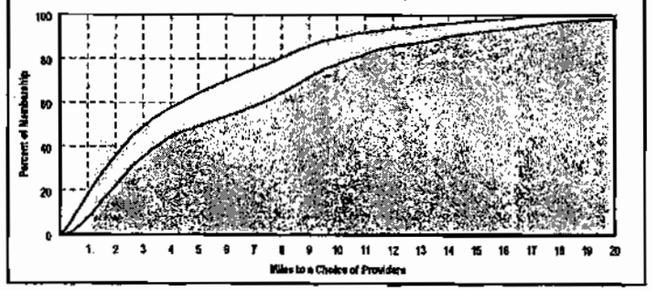
All Membership



Average Distances

Average distance to 1st closest provider	4.6 miles
Average distance to 2nd closest provider	6.5 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Urban

Urban Counties

December 18, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 30.0 miles

Summary Information

Member Group	Provider Group
75,897 membership 75,897 (100.0%) membership with access 0 (0.0%) membership without access	32 unique providers at 39 unique locations (41 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access #	With Access %	Without Access #	Without Access %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Hillsborough County, NH	15	25,878	25,878	100.0	0	0.0	3.2	4.1
	Rockingham County, NH	13	15,668	15,668	100.0	0	0.0	5.8	8.0
	Merrimack County, NH	5	13,064	13,064	100.0	0	0.0	6.0	9.0
	Strafford County, NH	2	11,505	11,505	100.0	0	0.0	5.9	8.3
	Totals	35	75,897	75,897	100.0	0	0.0	4.6	6.0
Without Access	No records meet the criteria								

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Urban
Urban Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
NEOPS

Access Standard
1 within 30

Provider Group
MH OUTPATIENT

[1] Providers To Membership ratio

[2] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 30.0 miles

County	All Membership								
	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Hillsborough County, NH	15	25,679	0.00	25,679	100.0	0	0.0	3.2	4.1
Merrimack County, NH	5	13,058	0.00	13,058	100.0	0	0.0	6.0	9.9
Rockingham County, NH	13	12,856	0.00	12,856	100.0	0	0.0	6.8	8.0
Strafford County, NH	2	11,505	0.00	11,505	100.0	0	0.0	5.8	6.3
Grand Totals	35	75,097	0.00	75,097	100.0	0	0.0	4.6	6.5

© 2011 Quest Analytics, LLC

Universal Map

NH Medicaid Urban
New Hampshire
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

