GRANITE STATE HEALTH PLAN

Transmittal Cover Letter

GRANITE STATE
HEALTH PLAN

December 16, 2011

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

RE: Request for Proposal (RFP) #12-DHHS-CM-01 issued by the Department of Health and Human Services for Medicaid Care Management Services in the State of New Hampshire

Dear Mr. Faasen,

Granite State Health Plan, Inc., a wholly owned subsidiary of Centene Corporation®, is pleased to submit this Request for Proposal (RFP) #12-DHHS-CM-01 to the Department of Health and Human Services (DHHS) for Medicaid Care Management Services in the State of New Hampshire on this day, December 16, 2011. The following items listed below fulfill the transmittal letter requirements:

- Christopher Bowers, Senior Vice President of Health Plans is located at 7700 Forsyth Boulevard, St. Louis, Missouri, 63105 and is authorized by Granite State Health Plan to contractually obligate the organization. He can be reached at (314) 725-4477 or cbowers@centene.com.

- Granite State Health Plan Inc. is a wholly owned subsidiary of Centene Corporation, which serves as its own fiscal agent.

- Brent Layton, Senior Vice President of Business Development, located at 7700 Forsyth Boulevard, St. Louis, Missouri, 63105 will serve as Granite State Health Plan's representative for all matters relating to the RFP. He can be reached at (770) 241-9066 or blayton@centene.com.

- Granite State Health Plan Inc. acknowledges that we have reviewed this RFP, understand it, and agree to be bound by its requirements.

- Granite State Health Plan Inc. explicitly states acceptance of terms, conditions and general instructions stated in Part 9 Mandatory Business Specifications, Contract Terms and Conditions.

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- Granite State Health Plan Inc. confirms that Appendix B Exceptions to Terms and Conditions is included in the proposal.

- Granite State Health Plan Inc. explicitly states that its submitted proposal is valid for a minimum of two hundred forty (240) days from the closing date for receipt of proposals.

Sincerely,

Chris Bowers

Christopher Bowers
Senior Vice President, Health Plans
Granite State Health Plan

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6.5 Proposal Narrative, Project Approach and Technical Response Statement of Work

Response to the State of New Hampshire Department of Health and Human Services

Request for Proposal (RFP) #12-DHHS-CM-01 for Medicaid Care Management Services

December 16, 2011

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Proposal Narrative, Project Approach and
Technical Response
EXECUTIVE SUMMARY

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Executive Summary

The Bidder shall submit an executive summary to provide DHHS with an overview of the bidder's organization and what is intended to be provided by the Bidder. This component of the proposal should demonstrate the Bidder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work. The Executive Summary should also show the Bidder's overall design of the project in response to achieving the deliverables as defined in this RFP. Specifically, the proposal should demonstrate the Bidder's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services.

History and Managed Care Experience

Granite State Health Plan, Inc. (GSHP) is a wholly owned subsidiary of Centene Corporation (Centene). Created for the purpose of providing services for the Medicaid Care Management Program in the State of New Hampshire, GSHP will draw from the experience and success of our Centene, our affiliate subsidiary health plans and our specialty division to bring the Care Management Program an innovative and progressive approach that will improve quality of care and access to services while generating savings for The New Hampshire Department of Health and Human Services (DHHS).

Highlights of GSHP's background, qualifications and approach to the project include:

- GSHP's parent company, Centene possesses over ***27 years of experience in Medicaid managed care*** programs for low-income populations, including TANF, SSI/ABD, long-term care, foster care, subsidized and commercial heath insurance for uninsured, and Medicare (Special Needs Plans) in both ***urban and rural*** markets, and currently serves over ***1.6 million members*** on a full-risk basis and operates managed care programs in thirteen states. We have the experience and ability to provide integrated services for ***all members through all phases of DHHS's Care Management Services program.***

- Drawing on the experience and expertise gathered during multiple simultaneous successful implementations (including multiple states that were moving from fee-for-service to managed care) and the enterprise resources of Centene, GSHP will be poised to meet an ***operational effective date of July 1 statewide***. Centene, has more experience in the past five years partnering with states to transition from fee-for-service to managed care than any other managed care organization, including five states transitioning from fee-for service and nine new market implementations overall.

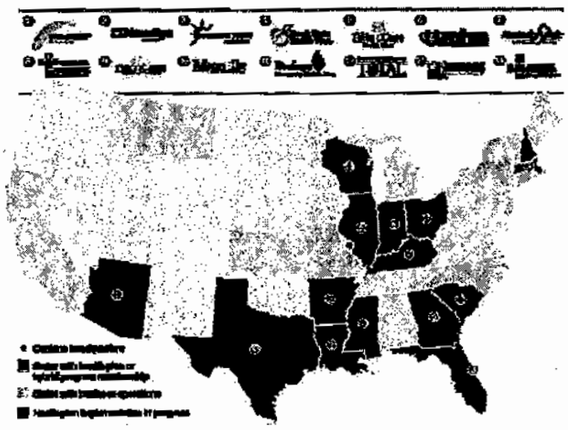
- Our integrated ***enterprise approach to care management reduces fragmentation.*** Because GSHP, Cenpatico (our behavioral health subcontractor); NurseWise (our 24/7

nurse advice line); Nurtur (our disease management subcontractor); US Script (our pharmacy subcontractor); and OptiCare (our vision services subcontractor) are all subsidiaries of Centene and share the organizational commitment to serve the Medicaid population. As an enterprise, we are able to provide ***holistic integration*** and share information in ways that unrelated companies cannot.

- GSHP is built on Centene's philosophy that ***health care is best delivered locally***. This local approach, which includes hiring from the communities we serve, enables Centene plans to provide accessible, high quality and culturally sensitive services. GSHP's emphasis on having ***staff on the ground*** differentiates us from our competitors. Based on a statewide contract award, we estimate that GSHP would bring approximately 50 jobs to New Hampshire during Phase One and over 100 jobs once Phase Two is implemented.

- GSHP has already established a strong ***strategic relationship with the Bi-State Primary Care Association (BSPCA)***. This partnership will give BSPCA an active role in shaping GSHP, including provider committee membership.

Centene possesses over ***27 years of experience in Medicaid and Medicaid-related managed care*** programs for low-income populations, including Temporary Assistance for Needy Families (TANF), the State Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (ABD), Foster Care, Long Term Care, subsidized and commercial heath insurance for uninsured and Medicare (Special Needs Plans) and currently serves ***over 1.6 million members*** on a full-risk basis in thirteen states: Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Mississippi, Ohio, South Carolina, Texas and Wisconsin. In addition, Centene health plans operate Medicare (Special Needs Plans) in Arizona, Georgia, Ohio, Texas and Wisconsin. We were also recently awarded a contract in Louisiana (anticipated operations commencing in 2012).



Centene health plans are also uniquely positioned to deliver an integrated **enterprise approach that reduces fragmentation** for our state customers and our members through our specialty solutions, which include Cenpatico Behavioral Health, OptiCare (vision care), Nurtur (life and health management), NurseWise (a nurse advice and medication treatment compliance line), and US Script (pharmacy benefit management. Through our specialty division, GSHP can offer a holistic solution for integrating health care and sharing information that allows us to address the complex needs of the Medicaid population in ways that unrelated companies cannot.

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Healthcare Coverage Solutions

Government Solutions	AZ	AR	FL	GA	IL	IN	KS	KY[1]	LA[2]	MA	MS	MT	OH	SC	TX	WI
TANF	•		•	•		•		•	•				•	•	•	•
CHIP	•			•		•		•	•				•	•	•	•
ABD (Non Duals)	•		•		•			•	•		•		•	•	•	•
ABD (Dually Eligible)	•		•					•							•	•
Long-Term Care	•		•												•	
Foster Care								•	•		•				•	
Medicare Special Needs Plans	•			•									•		•	•
Hybrid		•				•				•					•	
Specialty Health Solutions *(in addition to providing benefits to Centene's managed care plans, our specialty companies provide services to state agencies and other healthcare clients nationwide.)*																
Pharmacy Benefits	•		•	•	•			•		•	•			•		
Behavioral Health & Specialty Therapies	•		•	•	•	•	•	•		•	•		•	•	•	•
Life & Health Management	•		•	•	•	•		•	•	•	•		•	•	•	•
Managed Vision	•		•	•	•	•		•	•	•	•		•	•	•	•
Telehealth	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•

Drawing on the experience and expertise gathered during multiple large and simultaneous successful implementations (including multiple states that were transitioning from fee-for-service to managed care) and the enterprise resources of our parent company, GSHP will be poised to meet an ***operational effective date of July 1, 2012 statewide.*** Centene, has more experience in the past five years partnering with states to transition from fee-for-service to managed care than any other managed care organization. These successful transitions have included the ability of our affiliate health plans to overcome hospital skepticism and provider disenchantment and develop fully compliant provider networks that assure members have access to all needed healthcare services.

Local Approach. GSHP is built on Centene's philosophy that ***health care is best delivered locally.*** This local approach, which includes hiring from the communities we serve, enables Centene plans to provide accessible, high quality and culturally sensitive services. GSHP's emphasis on having ***staff on the ground*** differentiates us from our competitors. Our managed care model uses integrated programs that can be delivered effectively only by a local staff, resulting in meaningful job creation within the communities we serve and personal focus for local stakeholders. Based on a statewide contract award, we estimate that GSHP would bring approximately 50 jobs to New Hampshire during Phase One and over 100 jobs once Phase Two is implemented.

Centene's health plan subsidiaries have a connection with the communities they serve. Many health plan staff from executive leadership to MemberConnections Representatives are involved in community groups that support our members. This approach to managing health

plans ensures that members, providers, state regulators and community resource agencies are able to partner with trusted individuals from their communities and that our stakeholders have direct access to local, accountable health plan staff. GSHP understands the complexities of treating the populations who will participate in the Care Management Program, and issues these individuals face when attempting to access care. To help break down those barriers to care and assist these members by developing a model of care that fits their specialized needs, we have met with several providers to discuss this issue. These meetings included multiple discussions with senior leadership from the Bi-State Primary Care Association (BSPCA). As a result of these discussions, BSPCA has not only agreed to participate in GSHP's network, but has initiated conversations with us to create a collaborative relationship. This partnership uniquely positions GSHP to blend the national experience and expertise of Centene, with BSPCA's local expertise, understanding of the Medicaid members, and the local health care delivery system.

GSHP will bring to New Hampshire the vast experience and expertise of our affiliate Centene health plans serving many different Medicaid populations, including populations like those participating in the New Hampshire Medicaid Care Management Program. For example, in Arizona, Centene subsidiary Bridgeway Health Solutions provides long term care services that include nursing homes and home and community-based services (HCBS) such as home modifications, personal attendants, and adult daycare to older persons and people with disabilities on SSI. Superior HealthPlan (Superior), our affiliate health plan in Texas, has provided long term care support services to the ABD population since 2007 and most recently was awarded a new contract in the Dallas Service Area to provide long term care and acute care services to approximately an additional 17,000 ABD members. Through another contract, Superior manages health care needs for over 29,000 children in foster care. Centene health plan subsidiary, CeltiCare Health Plan (CeltiCare), became the first new Massachusetts health plan in over two decades when it was awarded a contract by the Commonwealth Health Insurance Connector Authority to serve Commonwealth Care recipients. The Commonwealth Care program is a publicly subsidized health insurance program serving approximately 159,000 low-income, working adults (up to 300% of the FPL) who are not eligible for Medicaid and lack access to employer-sponsored insurance. Centene's health plans also excel at delivering health care in states with large rural markets, as evidenced by their Texas-based health plan, which is the Exclusive Provider Organization for SCHIP recipients in 170 rural counties across the state. Centene's Ohio plan, where 22 of the 43 counties are rural, has more than 141,000 TANF and SCHIP members and 19,000 SSI/ABD members.

Centene has experience with all of the populations and all of the benefits in all phases of New Hampshire's Medicaid Care Management Program.

Experience with High-Risk Populations. Centene and their family of health plans has considerable experience with managing high-risk populations. Centene has served populations with chronic medical conditions, developmental and physical disabilities and serious mental illness since 1984, as well as members on SSI and dually-eligible Medicare/Medicaid since 2002

and members receiving long-term care supports and services since 2005. Our experience also includes providing long term care services and supports. This subgroup is often faced with multiple chronic conditions and requires intensive care coordination to address members' physical and behavioral health needs. Centene and GSHP are committed to ensuring that members are involved in their care planning and offer services to support long-term care including a 24-hour nurse advice line, integrated behavioral health programs, home modifications, attendant care, emergency alert systems and equipment to assist with mobility. We have proactive member assessments that eliminate functional barriers to care. Through this comprehensive approach, we encourage community involvement, consumer-directed care initiatives, team-based care management and integrated systems that facilitate partnerships with providers, caregivers, consumers and social services.

Nine of Centene's health plan subsidiaries (AZ, FL, IL, KY, MS, OH, SC, TX and WI) provide services to approximately **223,000 SSI/ABD members**. Centene subsidiaries currently operate managed long term care programs in Arizona and Texas. Our managed long term care programs include individuals who require a nursing facility level of care. Those who are appropriately served in a nursing facility receive intensive care management services to ensure the appropriate level of care is being provided. Those individuals who have the desire and ability to be in a home and community based setting receive the services and support needed to mitigate the triggers that can lead to nursing facility placement. Home and Community Based Services we offer include but are not limited to:

- Personal care and homemaking
- Self Directed Care
- Assisted Living
- Adult day care
- Nursing care
- Behavioral Health Wrap Around Supports
- Respite Care
- Home Delivered Meals
- Transportation
- Linkages to Community Resources
- Home Modifications
- Emergency Alert Systems
- Minor Home Modifications
- LTC Safety Checks
- TBI (traumatic brain injury) and BH focused supported group homes

In addition to these services, we have also found other innovative services to be instrumental in helping Long Term Care members remain in a Home and Community based environment while receiving personalized care such as:

- Therapeutic Pet Therapy Programs
- Pest Control Services
- Denture Care
- Telemonitoring

Behavioral Health Experience. Granite State Health Plan's behavioral health affiliate Cenpatico Behavioral Health, has extensive experience providing a full range of supports and services including long term care services in community settings. Their experience includes strong relationships with Community Mental Health Centers (CMHC) in every state market. In New Hampshire we have initiated network contracting efforts to ensure service accessibility for all behavioral health services including long term care services in community settings. We look forward to strong relationships with the New Hampshire CMHCs who provide a broad range of services, and have already met with providers including, but not limited to: Seacoast Mental Health Center, Mental Health Center of Greater Manchester, Community Partners and West Central Behavioral Health. Their service delivery offerings include, but are not limited to some of the following:

- Assertive Community Treatment
- Client-Centered Consultation
- Community Support Programs
- Mental Health Assessment
- Intensive Outpatient Service
- Outpatient Service
- Psychosocial Rehabilitation & Support (PSR)
- Services for the Blind and Hard of Hearing
- Supported Employment: Job Finding, Retention and Termination Supports
- Psychotropic Medication Administration, Monitoring &Training
- School-based, community and home-based mental health services
- Comprehensive Mental Health Services
- Crisis Intervention
- Psychological Evaluation
- Inpatient Services
- Intensive Family-Based Services
- Peer Supports
- Care Management: Mental Health, Transition Linkage and Aftercare.
- Short-Term Diagnostic and Mental Health Services
- Therapy/Counseling – Individual, Group and Family
- Treatment Plan Development, Review and Modification
- Short term crisis stabilization

Experience with Medicare Special Needs Plans. Centene offers Medicare Special Needs Plan (SNP) coverage to ABD Enrollees who are eligible for both Medicaid and Medicare through our health plans in Arizona, Georgia, Ohio, Texas and Wisconsin. By offering Medicare and Medicaid benefits, Centene is better positioned to effectively manage the care of our Enrollees. Our plans provide access to personal, local care and promote health and independence. Navigating the health care system across the complexities of both Medicaid and Medicare systems is made simple through our integrated Dual eligible Special Needs Plans.

The GSHP Difference – Programs that Accomplish DHHS Goals

As New Hampshire becomes the 38th state in the nation to turn to "at risk" Medicaid managed care to provide both savings and **improve budget predictability**, the State will benefit from GSHP's presence as we leverage the experience of our parent company, Centene Corporation and our affiliate health plans to provide high quality, specialized service to all members in the Care Management program, including adults with disabilities and older adults within the Care Management Program.

We will expand the boundaries of traditional health care services with integrated care coordination, focused on preventive care, behavioral health and an "outside the box" approach to come up with innovative and creative solutions to provide supportive, compassionate care to this vulnerable population. Centene has a strong and sustained track record of creating solutions that all strive for the triple aim -to improve health outcomes and access to quality care while lowering the rising costs of health care. Our ability to impact the rising costs of health care would be enhanced if we were able to fully manage the pharmacy benefit including the preferred drug list. By fully managing the pharmacy benefit the State could generate total savings of $6-$7 million half of which would be realized by the State.

GSHP offers several unique program features that set us apart from other Medicaid health plans and position us to help DHHS meet all of the goals of the Care Management Program, including :

Improve Beneficiary Health

Integrated Care Teams. Recognizing that multiple co-morbidities often exist in chronically ill individuals and that the level of support required by these individuals is likely to change over time, GSHP will deliver care management services through an Integrated Care Team (ICT) approach. This team will include co-located staff from GSHP and Nurtur and will include registered nurses, behavioral health clinicians, social workers, disease management health coaches, transition coordinators and other non-clinical support staff. Teams will be staffed differently for members with serious mental illness, developmental disability and members with physical or chronic health conditions. Co-location of the ICT will facilitate regular, in-person communication about the member's care and achieve a level of coordination and integration that voicemails and emails among multiple care managers cannot. Because Centene health plans have found that locally delivered services achieve the best outcomes, we will hire staff who are from and familiar with the communities they serve and will locate our ICT members in local office in either Manchester or Concord. Our relationship with BSPCA will allow us to

provide a level of integration with providers that other health plan cannot. GSHP will work with local FQHCs, such as Lamprey Health Care, and CMHCs, such as the Mental Health Center of Greater Manchester, to locate our Care Managers at their locations. The on-site care managers will work with provider care management staff to complete assessments on members we have been unable to reach by phone, collaborate on care plan development, provide member education and participate in care conferences with providers' staff. Our care managers will support and supplement provider staff, building on and enhancing the existing service infrastructure within the service area. A recent review recognized this embedded care manager approach as a valuable alternative for providing a Medical Home for people with serious mental illness, citing evidence for increased receipt of evidence-based services and for increased likelihood of having a usual source for primary care services.[1]

GSHP's relationship with BSPCA will allow us to provide a level of integration with providers that other health plan cannot.

GSHP's program includes a systematic approach for early identification of eligible members; needs assessment; development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services; as well as outcomes monitoring. The teams support and complement the primary medical provider, specialist medical providers and the behavioral health provider or CMHC in the following ways:

- Supporting the provider's treatment plan
- Improving client appointment show rate
- Facilitating communication and integration between behavioral health and medical provider
- Coordinated discharge planning
- Coordinating wrap-around health services
- Facilitating member access to non-covered community resources

Integrated Care Teams have had a significant impact on our member's mental and physical well being in our subsidiary health plans. Below is one such example of a successful outcome from our Ohio subsidiary Buckeye Community Health Plan.

[1] Alakeson V, Frank RG, Katz RE, Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders, Health Affairs 29(5) 2010; 867-873

In September 2008, member, Jill P., 47, was in an Extended Care Facility after surgery to repair a broken femur. Jill was homeless, struggling to maintain a methadone maintenance program, and without a PCP. She had been hospitalized five times in the previous year. Her life was extremely chaotic and she often lashed out at those trying to assist her. During her time in the ECF, a Program Specialist from Buckeye Health Plan's Integrated Care Team visited her and began to help Jill with discharge planning, assisting her in finding housing, and establishing with a PCP. Special assistance was provided to ensure Jill was able to complete the application process for subsidized housing. At the time of discharge from the ECF, Jill moved into her own apartment (the first she had ever had). She began working with a PCP, continued substance abuse and mental health treatment and began repairing her relationship with her son. Since November 2008, Jill has maintained her apartment, became a member of the Buckeye Community Health Plan member advisory board and has only had one hospitalization. Jill frequently expresses her gratitude to the Program Specialist and Care Managers that have worked so closely with her and credits them for "giving her a life".

Healthy Lifestyles Program. GSHP's Healthy Lifestyles Program identifies regional community health education needs, improves outreach and communication with GSHP and community-based organization members, and actively promotes healthy lifestyles such as disease prevention and health promotion. The Healthy Lifestyles Program includes the following:

- ***Healthy Habits***: GSHP staff will visit local Group Homes or day programs to teach members, such as members with developmental disabilities about healthy eating (including cooking demonstrations) and other healthy habits such as safety and hygiene education.
- ***Healthy Homes:*** This initiative assists individuals who live in low-income or public housing to identify and address health hazards in the home, particularly lead.

Pet Therapy. GSHP will adopt and offer a pet therapy program, which has proven a uniquely valuable and popular service with the Long Term Care population in our affiliate Arizona health plan. Therapy dogs are typically family pets which were initially considered for 'service dog' certification but experienced a 'career change' (typically due to medical issues, such as cataracts). These loving and compassionate canines are specially trained and certified to interact with all types of people in a variety of different situations and settings. Therapy dogs are used to lift the spirits of those in nursing homes, under hospice care, and in hospitals. Each GSHP Integrated Care Team will have access to a certified therapy dog and handler (which may also be the care manager in some instances), and work with the facilities to coordinate flexible or structured visits.

In-Home Telemonitoring. GSHP will provide telemonitoring services to the highest-risk members (such as those with multiple co-morbidities), for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. This patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level for a diabetic or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the member's care manager and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the care manager, trigger an Interactive Voice Response phone call to the member, and/or alert other members of the Integrated Care Team or the member's provider. The technology represents a

quantum leap forward – and sets GSHP apart as having the only device-agnostic, real-time biometric monitoring capability among its competitors.

Promote Shared Decision-Making

Community Involvement. Centene has a strong track record of community involvement. Since Centene's beginnings as a Community Health Center, the company has operated according to the fundamental principle that successful health and social services organizations must be active members of the community. Further, it is not good enough to come into an area simply to arrange services. Centene health plans hire local staff from within the communities we serve, who know our members, speak their languages, and are able to facilitate services in a culturally competent manner. As we interact with community organizations we teach each other and work together to find solutions to problems, creating a multiplier effect and our joint efforts will be more beneficial to the people we serve than the efforts of any single organization on its own. For example, our Arizona health plan, Bridgeway Health Solutions employs two care managers with physical disabilities. These care managers know better than anyone the challenges faced by people with physical disabilities; members feel better knowing someone truly understands their situation and health plan staff benefit from a deeper understanding and benefit from experiencing truly "teachable moments" regarding the physically disabled population.

> Successful health and social services organizations must be active members of the community.

Through community involvement, GSHP will be able to effectively locate resources in the community and coordinate them with covered services to deliver a seamless package of care that meets the full range of an individual's needs, thus enabling choice in the delivery of services and a voice in living independently in the community. GSHP will not only become aware of these resources, but become active partners with many organizations, through participation in community events and sponsorships of associations that provide advocacy and services for our members.

Member and Community Advisory Committees. GSHP will follow the best practice of other Centene health plans by developing both a Member Advisory Committee (MAC) and a Community Advisory Committee (CAC) to serve as mechanisms for GSHP to solicit input regarding our operations and management of the Medicaid Care Management Program. The MAC will be comprised of members, family members and other caregivers who are randomly selected in accordance with the Managed Care Reform and Patient Rights Act. The CAC will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Advocacy groups who have agreed to participate in the CACs include: Easter Seals, the Council on Community Transportation, and Community Support Network, Inc. (CSNI). Because GSHP recognizes that the Care Management Program will include different groups with very different perspectives and challenges in receiving appropriate health care, we will establish three separate CACs that address issues for members with:

- Developmental Disabilities
- Serious Mental Illness

- Physical Disabilities and Chronic Illness.

The MAC and CAC will provide feedback to the GSHP's Quality Improvement Committee (QIC) on GSHP performance from a member- and community- perspective, recommend program enhancements, identify key program issues that may impact community groups, provide input on service improvements and offer guidance on effective approaches for reaching members, and other member-related issues. These committees will review member and provider satisfaction survey results, evaluate performance levels and telephone response times, review member education materials for relevance, understanding and ease of use, and evaluate access and provide feedback on issues as requested by the QIC.

Consumer-Directed Care. GSHP's philosophy of care delivery and individual support is grounded in the belief that individuals should be empowered to direct and access services that give them the greatest flexibility in managing and living fulfilling lives. We will promote this philosophy through participation in initiatives which strengthen and encourage independence among disabled persons, and provide community based services for members who would otherwise be entitled to institutional services.

GSHP will draw from the experience of our affiliate Centene health plans in identifying and engaging in innovative approaches to the provision of services. Our approach to managing consumer directed care will be modeled off the Self Directed Attendant Care (SDAC) program being used by Bridgeway Health Solutions, our Arizona affiliate health plan. SDAC is a new model for attendant care (personal care) based on the concepts of consumer directed care. SDAC is available to most elderly and/or physically disabled Arizona Long Term Care System (ALTCS) Enrollees who live in their own home. This model provides members with more options in deciding who their Attendant Care Worker is, the ability to choose how/when services are delivered, more control over services received, and greater responsibility in managing personal health.

The SDAC program affords members the option and the ability to make decisions about how to best get their needs met, including who will provide the services and when the services will be provided. SDAC allows members to make decisions about the services they want and how to receive them. Inclusive of the SDAC service option, members will hire, train, supervise, and (if needed) fire attendants. The mission and basic philosophy of this service option is tied to Long Term Care guiding principles, based on the idea that members best know their own individual needs and how to address them. SDAC promotes choice, dignity and independence in efforts to improve the quality of life by empowering members and promoting in-home community living.

Facilitating Partnerships. GSHP understands the complexities of treating the populations who will participate in the Care Management Program, particularly members with serious mental illness (SMI) and issues these individuals face when attempting to access appropriate medical care. To help break down those barriers to care and assist these members by developing a model of care that fits their specialized needs, we have met with several providers to discuss this issue. These

GSHP understands the complexities of treating the populations who will participate in the Care Management Program.

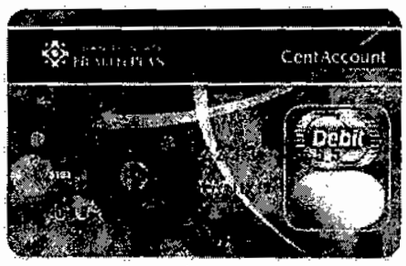
meetings include conversations with Seacoast Mental Health Center, Mental Health Center of Greater Manchester, Community Partners and West Central Behavioral Health.

GSHP wants to build upon the existing health care delivery system. There are, for example, innovative programs already in place within the CMHCs that provide inpatient diversion for patients visiting the emergency room with a behavioral health condition such as The Cypress Center offered through the Mental Health Center of Greater Manchester. The Cypress Center is a short term crisis stabilization unit, designed to give individuals a place to stabilize instead of going to an emergency room or hospital. Additionally, we will work with New Hampshire's Peer Support Agencies to encourage the use of Peers as a best practice technique to help individuals with serious mental illness (SMI) or serious and persistent mental illness (SPMI) enhance the recovery process. In other markets, Cenpatico has found working with Peers can help improve a member's engagement and participation in their individual care planning process and recovery.

Ensure Access to Primary Care and Prevention

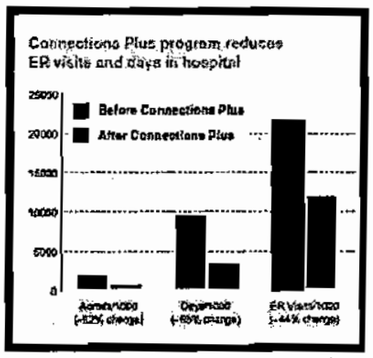
Partnership with Bi-State Primary Care Association. Through GSHP's unique partnership with BSPCA, we will be able to enhance the delivery of care to Medicaid members in the State of New Hampshire. We will develop on-site care management capabilities to assist members in meeting their healthcare needs. We will provide support enabling Bi-State to increase access to care by recruiting additional providers enhancing their ability to serve additional Medicaid recipients healthcare needs including access to social services, community outreach and support services. We will work with Bi-State to target the barriers to accessing care and will collaborate with them to provide solutions.

CentAccount. The CentAccount™ member incentive program is widely used by Centene health plans and promotes personal health care responsibility and ownership by offering financial incentives that are valued and appreciated by health care consumers. Rewarding members for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement. Eligible members can earn rewards for completing annual preventive health visits; participating in appropriate disease management programs and complying with the care plans; and completing other recommended preventive health and chronic disease care screening. The reward is loaded onto a GSHP-issued CentAccount MasterCard® debit card. Members can use this card at many merchants they already use every day, such as CVS and Wal-Mart stores, supermarkets, and other stores throughout the State, to buy a wide variety of health-related goods. Members may use the earned funds on their CentAccount cards towards healthcare goods and services not covered by Medicaid, including paying for over-the-counter medications, baby products, bus passes, utilities and childcare.



MemberConnections® Program. Each of Centene's health plans, including GSHP, benefit from the MemberConnections Program. The MemberConnections Program allows us to provide a level of in-person, "boots on the ground" interaction with our members that other health plans cannot. MemberConnections Representatives (MCRs) are health outreach workers hired from within the

communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and become an integral part of our Member Services and Care Management teams, which benefits our members and increases our effectiveness. MCRs will make home visits to members we cannot reach by phone. They will assist with member outreach, coordinate with social services, and attend community functions to provide health education and outreach. For example, MCRs will work with providers to organize Healthy Lifestyles events and work with other local organizations for health events.



Connections Plus. All Centene affiliates have implemented our Connections Plus® Program, which provides pre-programmed cell phones to our high-risk members who lack reliable phone access. This innovative program provides 24-hour instant access for our members, allowing them to make calls to and receive calls from their providers, care managers, GSHP personnel, NurseWise, and 911. The overall objective of the program is a reduction in preventable adverse events such as inappropriate ER use, hospital admissions or premature birth through improved access to health care information and treating providers. High-risk members receive a cell phone (at no expense to the member) that has pre-programmed direct dial to the member's PCP or OB/GYN, Care Manager, NurseWise (our 24/7 nurse advice line), and 911. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The cell phones are also used so that care managers can send the member a text message with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members.

As part of Connections Plus, we will provide these high-risk members MP3 players loaded with podcasts relevant to their condition. These podcasts will also be available for members to download from our Member Portal. Examples of podcast topics currently available include: diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches, healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, vaccinations, generic drugs, heart attacks and advance directives. Several members returning their MP3 player sent notes indicating that they returned it so that it would be available for another member to listen to it. This program received ***URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award*** and was a ***2009 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree.***

"Practice Visit" to OB/GYN. GSHP will offer the innovative method of reimbursing providers for "practice visits" to help make these visits less stressful for individuals with disabilities. This approach has proven to be successful at other Centene health plans and provides an opportunity for the member to become familiar with the provider's office, equipment, and processes prior to the actual date of service. This 'role-play' exercise also provides a setting for the member or caregiver to ask questions and express concerns. This helps the member feel more comfortable with the process, and it may enable the provider to identify barriers to ensure clear communication before the appointment takes place.

GRANITE STATE HEALTH PLAN

Reimburse Based on Outcomes

Through the creative structuring of provider incentives, GSHP believes we can engage providers in both cost containment and quality improvement initiatives. The traditional fee-for-service model has merely incentivized providers for providing quantity rather than quality, and now there are increased opportunities to reward providers for quality.

As we have moved away from the traditional fee-for-service model, we have developed contracts that use pay-for-performance incentives that reward providers, and have consequently resulted in, both for reductions in costs and for improvements in outcomes.

GSHP will work collaboratively with the State and other payers to explore opportunities to support patient-centric care and to further align incentives and standards in order to achieve common goals. GSHP will work in partnership with the state and local providers to create a solid payment reform model built around NCQA standards and state required guidelines.

We believe our delivery system based on the Patient centric medical home model is consistent in many aspects with the NH Citizens Health Initiative and will improve provider satisfaction, health care outcomes, care quality and patients' overall health while reducing preventable emergency room (ER) visits and hospitalizations and their associated costs. To develop its core patient centric payment model, GSHP will gather as much recent information as possible regarding national initiatives and current initiatives under way in New Hampshire. We will also survey our contracted providers to find out their level of knowledge regarding national and local payment reform initiatives, their level of commitment to working within a reformed payment model, and their ability to perform well within that environment. Compiling this information will help us to discover partnership opportunities and uncover challenges early in the process and guided our approach to developing strategies and goals that are measurable, achievable and, most importantly, tailored to the unique needs of the providers.

For example, GSHP-affiliated health plans have had experience with medical home models at different stages of development, and this pattern is consistent in New Hampshire, with Dartmouth Hitchcock Health System achieving level three PCMH certification in all of its PCPS practices to rural providers without such resources. In New Hampshire, we have been engaging with Bi-State Primary Care Association, multi-specialty PCP-centered medical groups and PCP offices who may be interested in becoming Medical homes, to aid them in the transition driven by Healthcare reform. GSHP will take a flexible approach, based on our assessment of each Medical Home's capabilities. Smaller offices are more likely to require all care coordination services be done by GSHP staff while larger ones already developing medical home skills may only require supplemental support and integration.

GSHP will work in partnership with the state and local providers to create a solid payment reform model built around NCQA standards and state required guidelines.

With approximately 90% of the PCPs in New Hampshire employed by hospitals or health systems, there are tremendous opportunities to support the Medical Home and truly coordinate care across the entire continuum of health care services. GSHP will encourage all of our providers, regardless of size, structure or degree of development, to continuously improve their capabilities for accessible, continuous, comprehensive, coordinated, compassionate and culturally effective patient-centered care. This may entail changes in staff culture and responsibilities and in appointment scheduling and office hours, use of registries for patients with chronic conditions, and implementation of an electronic medical record system.

Support Continuity of Care

GSHP's affiliate Centene health plans have significant experience ensuring continuity of care, including transitioning large numbers of newly enrolled members, including those with special health needs, from fee-for-service (FFS) to coordinated or managed care programs. Through the experience of our affiliate health plans in Georgia, Illinois, Kentucky, Mississippi and South Carolina, we are able to implement the best practices used in these markets that successfully handled the issues involved when state Medicaid and/or CHIP programs make such a significant change in the service delivery system, particularly related to ensuring that members with special health needs experience no disruption in their care. In the past year alone, from urban Chicago to the very rural Mississippi delta, our affiliate plans have demonstrated the flexibility and adaptability of Centene's approach by successfully supporting continuity of care while transitioning members from fee-for-service to managed care.

Centene's Texas health plans have transitioned more Medicaid and CHIP members than any other health plan in that state, which has the third largest Medicaid managed care population in the country,[2] as well as significant rural areas. They have ensured continuity of care for members with special health needs, those eligible due to age and disability, and children in foster care. For the recent implementation of the Texas STAR+PLUS Program, which provides acute care and long term supports and services to members on SSI in the Dallas Service Area, including dual eligibles, our affiliate plan transitioned over 20,000 new adult and child members with Special Health Needs (MSHN) from the FFS program. They ensured continuity of care by authorizing all existing services these members were already receiving at the time they enrolled. The plan also completed and distributed authorizations to the servicing providers within 45 days after the Operational Start Date, and provided a summary report to each provider listing the member, procedure code/s, modifiers if applicable, and diagnosis code to support a seamless billing process. Prior to implementation, our affiliate educated both network and non-network providers about its continuity of care policies and procedures, emphasizing that all current authorizations would be honored regardless of the provider's network status until the plan completed a comprehensive assessment. They also worked with existing providers and the member/family to determine whether and how the member's care could safely be transitioned to a network provider, and completed a new service plan in collaboration with the member/family and providers. The plan worked with the state to identify any services that had been requested but not yet authorized under the FFS program, and prioritized these members for immediate assessment.

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[2]Medicaid Managed Care Enrollees, as of June 30, 2009. http://www.statehealthfacts.org/comparemaptable.jsp?ind=216&cat=4

Our strategy for coordinating continuity of care for members entering GSHP, regardless of the situation or circumstance, incorporates the following features:

- identification of the new member
- assessment of the new member's health care needs
- determination of the presence of active care needs or possible outstanding service authorizations
- identification of the member's previous health plan (if applicable and following initial implementation)
- contact with the previous health plan and/or Primary Care Provider (PCP) to obtain relevant member information (if applicable)
- ensuring existing authorizations with the previous health plan or in fee-for-service are honored during the transition.
- supporting the physician community through an "any willing provider" approach that maintains consumer continuity of care.
- utilizing "Single Case Agreements" to allow a member to continue care with a provider who elects not to become part of GSHP's network.

Comply with Federal and State Laws

GSHP will follow the best practice of our affiliate Centene health plans by implementing a robust Integrity Program that ensures that we comply with all applicable federal and state laws. Our Integrity Program will be *fully integrated* into all business functions and activities. The daily operation of our Integrity Program consists of three inter-related sub-programs: our Fraud, Waste, and Abuse (FWA) Program; our Compliance and Ethics Program; and our Integrity Oversight Program. Together they create a sphere of integrity that will ensure compliance, ethical conduct, appropriate use of government funds, and transparency in everything we do to partner with DHHS and New Hampshire stakeholders in providing quality care for Medicaid Care Management Program members.

Our **Compliance and Ethics Program** is the primary organizational component of our Integrity Program. Our Compliance Program will implement eight compliance plan elements, as recommended by the U.S. Federal Sentencing Guidelines, Office of the Inspector General of the U.S. Department of Health and Human Services, and federal law:

- Written Standards of Conduct and Policies and Procedures
- A Designated Compliance Officer and Compliance Committee
- Continuous, Effective Education and Training
- Effective Lines of Communication
- Enforcing Standards Through Well-Publicized Disciplinary Guidelines
- Internal Monitoring and Auditing

- Prompt Responses to Detected Offenses
- Record Management and Protection

Our **Fraud, Waste and Abuse (FWA) Program** focuses specifically on the staffing, policies and procedures, technologies, and approaches we will dedicate to addressing FWA. Our FWA incorporates the continuous processes of: prevention, detection, investigation, prompt response, reporting, and full cooperation with State, federal and other law enforcement authorities. Our use of competitive technologies, clinical reviews, and investigative practices will provide *in-depth claim screening* for fraudulent, wasteful and abusive billing *prior to payment,* which is the most efficient and effective way to *protect State funds* and avoid the additional effort of recouping overpayments. GSHP will take an all-inclusive approach to fighting FWA, starting with employee hiring, provider contracting, and member education, and then applying ongoing monitoring and other actions to detect and respond to potential transgressions.

Our **Integrity Oversight Program** addresses our staffing, activities, and systems that will measure and monitor the effectiveness of our Compliance Program, both at the health plan and corporate (Centene) levels. To GSHP, program integrity means *actively* maintaining full compliance with all applicable State and federal requirements (which include State Contract requirements). It also means *proactively* assessing risks across operations that may compromise compliance. Our Enterprise Risk Management Program includes the comprehensive support of internal and external auditors. As an overarching monitoring and auditing program, our Integrity Oversight Program will help measure, maintain, and model sound business practices. It will also identify risks to ensure prompt alignment of resources and actions to promote successful delivery of quality managed care health services and fulfillment of our mission: *Better Health Outcomes at Lower Cost.*

The Patient Protection and Affordable Care Act and its Impact. One of the biggest factors influencing healthcare today is the Patient Protection and Affordable Care Act (PPACA). Signed into law on March 23, 2010, the PPACA comes at a time when the U.S. healthcare system faces unprecedented challenges, including one of the worst global recessions in history and a growing number of uninsured. While policy makers have yet to reach a consensus on many provisions in the bill, virtually all stakeholders agree that the healthcare market will undergo substantial transformation, with state leaders having power to shape reforms to adapt to local markets.

Centene represents one of the nation's most experienced health insurance organizations serving the uninsured and underinsured.

Clearly, state officials will play a critical role in ensuring that PPACA has the desired effect of increasing access to high-quality, affordable healthcare without disruptions in care for those who currently have health insurance. Having cultivated numerous coverage expansion programs, Centene not only has the experience to help states better understand the complex decisions they are grappling with, they also have the flexible affordable solutions needed to succeed in this market.

Centene - A History of Success with States Nationwide. With more than 27 years of experience in government services managed care programs for low-income populations including Medicaid and the

Children's Health Insurance Program (CHIP), Centene represents one of the nation's most experienced health insurance organizations serving the uninsured and underinsured. Furthermore, as a Fortune 500 company, Centene has the resources and the knowledge needed to identify opportunities and implement solutions that are best for each state.

Centene has a long history of working closely with government partners and local communities to find innovative solutions that address the unique challenges they face.

Because Centene's portfolio of subsidized and commercial health insurance solutions is highly customizable, we are able to create solutions tailored to individual states. As a result, we have been able to establish long-term collaborative relationships with various states. The many state programs we have been involved in include:

- **Exchange-based health plans** offered through the Massachusetts Health Connector
- **Consumer-driven small group plans** targeting small businesses with low-wage employees in Arkansas and Texas
- **State-subsidized health plans** promoting consumerism through HSA-like features in Indiana.

Centene has worked with state leaders across the nation to create hybrid insurance solutions that combine multiple revenue streams and offer affordable coverage to their members. As always, our goal is to help maximize state healthcare revenues and improve health outcomes.

Spectrum Health Solutions. Centene's latest development is the creation of "Spectrum Health Solutions", an innovative effort to help states better understand the impact of healthcare reform on coverage and medical costs at a detailed level. Spectrum Health Solutions begins by examining a state's pre-reform health insurance coverage environment, including individual coverage, employer sponsored insurance, Medicare and Medicaid eligibility criteria and levels. We layer in state-specific data on Medicaid costs by different demographic criteria (e.g., age, sex). These cost "cells" provide a granular view of per member per month" costs for Medicaid and low-income individuals. We then model the impact of healthcare reform and forecast future coverage needs and costs and construct innovative health care solutions for our states clients.

Prepare for 2014 Medicaid Expansion

Centene's core philosophy is that **every American deserves quality health care** and accordingly commits itself to a comprehensive, sustainable structure to address the impact of health reform. We continue to invest our resources in working with our State customers, care providers and individuals to design, develop and implement innovative solutions that addresses the growing needs of maintaining or improving cost affordability, increasing quality health outcomes, and driving personal accountability. We remain committed to the federal and various state level reform efforts. To that end, we invest in people, processes and technologies to assess and develop health care policies and innovative yet practical solutions. These investments include:

- Establishing a Health Policy function headed by a former Secretary of Agency for Health Care Administration

- Engaging at both State and federal level in policy discussions and demonstrating willingness to participate in various pilot projects
- Funding a dedicated team of Product/Innovation experts to focus on new market driven initiatives, lead by a Senior Vice President of Product and Innovation
- Continued investments in technology and systems infrastructure to support holistic approach to servicing the member across product lines and building scale in operations for future Medicaid and Exchange expansions
- Financial investments in non-traditional partnerships with provider groups (such as our FQHC partnership in Louisiana to create our Louisiana subsidiary) to expand quality access and reform payment structures

Health Insurance Exchanges. In addition to extending health insurance coverage through Medicaid eligibility expansion, the PPACA also offers individuals premium subsidies for the purchase of private health insurance through state health insurance exchanges. Eligibility for these programs is sensitive to income and can change over time with fluctuating income and changes in family composition, some of the recent national studies conducted and published in *Health Affairs* estimates that within six months of Exchanges going live, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. While churning is a long standing issue for Medicaid, the phenomenon will become more complicated and hit millions more individuals.

To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions caused by those transitions. Having cultivated numerous coverage expansion programs and as being the only national carrier participating in Massachusetts Health Exchange (Connector), Centene not only has the experience to help states better understand the complex decisions they are grappling with, we also have the flexible affordable solutions needed to succeed in this dynamic environment. With this experience, ***Granite State Health Plan is ready to partner with DHHS to develop and participate in a Health Benefits Exchange to allow members to maintain continuity of access to services as they transition between programs.***

National Advisory Committees. Centene routinely engages external experts on both a formal and informal level to stay abreast of the concerns and priorities of our key stakeholders as we develop new programs intended to improve health outcomes while lowering costs. Examples include:

Centene Health Policy Advisory Council. This council, comprised of national experts in health care and health care policy, advises Centene on strategies to improve health care quality at lower cost. Current council members include:

- William A. Peck, M.D, is the Chair of the Council. Dr. Peck directed establishment of a major new Center for the Study of Health Policy at Washington University. He is internationally recognized for his leadership in medical education and research.

- Michael F. Neidorff, is the Co-Chair of the Council. Mr. Neidorff is Centene's Chairman and CEO and has successfully developed and provided programs and services in Medicaid, Medicare and commercial managed care.
- Stephen Shortell, Ph.D., MPH, MBA, is the Dean of the School of Public Health at the University of California, Berkeley. Dr. Shortell is a prominent researcher in health policy and organization behavior and is known as a leading academic voice in advocating reform of the nation's health system.
- Gloria A. Wilder, M.D., MPH, is President and CEO of CORE HEALTH. Based in Washington DC, CORE HEALTH is a healthcare solutions company dedicated to assisting providers in underserved communities throughout the nation. Dr. Wilder is an internationally recognized public speaker and expert on poverty, economic segregation in health care, social justice, and care to underserved communities.
- Tim McBride, Ph.D., M.S., is Associate Dean for Public Health at Washington University. Dr. McBride is a health economics and policy expert with broad knowledge of health care delivery and financing at the State and federal levels.

The objectives of the Health Policy Advisory Council are to:

- Identify healthcare trends impacting the quality and cost of health care delivery with an emphasis on Medicaid, SCHIP, and uninsured populations
- Evaluate future direction of healthcare delivery and financing systems
- Identify specific opportunities for Centene and its health plans to improve health care quality and reduce costs
- Advise Centene and its affiliate businesses on specific business models and approaches to serving the Medicaid, SCHIP, and uninsured populations
- Advise and support Centene in communicating with its customers or potential customers, including State and federal legislatures and governmental agencies
- Advise Centene and its health plans in establishing strategic partnerships with providers around the delivery of healthcare to Medicaid, SCHIP, and uninsured populations
- Advise Centene Foundation on project funding strategies

Centene National FQHC Advisory Committee. This committee was created to provide a venue for FQHCs to provide Centene with candid, unfiltered feedback about the performance of their health plans and to make a difference at both a national and local level in how Centene and Primary Health Care Associations and FQHCs work together and support each other. The Committee is also closely aligned with the National Association of Community Health Centers (NACHC), which represents FQHCs across the country. This partnership has allowed for us to sponsor conferences and provide training, including a current joint opportunity for webinars and targeted training at all NACHC conferences. This committee currently includes representatives from Texas, Indiana, South Carolina, Mississippi, Georgia and Louisiana. As Centene continues to enter new markets, the composition of this committee will expand to allow participation in new markets, such as Washington.

Current initiatives underway that will positively impact safety net providers participating with all Centene health plans include:

- Developing standard operating protocols for both new and existing markets, including training materials, reimbursement strategies and metrics, and aligning quality goals (HEDIS, NCQA, JCAHO, etc.);
- Establishing FQHC liaisons in each market; and
- Assistance with NCQA Medical Home accreditation

Health Plan Engagement in State Initiatives. Centene's health plans are frequently asked to participate in projects outside the scope of their normal operations and they bring innovative solutions to their respective State agencies as they partner with them in planning for the future. Some examples of Centene health plans partnering with State and local entities include:

- Peach State Health Plan (Georgia) Medical Management staff are collaborating with GA DCH Medicaid Division on a Avoidable ER Use and Facilitation of Patient Centered Medical Homes
- Peach State's Director of Disease Management is a member of the Georgia Department of Public Health Obesity Action Network, Healthcare Workgroup
- Absolute Total Care (ATC - South Carolina) is working with the State on a Dual Eligibility Workgroup aimed at dual eligibles
- ATC participated in Medicaid Sustainability Workgroups aimed at reducing administrative costs and assessing areas for reduction due to the States' budget crisis in 2010-2011
- Bridgeway Health Solutions' (Arizona) CEO was appointed by the Speaker of the House to serve on the Blue Ribbon Legislative Committee on Medicaid
- Superior HealthPlan's IT Director serves on The Texas Health Services Authority (THSA); responsible for coordinating the implementation of HIE strategic and operational plans for the State of Texas
- Managed Health Services (Wisconsin) partnered with DHS in a grant to improve EPSDT rates in Kenosha county and identify children who were obese or prone to obesity
- Managed Health Services' (Indiana) CEO serves on the Board of Covering Kids and Families, which works with the state on various policy issues

In summary, GSHP brings New Hampshire a unique blend of national experience and local expertise.

- Through our parent company, Centene, we bring over 27 years experience providing all of the benefits for all of the populations included in all phases the Care Management Program, national expertise and a track record of multiple successful implementations that includes more experiences transitioning members from fee-for-service to managed care than any other organization.

- Through our affiliate specialty companies (including pharmacy, behavioral health, disease management and vision), GSHP is uniquely positioned to deliver an integrated enterprise approach that reduces fragmentation for our state customers and our members.
- By incorporating our partnerships with BSPCA, we are better able to understand the New Hampshire Medicaid market and offer a robust statewide network of qualified Medicaid providers allowing for a rapid market entrance.
- Our local approach will best serve our members, providers, DHHS and other stakeholders while adding approximately 50 jobs to New Hampshire during Phase One and over 100 jobs once Phase Two is implemented.
- Our care management programs offer New Hampshire's Medicaid recipients an innovative, integrated and locally driven model for coordinating care which will improve outcomes for the Medicaid members and provide an efficient, cost effective solution for the State of New Hampshire.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.2 Transitioning to the Care Management Program

GRANITE STATE HEALTH PLAN

3.2 Transitioning to the Care Management Program

Experience Initiating Similar Programs

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

Granite State Health Plan (GSHP) is a wholly owned subsidiary of Centene Corporation. Centene health plans operate on the core philosophy that quality health care is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive health care services to our members. Centene's Medicaid Managed Care Programs provide Medicaid and Medicaid-related health plan coverage to individuals through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care, Long Term Care, and subsidized and commercial health insurance for uninsured and Medicare enrollees (the latter through Special Needs Plans). Centene Specialty Services include pharmacy benefits management, vision care, behavioral health, life and health management, a 24/7 nurse advice line, and medication treatment compliance. Through the specialty division, Centene offers the whole package for integrating health care solutions that address the often complex needs of Medicaid enrollees. Our managed care model uses integrated programs that can be delivered effectively only by a local staff, resulting in meaningful job creation within the communities we serve, and because our staff is local, Centene's health plans have a strong connection with the communities they serve. This approach to managing health plans ensures that members, providers, state agencies and community resource agencies are able to partner with trusted individuals from their communities and that our stakeholders have direct access to local, accountable health plan staff. To reinforce this commitment, GSHP has partnered with Bi-State Primary Care Association. Through this partnership we will provide support enabling Bi-State to increase access to care by recruiting additional providers enhancing their ability to serve additional Medicaid recipients healthcare needs including access to social services, community outreach and support services. We will work with Bi-State to target the barriers to accessing care and will collaborate with them to provide solutions; Bi-State will have two board members on the GSHP Board of Directors as well as participation on our Quality Committees ensuring feedback and opportunities to improve the quality of care and access to care for our Medicaid members.