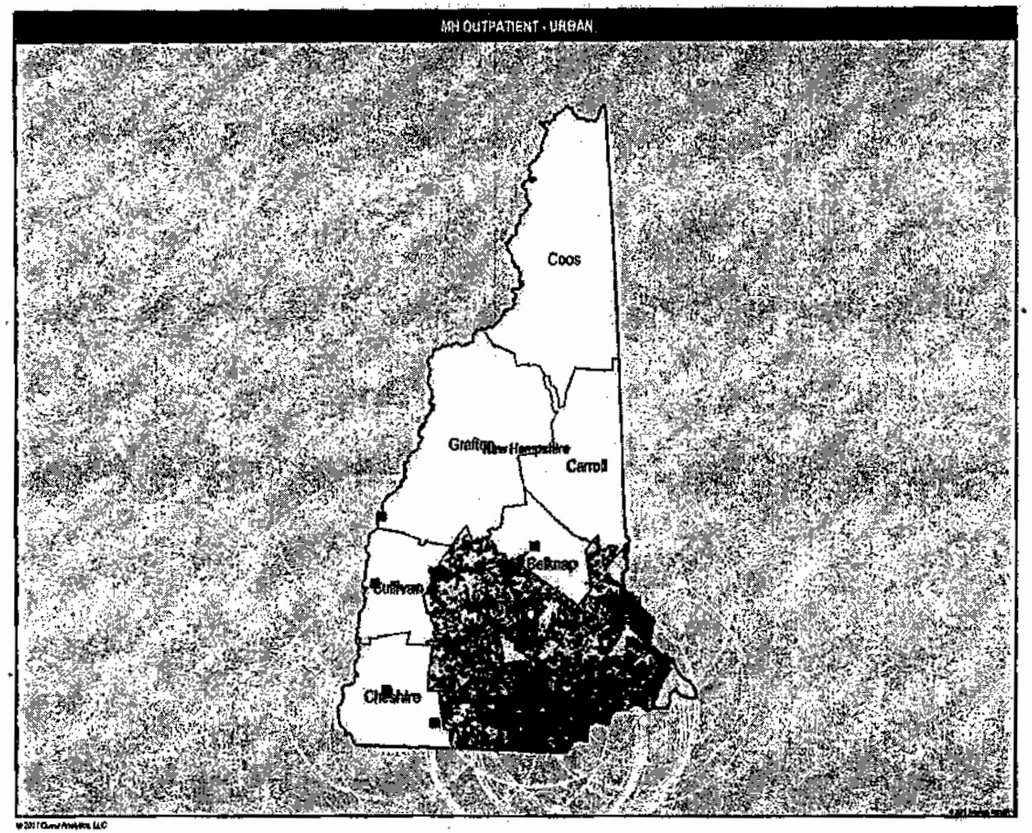
Created by...
HEDPS

NH Medicaid Urban
75,897 member locations
1 within 30
MH OUTPATIENT
- Membership with Access (75,897)
- Membership without Access (0)

MH OUTPATIENT
32 providers at 36 locations
- All Providers
- 30 mile radius

Service Areas
- Urban Counties

1 in. = 33.33 miles



© 2011 Claritas Analytics, LLC

RURAL by Mileage

Access Overview

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

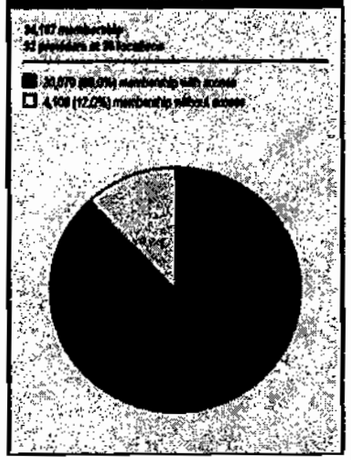
Provider Group
MH OUTPATIENT

Access Map
Member locations...
- Membership with Access
- Membership without Access
- Network Service Area

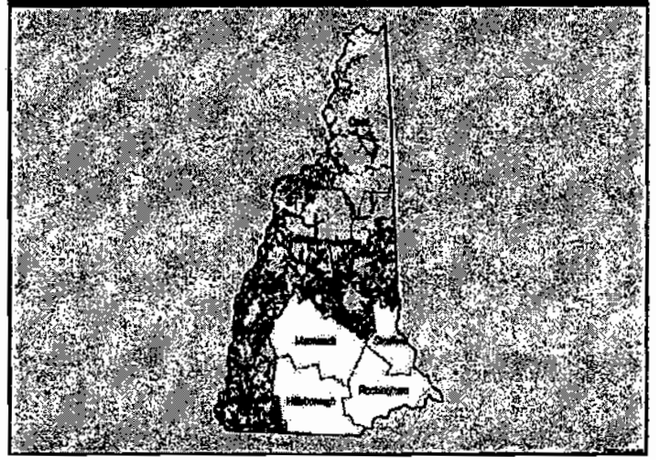
Comparison Graph
Percent of membership with access to a choice of providers over miles.
- 1st closest provider
- 2nd closest provider

[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 miles

Overall Access



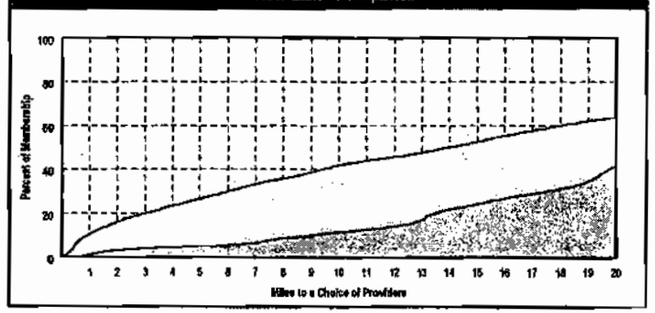
All Membership



Average Distances

Average distance to 1st closest provider	23.0 miles
Average distance to 2nd closest provider	30.9 miles

Access Standard Comparison



© 2011 Quest Analytics, LLC

Access Summary by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOPS

Access Standard
1 within 60

Provider Group
MH OUTPATIENT

Areas With Access
Top 15 counties in the market, sorted by the number of membership with access.