Providing **Medicaid Managed Care Services** and **Health Care** for the **Uninsured** and **Underinsured** is Our **Only** Focus

GRANITE STATE HEALTH PLAN

Medicaid Managed Care Experience

Centene has 27 years of experience in Medicaid Managed Care with over 5,100 full-time employees located in 26 states across the country covering over 1.6 million individuals. We have full risk managed care plans in: Arizona, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana (services begin Feb 2011), Massachusetts (uninsured), Mississippi, Ohio, South Carolina, Texas and Wisconsin. Centene has established itself as a national leader, providing fully integrated care to Medicaid populations. Centene's core philosophy is that quality health care is best delivered locally and our Granite State Health Plan (GSHP) is backed by the entire Centene family of companies to make New Hampshire's transition to managed care a successful one. We have partnered with the following states during their initial transition from fee-for-service to managed care in Georgia, South Carolina and Mississippi, Kentucky, Louisiana (operational February 2012) and Illinois and know what it takes to smoothly transition both members and providers.

Centene plans provide a full array of managed Medicaid services in the following states:

Health plans or hybrid programs

Medicaid Populations. Centene has experience serving many different Medicaid populations, including the populations that will be participating in New Hampshire's Care Management Program. These populations include adult and child members with a wide variety of chronic, complex and/or

catastrophic conditions and special health care needs. These members include those on SSI; those who are eligible for Medicaid due to age, blindness or disability; those who are dually eligible for Medicaid and Medicare; women and children who are eligible for TANF; and children in foster care. **Centene affiliate plans currently serve approximately 220,000 ABD members.** Our affiliated health plan's membership includes members with chronic conditions such as, severe and persistent mental illness, diabetes, asthma, congestive heart failure, cancer, transplants, spinal cord injury, para/quadriplegia, amputations, HIV/AIDS, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, autism, bipolar disorder, seizure disorder, cerebral palsy, and co-morbid/co-occurring conditions. In Arizona, Centene subsidiary Bridgeway Health Solutions provides long term care services that include nursing homes and home and community-based services (HCBS) such as home modifications, personal attendants, and adult daycare to older persons and people with disabilities on SSI. Superior HealthPlan (Superior), our affiliate health plan in Texas, has provided long term care support services to the ABD population since 2007 and recently was awarded a new contract in the Dallas Service Area to provide long term care and acute care services to an additional 17,000 ABD members. Through another contract, Superior manages health care needs for over 34,000 children in foster care. Centene health plan subsidiary, CeltiCare Health Plan (CeltiCare), became the first new Massachusetts health plan in over two decades when it was awarded a contract to serve Commonwealth Care recipients. The Commonwealth Care program is a publicly subsidized health insurance program serving approximately 150,000 low-income (up to 300% of the FPL) working adults who are not eligible for Medicaid and lack access to employer-sponsored insurance.

Below is a table of the populations we serve and the services we offer in the states where we do business:

Government Solutions	AR	AZ	FL	GA	IL	IN	KS	KY	LA	MA	MS	MT	OH	SC	TX	WI
TANF		•	•	•		•		•	•				•	•	•	•
CHIP		•		•		•		•	•				•	•	•	•
ABD (Non-Dual)		•	•		•			•	•		•		•	•	•	•
ABD (Dually Eligible)		•	•					•							•	•
Long-Term Care		•	•												•	
Foster Care								•	•		•				•	
Medicare Special Needs Plan		•		•									•		•	•
Other Subsidized Health Insurance Programs	•					•				•					•	
Specialty Health Solutions																
Pharmacy Benefits (US Script)		•	•	•	•			•		•	•		•[1]	•	•[1]	
Behavioral Health Management (Cenpatico)		•	•	•	•	•	•	•		•			•		•	•
Life & Health Management (Nurtur)		•	•	•	•	•		•	•	•	•		•	•	•	•
Managed Vision (OptiCare)		•	•	•	•	•		•	•	•	•		•	•	•	•
Telehealth (NurseWise)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

[1] OH and TX are carving the pharmacy benefit into the managed care programs in October 2011 and March 2012, respectively.

GRANITE STATE HEALTH PLAN

Rural Areas. Centene's health plan subsidiaries excel at delivering health care in rural areas and unlike some plans, have embraced the opportunity to serve rural communities. In Centene subsidiary health plans, 45% of the counties we serve are rural as designated by the Census Bureau. Centene health plans in Georgia and Texas have demonstrated the ability to serve rural areas that were once considered impossible to serve in a managed care environment. Centene's Texas health plan, is the exclusive provider Organization for CHIP recipients in 177 rural counties across the state. Centene's Ohio plan, where 22 of the 43 counties are rural, has more than 140,000 TANF and CHIP members and 19,300 SSI/ABD members. We offer services in rural areas such as telemonitoring and telemedicine to our highest risk members

45% of the Counties we Serve are Rural as Designated by the Census Bureau

Experience Transitioning FFS to Managed Care

Working with six states to transition significant populations from Fee for Service (FFS) to coordinated or managed care programs; we have established strong partnerships with the state agencies leading these efforts. The populations we serve include members in rural areas, as well as members in urban areas, members on SSI and members who are dually eligible. In 2011, we implemented Medicaid managed care for the ABD population statewide in Mississippi, including the very poor and rural Mississippi Delta area and six months later we implemented Medicaid managed care for suburban Chicago. We understand and have successfully handled the issues involved when state Medicaid and/or CHIP programs make such a significant change in their service delivery system, and we are particularly committed to ensuring that members with special health care needs experience no disruption in their care.

Since 2006, Centene has partnered with 6 States in their Transition from FFS to Medicaid Managed Care and Transitioned over 600,000 Medicaid Recipients

Today Centene affiliate health plans are located in 14 states, where we manage the care of over 1.6 million members. **To date, we have transitioned over 600,000 members from a FFS to a Managed Care Program.** Our experience transitioning FFS to Managed Care Programs is summarized in the table below.

Georgia	April 2006	TANF, CHIP	Statewide
South Carolina	December 2007	TANF, CHIP, ABD	39 of 46 Counties

Mississippi	Jan 2011	ABD, Foster Care	Statewide
Illinois	May 2011	ABD (Long Term Care, DD phase 2)	6 Urban Counties
Kentucky	Nov 2011	TANF, CHIP,ABD	Statewide
Louisiana	Scheduled Feb. 2012	TANF, CHIP, ABD, Foster Care	Statewide

Granite State Health Plan's (GSHP) **affiliated health plan in Texas, Superior Health Plan, has transitioned more Medicaid and CHIP members than any other health plan in that** state, which has **the third largest Medicaid managed care population in the country.**[3[1]] In both urban and rural areas, they have ensured continuity of care for members with special health care needs, those eligible due to age and disability, and children in foster care. For the recent implementation of the Texas STAR+PLUS Program, which provides acute care and long term supports and services to members on SSI in the Dallas Service Area, including dually eligible members, our affiliate plan transitioned over 20,000 new adult and child members with Special Health Needs (MSHN) from the FFS program. Superior ensured continuity of care by authorizing all services these members were already receiving at the time they enrolled. The plan also completed and distributed authorizations to the service providers within 45 days after the Operational Start Date, and provided a summary report to each provider listing the member, procedure code/s, modifiers if applicable, and diagnosis code to support a seamless billing process. Prior to implementation, Superior educated both network and non-network providers about its continuity of care policies and procedures, emphasizing that all current authorizations would be honored regardless of the provider's network status until the plan completed a comprehensive assessment. They also worked with existing providers and the members and their families to determine whether and how the member's care could safely be transitioned to a network provider, and completed a new service plan in collaboration with the members and their families and providers. Superior worked closely with the state to identify any members with services that had been requested but not yet authorized under the FFS program, and prioritized these members for immediate assessment.

Superior's experience includes transitioning large numbers of rural CHIP members throughout the state, and assessing and authorizing a service plan for every child in the state's STAR Health program (which serves approximately 34,000 members in foster care) statewide within the first 120 days of operation. This was a considerable accomplishment given the fragile nature of this population and the

[3[1]] Medicaid Managed Care Members, as of June 30, 2009. http://www.statehealthfacts.org/comparemaptable.jsp?ind=216&cat=4

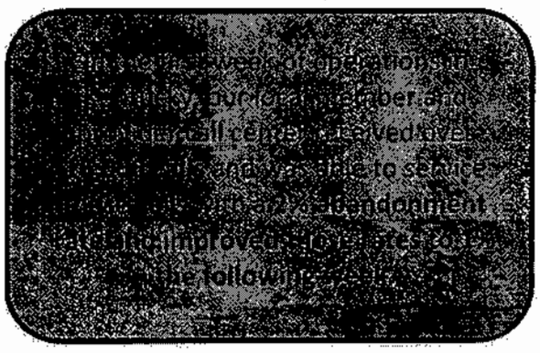
structural complexity of the program. In all cases, the plan incorporated data provided by the state into its continuity of care procedures to ensure continuation of services for new members with existing services.

Our newest health plan, Kentucky Spirit began serving members on November 1, 2011 as the state transitioned its Medicaid population from FFS to managed care organizations. In Mississippi, which also has a significant number of rural areas and health and access issues, GSHP's affiliate health plan transitioned 30,000 Aged, Blind and Disabled (ABD) members effective January 1, 2011. Our Illinois affiliate which serves the urban Chicago area transitioned ABD and SSI members, including those with developmental disabilities and serious and persistent mental illness, completing all assessments within 30 days. In South Carolina, the transition from FFS included members on SSI. **Our Georgia affiliate plan transitioned about 230,000 TANF and CHIP members on day one of program implementation in 2006**, adding another 55,000 members when the state implemented the phase-in of rural southwest Georgia. For all of these new program implementations, the plans used historical claims data (and in Illinois, a list of members in the state's care/disease management program) provided by the state to identify members receiving services, evaluate their health issues and to prioritize targeted outreach and assessment activities.

Our Illinois affiliate completed all assessments of members with SHCN **within 30 days** of implementation

Implementation Experience

All of this experience has taught us that each implementation is unique and needs to be treated as such. We realize our success is dependent on the strength of our partnerships with state agencies, providers and members. Our high touch approach to implementation and state-centered operating models are at the core of our business philosophy and will help us become an effective, efficient and transparent partner with DHHS. Our local approach has made us particularly effective when we have faced a short period between the contract award and the launch of a new plan. In Kentucky, for example, **we went from zero to operational and providing services in 18 weeks.** In the first week of operations our local member and provider call center received over 16,000 calls and was able to service these calls with a 2% abandonment rate and improved that rate to 1% the following week.



We have partnered with states across the country to deliver high quality, low cost managed Medicaid programs, and we have implemented statewide and regional plans in states with limited experience with Medicaid managed care, expanded our state plans in states where we have existing relationships and have acquired plans in other states. We work to be responsive to the needs of our state partners and work to provide them with the tools necessary to hold us accountable for improved outcomes for the people we serve. From small scale deployments for specific populations, services or geographies, to comprehensive state-wide full risk

implementations, our team and process provides the experience and flexibility to tailor a program and process to meet the expectations of DHHS.

In 2011 alone, we implemented Medicaid managed care statewide in Mississippi, Kentucky and six suburban Chicago counties in Illinois. Further, in early 2012 we will begin operations on a statewide basis in Louisiana and begin serving new populations in new geographic regions in Texas.

New business implementations include:

- **Kentucky Spirit.** On November 1st, 2011, began providing services to ABD and TANF members statewide.
- **Illinois Integrated Care Program.** IlliniCare Health Plan, effective May 1, 2011, began serving seniors and persons with disabilities in the Medicaid program.
- **Mississippi Medicaid.** On January 1, 2011 Magnolia Health Plan began serving approximately 33,000 members in the MississippiCAN program providing services to ABD, Foster Care and TANF population.
- **Louisiana Coordinated Care Network Program.** In February 2012 Louisiana Healthcare Connections will begin serving members statewide as a Coordinated Care Network providing services to TANF, CHIP, ABD and Foster Care populations.

Organic expansions include:

- **Texas Dallas STAR+Plus Expansion.** In February 2011, Superior Health Plan expanded their SSI operations to the Dallas market.
- **Indiana Healthy Indiana Plan (HIP) and Re-Procurement.** In January 2011, Managed Health Services began serving uninsured childless adults through the State's HIP Program.

GSHP will have a dedicated implementation team that partners with DHHS representatives to identify and work through start-up issues.

We have already begun work with the provider and stakeholder community organizations across New Hampshire and will actively engage with providers in their locations to educate and train them on the changes that come with moving from FFS to a care management system. These face-to-face interactions create a dynamic working relationship that minimizes provider push back and calls to state agencies and legislators. GSHP will use a variety of communications mechanisms, coupled with carefully developed and well-tested content, to ensure that providers receive the information needed to work with us successfully, maintain high performance standards, and achieve optimal outcomes for our members.

Pre-Implementation GSHP's community-based Provider Relations Specialists (PR Specialists) will provide pre-implementation Provider Orientation for PCPs, specialists, hospitals, and ancillary providers usually at physician offices for large practices and at hotel conference rooms or community facilities for group sessions, with scheduled follow-up training after implementation. We will partner with the New Hampshire Medical Society to expand our outreach and orientation efforts.

Our face-to-face pre-implementation provider education and training provides a forum within which we receive feedback and answer provider questions in real-time. To reinforce our training, we provide written manuals and guides for providers and their staff to use as reference materials, and use peer support, web-based communication, standing committees, and a provider call center to round out a communications system that has proven to be highly successful.

Engaging Stakeholders. We have met with advocacy organizations such as Community Support Network, Inc., Granite State Independent Living and Easter Seals Disability Services and provider groups such as Bi-State Primary Care Association with whom we have formed a collaborative partnership – we find it critical to obtain immediate and ongoing support from these types of organizations and engage them early and often. CSNI, Easter Seals and the Council on Community Transportation have expressed interest in participating on our Community Advisory Committee. **We have already appointed three board members to the Granite State Health Plan Board of Directors: Donald L. Shumway, Crotched Mountain President & CEO, Lori Real, COO for Bi-State and Janet Atkins, Executive Director of Goodwin Community Health.**

Our provider partner Bi-State Primary Care Association will also actively participate on our Quality Committees; **Lori Real, COO for Bi-State and Janet Atkins, Executive Director of Goodwin Community Health will sit on our Board of Directors. Dr. Robert Slocum and Chris Heatherton M.D. will participate on the Quality Improvement Committee, Paul Friedrichs, M.D. will sit on the Pharmacy & Therapeutics Committee, Ed George from Manchester Community Health Center will sit on our Peer Review Committee and we will have Dr. Jennifer Koop and Frederick S. Kelsey, M.D., F.A.C.P. participating on our Provider Advisory Committee.**

We also work to ensure a smooth transition for members. With our enterprise-wide approach, we can bring together a call center that is ready and able to field member calls, not just on day one but also prior to go live. In recent implementations we have opened our call centers 30 days prior to go-live to assist with the transition and partner with the state enrollment broker. In addition, with DHHS approval GSHP will conduct welcome calls upon receipt of the enrollment file (prior to go live) to provide new member education, assistance with the transition and confirmation of the member's mailing address. This proactive approach helps to reduce member's anxiety and uncertainty with regards to the transition from FFS to managed care.

Enterprise Experience and Approach

We leverage proven experience and technologies, existing Centene resources and best practices throughout our family of companies to provide integrated programs that are delivered by a local staff in order to be effective. This local approach enables us to provide accessible, high quality and culturally sensitive health care services to our members. We know how to transition from FFS to managed care and have all of the necessary resources in-house to do this with greater efficiency and effectiveness than if critical components were outsourced.

Specialty Companies. Centene's Specialty Companies, affiliates of GSHP, allow us to seamlessly provide behavioral health coordination (Cenpatico Behavioral Health), disease management (Nurtur

Health) , pharmacy benefits management (US Script), 24/7 nurse helpline services (NurseWise), and managed vision care services (OptiCare) as one entity with a single centrally located care plan and record of services. Our on the ground, locally based call centers, community outreach associates, care coordinators, and hospital based discharge nurses ensure each member is supported by someone who understands the local culture and available community resources. The advantages of having all physical health, behavioral health, long-term care, disease management, pharmacy and other member data in a single repository represents a best practice, and enables us to respond rapidly to the states' administration needs and most importantly, to the changing needs of a member.

Implementation Approach for Step One

Q2. Describe your proposed implementation approach for Step One.

Overview

Our systematic approach to the implementation of a health care delivery system that will meet the needs of the New Hampshire Medicaid population and exceed the expectations of the State of New Hampshire has proven to be efficient and cost effective. This process begins with our ***New Business Development Team*** which continually looks for opportunities to partner with DHHS and other individual state agencies interested in transitioning to managed care. Upon completing the process of collaborating on the RFP response and receipt of an award, a formal transition to the ***Business Implementation Team*** will occur.

The ***Business Implementation Team*** is comprised of specialized project managers and healthcare professionals, whose collective experience provides a depth and breadth of knowledge regarding the planning and execution of complex health care business initiatives. This team is responsible for the deployment of the tools and protocols used to support all aspects of an implementation following a rigorous project management process highlighted by:

- A project lifecycle methodology with defined stages, activities and deliverables
- Proactive review of progress, issue identification/assessment, alternatives analysis and resolution
- Deployment of a dedicated and specialized team of professionals with defined levels of authority
- Defined meeting schedule and planned/consistent communication with all relevant parties
- Industry standard and proprietary tools to define and track progress and identify/mitigate risks
- Integration of "lessons learned" and "best practices" from previous implementations

A critical step in partnering with DHHS will be to offer a variety of tools developed through several successful implementations which can be used between DHHS and GSHP to track the progress of the program.

GRANITE STATE HEALTH PLAN

Project Lifecycle Methodology

Our project lifecycle methodology provides a solid framework for managing new business and implementation activities according to a defined set of proprietary standards. This methodology includes the same framework as a typical "Project Office," meaning resources and tools are tracked and deployed from implementation to implementation. Projects are managed consistently by:

- Applying standards and metrics to each phase of the implementation and development life cycle
- Assigning key milestones and deliverables to each phase with specific ownership
- Reporting weekly status, by phase and by function to key stakeholders
- Assignment of owners to action items for identified risks to ensure mitigation and resolution

This project life cycle is categorized by four distinct phases which encompass multiple activities to ensure consistent and appropriate resource support from launch to full business operations. From a timeline perspective, the four phases of the lifecycle are closely linked to key implementation milestones and are intentionally overlapping.

During the Project Initiation Phase – (*RFP Release – RFP Response*)

- Initial implementation timeline development – A high level schedule, including estimated milestones and timing of project deliverables, is developed by the Business Implementation Team. The schedule incorporates all functional elements necessary to meet all of DHHS's requirements.
- Initial resource planning – Resources required by the project team are identified and secured based on DHHS requirements and the levels of engagement needed by various operational areas throughout the organization.

During the Pre Implementation Phase – *(RFP Response – Contract Award)*

- Establish project tools –The project team begins gathering essential information and pre-populating project tools.
- Finalize implementation plan – The Business Implementation Team confirms all milestones, supporting activities, delivery dates and accountabilities with each implementation team member to ensure availability of appropriate resources and support
- Finalize/engage resources – The Business Implementation Team integrates the project resources proposed in the Project Initiation Phase. This activity culminates in a series of Implementation "Kick-Off" meetings with internal and external resources to ensure consistent understanding of the implementation strategy, key milestones and potential risks.

During the Implementation Phase – (*Contract Award – Health Plan Go-Live*)

- Conduct functional team meetings – The Business Implementation Team conducts weekly integrated lead meetings to monitor project scope schedule, and deliverables while continuously resolving issues, identifying and mitigating risks
- Conduct regular progress checks - In addition to regularly occurring meetings, the integrated project team prepares for our go-live period through a series of internal operational readiness reviews
- Consistent reporting and issue resolution- The Business Implementation Team presents weekly updates on progress toward milestones, hiring targets, critical risks and updates to the mitigation strategies to the Executive Steering Committee. These updates are conducted to ensure all activities and deliverables are moving toward completion on a timely basis.
- Engage with DHHS on a regular schedule to ensure appropriate communication and resolution of issues, timely data exchange and transparent planning and execution of agreed objectives.

During the Cut-Over Phase – (*Health Plan Go-Live – 90 Day Post Operational Audit*)

- Consistent monitoring of plan initial activity – The Business Implementation Team conducts daily cutover meeting two weeks prior to go-live and two weeks post go-live to review issues, escalate to advisory and executive committee members for assistance in removing critical go-live barriers, and provide ongoing status updates to all leadership and key stakeholders in the project
- Monitor and measure plan performance – Throughout the initial weeks of plan operations, the Business Implementation Team tracks key plan performance indicators , and conducts a 30 day post go-live review and collaborates to deliver a 90-day post Internal Audit Assessment
- Transition functional area accountabilities – With the local health plan leadership in place, the Business Implementation Team works to facilitate operational oversight from the Implementation team to Health Plan Leadership.

Proactive Review of Implementation Progress

Implementation Monitoring Process. Monitoring and controlling activities vary for each project, in the same way that planning the project varies by type of project. The purpose is to monitor the progression of the implementation and provide assurances to senior management that risks are being monitored and objectives are being achieved. The overall objectives of the monitoring process are to:

- Monitor actual project accomplishments against expected results
- Provide global visibility and issue identification, so that corrective action can be taken early
- Ensure coordination among the implementation stakeholders to achieve overall project results

Regular Status Meetings. Throughout the implementation a series of both status and working meetings are conducted with the implementation team members and appropriate Subject Matter Experts (SMEs). Standing agenda items at these meetings include the identification of new issues and comprehensive discussions on progress made to resolve existing issues.

Executive Operational Readiness Reviews. At key points throughout the implementation, an executive leadership team from Centene conducts an on-site internal operational review. During these reviews, leadership for each operational area is required to illustrate the current state of their teams' ability to support the health plan and any plans to address open activities associated with operational readiness.

Risk Identification and Management. By utilizing the implementation monitoring process previously discussed, issues and risks that may impact the implementation are identified. We use a ***Risk Log*** to track and monitor issues from identification to resolution. All issues are assigned a priority level and an owner who is responsible for ensuring issue resolution.

Dedicated and Highly Specialized Team

Centene's operating model revolves around a high-touch approach with our State agencies, enrollees and providers. To accomplish this, we engage a dedicated team of corporate resources. Achieving operational excellence and working with local health plan staff to transition full health plan operations as effectively and efficiently as possible is the goal of our team. During the Implementation phase, the team assists in all aspects of plan implementation including the development of health plan operations and the assistance in hiring and training of plan leadership and new staff. During the cutover phase, this team along with additional corporate staff with experience implementing multiple health plans will be onsite to support the Granite State Health Plan leadership team and assist in resolving any operational challenges.

GRANITE STATE HEALTH PLAN

Goals
- Consistent management structure across products
- Single points of accountability for execution
- Consistent forum for communication & feedback

Executive Steering Committee

Executive Sponsor

New Business Project Lead

Market Lead
Provided by Business Dev

New Business Project Manager

Cross Functional Leads

IT Solutions, Infrastructure, Testing Release Management*	Network	Program Integrity	CBO Operations	CBO Services	Medical / Pharmacy	Quality Improvement	Finance	Facilities
Human Resources / Training Marketing / Communications Specialty Companies / Vendors** Internal Audit	- Prospecting - Contracting - Pricing - Third Party Vendor - Credentialing - PDM - Provider Relations	- Contract Compliance - Compliance Reporting	- Claims Processing - EDI - Macess - Encounters - Benefits - Configuration	- Enrollment - Member Svcs - Provider Svcs - Call Center - Web - IVR	- CM / DM / UM - BH - Pharmacy Mgmt - Pred. Modeling - Grievance & Appeals - Innovative Programs - Predictive Modeling	- HEDIS - Quality Monitoring - Performance Improvement	- Claims Payable - Capitation / Admin - Remittance	- Real Estate - Facilities

Integrated Leads

** IT General Oversight. Accountable for IT Project deliverables and coordinating IT resources*
*** Specialty Provider & Third Party vendors includes: US Script, OptiCare, Nurtur, Nursewise,*

Roles & Accountabilities

Executive Steering Committee
- Provide strategic direction
- Approve project budget
- Approve project charter

Executive Sponsor
- Project champion
- Ensure implementation funding is available
- Define / Approve Business needs

New Business Project Lead / Project Manager
- Engage Integrated Leads
- Plan and drive overall work plan
- Coordinate meetings, manage issues / risks
- Report progress and engage executive committee
- Project champion
- Ensure implementation funding is available
- Define / Approve Business needs

Integrated / Cross- Functional Leads
- Drive individual business model
- Engage / coordinate resources needed for deliverables
- Manage functional area specific work plan
- Report on project deliverables

Defined meeting schedule and communication with all relevant parties

Business Implementation Meetings. To coordinate cross functional task completion, process development and issue resolution the Functional Project teams will participate in the following subset of Implementation meetings.