Areas Without Access
Bottom 15 counties in the market, sorted by the number of membership without access.

[1] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 miles

Summary Information

Member Group		Provider Group	
	34,167 membership 30,070 (88.0%) membership with access 4,103 (12.0%) membership without access		33 unique providers at 36 unique locations (91 total access points)

Key Geographic Areas

	County	Provider Locations	Total Membership	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Average Distance to Providers 1	Average Distance to Providers 2
With Access	Grafton County, NH	1	7,239	7,157	98.9	70	1.1	20.4	26.8
	Cheshire County, NH	3	6,873	6,873	100.0	0	0.0	8.0	11.5
	Belknap County, NH	1	6,208	6,208	100.0	0	0.0	6.2	14.7
	Carroll County, NH	0	4,827	4,827	100.0	0	0.0	32.4	38.5
	Sullivan County, NH	1	4,286	4,286	100.0	0	0.0	7.1	27.1
	Coos County, NH	0	4,277	248	5.8	4,029	94.2	66.9	61.5
	Totals	6	34,167	30,070	88.0	4,103	12.0	20.0	24.3
Without Access	Coos County, NH	0	4,277	248	5.8	4,029	94.2	73.8	79.0
	Grafton County, NH	1	7,239	7,157	98.9	70	1.1	61.8	62.8
	Totals	1	11,516	7,405	64.3	4,099	35.7	70.4	71.0

© 2011 Quest Analytics, LLC

Access Detail by County

NH Medicaid Rural
Rural Counties
December 15, 2011

Created for...
Boston Medical Center HealthNet Plan

Created by...
HEOP9

Access Standard
1 within 60

Provider Group
MH OUTPATIENT

[1] Provides To Membership ratio

[2] The Access Standard is defined as having: 1 (MH OUTPATIENT) Provider within 60.0 miles

	All Membership								
County	Provider Locations	Total Membership	Ratio[1]	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Distance to Providers 1	Average Distance to Providers 2
Belknap County, NH	1	6,295	0.00	6,295	100.0	0	0.0	8.2	14.7
Carroll County, NH	0	4,827	0.00	4,827	100.0	0	0.0	32.4	38.9
Cheshire County, NH	3	8,873	0.00	8,873	100.0	0	0.0	8.0	11.6
Coos County, NH	0	4,277	0.00	248	5.8	4,029	94.2	72.6	78.8
Grafton County, NH	1	7,238	0.00	1,059	14.6	79	1.1	28.8	36.9
Sullivan County, NH	1	4,768	0.00	4,768	100.0	0	0.0	7.1	21.1
Grand Totals	6	34,187	0.00	30,679	88.0	4,108	12.0	23.6	30.9