State Coordination Meetings. The most successful and cost effective implementations are a direct result of a strong partnership with the State Medicaid agency. Many transactions, such as eligibility, capitation payments, encounters and compliance/operational reporting, require close coordination to ensure alignment with state agency direction and testing to mitigate potential challenges. To foster our relationship with the DHHS and ensure a timely, effective and smooth transition to managed care, we will ask to hold regularly scheduled "Coordination Meetings" during the Project Implementation stage. Attendees should include health plan representatives, state agency staff and the state's fiscal agent. The agenda will be structured to allow discussion on project status, issues, items on "risk log" and items in need of additional clarification.

We have extensive experience working with many State fiscal intermediaries, such as ACS, AHM, EDS, Unisys and D&T. In a number of previous implementations we have provided proven eligibility, encounter and reporting interface templates helping minimize expensive changes for states and contractors.

Internal Integrated Leads Meetings occur bi-weekly from the Pre-Implementation Phase to the Cut Over Phase, are attended by the entire Project Team and are focused on key deliverables and issue resolution.

- Ensures project solutions comply with State, corporate and IT policies, procedures and practices
- Performs issue/risk/decision management
- Manages cross-functional dependencies
- Monitors implementation and post-implementation dashboards

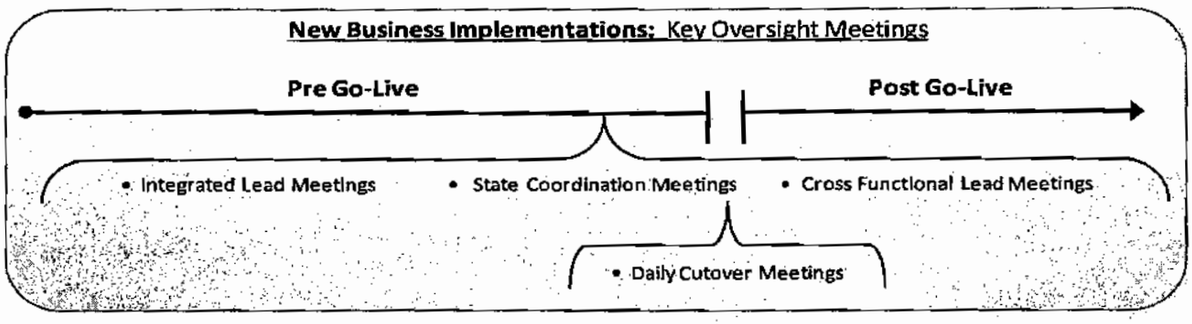
Internal Focused Cross Functional Leads Meetings occur bi-weekly (off weeks from Integrated Leads Meetings), with attendance driven by current need, but will consist of members of the Project Team and will be focused problem solving work sessions. Workgroups include:

- Provider: Network, Provider Data Management, Configuration, Claims, Provider Services, Specialty
- Enrollee: Enrollee Services, Communications, Web, Eligibility
- Infrastructure: Facilities, Human Resources, IT:
- Clinical: Medical Management, Behavioral Health, Pharmacy, Quality Improvement

Internal Cutover Meetings occur daily and begin two weeks prior to the health plan go-live and run through two weeks post health plan go-live. Attendance is required by all Integrated Leads. The meetings ensure open channels of communication and are focused on:

- Proactively identifying any potential issues
- Mitigating and escalating risks
- Assigning accountability and tracking resolution progress

Key Stakeholders Meetings. To ensure a successful implementation, Granite State Health Plan will engage in meetings with member/caregiver, provider and community stakeholder groups, such as Bi-State Primary Care Association and Easter Seals Disability Services. These meetings may occur at the request of stakeholders, DHHS or as part of our outreach strategies. Granite State Health Plan will ensure communication of these meetings to DHHS.



Tools to Track Implementation Progress

Implementation Plan. To manage the completion of project deliverables each functional team will track to a detailed Implementation plan. The plan will be developed in Microsoft Project, using past new business implementation experiences (Kentucky, Illinois, and Magnolia for example) and current DHHS specific requirements. The plan includes the time required to complete each task and identifies dependencies between tasks to provide the ability to easily see the impact one task has on another. This enables the Project Team to make changes as needed to ensure the overall objectives and timeline remain on course. The plan is the basis for monitoring progress, communicating status and taking corrective action. Progress is determined by comparing actual work against the prescribed milestones within the project schedule. This enables timely action to be taken when performance deviates from the plan.

**Note: The implementation plan task start and end dates are targeted dates. Some dates for tasks such as Committee Meetings start dates have been set as placeholders. Variables that are outside the control of Granite State Health Plan such as a new contract start date could also potentially impact the schedule.*

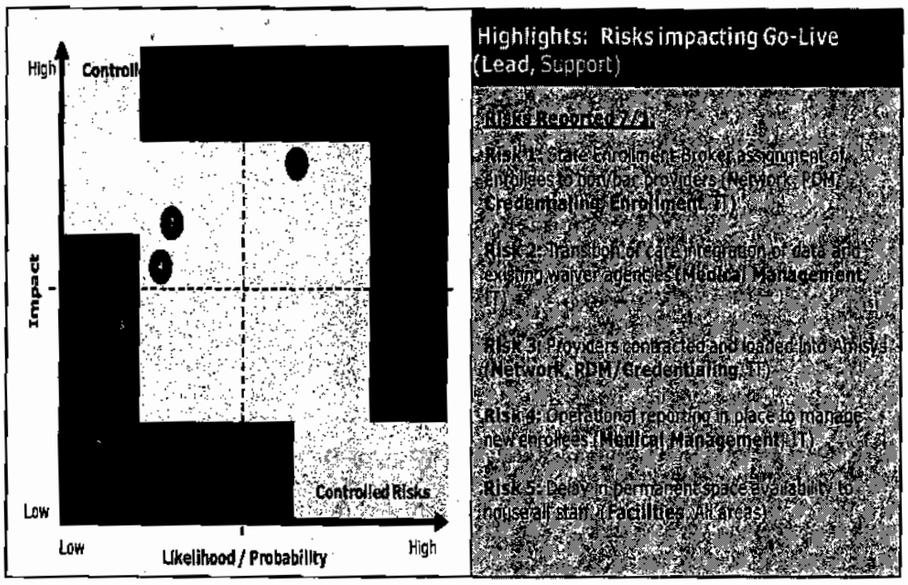
Project Status Reporting. Centene utilizes a formal system of documentation to monitor, track, assess, and report progress with each project. On a weekly basis, our implementation team provides an update of key measures within their functional area as part of our implementation dashboard.

We then utilize these tools to develop a limited set of reports relative to project status. The level of detail and type of information included in our various project status reports varies based on the type of report and its audience. Reports are then used as a basis for discussion for our regularly scheduled meetings. If any changes are required to the frequency, format, and/or content within our reports, we will adjust them to meet the needs of the Contract. **Implementation Metrics.** At the start of operations and continued through the duration of the contract Granite State Health Plan will utilize customized reporting metrics to monitor key performance indicators. Below is a sample network status build report to track member access to care.

	All Counties				PORTICO	
	Desired Provider Network	Providers Needed for Network Adequacy	Total Contracted Providers	In Loading process	Committee Review	PAR
Hospital Sites	58	2	59	6	1	52
FQHC Sites	53	N/A	90	0	0	90
PT/ST/OT	20	5	5	2	0	3
DME	NA	N/A	139	17	4	118
Home Health	NA	N/A	11	1	0	10
PHYSICIAN PER						
Family Practice	114	38	535	120	11	404
Internal Medicine	114	38	494	61	5	428
OB/GYN	114	38	156	33	4	119
Pediatrics	76	38	186	32	9	145

Proprietary Business Implementation Tools and Templates. *Centene's project management tools are customized to reflect our proprietary operating model and implementation approach. The template tools utilized during each phase of the implementation include, but are not limited to the following:*

- As questions that require input or decisions from DHHS are identified, they are tracked and communicated to DHHS in a ***Questions and Answers Grid***. This formal document ensures that information is accurately and consistently communicated across the project team, and minimizing disruptions to DHHS staff.
- All specific issues are documented on a ***Risks Log*** which stratifies issues based on probability and impact. Using this stratification, team members ensure all issues are logged and tracked.
- Once the risks are identified and priority levels are determined, the Implementation Lead uses the ***Risk Map*** to provide a visual program level documentation of the risk and track movement as the risk is managed. Those risks identified in red receive immediate attention by the project team.



- Any issue or action that requires additional decisions or activities not captured in our implementation plan are documented and tracked on our ***Key Decisions and Next Steps Document.***
- The ***Day Two Activity Log*** is a variation of the Key Decisions and Next Steps Document and captures any open items that do not have an impact on successful go-live implementation; but, is used as part of the transition from the corporate integrated leads to the local health plan.
- The implementation ***Cutover Calendar*** provides a chronologic view of all key activities needed to implement Granite State Health Plan for the month prior to and month following go-live.

These implementation project management tools provide a safety net to ensure key milestones are documented and met, key issues are identified and resolved, and there is a clear understanding amongst the parties of the status and next steps of the program. Collectively, they serve to improve the success of each implementation for the state, members and providers.

Experience with Dually Eligible Populations

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

Dually Eligible Experience

For dually eligible members, navigating the healthcare system across two programs can be complex. Nine of GSHP's affiliated health plans (AZ, FL, IL, KY, MS, OH, SC, TX and WI) provide services to approximately 223,000 SSI/ABD members with over 45,000 of those members part of the dually eligible population. We also operate managed long term care programs in Arizona, Florida and Texas.

The dually eligible members often face multiple chronic conditions and require intensive care coordination to address both physical and behavioral health needs, including substance abuse. We believe the greatest success comes when members are involved in their care planning. We have proactive member assessments that eliminate functional barriers to care. We encourage community involvement, consumer-directed care initiatives, team-based care management and integrated systems that facilitate partnerships with providers, caregivers, consumers and social services. We provide a variety of services to members including a 24-hour nurse advice line, integrated behavioral health programs, disease management, pharmacy supports, telemonitoring, home modifications, attendant care, emergency alert systems and equipment to assist with mobility. We do all this as one entity with a single centrally located care plan and record of services.

Care Coordination and Integrated Treatment teams (ICTs). GSHP will coordinate care for dually eligible members through Integrated Care Teams (ICTs) with expertise in Medicare and Medicaid, including community-based Long Term Services and Supports (LTSS). Dual eligible adult members in care management are assigned to one Care Manager for both sets of benefits, providing better coordination and value than the FFS system. Care plans incorporate both Medicaid and Medicare services where the Care Manager can discuss and educate members regarding the differences between Medicaid and Medicare benefits and how they are coordinated in the health plan. The ICT works with the member, family, all providers (whether in-network or not) and necessary community resources, to educate them about Care Coordination, and to develop and implement a Care Plan that is understandable to the member and combines all needed primary, acute, specialty, behavioral health (BH) and other non-covered and non-capitated services regardless of payer. The ICTs will work very closely with the community health centers, FQHCs and the community mental health centers to coordinate with these and other patient-centered medical home initiatives already underway in New Hampshire. We support the physician community through an "any willing provider" approach that maintains consumer continuity of care. In addition, we reduce the historical "hassle" of managed care by asking for the lowest level of required authorizations possible, accepting out of network care episodes, reducing no-shows by facilitating transportation, arranging specialist appointments, offering electronic interfaces, and identifying consumer needs related to disabilities prior to the treatment visit.

Our ICT approach involves a nurse Care Manager, Cenpatico behavioral health (BH) clinician, Program Specialist (social worker), Nurtur Health Coaches, Program Coordinators and Member Connections Representatives who are physically co-located in an open office. For the Step 2 population, the dually eligible members, we will have a specialized MemberConnnections Representative (MCR) – the **Special Healthcare Needs Connections Representative (SHCNCR)**. The SHCNCR will be focused on connecting members and caregivers with services and supports related to developmental disabilities, traumatic brain injury and Home and Community Based Services. New members will be assessed and stratified and those with BH primary conditions are assigned to a BH care team with experienced BH care managers. Each CM will have expertise in both institutional and Home and Community Based Services (HCBS), ensuring continuity and comprehensive care planning for members transitioning from one setting to another. Each member will be assigned a CM with support from the Waiver/LTC Community Connections Representative who is knowledgeable about available resources within the community, understands how to locate those resources and coordinate them with covered services, and is able to accommodate the member's specific cultural and linguistic needs. Care plans are based on each member's individual needs and contain measurable goals developed in partnership with the member or caregiver. Each care plan includes steps to achieve established goals, and is geared toward providing services that allows the member to be in the most integrated, least restricted setting that is appropriate for and acceptable to the them.

Easier Navigation and Reducing Barriers. Dual Eligible members are often uncertain about how to take advantage of the resources that are available to them and that provide a great benefit to overall care. Our holistic member centric approach to care consists of the coordination between Medicaid and Medicare as well as non-covered services that are provided by community resources; all of these services are incorporated into a member's care plan. Dual Eligible adult members benefit from the Care Managers' in depth knowledge of community resources, how to locate those resources, and the coordination of covered and non-covered services to ensure continuity within care planning. Our Care Managers are able to identify and address barriers, such as cultural and language needs, lack of transportation, and financial issues that may impact the member's health or ability to access services and seek needed care. In many instances, the dually eligible member is already connected to a New Hampshire FQHC, CHC or CMHC providing care management. In such instances, GSHP 's role will be to augment and support the care management already provided, to continue opportunities to collaborate between physical health and behavioral health and to add to existing resources.

Dually eligible members with Behavioral Health Needs. For dually eligible members with behavioral health (BH) needs achieving optimal health outcomes requires skilled coordination of care and communication that treats the member in the location that is most easily accessed and most comfortable for them. Our specialty is providing collaborative behavioral health services that meet the needs of the state customer and the consumers, families, and communities they represent. Members with behavioral health needs can benefit from services that aim to keep them stabilized and engaged in care, even when they do not have an acute need. Services such as peer support and health coaching for disease self-management make a difference and positively impact the member's healthcare experience. We believe in and engage peer support and/or peer-led services to facilitate and support ongoing recovery for members. GSHP's affiliate, Cenpatico, has corporate staff that includes a national

Recovery and Resiliency Advisor, a self-identified member, who works with our senior management team to ensure the member voice is heard at the highest level of our organization. Coordination of behavioral health and physical health services, including the development of community supports that can best serve members, is among the most prevalent challenges in the current system. GSHP's affiliate, Cenpatico Behavioral Health (Cenpatico), has developed the expertise to work with dually eligible Medicaid and Medicare members to improve their behavioral health status and overall quality of life. GSHP will work closely with the Community Mental Health Centers to implement a collaborative approach to providing and coordinating appropriate services and support for dually eligible members with BH Needs. GSHP's ICTs include expertise to take a holistic approach to care management and support for dually eligible members. We know in some areas of New Hampshire, there exists a high level of integration between the CHCs, FQHCs and the CMHCs, such as Nashua and the Lakes region. In other areas, GSHP will facilitate improved collaboration between the CHCs, FQHCs and CMHCs so that dually eligible members with Behavioral Health needs are receiving appropriate services in the most appropriate setting.

Experience with Long-Term Services and Supports

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.

Long-Term Care Services and Supports Experience

Granite State Health Plan affiliates currently operate managed long term care programs in Arizona, Florida and Texas. Our approach fully supports self-directed care in the least restrictive, safe environment. Service measures of these programs are closely monitored, building program transparency and accountability. Those who are appropriately served in a nursing facility receive intensive care management services to ensure the appropriate level of care is being provided. Those individuals who have the desire and ability to be in a home and community based setting receive the services and support needed to mitigate the triggers that can lead to nursing facility placement. Since the inception of managed long term care, Arizona, Florida and Texas have all seen improvements in consumer satisfaction, decreased nursing facility placement and have realized significant cost-savings through the promotion of home and community based services. These states have had such success that Florida and Texas has either recently expanded or are in process of expanding the geographic reach of these programs

Our approaches were developed specifically to address the challenges of providing impactful services to the dually eligible population. These challenges include discharges from an inpatient setting where Medicare is the primary payer but Medicaid Long Term Services and Supports are being provided. Our approach engages the member, caregivers, and LTSS providers in creative and flexible

At GSHPs Arizona affiliate, All 4,800 members are qualified for nursing home level care; **However, Less Than 30% Live in Custodial Nursing Homes; 70% Live Successfully Within the Community**

approaches that ease the member though the inpatient episode. While well documented, Medicare and Medicaid have differing regulatory requirements in areas such as member grievances and member communications our experience has allowed us to create training programs and approaches to processes that ensure we meet compliance requirements for both programs while providing a seamless coordination of benefits for members and caregivers. Finally, a major challenge for providers has been coordinating authorization rules and payment reconciliations between the two programs. When a provider serves a member though both our Medicaid and Medicare Programs, we can offer a single source for authorization, case management, and contracting support. A single request for reimbursement triggers a primary Medicare payment and Medicaid copayment in a single transaction.

In Arizona, long term care services have been managed on a full-risk basis since 1989. Bridgeway Health Solutions (Bridgeway), a GSHP affiliate, currently serves approximately 4,800 members and was awarded a contract to serve three additional counties effective October 1, 2011. All 4,800 members are qualified for nursing home level care; however, less than 30% live in custodial nursing homes. 70% live successfully within the community. 85% of these members are dually eligible and one third have **voluntarily joined Bridgeway's Medicare Special Needs Plan.** The integrated, co-located care team completes all member assessments within 10 days of enrollment, and conducts reassessments every three months in community-based settings and every six months within nursing home facilities. Care plans incorporate innovative Bridgeway services that go beyond covered services to maintain members safely in their homes and enhance our ability to monitor their conditions. For example, certain members with high risk conditions such as diabetes, hypertension, chronic obstructive pulmonary disease, and congestive heart failure may receive telemonitoring services. We provide telemonitoring devices such as glucometers, blood pressure monitors, weight scales, and pulse oximeters that connect to an electronic transmission center. Transmitted data that fall within certain ranges (which are established for the individual member but based on evidence-based guidelines) trigger an Interactive Voice Response phone call to the member, Care Manager (CM), and the member's provider as an alert to reassess the member's condition. CMs analyze telemonitoring data to identify patterns in the members functioning and compliance with treatment plans. During 2010, Bridgeway realized an 80% reduction in readmissions for members receiving telemonitoring services. Beginning in the 4th Quarter of 2011, and through a partnership with the Microsoft Corporation, Bridgeway is piloting an On-Demand In-Home Video Pilot between Bridgeway equipped ALTCS members (with member consent) and Bridgeway's staff of LTC Care Managers. With this exciting pilot, Bridgeway anticipates demonstrating how the viability of on-demand video conferencing can dramatically increase the frequency and augment the quality of member contact with our Care Managers.

80% Reduction in Readmissions for Members Receiving Telemonitoring Services

Bridgeway has created unique partnerships within the community such as a disability sensitivity training and community living program with the Arizona Bridge to Independent Living, a large Center for Independent Living who also serves as Bridgeway's largest personal attendant provider and home modification contractor. The Bridgeway Director of Long Term Care serves on the Arizona Direct Care

Task Force, a statewide initiative to promote professionalism and retention of direct care workers. Bridgeway is also sponsored, in concert with the Arizona Nursing Home Association, a series of training and education opportunities for Nursing Homes and Assisted Living Centers.

In Texas, long term care services have been managed on a full-risk basis since 1998. Centene's subsidiary, Superior HealthPlan (Superior), currently provides services for over 57,000 STAR+PLUS members. Superior's approach supports member-directed care, prioritizing functional and behavioral health needs as highly as medical needs and providing services in the most integrated, least restrictive setting possible. Service Coordinators ensure members receive Long Term Services and Supports and other services necessary to prevent or delay the need for institutionalization. Superior offers Health Passport, a patient-centric community health record, to give the medical home and other providers immediate, web-based access to utilization, medications, lab results and other information. The Service Coordination teams share with the medical home assessments and monitoring results, as well as the Service Plan that integrates all Covered and non-Covered Services. Passport supports Superior's Medical Home+PLUS model by linking providers and Service Coordination Teams together around the member record for coordinated and holistic care delivery.

In Florida, a capitated nursing home diversion program has been in existence since 1998. Centene's, Sunshine State Health Plan began serving nursing home diversion members in December 2010 and currently coordinates home and community based services to over 1,700 individuals. The program has been so successful the state is expanding it.

Benefits and Innovative Supports

Home and Community Based Services that are offered include but are not limited to:

- Personal care and homemaking
- Self Directed Care
- Assisted Living
- TBI (traumatic brain injury) and BH focused supported group homes
- Adult day care
- Nursing care
- Behavioral Health Wrap Around Supports
- Home Delivered Meals
- Transportation
- Linkages to Community Resources
- Home Modifications
- Emergency Alert Systems

- Minor Home Modifications
- LTC Safety Checks
- Respite Care

In addition to these services, we have also found other innovative services to be instrumental in helping Long Term Care Members remain in a Home and Community based environment while receiving personalized care such as:

- Therapeutic Pet Therapy Programs
- Pest Control Services
- Denture Care
- Telemonitoring

PPACA

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.

According to the U.S. Census Bureau there are 93.2 million individuals covered by government health insurance and another 50 million uninsured (10% of New Hampshire's population is uninsured). State decision makers have a vital role in ensuring access to quality and affordable healthcare. Decisions that states face regarding healthcare are complex and require balancing the needs of many individuals. Centene works with states to create innovative solutions that are unique and address the distinct needs of these populations. Centene has the resources to provide customized solutions to our state partners through extensive experience in the Medicaid industry and uninsured market, as well as a portfolio of specialty health solutions.

One of the biggest factors influencing healthcare today is the Patient Protection and Affordable Care Act (PPACA). Signed into law on March 23, 2010, the PPACA comes at a time when the U.S. healthcare system faces unprecedented challenges, including one of the worst global recessions in history and a growing number of uninsured individuals. While policy makers have yet to reach a consensus on the many provisions in the bill, virtually all stakeholders agree that the healthcare market will undergo substantial transformation, with state leaders having power to shape reforms to adapt to local markets.

The Affordable Care Act intends to extend health insurance coverage by both expanding Medicaid eligibility and offering premium subsidies for the purchase of private health insurance through state health insurance exchanges. But by definition, eligibility for these programs is sensitive to income and

can change over time with fluctuating income and changes in family composition. The law specifies no minimum enrollment period, and subsidy levels will also change as income rises and falls. One of the national studies conducted by researchers Dr. Rosenbaum and Dr. Sommers, and published in February *Health Affairs*, estimates that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will experience this shift. While churning is a long standing issue for Medicaid, the phenomenon will become more complicated and hit millions more individuals.

To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions created by those transitions. Having cultivated numerous coverage expansion programs, Centene not only has the experience to help states better understand the complex decisions they are grappling with, they also have the flexible affordable solutions needed to succeed in this dynamic environment. With this experience, ***Granite State Health Plan is ready to partner with DHHS to develop and participate in a Health Benefits Exchange to allow members to maintain continuity of access to services as they transition between programs.***

Additionally, GSHP has a strongly aligned relationship with Bi-State Primary Care Association and its members where we will work together to enhance access and services to current and future Medicaid beneficiaries. Bi-State Primary Care Association members current self-pay patients represent the target population that will be available for health coverage either by Medicaid or the Exchange under the PPACA in 2014. These individuals will be more apt to transition between healthcare coverage from Medicaid and the Exchange, creating a need for continuity of care among the individual's physician and health plan. Our partnership will ensure the needed continuity of healthcare coverage for these individuals as they move back and forth between the Exchange and Medicaid as their health plan will be portable among the programs and keeping their physician in the network.

Centene - A history of Success with States Nationwide

With more than 27 years of experience in government services managed care programs for low-income populations including Medicaid, Children's Health Insurance Program (CHIP) and most recently Health Benefit Exchange Products in Massachusetts, Centene represents one of the nation's most experienced health insurance organizations serving the uninsured and underinsured. Furthermore, as a Fortune 500 company, we have the resources and the knowledge needed to identify opportunities and implement solutions that are best for each state.

We serve over 1.6 million members in 14 states and have a long history of working closely with government partners and local communities to find innovative solutions that address the unique challenges they face.

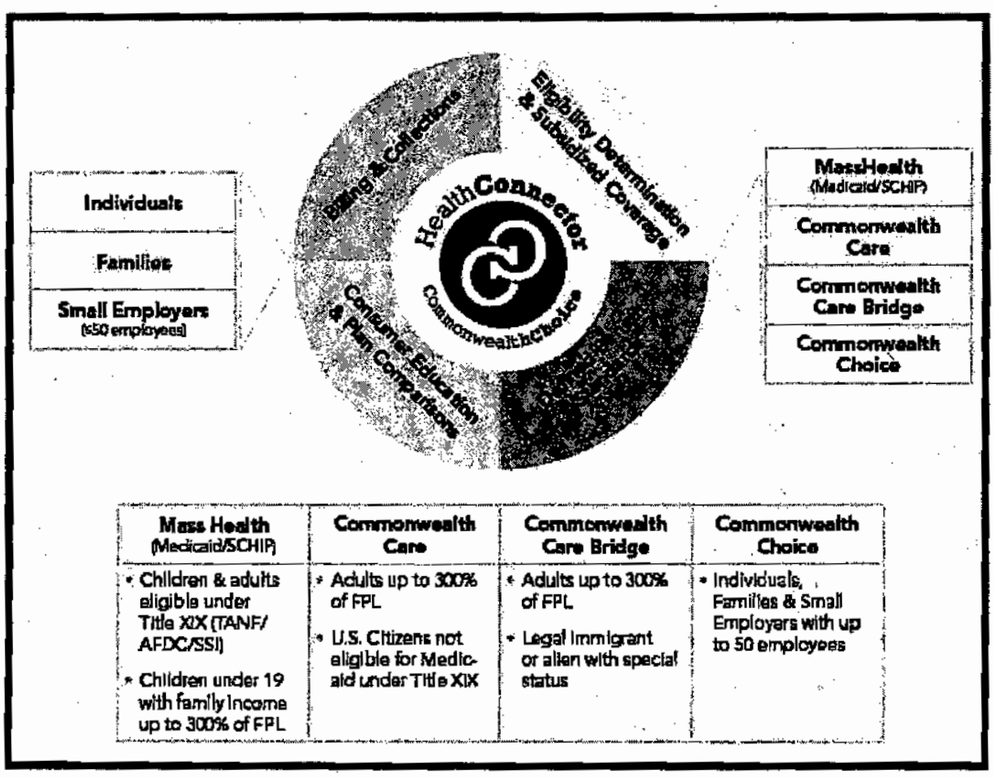
Because our portfolio of subsidized and commercial health insurance solutions is highly customizable, we are able to create solutions tailored to individual states. As a result, we've been able to establish

long-term collaborative relationships with them. The many state programs we've been involved in include:

- Exchange-based health plans offered through the Massachusetts Health Connector
- Consumer-driven small group plans targeting small businesses with low-wage employees in Arkansas and Texas
- State-subsidized health plans promoting consumerism through HSA-like features in Indiana.
    - Based on the experience and success of these programs at Centene's subsidiaries, and in alignment with Centene's mission to partner with states to build low cost solutions with better health outcomes, Centene's leadership have met with several state leaders to discuss strategies on the structure and potential benefit designs for State Health Exchanges. Our experience in working with different states gives us a broad understanding of range of options for a Health Exchange.

Centene will continue to work with state leaders, including DHHS, to create hybrid insurance solutions that combine multiple revenue streams and offer affordable coverage to residents of New Hampshire.

Massachusetts Programs *CeltiCare Health Plan of Massachusetts, Inc.™ (CeltiCare)* is a subsidiary of Celtic Group, a subsidiary of Centene. CeltiCare has been in operation since May 2009 and working with the Commonwealth Health Insurance Connector Authority (Connector) on three health exchange programs: Commonwealth Care, Commonwealth Choice and Commonwealth Care Bridge.



Mass Health (Medicaid/SCHIP)	Commonwealth Care	Commonwealth Care Bridge	Commonwealth Choice
• Children & adults eligible under Title XIX (TANF/ AFDC/SSI) • Children under 19 with family income up to 300% of FPL	• Adults up to 300% of FPL • U.S. Citizens not eligible for Medicaid under Title XIX	• Adults up to 300% of FPL • Legal immigrant or alien with special status	• Individuals, Families & Small Employers with up to 50 employees

Commonwealth Care was implemented July, 2009 and is run by the Connector, an independent state agency that helps Massachusetts residents find affordable health insurance coverage. The agency "connects" eligible residents with approved subsidized and non-subsidized health plans depending on certain eligibility criteria. Commonwealth Care is a subsidized insurance program (funded through a combination of state and participant funds) for low-income adults (≤300% of FPL) who don't have access to affordable health insurance outside of the Connector. The Connector contracts with five Managed Care Organizations (MCOs) who are awarded contracts through an annual competitive procurement. CeltiCare is one of the lowest cost health plan.

Commonwealth Care offers 3 benefit plan types based on the individual's income level. Each plan type varies in out-of-pocket expenses and by Enrollee premium contributions. Plan Type I enrollees do not pay premiums (fully subsidized) while Plan Types II and III have monthly premium contributions based on a sliding income scale. From 100% to 300% of FPL, Enrollee premium contributions range from $0 - $116 pmpm for CeltiCare, a lower cost health plan, and increase to $21 - $197 pmpm for other health plans. Those eligible for Commonwealth Care include:

- Adults ages 19 and above with family income at or below 300% of FPL
- Must be uninsured and not eligible for affordable health insurance through their employer, Medicaid, Medicare, or other public insurance coverage
- Must be a U.S. Citizen or National.

The Commonwealth Choice Program was implemented in April 2010 and offers non-subsidized, affordable commercial health insurance to moderate-to-higher income adults, families, and small groups. Only plans with the Connector's Seal of Approval may sell through the Connector, and Celtic's subsidiary, CeltiCare, is one of seven insurers with this distinction. All carriers are limited to offering four standardized benefit plans (Gold, Silver, Bronze and Young Adult) which vary in costs and the richness of benefits. Those eligible for participation in the Commonwealth Choice Program include:

- Individuals and families who don't qualify for publicly subsidized health insurance or have coverage through their employer, OR
- Small employers with 1 - 50 employees

The Commonwealth Care Bridge (Bridge) is an unprecedented coverage preservation program that was jointly developed by CeltiCare and Commonwealth officials in the wake of budgetary cutbacks that eliminated eligibility for approximately 30,000 legal immigrants who were enrolled in Commonwealth Care until August, 2009. The program was implemented in October 2009 and is funded through a combination of State funds and Enrollee contributions. CeltiCare is the exclusive MCO for the Bridge program, which offers a high-quality, lower cost benefit plan alternative to traditional Commonwealth Care. This lowest cost alternative has allowed thousands to maintain comprehensive health insurance. Through CeltiCare's leading cost and care management strategies, the cost of the Bridge program was approximately $40M, or a 70% reduction relative to the projected cost of Commonwealth Care coverage.

The Bridge benefit plan includes no cost sharing for preventative care or generic drugs while offering more modest cost sharing for other benefits such as non-emergent ER visits and brand name prescriptions. Enrollees can earn up to $150 on their personalized, restricted-use CentAccount card to use towards out-of-pocket expenses like copayments or other health related items. The member earns dollars by completing a health risk assessment, receiving an annual wellness visit and by visiting their PCP within the first 90 days of enrollment. Those eligible for participation in Commonwealth Care Bridge include:

- Must meet Commonwealth Care age and income eligibility (ages 19 & above with family income ≤300% of FPL)
- Special status legal immigrant (sometimes called aliens with special status - AWSS) enrolled in Commonwealth Care as of August 31, 2009.

Texas Program. *HealthyTexas* is a statewide health insurance program implemented in November, 2010 and designed to help small employers and their employees with affordable small group health insurance. *HealthyTexas* is a public/private partnership with the Texas Department of Insurance (TDI) that allows contracted commercial health plans such as Celtic (a subsidiary of Centene focused on offering individual and families low cost health insurance solutions across 33 states) to access a state-funded reimbursement mechanism to lower the cost of insurance for the growing number of small businesses who are unable to afford to offer comprehensive health coverage to their hard-working employees or their families. ***HealthyTexas*** is funded through a combination of State General Funds, Health Resources and Service Administration Grant, Employer and Employee premiums. Celtic handles all aspects of eligibility determination and distributes ***HealthyTexas*** plans through a unique combination of direct sales (phone & online), independent brokers, and internal captive agents.

Using a traditional employer-sponsored health plan model, the program is uniquely funded by a combination of state, employer and employee dollars. TDI reimburses carriers for 80% of claim costs between $5,000 and $75,000, which carriers pass along to consumers through lower premiums. Celtic is also the exclusive provider of Cost Sharing Accounts, which allow employees earning ≤300% of FPL to receive additional subsidies in the form of premium reductions or a restricted-use debit card for out-of-pocket expenses. Those eligible for participation in the ***HealthyTexas*** Program include:

- Texas small businesses with 2 - 50 employees
- At least 30% of employees must receive annual wages at or below 300% of FPL
- Dependents of employees may also receive coverage.

Arkansas Program. *AR Health Networks* is a statewide limited benefit PPO health plan designed specifically for small businesses and self-employed individuals earning ≤200% of FPL. *AR Health Networks* was implemented in January, 2007 and is funded through a Section 1115 Medicaid Waiver and modest employer and employee contributions. NovaSys Health, a GSHP affiliate, is the sole administrator providing all administrative functions ranging from marketing and sales, eligibility, customer and provider services, claims processing, network management, billing and collections, and other TPA services on a non-risk basis.

ARHealthNetworks offers a robust commercial PPO network instead of a HMO model to overcome the rural terrain of Arkansas. The limited benefits package is a cost-effective means to ensure Arkansas small businesses and their employees have access to basic healthcare services without cannibalizing the comprehensive plans available in the commercial market. Those eligible for participation in *the* AR Health Networks Program include:

- Small businesses, up to 500 full-time employees, and sole-proprietors
- Employers may not have offered group coverage in the past 12 months
- At least one employee must be earning ≤200% of FPL
- Spouses of employees may also receive coverage
- Employees not qualifying for the plan based on income may purchase the health plan at full cost.

Indiana Program. Modeled in the spirit of Health Savings Accounts (HSA), the *Healthy Indiana Plan (HIP)* is an innovative coverage expansion program targeting low-income parents and childless-adults earning up to 200% of FPL. HIP, a statewide health insurance program, is paired with a personal healthcare account called a POWER (Personal Wellness and Responsibility) Account that may be used for deductible-eligible expenses. Implemented in January, 2008, HIP is funded through a *Section 1115 Medicaid Waiver, modest Enrollee contributions, and voluntary employer contributions.* Subsidies vary based on income and are applied on two levels including monthly premiums and POWER Account contributions limiting a Enrollee's out-of-pocket expenses to fixed percentage of their annual income. Similar to a commercial plan, health plans bill Enrollees directly and encourage employers to also contribute up to 50% of the Enrollee premium.

The program promotes consumerism through the use of an HSA-like feature known as a POWER Account for which many Enrollees must contribute to on a monthly basis and all Enrollees must receive predetermined preventative services to carry over any remaining account balances into the preceding year. Upon enrollment, HIP Enrollees receive a personalized POWER Account card to use towards deductible-eligible expenses. Those eligible for participation in the HIP Program include:

- Uninsured adults earning ≤200% of FPL but don't qualify for Medicaid
- Must not have access to employer sponsored health insurance coverage
- Individuals must be uninsured for the previous 6 months
- Uninsured adults above 200% of FPL, up to 300% of FPL, may purchase HIP coverage at full-cost (no subsidies) directly through the health plans.

The remarkable partnership with states in the development of these programs is a reflection of the innovation and creativity that Centene subsidiaries strive to deliver to their State partners. It further emphasizes GSHP and Centene's commitment to working with DHHS and developing strategies including the participation in Health Exchange programs that offer members an opportunity to stay with GSHP to continue to access their services and improve their overall health outcomes.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.3 Pharmacy Management

GRANITE STATE HEALTH PLAN

3.3 Pharmacy Management

General Approach to 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.

Introduction

Granite State Health Plan (GSHP) and *US Script*, our subcontracted pharmacy benefits manager (PBM) affiliate bring vast experience in achieving healthy, cost-effective pharmacy outcomes for low-income members. US Script administers pharmacy services for ten Centene affiliated health plans in nine states, including Arizona, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Ohio, and South Carolina. In cooperation with their Medicaid health plan partners, US Script currently provides prescription benefit management services to health plans representing 1.2 million low-income members and their families. These members span a wide range of age and program categories, including: the aged, blind and disabled (ABD), Temporary Aid to Needy Families (TANF) children and adults, children in Foster Care, residents of nursing and other long-term care facilities, and individuals enrolled in the Children's Health Insurance Plan (CHIP) or other state-sponsored programs.

US Script will support GSHP with a state-of-the-art point-of-sale (POS) claims processing system that is available to adjudicate claims with all contracted pharmacies 365 days a years, 24 hours a day. Claims are processed using the National Council for Prescription Drug Programs (NCPDP) D.0 standard. Once the system has determined a member is eligible for benefits, the system applies prospective drug utilization review editing to ensure the medication is safe for the member. Prospective Drug Utilization Review (DUR) edits include drug interactions, duplicate prescription, refill too soon, proper dosage, proper days' supply, duplicate therapy, etc. In addition, quantity limits, age limits and plan-specific benefit restrictions are checked. If all conditions are met, the claim is approved and information returned to the pharmacy indicating payment amounts. If the claim is denied, the claim denial code(s) and specific reasons are returned to the pharmacy.

Building on the lessons learned and successful practices of our Centene plan affiliates and US Script, GSHP is acutely aware and prepared to address pharmacy issues associated with low-income, medically

complex populations, such as polypharmacy, underutilization, changes in drugs and drug therapies, specialty pharmacy, and formulary and prior authorization requirements under Medicaid manufacturer rebate programs. We will work to educate providers and members regarding the cost effective usage of drugs and to provide useful feedback to improve the quality of patient care. **If we were able to fully manage the pharmacy benefit including the PDL; the gross additional savings is $6 million to $7 million – of which the State would realize 50%, or $3 million to $3.5 million.**

Following are details on our approaches to medication adherence, specialty pharmacy, pharmacy lock in, and accessibility of pharmacy service information for members, as specifically requested by DHHS.

Monitoring Our Members' Medication Adherence

Medication monitoring is an essential component of our care management efforts for members with chronic and complex conditions and other special needs. To access information about a member's condition, treatment, medical and pharmacy claims history, and to document information received from member contacts, GSHP's care management staff will use Centelligence™, Centene's trademarked brand name for our existing and planned family of integrated decision support and health care informatics solutions. Care Managers will use pharmacy information to discuss compliance and experience with drug therapies and needed refills with the member. When members report a problem with their medicine, or with adherence to drug therapy, Care Managers will educate, coach, and help resolve barriers to compliance.

Care Managers will monitor member medication use and compliance, and intervene with strategies as necessary to increase adherence and thereby improve appropriate pharmacy utilization. For example, Care Managers will identify members for outreach reminders on the use of their medicine and the importance of visiting their Primary Care Physicians (PCPs) and other prescribers. Care Managers may follow up with prescribers to request help with medication management issues and reinforcement to members on the importance of taking their medicine. Care Managers will directly educate identified members when they call in about other issues, and will answer questions about their medicine, whom to call when they have questions about their prescriptions, possible enrollment in disease management, prescription costs and the Preferred Drug List (PDL). Care Managers may provide high-risk members with a ConnectionsPlus™ cell phone that is pre-programmed with the phone numbers of their prescriber, pharmacy, our NurseWise® 24/7 nurse advice line, 911 and the Care Manager, all which will facilitate and support access to good primary care and appropriate pharmacy use.

US Script also will provide us with sophisticated over and underutilization monitoring in its claims processing system. For example, US Script will identify when members do not receive their asthma drugs within 15 days of a needed refill. Information on the identified members will then be forwarded electronically to NurseWise, our 24/7 nurse line affiliate, so that outreach calls may be made to the members to assist them with medication compliance, to arrange visits with their prescribers, or to resolve other barriers to care, as needed. US Script will export pharmacy data for access by Care Managers, flagging members that may need care management or more intensive support. The system interface includes identification of when NurseWise interventions have been made and will prevent duplicate calls and interventions to our members.

Additionally, we will engage the participation of a cross-section of health professionals in weekly High Needs Rounds to develop care approaches for *high-risk, high-needs members.* The High Needs Rounds will include the review of clinical and claims data to proactively identify members for disease management. Staff may determine whether members who appear to have medication compliance or other pharmacy utilization related issues warrant additional care management services. They will continue to monitor the status of members reviewed in previous meetings to determine the outcome of referrals and improvements in medication compliance. The Pharmacy Director also will assist staff, as needed, in their routine review of member-specific medication utilization and other information to support care management.

Assuring Access to Specialty Pharmacy Services

We will assure access to specialty pharmaceuticals through the US Script Specialty Network of pharmacies and through a contract with our preferred, but not exclusive, Specialty Pharmacy Vendor CVS Caremark Specialty Pharmacy (CVS Caremark). CVS Caremark will ship medications and administration supplies to a member or directly to a provider's location for office administration. CVS Caremark also will offer training to our DHHS members on drug administration/storage and a call-line to assist members with their medication questions. The US Script Specialty Network pharmacies and CVS Caremark meet our quality, supply demands, dispensing turn-around and other member support standards and will assure access to specialty drugs that have stringent handling and storage requirements and are often expensive and unavailable through local pharmacies. Examples of available products from our specialty pharmacies include, but are not limited, to the following injectables: Synergies, Epogen, immune globulin, gamma globulin, interferon, antihemophilic factors, cyclosporine and oncology products. Our Pharmacy Department maintains a prior authorization (PA) process for specialty drugs. All requests for specialty drugs, including those supplied by CVS Caremark, are reviewed by our Pharmacy Department. We will provide information on our specialty pharmacy PA requirements for approval, as part the DHHS-required formulary review process.

Member and Provider Information on Specialty Pharmacy Services

Both Members and providers may check on the GSHP website for information on specialty pharmacy service coverages, what specialty pharmaceuticals are available through our CVS Caremark contract and how to obtain these products for DHHS members. Our Provider Manual will also contain a description of our specialty pharmacy services.

Our offerings for DHHS members will include a MemberConnections™ program that will provide community face-to-face education designed to create a link between the member and the provider. Members may call the toll-free MemberConnections line to inquiry about specialty pharmacy issues. MemberConnections staff will follow-up by sending them information or visiting their homes to address questions. Our Members Services staff will be available to answer questions on specialty pharmacy coverages and to refer members to MemberConnections, as needed.

Specialty Pharmacy and Care Management Coordination. US Script will export pharmacy data, including specialty pharmacy claims, to GSHP daily for integration into our CentelligenceTM enterprise management system. From this platform, our disease and care managers may access and monitor a member's medical, physician-administered drug, pharmacy (including specialty drugs), laboratory and other claims along with health plan clinical documentation. This concentric approach allows our disease and care managers to monitor specialty drug use in light of a member's entire health history and intervene with the member, prescriber, specialty pharmacy and other health care providers, as necessary, to promote optimum care for the member.

Pharmacy Utilization Management

GSHP and US Script will use state-of-the-art technology, fully integrated data, evidence-based guidelines and best practices to comprehensively monitor member, pharmacy and prescriber utilization, expenditures, compliance and other trends. Our pharmacy utilization management will be conducted using criteria, protocols and procedures in accordance with federal and State requirements and Utilization Review Accreditation Commission (URAC) and National Committee for Quality Assurance (NCQA) standards. Our programs will identify opportunities to continuously improve care quality and safety, including adjusting our claims processing utilization controls and formulary, intervening with members and prescribers, and addressing geographic, prescriber and program trends. We will tailor our utilization management activities to characteristics of DHHS members and will incorporate DHHS-required clinical and therapeutic edits. Following are descriptions of key pharmacy utilization management practices that we will employ.

If GSHP were able to fully manage the pharmacy benefit including the PDL, the gross additional savings would be $6 million to $7 million – of which the State would realize 50%, or $3 million to $3.5 million

Formulary/Prior Authorization Criteria and Reporting for Rebate Collections. We will align our formulary with the New Hampshire Medicaid Preferred Drug List. Our pharmacy staff stand ready to present our formulary and prior authorization criteria for DHHS review and approval and to participate on the State of New Hampshire Drug Utilization Review Board (DUR). Also, we will provide necessary pharmacy utilization and encounter data to support DHHS rebate collection under the Omnibus Budget Reconciliation Act of 1990 and the State's supplemental rebate program – including both pharmacy-dispensed prescriptions and physician-administered drugs.

Our Pharmacy and Therapeutics (P&T) Committee will be responsible for formulary-related issues and prior authorization criteria for DHHS members, address quality and utilization issues related to pharmaceuticals and review pharmacy-related complaints. The committee will be chaired by our Chief Medical Director and is composed of participating providers, network pharmacists, and clinical pharmacists. Other P&T Committee's responsibilities will include but will not be limited to supporting care management staff in ensuring member access to appropriate medications and identifying, assessing and addressing issues with drug utilization including DUR edits and quantity limits.

If GSHP were able to fully manage the pharmacy benefit including the PDL; the gross additional savings would be $6 million to $7 million – of which the State would realize approximately 50%.

Prior Authorization (PA) Process. We will provide a proposed list of PA products, as requested for DHHS approval. PA will typically be placed on non-preferred alternatives of preferred drugs and for clinical efficacy and safety reasons. To obtain authorization, a prescriber must submit by fax or phone a PA request that satisfies all requirements for approval. Within 24 hours of receipt of all necessary and requested information, a US Script pharmacist will review the request and notify the prescriber's office of approval or denial. We will notify the prescriber by fax of denials and either request prescribing a preferred drug therapy or seek additional information to support the use of non-preferred drug therapy. We will make non-preferred drugs available through our PA process. Our Chief Medical Director will review exception requests on a case-by-case basis to ensure members receive medications appropriate to their conditions regardless of whether the medication is a preferred drug. The following examples describe several of our PA policies and procedures.

- ***Point-Of-Sale (POS) Expedited PA.*** When appropriate, step therapy will be programmed into our PBM's claims processing system to avoid PA paperwork. The system reviews the member's prescription history to allow new prescribing of non-preferred drugs when the only requirement is prior use of preferred drugs.

- ***PA of Brand Equivalents to Generics.*** Requests for brands, when an approved, bioequivalent generic alternative is available, will require trials of at least two generic equivalents (when market availability allows). In addition, the prescriber will be required to submit a MedWatch form to the Food and Drug Administration (FDA) documenting the bioequivalence problem. Generic substitution will be mandatory when FDA approved (A-B rated) generic equivalents are available. The mandatory generic substitution provision will be waived for drugs that have a narrow therapeutic index such as warfarin, levothyroxine and digoxin.

Emergency Drug Supply. We will provide an emergency drug supply to members when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the member's health and safety. In these instances, we will require pharmacies to provide a 72 hour emergency supply of drugs and allow them to electronically override a claim stop when prescribers are unavailable to respond to a PA. We will instruct pharmacies to make a good faith effort to contact prescribers for prescriptions that could jeopardize a member's health and safety and will reimburse pharmacies for dispensing the temporary supply, when they are unable to do so.

Continuity of Care. We will authorize continuation of existing prescriptions for new members, especially those with special needs such as those taking insulin, seizure medications or prescriptions for mental health conditions. We also will honor DHHS-approved pharmacy PAs in place at the time a member transitions from fee-for-service to our plan for 90 days.

Drug Utilization Review (DUR). Our DUR activities support effective medication regimens and compliance, which will help reduce preventable emergency department visits or nursing facility admissions due to drug over- or underutilization, drug-to-drug interactions, etc. DUR monitoring will

help us assess the progress of our clinical initiatives, for example, on appropriate drug use for asthma and for attention deficit hyperactivity disorder (ADHD) and the progress of our monitoring of psychotropic drug use across programs. We will support good pharmacy care by developing prescriber benchmarks to identify prescribing patterns that may exceed or fail to achieve best practices of care. We will use pharmacy, medical, behavioral health, and lab data to conduct predictive modeling analyses to identify members at risk of intensive medical and behavioral health services, and quickly and appropriately intervene, such as providing additional support to assure medication compliance or prescriber education on best practices. GSHP with the assistance of US Script will conduct prospective, concurrent and retrospective DUR.

Prior to Prescribing. Our prospective DUR starts with activities designed to prevent breakdowns in patient safety, such as our processes in developing utilization controls, clinical PA requirements and provider education.

Concurrent Review at Point-of-Sale. US Script's electronic claim adjudication process will compare the prescribed medication against a member's previous drug history for drug-to-drug interactions, ingredient duplication, therapeutic duplication, and high dose situations. The review then will cover other potentially dangerous or inappropriate prescribing, such as drug/age and drug/gender matches, and POS messaging may either stop the claim when a PA is required or request pharmacist oversight. For example, our messaging system will stop a claim until a PA is received for non-preferred drugs, and drugs that have clinical restrictions, such as quantity limits, age limits, step therapy requirements and duplicate therapy/dose consolidation concerns. This editing will be based on FDA recommendations and promote safe and effective medication utilization by our members, as explained below.

Georgia Medicaid: Seven Percent Decrease in PMPM Cost for Long-Acting ADHD Drugs

Our Georgia Centene affiliate implemented *duplication therapy and dose consolidation edits* for Medicaid members taking long-acting ADHD medications. Results showed a 100% decrease in members using chronic duplicate therapy, a 46% decrease in members using transitional duplicate therapy, and a 59% decrease in costs associated with duplication therapy. Overall this monitoring resulted in 7% decrease in per member per month cost for long-acting ADHD drugs.