© 2011 Geo Analytics, LLC

Universal Map

NH Medicaid Rural
New Hampshire
December 16, 2011

Created for...
Boston Medical Center HealthNet Plan

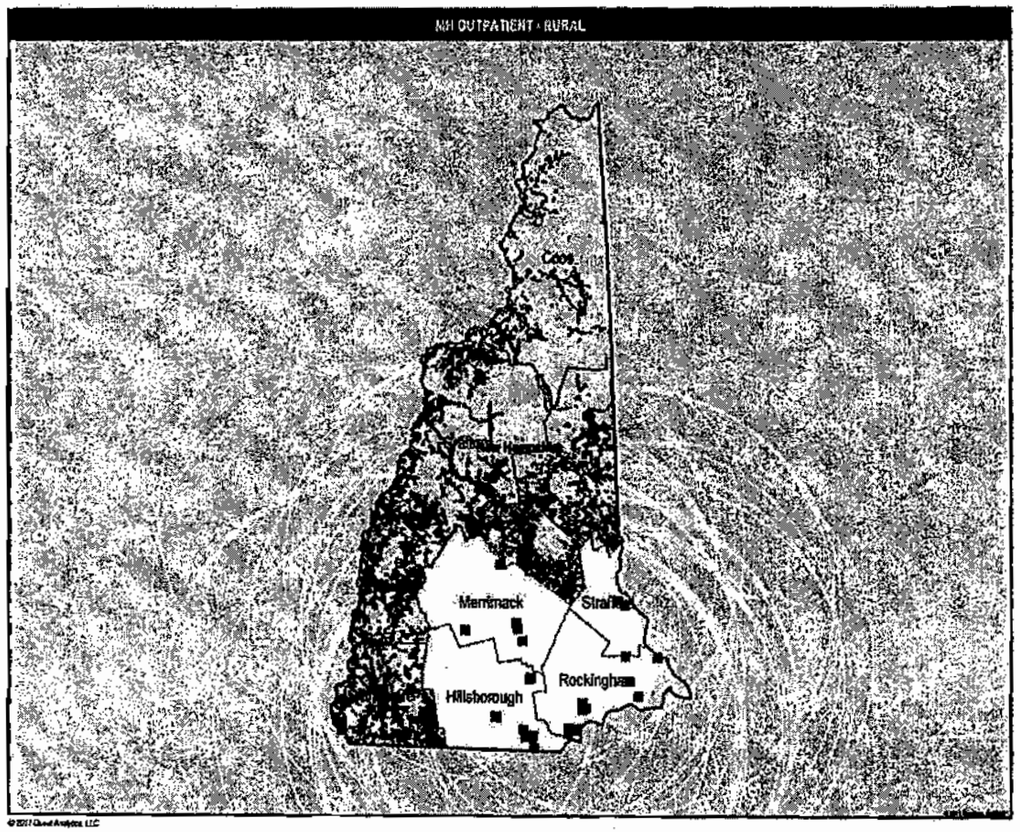
Created by...
HEOPS

NH Medicaid Rural
34,187 member locations
1 within 60
MH OUTPATIENT
- Membership with Access (30,079)
- Membership without Access (4,108)

MH OUTPATIENT
32 providers at 36 locations
- All Providers
- 60 mile radius

Service Areas
- Rural Counties

1 in. = 33.33 miles



© 2011 Quest Analytics, LLC

BOSTON MEDICAL CENTER HEALTH*NET* PLAN

6.16 Appendix B (Exceptions)

APPENDIX B

EXCEPTIONS TO TERMS AND CONDITIONS

A Responder shall be presumed to be in agreement with the terms and conditions of the RFP unless the Responder takes specific exception to one or more of the conditions on this form.

RESPONDERS ARE CAUTIONED THAT BY TAKING ANY EXCEPTION THEY MAY BE MATERIALLY DEVIATING FROM THE RFP SPECIFICATIONS. IF A RESPONDER MATERIALLY DEVIATES FROM A RFP SPECIFICATION, ITS PROPOSAL MAY BE REJECTED.

A material deviation is an exception to a specification which 1) affords the Responder taking the exception a competitive advantage over other Responders, or 2) gives the State something significantly different than the State requested.

INSTRUCTIONS: Responders must explicitly list all exceptions to State of NH minimum terms and conditions. Reference the actual number of the State's term and condition and Exhibit number for which an exception(s) is being taken. If no exceptions exist, state "NONE" specifically on the form below. Whether or not exceptions are taken, the Responder must sign and date this form and submit it as part of their Proposal. (*Add additional pages if necessary.*)

Responder Name:	
Term & Condition Number/Provision	**Explanation of Exception**
Section 8	The RFP references several matters as open and to be addressed in the eventual contract; BMCHP will negotiate such matters in good faith with the State.

By signing this form, I acknowledge that the above named Responder accepts, without qualification, all terms and conditions stated in this RFP Section 9- Mandatory Business Specifications, Contract Terms and Conditions except those clearly outlined as exceptions above.

Signature	Executive Director	12/16/2011
	Title	Date