- ***Quantity Limits*** (claim's quantity per day) implemented to prevent doses above or below the FDA approved guidelines for a drug
- ***Lower Age Limits*** implemented to prevent children below the FDA approved age from receiving medications off-label. Examples of drugs classes with lower age limit include, but are not limited, to atypical antipsychotics, long-acting attention ADHD medications (stimulants and non-stimulants), short-acting ADHD medications (stimulants), benzodiazepines, and sedative-hypnotics.
- ***Upper Age Limits*** implemented to prevent adults from receiving medications commonly indicated for pediatric use only (without proper documentation of diagnosis).Examples of drug

classes with upper age limits include, but are not limited, to long-acting ADHD medications (stimulants and non-stimulants) and short-acting ADHD medications (stimulants).

- ***Duplicate Therapy Edits*** implemented to prevent members from receiving excessive medication regimens with the same (or similar) drug classes. Examples of drug classes with duplicate therapy edits include, but are not limited, to atypical antipsychotics, long-acting ADHD medications (stimulants and non-stimulants), short-acting ADHD medications (stimulants), alpha agonists (pediatrics only), selective serotonin receptor inhibitors and serotonin norepinephrine receptor inhibitors, tricyclic antidepressants, antidepressants, benzodiazepines, sedative-hypnotics, and opiate analgesics (narcotics).
- ***Dose Consolidation Edits*** implemented to prevent members from receiving multiple strengths of the same medications. Examples of drug classes with dose consolidation edits include, but are not limited, to long-acting ADHD medications (stimulants and non-stimulants) and short-acting ADHD medications (stimulants).
- ***Step Therapy Edits*** implemented to steer members toward preferred medications in a drug class. Examples of drug classes with step therapy edits include, but are not limited, to atypical antipsychotics and sedative-hypnotics.
- ***Teratogenetic Edits*** implemented to prevent female members from receiving potential harmful medication prior to confirmation of pregnancy status.

Florida Medicaid: Four Percent Savings for Entire Atypical Antipsychotic Drug Class

Our Florida Centene affiliate implemented a *duplicate edit* that limited Medicaid members to one atypical antipsychotic per month. Results showed the edit decreased members using therapeutic duplication by 80% and reduced total member costs by 39% (for those members specifically identified with therapeutic duplication prior to the edit implementation). Overall this monitoring resulted in 4% savings for the entire atypical antipsychotic drug class.

Our POS system also will include messaging that will not stop the claim but will alert the pharmacist to potential problems, such as overdose/toxicity concerns, drug-gender concerns, insufficient dosage concerns, and drug-drug/food/alcohol interactions. We will use Medi-Span® alerts as our clinical drug database and messaging system, which draws continuously from updated, comprehensive drug information. For POS messaging we will use standard NCPDP messages, and write text for messages specific to DHHS programs, for example, giving the name of a preferred drug when a non-preferred claim is filed. The US Script pharmacist and our Pharmacy Director will review as often as necessary the type, number and frequency of POS messages to determine the need for adjustments or provider education. Once identified, for drugs that tend to trigger a high volume of POS passive messaging, GSHP may add PA requirements, following DHHS procedures for approval, to protect member safety or enhance provider education on best practice prescribing.

Retrospective Reviews. Retrospective Drug Utilization Review (RetroDUR) occurs after a member has received prescription medications and includes periodic examination of member electronic claims data and other available records, to identify patterns of inappropriate or medically unnecessary care. Claims will be reviewed for therapeutic appropriateness, cost-effectiveness, quality of care, fraud and abuse, over- and underutilization, adverse drug events, and outcomes management. Once analysis is complete, we will pursue educational intervention for prescribing and dispensing to improve medication therapy and assure positive patient care outcomes and quality care.

Our Pharmacy Department will administer our RetroDUR program with the cross-departmental participation of the Chief Medical Director, Medical Management nurses and behavioral health clinicians. We will examine customized pharmacy claims-based reports supplied by US Script and other GSHP clinical, member and prescriber data to obtain insights on individual member medication use, programmatic medication patterns, physician prescribing and pharmacy dispensing. The review also will determine whether services were delivered as prescribed and consistent with GSHP's payment policies and procedures. Based on these reviews, we will identify and educate prescribers of potential concerns and identified outlier results, as necessary. The Pharmacy Director, with assistance from the Chief Medical Director, Medical Management and Quality Improvement staff, will annually establish benchmarks for select prescribers, based on the previous year's prescribing patterns and statistics from recognized expert sources, such as NCQA, and the Centers for Medicare and Medicaid Services (CMS). We will begin with quarterly reviews of Primary Care Physician (PCP) rates for generic dispensing and use of PDL drugs (as benchmarked against plan averages and goals), which we will share with PCPs in their provider profile reports. Other benchmarks could include utilization of selected drugs or drug classes, such as narcotics or costly brand-name drugs. We will educate members who may benefit from information about disease treatment or medication compliance and ask US Script to inform network pharmacies of issues, as needed. Our Pharmacy Department will at least annually review and update our RetroDUR program based on drug utilization trends, changes in prescribing practices, emergence of new drug therapies, contemporary issues in pharmacy care, and our P&T Committee recommendations.

The following table lists *standard* DUR monthly clinical reports, management reports and intervention tools used by our RetroDUR staff. Within the context of these reports, we will review reports showing the use of potentially high-risk drugs (Beers List) for members over age 65; antipsychotic drug use by members who are diagnosed with dementia; and psychotropic compliance for members who are bipolar or schizophrenic. US Script experience has shown these members tend to have higher rates of diabetic and psychotropic drug use and narcotic use and abuse, so we expect to intervene more frequently with educational outreach to their prescribers and offer care management services for these member groups.

Table 1: Monthly RetroDUR Reports and GSHP Intervention Tools

Clinical Reports	• Antipsychotic use by members • Drug regimen adherence (refills within past three months) of medications used by members with chronic obstructive pulmonary (COPD), asthma, diabetes and hypertension (inhaled corticosteroids, anti-hypoglycemics, and lipodemia drugs) • Underutilization of maintenance drug therapies used to treat COPD/asthma and diabetes • Overutilization of asthma rescue medicine and narcotic analgesics (including the

	identification of members who receive narcotic prescriptions from 3+ prescribers)
Management Reports	• Drug utilization by prescriber • Dispensing by pharmacy • Generic utilization rates by prescriber • Formulary adherence rates by prescriber • Top 20 drugs dispensed by program • Drug denials by drug • Prior authorization volume by drug • 72-hour emergency supplies
Intention Tools	• Prescriber educational outreach letters, for example, focusing on inappropriate member utilization, prescribing patterns outside clinically accepted guidelines, updates on evidenced-based medicine, cost-saving strategies, etc. • Onsite visits in prescribers' offices by our Medical Director to discuss prescribing patterns outside clinically accepted guidelines, updates on evidenced-based medicine, cost-effective prescribing practices, etc. • Referrals to review members, who are identified as high-risk for medication abuse or misuse, as potential candidates for the Lock-In Program

DUR Initiatives. Following are examples of DUR initiatives conducted by our Centene affiliates that will be included in our DUR activities.

Psychotropic Drug Use by Children. We plan to adopt the nationally recognized Texas Psychotropic Medication Utilization Review (PMUR) criteria that several Centene-affiliated plans use in other states. PMUR is a proven means of assuring appropriate utilization of psychotropic drugs, which often do not have FDA-approved use for children. PMUR will help reduce the incidence of adverse drug effects (including obesity), reduce unnecessary drug costs, and identify where psychosocial interventions may be more effective or needed to complement drug therapy.

Since 2008 our Centene affiliate *Cenpatico Behavioral Health* (Cenpatico) and Centene Medical Directors have worked with Texas agency staff to implement and refine PMUR for children in foster care. The review process begins with a screening to ensure that any child receiving psychotropic medication:

- Has received a thorough assessment, including a diagnosis of a psychiatric condition
- Is not receiving five or more psychotropic medications at the same time
- Is not receiving multiple medications for the same condition(s)
- Is not receiving multiple medications for a single condition without first a trial on a single medication
- Is not receiving medication dosages exceeding manufacturers' recommendations
- Is receiving age-appropriate medications and dosages
- Is receiving medication consistent with the stated diagnosis; and

- Has a PCP who is consulting with a psychiatrist when treating conditions other than ADHD, uncomplicated Anxiety Disorders or uncomplicated Depression.

Based on this screening, the Medical Director contacts treating psychiatrists to determine if there is an opportunity to reduce or make other changes to the medication regimen. The Medical Director also assists psychiatrists and other physicians, upon request, with medication reviews and therapy options and reviews cases referred by other sources.

As an adjunct to this initiative for the foster care population in Texas, our Centene affiliates Superior Health Plan and Cenpatico implemented a first generation electronic community health record, Heath Passport, conducted a significant educational effort with stakeholders, and employed an integrated model of care management to improve communication and coordination. These innovative programs improved health outcomes (Table **2**) and helped achieve the following results:

- According to data from the Texas Health and Human Services Commission there was a 16.6% decline in the number of foster children prescribed psychotropic medications overall and specifically a 29% decline in polypharmacy from FY 2007 (prior to our program) and FY 2010.
- A 24.2% decline in Average Length of Stay (ALOS) and a 17.7% decline in inpatient admissions for foster children from 2008 (the first year of the contract) to 2011 (as of November 17, 2011).

Table 2: Texas Foster Care Inpatient Outcomes

	FY 2008	FY 2010	FY 2011
Admissions/1000 Members	156.8	135	129.1 (YTD)
Average Length of Stay (Days)	13.2	10.1	10.0 (YTD)

Asthma Care. Because the incidence of asthma in children is growing, and uncontrolled asthma can affect their education, social interactions and exercise, we will monitor asthma drug regimen adherence, under-utilization of maintenance drugs and over-utilization of rescue medicine. We will additionally profile pediatricians for prescribing of appropriate asthma medications, comparing their prescribing average against plan and NCQA averages. Our Medication Underutilization DUR helps support our Asthma Performance Improvement Program by identifying members and prescribers who could benefit from appropriate education about best practice asthma medication therapy, which can be extremely effective in preventing emergency room visits and hospitalizations and providing a better quality of life. Early intervention and education with members can improve asthma control, especially for members who previously relied on short-acting beta-agonists for control. By notifying providers of member non-adherence to inhaled corticosteroid (ICS) therapy, they may then act using guidelines as recommended by the National Heart Lung and Blood Institute for the diagnosis and management of asthma.

Diabetes Care. Diabetes Mellitus is estimated to affect nearly 24 million individuals in the United States. Diabetes is currently the sixth leading cause of death in New Hampshire with approximately 7.2% of the population from age 18 to 64 reporting have been diagnosed with diabetes (NH Behavioral Risk Factor Surveillance Survey, 2006).[4] While good diabetes control can help reduce the risk of complications and mange healthcare costs, recent studies suggest that only a small number of diabetics have key health markers under control. Non-adherence to diabetes treatments is commonly the root cause for patients not reaching their diabetes goals, putting them at risk for complications, such as heart disease, stroke and kidney failure. We will help ensure member health by closely reviewing their antidiabetic maintenance drug use for signs of noncompliance or underutilization, including a focus on incidence of diabetes in children and the risks associated with gestational and type I and II diabetes during pregnancy. Provider profiling of the top prescribers of antidiabetic medications will help identify physicians who may requirement additional educational outreach.

Medicare/Medicaid Dual Members. We will have capabilities to conduct DUR activities for our dual eligible members including, but not limited, to: underutilization of COPD and asthma drugs, overutilization of asthma rescue drugs, drug regimen adherence for members with COPD, asthma and diabetes, and antipsychotic use by members over age 65.

Pain Medication Management Program. We plan to build on our Centene Georgia affiliate's Pain Medication Management program which was a recent winner of a *Case in Point Platinum Award* for innovative and successful care management. For the 4,733 members identified during the Georgia program's baseline period as having 10 or more emergency room visits, only 1,009 of these members continued to have high emergency room utilization following implementation of the narcotic program and integrated team approach. The results showed a decline in overutilization of services related to drug-seeking behaviors and associated negative outcomes. Overall savings comparing the total expenditures of members in 2009 versus 2010 was $2.3 million.

Pain Medication Management Program

Overall savings comparing total expenditures of members in 2009 vs. 2010 was **$2.3 million**

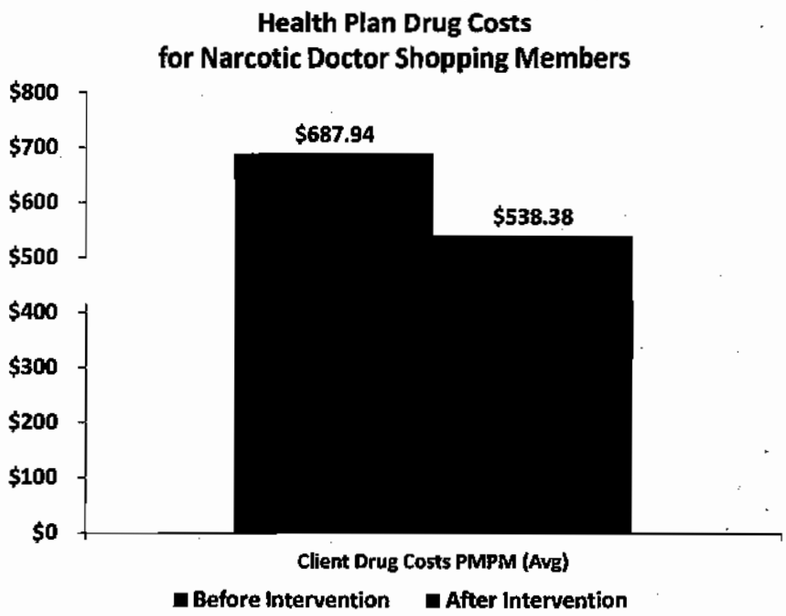
Narcotic Doctor Shopping (NDS). Doctor shopping is the act of visiting several different doctors to obtain prescriptions for the same (or similar) medications. Abuse of prescription medications often begins with legitimate use, however certain medications such narcotics, have high risk for dependence and members can become addicted. According to the Drug Enforcement Administration (DEA), doctor shopping is one of the primary ways addicts obtain prescription drugs for non-medical use. To identify probable doctor shopping, US Script identifies and reviews pharmacy claims for (1) members using three or more different prescribers to fill narcotic medications during a 30-day period and the top prescribers of these (doctor shopping) members and (2) the top prescribers of all members receiving

[4] Diabetes Education Program, New Hampshire Department of Health and Human Services, available at http://www.dhhs.nh.gov/dphs/cdpc/diabetes/

narcotics during a 30-day period. As substantiated by review findings, US Script sends intervention letters to the identified prescribers.

This process has proven very successful in reducing narcotic doctor shopping. One Medicaid plan working with US Script reduced its baseline of nearly 180 members exceeding the Narcotic Doctor Shopping criteria of three or more different prescribers by 98%. Another Medicaid plan found 81% of the prescribing stopped for the members identified through the Narcotic Doctor Shopping intervention – saving the plan 22% in the identified members' drug costs.

Figure 1: Narcotic Doctor Shopping Intervention Results



Special Projects. Our Pharmacy Director, with assistance from our Chief Medical Director (CMD) and other staff, will conduct special DUR initiatives to address a potential or identified concern, for example, as shown by outliers or results of medical and pharmacy claim trends, member demographic and program data, and recommendations from DHHS, our providers, the P&T Committee, and other staff. These DUR projects may focus on issues relevant within a specific plan and region, or spanning regions and programs.

Based on findings from the reports listed below or in response to other trends, our Pharmacy Director may conduct special studies on one pharmacy, a pharmacy chain, or pharmacies within a geographic area to further identify important utilization trends and improve appropriate pharmacy utilization.

- ***Utilization by Pharmacy Report*** showing pharmacy name and location; number of claims filled; percent of total plan claims filled; days' supply; metric quantity; claim costs and averages, including costs related to ingredients, dispensing fees, and co-pays; and number of members served

- ***Utilization Summary by Prescriber*** showing prescriber name; number of claims prescribed; percent of total plan claims filled; days' supply; claim costs and averages, including costs related to ingredients, dispensing fees, and co-pays; generic dispensing rates; the number and percentage of controlled substances prescribed; and the number of members served
- ***Profile Report for Prescribers*** showing, by prescriber, location and other identifiers, average costs per prescription, average drug utilization rate for their member panel, generic prescribing rate, prescribing rate for controlled substances, and performance against plan benchmarks.
- ***Daily Spend Report*** showing the number of pharmacy claims filed, the amounts paid, the number of generic drugs, and the amount paid for generic drugs for a given day
- ***Generic Product Indicator (GPI)*** Totals Report showing for each GPI Code: the generic name, strength, and dosage form, total co-pays, dispensing fees, and claim amount payments, number of claims paid and number of members using the drug
- ***Utilization Summary for GPI 4 Drugs Report*** (single source, brand name) showing for each GPI 4 Code: the drug class, number of claims, billed amount, and per member/per month (PMPM) use.
- ***Member Utilization Report*** showing members who filled a prescription; the average number of prescriptions filled per member, the number of refills filled per original prescription, and the number of controlled substances filled by member
- ***Pharmacy-Stratified Reports*** showing number and percent of claims filled for controlled substances, average cost of all medications dispensed, generic dispensing rates, and utilization by therapeutic class

Pharmacy Lock-In Program

Members who are identified as high-risk for medication abuse or misuse are often assigned to lock-in programs, making their benefit only available when using one designated prescriber or pharmacy (or both). We will have capabilities to customize our Lock-In Program to comply with the State's criteria, described in *Appendix D DHHS Office of Improvement and Integrity Pharmacy Lock-In Program* of the RFP, and other criteria specified by DHHS and the State of New Hampshire DUR Board. We are prepared to present our Lock-In policies and procedures and to report the status of all members enrolled in the Lock-In Program, as requested by DHHS. Following is an overview of our process.

Identification Process. Potential candidates for the Lock-In Program may be identified from member patterns of overutilization through data analytics in our CentelligenceTM enterprise management system, through review of pharmacy data by our PBM, and through referrals from providers. Monthly we will generate and review a pharmacy utilization report of members who meet the State's criteria from Appendix D of the RFP.

Table 3: State Algorithm Criteria for Pharmacy Lock-In

1. Members with three or more pharmacies used within 90 days
2. Members with three or more physicians prescribing within 90 days

3. Members with two or more emergency room visits within 90 days or exceeds the emergency room and physician visit service limits as outlined in He-W 530.03
4. Members with 100 units per prescription per 7-day supply
5. Members with three or more medications prescribed of the same drug class within 90 days
6. Members with the same or similar drug obtained within 2 days from different pharmacies

Once members are identified based on the algorithm criteria listed in table 3, we will initiate the *action steps* listed below and described in further detail in the next sections.

Algorithm Results	GSHP Action
Process to Identify Potential Lock-In Candidates and Member Notification of a Lock-In Assignment:	
If a member is identified as meeting one criteria	• Initiate monitoring every three months for the identified member
If a member is identified as meeting two criteria	• Send a warning letter to the member
If a member meets three criteria	• Initiate the lock-in process by sending a notification letter with at least 30-days notice to the member • Determine the lock-in pharmacy using first the member's selection and next a pharmacy geographically close to the member's home • Make claims processing changes to initiate the member's lock-in effective once the time for appeal has expired – unless an appeal is initiated. • Perform a pharmacy utilization review to determine if the member meets criteria for extend lock-in, as described below
Determine if the Member Meets Criteria for Extended Lock-In *Review at least 6 Months Pharmacy Data*	
If the review shows a demonstrated pattern of "total" improvement in the member's pattern of pharmacy utilization	• Release the member from the Lock-In Program
If the review shows a demonstrated pattern of "some" improvement in the member's pattern of pharmacy utilization	• Continue the member's participation in the Lock-In Program for an additional 12 months
If two criteria from are met.	• Send a warning letter and perform a 3-month follow up.
If three or more criteria from are met.	• Designate the member for an additional 2 years in the Lock-In Program

Review Process. A GSHP pharmacist or Medical Director must review a member's drug utilization, taking consideration existing diagnoses such as cancer, before a member is considered for the Lock-In Program. If we identify a pattern of overutilization or drug seeking behavior, the member may be restricted to using a single pharmacy and/or prescriber.

Warning Letters. If a member's utilization meets several monitoring criteria from Table 3: State Algorithm Criteria for Pharmacy Lock-Inbut our review determines the member should not be placed in the Lock-In Program, we will send the member a "warning" letter.

Member Notification for Lock-In. If either the GSHP pharmacist or Medical Director determines that lock-in should be invoked, members will receive written notification, at least 30 days prior to the effective date of their enrollment into the Lock-In Program. In accordance with the State's rule at He-W 570.07, this notice will include: (1) the date of a member's proposed lock-in enrollment, (2) instructions regarding selecting a specific pharmacy as the only source for obtaining all prescribed drugs, within 21 days of the date of the written notification, (3) notification that if members fail to choose a primary pharmacy timely, or the pharmacy is unwilling or unable to be the primary pharmacy, we will select a primary pharmacy for them, and (4) information regarding their right to appeal pharmacy lock-in and request a fair hearing if they disagree with the decision.

If the member responds with a selected pharmacy, we will notify the identified pharmacy and confirm the pharmacy's acceptance of the member into the Lock-In Program. If the member does not respond, we will select a Lock-In participating pharmacy based on the member's location and past claims history and then confirm the pharmacy's acceptance of the member. Once pharmacy confirmation is received, we will provide the member the name of the assigned pharmacy at least seven days before the effective date of the lock-in and make necessary changes within the US Script claims processing system. When the lock-in becomes effective, any claims or authorization requests received other than from the assigned pharmacy (unless otherwise previously authorized or in emergencies) will be denied.

Member Appeals. If a member appeals a Lock-In decision within 30 days from our written notification, the lock-in process will stop until the appeals hearing is completed and a decision is reached.

Care Management. Members assigned to our Lock-In Program also will be enrolled into our Care Management Program, so they can be educated on the appropriate use of prescription medications. A Care Manager will contact both the member and the member's PCP to inform them of the pharmacy assignment and the rationale for the decision.

Emergency Supply for Lock-In Members. We will allow an emergency 72-hour supply of medication from other pharmacies in the following circumstances: emergency room prescriptions dispensed when the assigned pharmacy is closed; antibiotic prescriptions filled when the assigned pharmacy is closed; and the prescription is needed while out of town when the assigned pharmacy is inaccessible.

Assignment of Lock-In Members to a Different Pharmacy or Provider. If, during the course of the lock-in assignment period, the assigned pharmacy can no longer meet the member's pharmaceutical needs

(i.e., member has moved, the pharmacy does not carry a prescribed medication, the pharmacy has disenrolled from our pharmacy network), the member will be re-assigned to another pharmacy.

Review to Determine If a Member Meets Criteria for Extended Lock-In. We will comply with the requirements of He-W 570.07 and prior to the end of a 12-month lock-in enrollment period will review a member's prior six months of pharmacy utilization to determine whether the member has continued to use excessive or inappropriate pharmacy services. Based on review findings, we will release the member from lock-in, perform additional follow-up reviews, send the member a warning letter, or extend the lock-in period, as described in the above table.

Making Pharmacy Information Accessible to Members

We are firmly committed to making pharmacy information readily accessible to our members. Our Member Handbooks, distributed to all members, will provide an overview on our pharmacy program policies and the toll-free telephone number for our Member Services staff who can assist members with pharmacy questions or problems. Members may reference our formulary and an electronic copy of the Member Handbook from our public website or track their pharmacy claims history within their individual health records through our secure Member Portal. We will support pharmacy claims tracking for members through *Microsoft Healthvault*, if a member chooses to enroll in this online personal health platform that allows patients to securely gather, store and share health information.

Members also may turn to our MemberConnections staff, care managers and disease management staff either by phone or face-to-face to discuss the medications that they are receiving, any medication problems that they are experiencing and which medications are covered.

Our member newsletters, on hold messaging for our member call-in lines and disease management educational programs will convey and re-enforce messages about our pharmacy coverages; upcoming coverage changes; medication administration, storage, safety and other best practices; and the availability of our pharmacy resources for members and how to obtain this information.

Academic Detailing Program

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

Our Pharmacy Director, with assistance from other quality monitoring staff, will establish annual benchmarks for physicians based on NCQA percentiles, current Centene affiliate trends, or the previous year's prescribing patterns. Our Pharmacy Director and our Medical Director then will review monthly reports that show individual prescriber performance against these benchmarks and conduct special studies, if necessary, to explore physician prescribing patterns that are above or below the norm. We will have capabilities to incorporate prescriber benchmarks and data into predictive modeling analyses to enhance our ability to identify members at-risk of intensive medical and behavioral health services. Our PBM, US Script, will use prescriber profiling to review the top prescribers based on total claim count and total claim cost within a therapeutic class and based on

provider specialty to determine if a prescriber has a tendency to prescribe more expensive or a higher number of medications to treat a particular disease state relative to the norm. Once analysis is complete, appropriate and timely intervention for prescribing and dispensing will be recommended. These interventions will include educational outreach and prescription change requests in an effort to improve patient outcomes and provide cost-savings. Physician-intervention letters will be sent to document inappropriate prescribing and dispensing practices. Also through our academic detailing program, our Medical Director will provide additional follow-up by phone or onsite visits to prescribers' offices.

Pharmacy Network

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

Our PBM, US Script, will analytically establish a pharmacy network that ensures DHHS member access, deliver culturally and linguistically competent care, and improve cost-effectiveness. US Script works with chain and independent pharmacies and to-date contracts with over 63,000 pharmacies nationwide, including **255 New Hampshire pharmacies that now serve Medicaid members**. The current US Script pharmacy network will provide GSHP members access to over 97% of the non-hospital pharmacies licensed in New Hampshire,[5] including retail, long-term care, and compounding pharmacies.

The Current US Script Pharmacy Network will provide Granite State Health Plan Members Access to Over 97% of the Non-Hospital Pharmacies Licensed in New Hampshire

We understand the role independent pharmacies play in their communities and will make extra efforts to reach out to them, for example, as we did working with the Mississippi Independent Pharmacy Association prior to our Medicaid plan operations in that state.

Pharmacy Credentialing. As part of the contracting and credentialing process, US Script will confirm that each pharmacy is not under sanction or exclusion and is licensed by the New Hampshire Board of Pharmacy. US Script will support access to care by encouraging network pharmacies to become Medicaid-enrolled durable medical equipment (DME) providers, for example, by asking them to supply diabetic testing devices, nebulizers and other commonly carried DME. To meet evolving or localized health care trends and needs, US Script may also offer pharmacies the opportunity to contract as a Specialized Network Provider, so that they may provide members with a 90-day instead of 30-day drug supply or administer flu vaccines.

Pharmacy Program Compliance. We will help keep our pharmacies current on relevant program and pharmacy issues using high-impact faxed bulletins targeted to all or a subset of our network and, as necessary, supported by direct contact by our Network Coordinators. To ensure accountability, US Script continuously audits its network pharmacies according to provisions as specified by contract.

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[5] Based 262 non-hospital pharmacies licensed as reported from *New Hampshire Board of Pharmacy Licensing Statistics As Of 1/1/2011*, available at http://www.nh.gov/pharmacy/documents/license-stats-20110101.pdf

Role Pharmacies Play in Disease and Care Management Program

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

We understand and appreciate the valuable partnership our participating pharmacies provide to ensure safe and cost-effective therapeutic care for our members. Following are examples of the role that pharmacies play in our disease and care management programs:

- **Periodic Liaison Meetings with Our Network Pharmacists.** Because accurate information is vital to appropriate drug utilization, we and our PBM, US Script, will meet with our pharmacists regularly to share clinical information about new pharmaceuticals, pharmacy benefit industry news, up-to-the-minute data on medication utilization and to exchange ideas to improve our disease and care management programs.
- **Pharmacy Counseling Supported by Instant Online Messaging.** To assist pharmacists in making the most appropriate clinical decisions and providing prescription drug counseling for our members, US Script provides instant online messaging to keep network pharmacists informed of drug-to-drug interactions, appropriate dosages and refill schedules.
- **Pharmacy Participation on our P&T Committee.** We will include representatives from our network pharmacies on our P&T Committee.
- **Medication Therapy Management Pilot.** Because pharmacists play an important role in member health maintenance, we will offer opportunities to pilot Medication Therapy Management (MTM) programs to support our disease and care management programs, as appropriate to member needs and pharmacy interest and expertise.
- **Pharmacies as a Point of Service Contact for Our Care Managers.** Our Care Managers will engage pharmacies to help find members who may be homeless or when we have incorrect contact information for the member. For example, we may track pharmacy prescriptions to identify approximate refill dates and ask the pharmacy to notify use when the member is there.

Strategies to Promote E-Prescribing

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

Most community pharmacies in New Hampshire (95%) have e-prescribing capacities. While the State's physicians who e-prescribed approximately tripled from 2009 to 2010, only 40% routed prescriptions electronically during 2010. GSHP and our PBM, US Script, will work collaboratively with DHHS to increase e-prescribing use.

US Script already contracts with Surescripts, the industry's dominant pharmacy information exchange. Surescripts operates the country's largest e-prescribing network. Available during emergencies or routine care, the Surescripts network is used every day by thousands of prescribers, across all 50 states, to electronically access prescription information and route prescriptions. Over 160 vendors of Electronic Medical Records (EMR) systems and over 35 vendors of stand-alone e-prescribing systems are connected to Surescripts. The strength for network providers is that physician offices and hospitals have a choice of end-user applications, many of which fit seamlessly into their current office protocols and workflows. Through the US Script connection to Surescripts, our providers using an e-prescribing application will have access to member eligibility and formulary information, potential drug-drug interactions, PA requirements and pharmacy network information.

- To support e-prescribing expansion in New Hampshire, we will engage in the following activities:
- Provide Surescripts electronic data on our DHHS formulary, PA requirements, other utilization controls, beneficiary enrollment, and medication histories to support e-prescribing transactions
- Distribute promotional materials to our physicians, encouraging the use of e-prescribing
- Post e-prescribing background and resources on our website
- Provide an e-prescribing web portal for our network providers, as required at Section 2.4.4.5 Web Access For Providers and Enrollees of the RFP (Providers will also have the option of utilization other e-prescribing vendors.)

Strategies to Make Formulary and Prior Auth Accessible to Network

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

We will provide participating pharmacies and providers with our formulary, PA requirements and procedures for submitting PA requests in our **Provider Handbook** and on our **Provider Portal**. Our Provider Web Portal will include a link to the GSHP formulary that offers providers options for searching for product-specific coverages and PA requirements or a print download of the most current GSHP PDL. Major changes to the PDL will be communicated to providers through our Pharmacy Department or by direct mail, upon request. We will use electronically transmitted **POS messaging** that will inform pharmacies about which drugs are covered by our formulary or what conditions need to be met to avoid a PA requirement. Also, our formulary and PA requirements will be accessible for prescribers through **e-prescribing applications** as part of our ongoing file exchanges with Surescripts. Lastly, **provider requests for addition or removal of covered drugs** may be made in writing to the GSHP Pharmacy or Medical Director or to US Script staff for consideration by the P&T Committee.

Pharmacy Claims Adjudication

Q12. In regards to pharmacy claims adjudication:

- ***Who adjudicates your pharmacy claims?***
- ***Describe how you ensure adequate oversight and monitoring of the pharmacy claims processor.***
- ***If pharmacy claims are paid through a different claims platform than medical claims, describe how third-party liability information is coordinated and shared.***
- ***If pharmacy claims are paid through a different claims platform than medical claims, describe how encounter data are aggregated.***
- ***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.***

Our Pharmacy Claims Processor

We will use US Script, our subcontracted Centene PBM affiliate, to adjudicate pharmacy claims for DHHS members. Founded in 1999, US Script provides progressive pharmacy benefit management services through custom benefit designs, clinical programs, technology strategies, and cost management techniques to meet drug management and quality of care goals.

Claims Processing Capabilities. US Script's system is supported by an Oracle database running on Sun Microsystems servers from a primary datacenter with fail-over to redundant equipment housed in a secondary facility. Retail and mail order pharmacies in the United States are connected to US Script's claims processing system through a highly secured, private intranet. Claims processing is available to adjudicate claims 365 days a years, 24 hours a day. Ninety-nine percent of all claims adjudicated by the system are processed in less than two seconds, after which a message is sent to the pharmacy confirming acceptance or denial of the submitted claim. In 2008, US Script was one of the first PBMs to receive Pharmacy Benefit Management accreditation from URAC. This accreditation was achieved by demonstrating and meeting industry practice standards in organizational quality; customer service, communications and disclosure; pharmacy distribution channels; drug utilization management; and formulary development.

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Functions Supported by US Script – Subject to GSHP Oversight. One of US Script's strengths is its ability to create customized programs that address the specific needs of the populations its staff serves. US Script's clients include Medicaid health plans, third-party administrators, brokers, colleges, school districts, and self-funded employers. Medicaid health plans represent a significant portion of US Script's client portfolio. In total, either as a pharmacy provider or support to Centene-affiliated health plans, US Script serves 1.2 million low-income members and their families who span across a wide

scope of age and program categories. US Script's extensive experience will provide us with a unique understanding of the nuances of Medicaid populations and their medication issues.

US Script functions, subject to GSHP oversight, will include Preferred Drug List (PDL) administration, clinical authorizations, pharmacy network contracting and management, claims adjudication, rebate administration, reporting, account management, pharmacy provider call center and services, pharmacy and therapeutics support, e-prescribing portal, pharmacy auditing, and selected drug utilization review and quality improvement functions.

Oversight and Monitoring of the Pharmacy Claims Processor

We will delegate our pharmacy claims processing to our PBM affiliate, US Script that has a long standing relationship with all Centene-affiliated health plans and extensive experience implementing and maintaining pharmacy benefit plans for Medicaid populations.

Day-To-Day Oversight and Monitoring of Pharmacy Claims Processing. Our Pharmacy Director will be responsible for day-to-day oversight and monitoring to assure that US Script pharmacy claims processing meets DHHS specifications. These review activities will be enhanced by US Script's encounter submission and tracking system that will allow us to create customized reports and quickly review complete and accurate pharmacy data on DHHS members. If processing discrepancies are identified, our Pharmacy Director will expeditiously make corrections with US Scripts to assure that appropriate pharmacy services are available for DHHS members. Examples of ongoing monitoring and oversight activities include, but are not limited, to the following:

- **System Testing.** Our Pharmacy Director will closely review testing data to assure claims payment accuracy before the implementation "go-live" date of our DHHS pharmacy benefit and throughout our contract with DHHS when changes are made to the pharmacy claims processing system.
- **Monitoring Quantity and Days' Supplies.** Our Pharmacy Director and US Script staff will collaborate to implement POS edits to prevent payment of questionable values for quantity and days' supply billed by pharmacies. Our POS messaging system will stop a claim until a PA is received for drugs that have clinical monitoring, such as quantity limits, age limits, or duplicate therapy/dose consolidation concerns.
- **Quarterly Joint Operational Meetings.** Our Pharmacy Director will hold quarterly meeting with US Script staff to discuss operational and reporting issues along with potential enhancements, overall performance and contract compliance.
- **Follow-Up on Reported Claims Processing Errors.** Our Pharmacy Director will investigate pharmacy- and member-reported accounts of claims processing errors and assure corrective actions are made, as warranted.
- **Random Review of Claims.** At least annually, the Pharmacy Director will audit a random sample of pharmacy claims to verify payment accuracy.

Audits of the Claims Processing System. In addition to our Pharmacy Director's day-to-day oversight and monitoring, US Script undergoes an annual audit conducted by our parent company Centene Corporation (Centene) and an URAC reaccreditation audit every two years.

Centene Annual Delegation Audit. Centene's corporate Quality Improvement (QI) Department, in conjunction with the corporate Pharmacy Department, audits US Script annually. Health plans that subcontract with US Script, such as GSHP, are invited to participate in the audit. Conducting a single audit, with health plan participation, ensures consistent application of standards and coordination of any corrective actions across all Centene health plans that manage pharmacy benefits as part of their state contracts. At the same time, this audit approach enables each health plan to ensure compliance with any state-specific requirements. Centene corporate QI staff will provide annual delegation audit results as a report, which includes any corrective action plan (CAP), to GSHP and to US Script within 30 days following the audit. Our Quality Assurance Program Committee (QAPC) will review a received audit report at its next soonest quarterly meeting, and may require operational policy or procedure changes in response to audit findings. The QI Committee also reports the audit results to the GSHP Board of Directors at its next soonest meeting following the audit's completion, along with any responsive action taken or recommended. Centene corporate QI staff will promptly advise GSHP on any CAP updates and completion. In addition, the US Script QI Committee and US Script Board of Directors review the delegation audit results at their next soonest meeting following the audit's completion and take any appropriate responsive action.

Audits consist of an annual onsite visit, policy and procedure (P&P) review as well as file reviews, addressing at a minimum the following topics:

- DHHS contract compliance
- Network of pharmacy providers that meets access standards and has evidence of State licensing and a signed agreement by the "pharmacist in charge"
- Pharmacy provider call center and responsive customer service measures and protocols
- Processing of DHHS eligibility files within one business day of receipt
- Reporting that measures drug utilization and pharmacy drug expenditure trends
- Disaster recovery plan
- Policies and procedures for responding to any complaints from pharmacies and practitioners
- Personal health information (PHI) policies and procedures that address member rights to authorize or deny the release of PHI beyond uses for treatment, payment or health care provision of service
- Management of the preferred drug list (PDL) in accordance with DHHS coverage protocols, including PDL and prior authorization criteria
- Adverse coverage determinations communicated to both member and provider
- Point of service messaging to pharmacies on DHHS-specific requirements

- Policies and procedures for drug recalls that have the potential to produce harm, including limiting ongoing coverage and providing a notice to prescribers and members of potential risks regarding drugs in recent pharmacy claims submissions.
- Quality Improvement Program including requirements for assessing performance, tracking issues, and setting improvement goals.
- Pharmacy audits triggered by claims submissions for identifying potential fraud and abuse.

If GSHP determines that US Script is out of compliance with contractual or regulatory requirements, GSHP will require a written and signed CAP that spells out a detailed action plan, expected, measurable results, and a due date for completion. US Script must provide the CAP within two weeks of receiving GSHP's notice, and must complete the CAP within 30 days of GSHP's approval of the CAP, unless another period is agreed to in writing. If US Script fails to complete the CAP as specified, GSHP may suspend or revoke delegation of PBM services. GSHP may issue a notice of material breach of contract and opportunity to cure, based on US Script's breach of contract, allowing 60 days to cure. Finally, for specified reasons such as loss of insurance, GSHP may terminate the contract immediately.

"Full accreditation gives US Script a seal of approval that employers, consumers, regulators and providers can trust. It is something that each employee at US Script can be proud of because it demonstrates our commitment to quality and safety. By receiving URAC PBM Reaccreditation, US Script has demonstrated its continued commitment to quality healthcare pharmacy services."

Lisa Gallegos, Quality Improvement Analyst, US Script

URAC Reaccreditation Audit. URAC is an independent, non-profit organization know for promoting health care quality through its accreditation and certification programs. US Script was initially URAC-accredited in 2008 and attained reaccreditation from March 2011 through March 1, 2014. URAC provides the outcome of its reaccreditation audit to US Script, which in turn provides the outcome to GSHP and Centene. After an investigation conducted through URAC's grievance process, URAC may impose sanctions on an accredited company. Sanctions range from a letter of reprimand to revocation of accreditation, depending on the nature and frequency of the violations.

Coordinating Claims from our Pharmacy and Medical Claims Platforms

We will pay pharmacy claims on a different claims platform than medical claims and then use technology and processes that effectively integrate data from these two platforms plus a variety of other sources to monitor pharmacy utilization and measure member compliance with medication regimens. As requested by DHHS, following are descriptions of (1) how we share third party liability information between the pharmacy and medical platforms, (2) how we aggregate encounter data between these platforms and (3) how we link pharmacy utilization data and medical claims data at the member level in our disease and care management programs.

Sharing Third Party Liability Information between the Pharmacy and Medical Platforms. Daily GSHP will provide US Script data on member third party resources (identified by DHHS or us) in membership eligibility records. A member's entire eligibility history is maintained within US Script's system so that an accurate determination of coverage and coordination of benefits can be made regardless of the date the claim is submitted. When the US Script POS claims processing system identifies a member has coverage for a prescription from Medicare Part B and Part D or from another resource identified by Bank Identification (BIN), Processor Control Number (PCN) and Group ID; the billing will be denied with a message to the pharmacy to bill Medicare or the other resources. When the resource is not identified by BIN, PCN, and Group ID, the POS claims processing system will provide the billing pharmacy information on the third party resources but not deny the claim. US Script also encourages pharmacies to report whether members have other pharmacy coverages. We will verify these reported resources and as appropriate, update a member's eligibility records

Aggregating Pharmacy with Other Encounter Data. Daily US Script will report pharmacy claims data to GSHP. Because it is a Centene affiliate, US Script's state-of-the-art technology is completely compatible with and supportive to GSHP systems. Our Centelligence™ enterprise data analytics platform will combine pharmacy claims data with GSHP's medical, other providers', and behavioral health claims data, eligibility and enrollment information, and other clinical, support service and demographic information. Our strategic and integrated use of pharmacy data improves treatment and outcomes and supports all aspects of our disease and care management programs.

Linking Pharmacy Data with Our Disease and Care Management Programs. Our Disease and Care Management staff use pharmacy data reported in our Centelligence™ enterprise management system (described above) in their evaluation of member health status and needs and coordination of care. Prior to each contact with a member, our Disease and Care Managers create and review a virtual medical record that shows the member's medical and pharmacy claims history and health plan clinical documentation. Disease and Care Management staff uses pharmacy data in numerous ways. For example, they use pharmacy information:

- To discuss a member's compliance and experience with drug therapies and needed refills with the member
- To monitor pharmacy data for medication reconciliation and potential noncompliance issues, such as appropriate controller medications for members with asthma
- To educate members about identified problems and the importance of medication compliance in maintaining optimal health and avoiding acute and emergent conditions
- To outreach to PCPs to coordinate care for members noncompliant with pharmacy regimens
- To educate, coach, and help resolve barriers to compliance, when members report a problem with their medicine, or with adherence to drug therapy.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.4 Member Enrollment

GRANITE STATE HEALTH PLAN

3.4 Member Enrollment

Assisting Members in Retaining Medicaid Eligibility

Q13. Describe your strategy and experiences with assisting members in retaining their Medicaid eligibility.

Assisting Members in Retaining Medicaid Eligibility

Granite State Health Plan (GSHP) knows that retaining eligible Medicaid members in their health coverage enhances health outcomes, supports personal responsibility, and better ensures access to health care services and continuity of care. Helping to ensure that members complete eligibility redeterminations without gaps in coverage reduces administrative costs as well.

Experience Assisting Members with the Medicaid Renewal Process. We have well-developed strategies for helping members maintain their Medicaid eligibility based on the extensive experience of our affiliated health plans, which currently serve over 1.6 million members in full-risk managed care programs in 13 states. Building on Centene's experience in other states, we propose several strategies and tools for supporting members through a successful redetermination process to avoid unnecessary gaps in coverage.

Strategies to Help Members Retain Medicaid Eligibility. Key strategies to assist members through the redetermination process include effective use of information technology, staff training and member education, as described below.

Telephonic Outreach to Members. GSHP will work with DHHS to obtain a monthly redetermination file or will utilize the redetermination date provided on the 834 file to identify members for telephonic outreach regarding their annual redetermination of Medicaid eligibility. For example, in some of our affiliated health plans, the state Medicaid program provides a monthly file (separate from the 834 file) of members whose eligibility redetermination date is in 60 days. Of those members identified in any given month, GSHP will send an automated telephone message to the head of household as a reminder to complete the redetermination process.

Inbound Notification of Redetermination. As with our health plan affiliates, GSHP will have the capability to populate a field on the member record from the redetermination file to indicate when a member is due for Medicaid renewal. On inbound calls, if a member has this field populated with a date, a Member Services Representative (MSR) will offer a friendly reminder about renewing his or her Medicaid.

GSHP will ensure that DHHS has approved the automated script prior to use, and that it will not include any marketing language or words intended to coerce members to change health plans. This message

will explain the process and what documents members may need to complete it. The message will provide GSHP's toll-free telephone number for the member to call with questions or further assistance.

On a monthly basis, GSHP will receive a report that summarizes the results of its telephonic outreach. The report will include the results and numeric totals for different call scenarios, such as:

- The member answered the call and listened to the entire message in English or Spanish.
- The member called and asked to speak to the GSHP Member Services Representative (MSR).
- The call was recorded on an answering machine.
- The telephone number was invalid.
- The individual answering the call hung up before hearing the message.

If the member's telephone number changed and the new number was provided, GSHP will share this information with DHHS if there is a process established to do so.

Because it is often difficult to reach our members due to a lack of up-to-date contact information, GSHP staff will verify member addresses and telephone numbers during each member contact. Implementing this best practice maximizes our opportunities for successfully reaching our members to remind them to complete the renewal process in a timely manner.

> Granite State Health Plan Staff will verify member addresses and telephone numbers during each member contact. Implementing this best practice maximizes our opportunity for successfully reaching our members to remind them to complete the renewal process in a timely manner

GSHP will actively assist DHHS in any of its own initiatives to promote uninterrupted care, as our affiliated health plans do in other states.

Staff Training on Medicaid Renewal Processes. Member Services Representatives (MSRs) and all new GSHP employees will be trained during new employee orientation and annually thereafter about how to answer basic member questions about the redetermination process. As permitted by DHHS, MSRs will assist our members in obtaining the documentation they may need to complete their eligibility redeterminations.

Mailed Reminder Notification. As we do in other states, we will produce an annual GSHP Reminder Notification for members that will provide, among other vital information, easy-to-follow reminders about the importance of completing the redetermination process and the steps involved. In addition, GSHP will provide a Quick Reference Guide (QRG) to our members to answer questions regarding the redetermination process. We will customize this tool—currently available to members and used by MSR staff in other states—to the New Hampshire Care Management Program.

Support and Strategies for Members Transitioning Due to Loss of Eligibility

Q14. Describe the support and strategies you will employ to assist members who transition in and out of your plan, due to loss of Medicaid eligibility.

Coverage Transitions

Overview of Assisting Members through Coverage Transitions. GSHP will ensure continuity of care and coordination of medically necessary services for members who transition into or out of our health plan. Internal processes and procedures focus on providing individualized attention to a member's health care needs, regardless of the source or destination of the transition.

The Integrated Care Team (ICT) will manage all transitions of member care and services into and out of GSHP. As described in Section 3.11 Care Management Overall Approach, the ICT is a multi-disciplinary team of staff from Granite State Health Plan, Nurtur Health, Inc. (Nurtur), our affiliated disease management subcontractor, and Cenpatico Behavioral Health, LLC® (Cenpatico), our affiliated behavioral health subcontractor, who provide care management services, including assistance with coverage transitions.

ICT staff will identify new GSHP members in active care who require transition assistance, respond to identified transition needs, and ensure continued, uninterrupted access to medically necessary care. Care managers will receive and respond to inquiries from providers and other MCOs, as necessary, share medical information, and coordinate care for newly enrolled or former GSHP members who are in active care, in accordance with HIPAA and other confidentiality requirements.

Granite State Health Plan will address many types of transitions for our members, including:

- Transitions for members receiving behavioral health services, especially for those members who have received prior authorization from their previous health plan, or through fee-for-service
- Member transitions into GSHP from traditional fee-for-service
- Member transitions between MCOs, particularly during an inpatient stay
- Members exiting GSHP to receive excluded services
- Member transitions to private insurance
- Member transitions to no coverage.

Our strategy for coordinating continuity of care for members entering GSHP, regardless of the situation or circumstance, incorporates the following features:

- Identification of the new member
- Assessment of the new member's health care needs
- Determination of the presence of active care needs or possible outstanding service authorizations

- Identification of the member's previous MCO (if applicable)
- Contact with the previous MCO and/or Primary Care Provider (PCP) to obtain relevant member information (if applicable)
- Ensuring existing authorizations with the previous health plan or in fee-for-service are honored during the transition, for a minimum of 60 calendar days from the date of enrollment in GSHP (if applicable).

GSHP's strategy for coordinating continuity of care for members leaving GSHP, regardless of the situation or circumstance, incorporates the following features:

- Identification of the disenrolling GSHP member
- Identification of the disenrolling member's continuing health care needs and outstanding service authorizations
- Communication as requested by the receiving MCO and/or PCP to provide relevant member information
- Notification to the disenrolled member of their authorizations approved by GSHP.

Our policies and procedures will address the health care authorization and transition needs of members who were receiving services prior to their enrollment date with GSHP. GSHP will notify members about the transition process through the Member Handbook, Member Portal, the new member welcome call, and care managers.

We will notify providers about the transition process through the Provider Manual, Provider Portal and Care Managers working with members in active care. The information provided will emphasize the importance of notifying GSHP when a member requires transition assistance. GSHP will also help to ensure continuity of care for our members through effective communication processes with other MCOs. We will cooperate fully in identifying and exchanging medically necessary information on a timely basis when members make a transition between MCOs and programs.

Transition into Granite State Health Plan

We will follow three key steps related to transition into GSHP, as detailed below, based on best practices developed over 27 years of experience across our affiliated health plans.

Identification of Members Needing Transition Assistance. GSHP will identify our new members needing transition services from a variety of sources, but primarily through: 1) prior claim history as provided by DHHS 2) information obtained from the initial Health Risk Screening (HRS) that new member complete; 3) incoming communication from providers requesting information and service authorizations for GSHP's new members in active care; and 4) phone calls or communications from members who are in active care. Our policies, procedures and processes focus on the identification of members who have existing prior authorization approvals at the time of their enrollment with GSHP.

Health Risk Screening. A member may complete the HRS form during the new member welcome call, submit it through the Member Portal or by mail after receiving it in the new member packet. Hard copies will be entered into the Member Portal for reporting purposes. Results of any HRS that identifies members in need of transition assistance will be forwarded to the Integrated Care Team (ICT), from which a designated team member will provide follow-up.

Provider or MCO Contact. We may identify members needing transition assistance when providers requesting service authorization for new members in active care contact GSHP's Prior Authorization unit. We may also identify these members if a facility's utilization review nurse or provider contacts GSHP Care Coordinators about a member who will be transitioning to GSHP services after discharge from their facility.

Contact From New members. Member Services Representatives (MSRs) will identify members needing transition assistance when new members contact the GSHP call center to inquire about previously authorized services or care. These phone calls are referred to the ICT who obtains information from the member about the services needed.

Coordinating Care Transition. Once a member has been identified for care transition, the ICT will reach out to the member to assess the member's health care needs and services requiring transition. The ICT may also reach out to the member's PCP or other provider of care by secure e-mail, telephone, or fax to confirm and initiate any coordination of care and service transitions that need to occur, including orders for authorized services, as well as any care or service plans in place for the member at the time of enrollment in GSHP. Taking into consideration any special needs of the member, in some instances the ICT and/or a MemberConnections Representative (MCR) may conduct a face-to-face assessment of needs to explain and initiate coordination of care for the member. (See Section 3.11 Care Management in response to Question 46 for more information about the MemberConnections Program.)

Honoring Outstanding Authorizations. Once the ICT has identified a member's previous care needs, we will reach out as needed to initiate any coordination of care and service transitions that need to occur, including honoring orders for any of the member's previously authorized services with network providers, and any care or service plans in place for the member at the time of enrollment in GSHP. (See below for continued authorization of services from non-participating providers). We will follow this process for any member transitioning to GSHP from another health plan or from fee-for-service.

GSHP will honor outstanding prior authorizations from fee-for-service until we complete an assessment of the member's needs and initiate a transition of care plan. Outstanding service authorizations may include but are not limited to:

- Surgeries
- Therapies
- Durable Medical Equipment
- Pharmacy

- Home health
- Physician services
- Behavioral Health services
- Follow-up specialty visits.

When DHHS notifies GSHP of active prior authorizations for members new to our plan, an ICT staff member will input the information into TruCare, our clinical documentation system, and authorize the services through the transition period, regardless of whether the provider is participating in the GSHP network.

Behavioral Health Services. For incoming members receiving behavioral health (BH) services at the time of enrollment into GSHP, a BH Care Coordinator will coordinate transition of care.

Pregnancy. For incoming members who are pregnant at the time of enrollment, a MSR or Maternal/Child Health Integrated Care Team Care Manager will assist the new member in continuing to see her desired GSHP OB/GYN provider. Members who are in their second or third trimester of pregnancy at the time they enroll in GSHP and who have initiated prenatal care with a physician may continue to receive prenatal, delivery, and postpartum care from that physician, even if that physician is not a member of the GSHP network, as long as the provider is enrolled in the New Hampshire Medicaid program.

When a pregnant member notifies GSHP that she wishes to maintain her existing relationship with a non-network OB/GYN, a MSR will stay on the line with the member to connect to a Referral Specialist, who will obtain the provider information from the member. The Referral Specialist will enter an authorization into TruCare and create a task for referral to the Maternal/Child Health ICT for completion of the NOP if not yet completed. Completion of the NOP automatically enrolls pregnant members into our Start Smart for Your Baby® program, described in response to Question 16 in this section.

Out-of-Network Providers. During a transition of care, the ICT may identify new members who are in need of continued services from a non-contracted provider or facility. If the member is in an active, ongoing course of treatment, is within the second or third trimester of pregnancy, or is currently receiving inpatient care, an ICT Care Manager will authorize out-of-network care. This care will be authorized until we complete an assessment of the member's needs and initiate a transition of care plan, or through the postpartum period, as applicable, as long as the provider agrees to:

- Accept reimbursement at established rates for similar network physicians
- Adhere to GSHP's quality assurance requirements and to provide necessary medical information related to such care
- Otherwise adhere to GSHP policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

After immediate transition needs are arranged, GSHP's Provider Relations department may approach out-of-network providers about joining the GSHP network. Our affiliated health plans in Georgia, South Carolina, and Florida have participated in new Medicaid managed care implementations. In each state, the Network team reviewed a report of claims from non-participating providers, identifying those with a high volume of members. A Provider Relations Specialist (PRS) contacted these non-participating providers for possible inclusion within the network. GSHP will capitalize on this experience and implement a similar transition period during the initial start-up.

Transition Out of Granite State Health Plan

We also have a systematic and well-tested process for assisting members when they are disenrolled from GSHP for any reason. Informing our former members about care and services they were receiving with our plan is critical not only to the timely continuation of their care, but also empowers members to take an active role in their own health care.

Informing our former members about care and services they were receiving with our plan is critical not only to the timely continuation of care, but also empowers members to take an active role in their own health care.

Process for Identification of Disenrolled Members. GSHP will proactively identify and reach out to disenrolled GSHP members who require continuity of ongoing care and coordination of services. The ICT Care Manager will receive a bi-monthly report of members who have disenrolled from GSHP for any reason. The list will be compared to our TruCare (medical management documentation) system to identify those members who have open authorizations. By comparing the current and previous lists every 15 days, we can identify individuals who are no longer GSHP members but have open, approved physical or behavioral health service authorizations, and/or are being followed by care management staff on a timely basis. This comparison produces a list of former GSHP members with current, open authorizations, as well listing any member who did not have an open authorization at that time, but was receiving care management services.

Transition to Another MCO. GSHP will send an open authorization notification letter (as described below) to each disenrolled member who has open authorizations in place with GSHP, or who was receiving care management services at the time of their disenrollment. GSHP will also share information with the new carrier or care Providers as requested.

Information Shared with Receiving Entity. The ICT Care Manager will provide the receiving entity with member information via HIPAA compliant transmissions in accordance with written GSHP policies and procedures. At a minimum, GSHP will provide the following information:

- Procedure codes, and ICD-9 codes, as applicable
- Duration and frequency of authorization

- Other pertinent information necessary for the continued provision and transition of medical care and services.

A GSHP Care Manager will also provide an overview of the member's care plan to the receiving MCO or provider, to ensure that the receiving care management contact has current, complete information about the member, and that no gaps in care will occur due to information not being transmitted. The care manager will provide the member's contact information, including a phone number and an address, so that the receiving care manager can readily contact the member to continue care management interventions.

Communication to Disenrolling Members. Once GSHP identifies disenrolled members, Care Management staff will send a letter to notify them of any open authorizations they had at the time of their disenrollment from GSHP. We will ensure that DHHS has approved the format and content of this letter prior to its implementation, in accordance with State requirements for member material content and approval. The letter will provide individuals with a list of currently open, authorized services at GSHP, and advise disenrolled members to notify their new MCO and/or provider of the services they are receiving. A copy of this letter will also be sent to the member's last known GSHP PCP. GSHP understands that members with cognitive or mental health issues may need a more hands on approach with care transition and is prepared to explain the transition during a face-to-face visit with the member and appointed care giver.

Excluded Services, Private Insurance, or No Coverage. GSHP will assist members who transition from GSHP to excluded services, private insurance or no coverage, with the understanding that there may be limitations imposed on our ability to contact and arrange services for individuals who are no longer GSHP members. GSHP will attempt to proactively provide information regarding the member's continued care needs to the member, the appropriate designated personnel at an identified health plan, community agency, service provider, or other transition point responsible for the individual's care and authorized to receive information. If a member has transitioned to no coverage, GSHP will work with the member's last known PCP to assist in locating other possible resources or community assistance to meet their needs.

Provider Education on Transition Processes. GSHP will provide initial and continuing education to our provider network to guide them in a timely, accurate, and HIPAA-compliant submission or release of member information to GSHP and other appropriate entities. We will educate providers about how to submit information regarding services authorized by another MCO or entity to GSHP through a variety of means, including provider orientation, the Provider Manual, Provider Portal, the Provider Newsletter, and other periodic mailings. We will also educate providers to proactively submit information to the ICT about new member health needs, such as pregnancy, disabilities or special health care needs, chronic conditions, including behavioral health conditions, and upcoming surgeries.

Experience Collaboration with State's Enrollment Assistance Function

Q15. Describe your experience collaborating with a State's enrollment assistance function and your strategies and processes to assist members in plan choice and enrollment.

Member Enrollment and Plan Selection

Centene Experience Collaborating with States on Enrollment Assistance Functions. Granite State Health Plan (GSPH) will rely on the 27 years of experience of our parent company, Centene Corporation (Centene) and the lessons learned among our 13 affiliated health plans to ensure we implement enrollment procedures that are compliant with DHHS enrollment policies and that ensure our members are enrolled into our system appropriately and timely.

For example, when open enrollment is underway, our Member Service Representatives (MSRs) strictly follow state-approved FAQ responses in providing information to callers. If there are specific enrollment questions, the MSRs direct callers to the state's designated phone number, or the enrollment broker, to answer questions outside our scope of responses.

Designation of an Eligibility Specialist as a "State Contact." In most states where one of our affiliated health plans is operating, we designate a point person within the eligibility department to be the "state contact". Through this partnership, the state has the ability to address enrollment discrepancies in a timely manner. In Massachusetts, the state contact from the eligibility department of our affiliate Celticare Health Plan, has partnered with the state on a secure portal for email transmissions to resolve pending enrollment issues. The state portal allows the Eligibility Specialist to log in securely to retrieve emails from the state requesting specific research for members.

GSHP will adopt policies and procedures for advising the state on member demographic changes as received through the call center. To comply with HIPAA guidelines, our MSRs verify member demographics with the caller before proceeding with the call. This verification gives the MSR the ability to update or modify current address and phone number information. Kentucky Spirit Health Plan, our affiliate in Kentucky, follows a policy as required by the state to keep track of member address changes. The Eligibility Specialist designated as the state contact sends the Medicaid agency a monthly summary report of all known changes of address. The report is utilized by the state to reconcile current demographic information against the last reported address. Further collaboration with the state is detailed in *Q13 Assisting Members in Retaining Medicaid Eligibility* through the **Inbound Notification of Redetermination.**

Collaborating on Quality Improvement of the Enrollment Process. In addition to these kinds of health plan-state agency collaborations, our affiliated health plans communicate regularly with Medicaid and CHIP programs and/or their agencies and participate in meetings and workgroups, as requested, to exchange feedback on the effectiveness of enrollment procedures and systems, and how to improve them.

And finally, each Centene health plan utilizes the HIPAA-compliant 834 enrollment transactions for enrollment processing. We configure our Electronic Data Interchange (EDI) toolset for the specificity of each transaction, based on each state's specific rules, types of data, and frequency of file transfer.

GSHP Coordination with DHHS. The Eligibility Specialist will be responsible primarily for coordinating with DHHS (or its designee) on enrollment procedures, including communicating regularly with DHHS; facilitating the acceptance of daily Benefit Enrollment and Maintenance transaction files, as specified in the 834 Companion Guide; and reviewing the Monthly 834 audit file against our internal records.

The Eligibility Specialist will also work with DHHS to resolve potential issues that include but are not limited to:

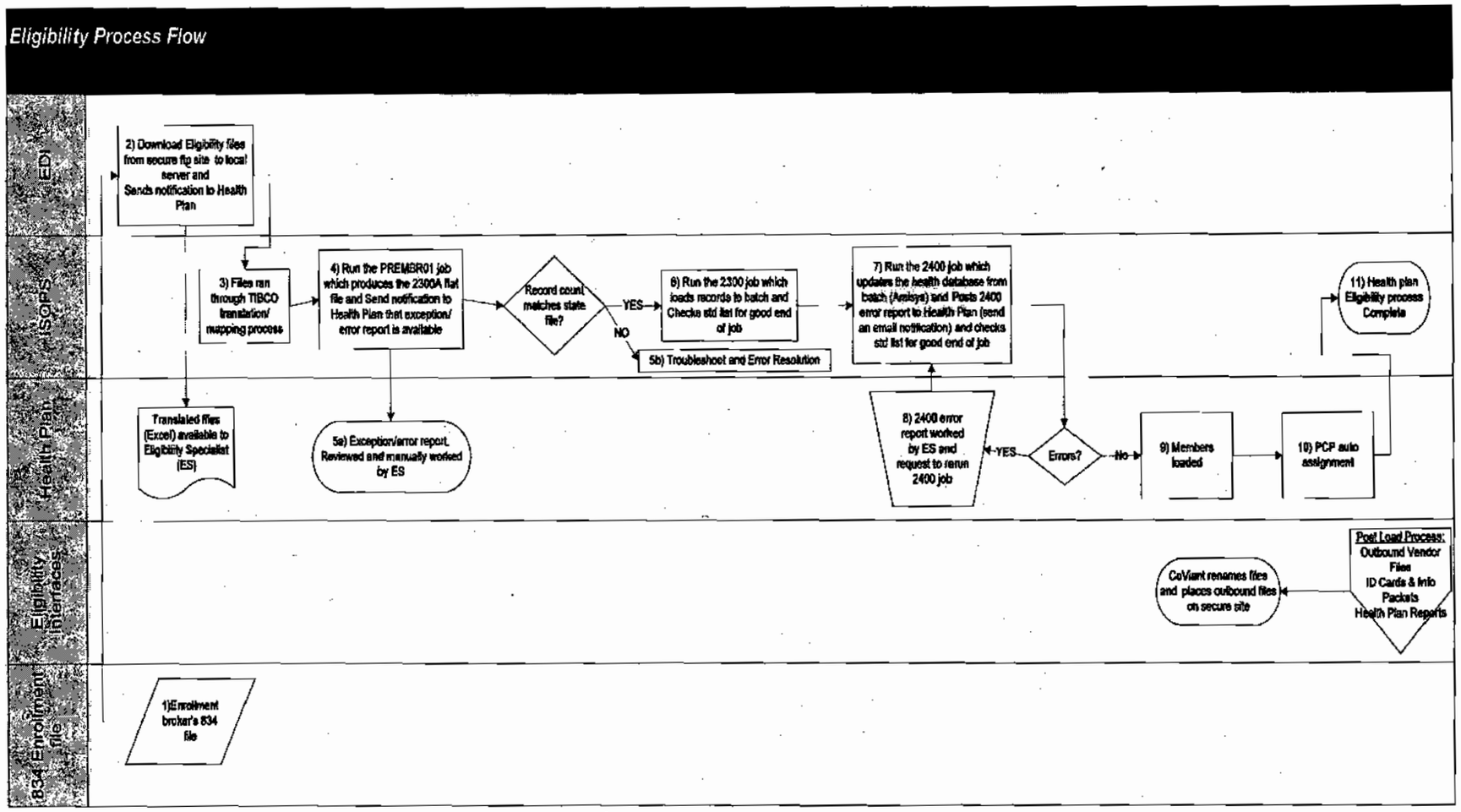
- ***Member information inconsistent with DHHS files.*** This will include date of birth, category of aid, effective or term dates, etc. The ES will work with DHHS, or its designee, to resolve any data issues identified at the time of the load.
- ***Subsystem Issues.*** The ES will monitor a work queue for internal departments to report eligibility or enrollment information problems. The ES will investigate and reach out to DHHS if needed to resolve issues. The ES will also work with the Finance Department to reconcile discrepancies related to capitation.
- ***Vendor Files.*** The ES will generate an error-free membership file for vendors, such as OptiCare Managed Vision®, our affiliated vision benefit subcontractor. The ES also will track and monitor file exchanges with vendors to ensure a load match of data. We will require vendors to confirm receipt of enrollment and provide membership counts.

Enrollment Process. Centene's Information Technology (IT) department has created mapping/translation programs, currently used for Centene's other Medicaid/CHIP health plans, for loading membership and linking member eligibility status to all of Centene's AMISYS Advance subsystems. GSHP will use these same programs for our members in New Hampshire. The mapping/translation programs load State eligibility files, then validate and map each data item to the AMISYS Advance standard membership batch input file format. The batch membership interface subsystem then validates, cross-checks and loads the membership data (including member name and date of birth, Member and Provider ID numbers, Member demographics, PCP and other information) into the main AMISYS Advance tables, where the data is accessible from all subsystems. GSHP will ensure that the file load includes New Hampshire-specific business rules for processing the data provided by DHHS against the internal member database.

Ensuring Accuracy. An Eligibility Specialist (ES) will use standard and customized reports to ensure data validity and to provide support for GSHP to track new membership, member changes (such as PCP changes), and verify terminated membership. The raw data received in the DHHS and enrollment files will also be stored in an easily accessible area where the ES can search and review the original data DHHS submits for reconciliation. To ensure accurate data, the ES will monitor the load process, check initial record counts, and address errors before member records are loaded into our core systems as illustrated in Figure 1, below.

GRANITE STATE HEALTH PLAN

Figure 1. Flow Chart of Eligibility Process



Assistance to Members in Plan Choice and Enrollment. Granite State Health Plan will exchange information with DHHS (or its designee) to include plan benefit descriptions, accurate up-to-date provider network information (updated no less than every 30 days), and information contained in the Member Handbook , as described in Section 3.5 of the RFP. GSHP will also build on Centene's experience and procedures for effectively enrolling individuals into the plan, educating them, and ensuring that they receive needed services as quickly as possible. GSHP will accept all eligible individuals without restrictions or discrimination on any basis. GSHP will accept potential enrollees in the order in which they are assigned, without restriction, up to the enrollment capacity limits set under the contract with DHHS.

New Member Packet. After receiving the state enrollment file, GSHP will mail a new member packet containing the Member ID, Provider Directory, Member Handbook and other materials about GSHP's program, benefits, services and providers. The materials will emphasize the importance of appropriately accessing preventive and primary healthcare services, detail available services, and provide instructions for requesting help understanding the plan and accessing services.

Phone or In-person Contact. In addition to mailing information, GSHP will attempt to contact all new members by phone within the first 30 days of enrollment. GSHP will make a minimum of three attempts to reach the member. The objective of the new member welcome call is to introduce members to GSHP and to educate them about how to access services. This is often the more effective approach since some members move frequently and may not receive mail in a timely way, and may not recognize the importance of carefully reading all mailed materials. During the call, a GSHP Member Services Representative (MSR) asks important access-related questions to:

If We Cannot Reach a Member by Phone, a MemberConnections Representative Will Make a Home Visit.

- Confirm the member's Primary Care Provider (PCP) selection
- Conduct a brief health risk screening
- Screen for special needs and/or services of the member
- Answer any of the member's questions about the MCO.

If we cannot reach a member by phone, a MemberConnections Representative (MCR), a health outreach worker hired from within the communities we serve, will make a home visit. (See Section 3.12 Care Management in response to Question 46 for more information about this unique program.)

Policies Toward Enrolling a Newborn

Q16. Describe your policies toward enrolling a newborn

Newborn Enrollment and PCP Selection

Overview and Experience. As with our affiliated health plans, Granite State Health Plan (GSHP) will adopt several methods for identifying pregnant members early and encouraging pregnant members to select a Primary Care Provider (PCP) for their newborn baby before delivery. These practices support members as they establish the life-long habit of appropriately accessing preventive care services—which start with the newborn exam during the delivery admission. In the event that a pregnant member does not select a pediatrician, or other appropriate PCP, we will assign one through our auto-assignment process.

Methods for Identifying Pregnant Members Early. GSHP will follow well-tested protocols of affiliated Centene health plans in identifying pregnant members.

Enrollment Data. When a pregnancy indicator is provided on the enrollment file, GSHP will load this information into our TruCare utilization and care management system and our Member Relationship Management (MRM) system. When a pregnant member, as identified by the eligibility pregnancy indicator, contacts GSHP, a Member Services Representative (MSR) will check to see if a Notification of Pregnancy form (described below) has been completed, and if not, the MSR will assist the member to complete the form. Completion of the form automatically enrolls the member in our Start Smart for Your Baby program, as described below, and initiates the introductory mailing.

Notification of Pregnancy (NOP). GSHP will adopt the NOP process that our health plan affiliates use to identify and engage pregnant members as early in their pregnancy as possible to establish a relationship between the member and health plan staff. The NOP form includes the member's current contact information, provider information, Estimated Date of Confinement (EDC), medical history pertaining to pregnancy and newborn PCP selection if known at that time. GSHP will educate and incentivize our providers to submit an NOP upon confirmation of pregnancy. We also encourage our members to submit an NOP.

If a member completes an NOP, GSHP will offer a small incentive such as a digital thermometer; members who have a NOP on file will be eligible for rewards through our CentAccount member incentive program for receiving prenatal and timely postpartum care. If the NOP includes selection of a PCP, we will document this information in TruCare. A copy of the form will be included in the Provider Orientation packet, is available to print from the GSHP website and can also be submitted electronically through our secure Member and Provider Portals.

Health Risk Screening. The HRS form may be completed during the new member welcome call, submitted through the Member Portal or through the mail after being received in the new member

Welcome Packet. If a member is identified as pregnant during the welcome call, we will complete a NOP form with the member at that time. HRS forms completed in hard copy or telephonically are entered directly into TruCare. GSHP will generate a weekly report identifying those members who indicated pregnancy on the HRS and conduct outreach to those members to enroll them in our Start Smart for Your Baby program.

Claims Data. GSHP will also use claims data to identify members who may be pregnant. We will reach out to members identified through this process to let them know about our Start Smart program and to encourage them to contact us to confirm pregnancy and complete the NOP form.

Encouraging Pregnant Members to Select a PCP for their Newborn. GSHP will implement programs and strategies to further encourage pregnant members to select a pediatrician or other PCP as a medical home for their newborn.

Start Smart for Your Baby. GSHP will implement Centene's successful Start Smart For Your Baby® (Start Smart) pregnancy program. Start Smart is a comprehensive pregnancy and postpartum management program, which incorporates the concepts of care management, care coordination, and disease management. Start Smart is designed to improve birth outcomes and infant health by focusing on early identification and risk screening, one-one-one care management, increased frequency of recommended pre- and post-natal care, member and provider incentives, and member education and empowerment.

For all pregnant members enrolled in our Start Smart Program, our key objectives are to extend their gestational period and improve their baby's birth weight; reduce the risks of pregnancy complications, premature delivery, and infant disease; and ensure a healthy first year of life for their newborn. In 2010, this program received the inaugural URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.

Upon confirmation of pregnancy, GSHP will mail pregnant members our Start Smart packet which will include a newborn PCP selection form. We will include instructions on how and when to select a PCP, and notify the member that if a PCP is not selected that one will be automatically assigned to the newborn.

Telephonic Outreach. For high-risk pregnant members that are engaged in our care management programs, selection of the newborn's PCP will be included in the member's care plan. The Care Manager will educate the member about PCP selection and encourage her to select a PCP prior to the third trimester of pregnancy.

Selection at Time of Delivery. In some cases, GSHP may not become aware that a member is pregnant until she presents for delivery. In these cases, a Concurrent Review Nurse will work with the member to encourage PCP selection upon delivery. This may occur telephonically through interaction with a hospital's case management staff or directly with the member at high-volume hospitals where GSHP may have an onsite ICT care manager.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.5 Member Services

GRANITE STATE HEALTH PLAN

3.5 Member Services

Accommodating Non-English Speaking Members

Q17. Describe how you will accommodate non-English speaking members in member services.

Overview of Member Services for non-English Speaking Members

Granite State Health Plan (GSHP) recognizes that although at a state level, New Hampshire is 94% Caucasian, there are communities around the state, particularly in Southern New Hampshire, that are experiencing growth in ethnically and culturally diverse populations, primarily due to refugee settlements. As newcomers to the United States and to the Medicaid program, providers often face challenges in providing care that is culturally appropriate and linguistically competent.

The Manchester Community Health Center (MCHC), a Federally Qualified Health Center (FQHC), for example, is located in one of the most diverse areas of one of the most diverse cities in New Hampshire, and serves an area that includes a refugee resettlement with a large Somali population. MCHC patients speak 60 languages at last count. Lamprey Health Care, an FQHC in Nashua also serves Somali refugees and its Newmarket location serves a sizable Laotian population. In addition, a significant percentage of the elderly population in rural Northern New Hampshire speaks French. For example, about 14% of the patient population of the Indian Stream Health Centers, located in Coos County, speaks native French.

Our member communications philosophy focuses on meeting members' needs in the most culturally sensitive manner wherever they live and for any type of care needed. GSHP will provide language access services to members through real-time, oral interpretation and translated, written member materials to accommodate the needs of people with limited English Proficiency (LEP).

Identifying Language and Communication Needs. GSHP will load any preferred language information from the DHHS enrollment file into our Member Relationship Management (MRM) system. Additionally, on the new member welcome call, staff will determine or verify members' preferred language and document or update it in the MRM system. This information helps us assist members in many ways including their selection of a PCP who speaks their preferred language.

Cultural Appropriateness. We will customize written member materials to ensure that they are geared toward the ethnicities within our membership and their specific health care needs, and are consistent with member cultures and local idioms.

Language Assistance Services for Members with LEP

GSHP Call Center. When members call GSHP's toll-free number, they will have an opportunity, to select their preferred language, including English, Spanish, or any other language that meets the 10% threshold for a major population group, to help prompt them to speak to a Member Services Representative (MSR) or obtain desired information available through automation. Members with LEP will be able to speak with bilingual staff or a staff member who engages a translator. Through our parent company, Centene, GSHP will have access to Language Services Associates (LSA), which provides interpretation for over 250 spoken languages. After regular business hours, callers will reach our 24/7 nurse advice line, NurseWise. Approximately 40% of NurseWise staff are bilingual in Spanish. When bilingual staff are not available after hours, NurseWise staff also will have access to LSA.

Accountability for Quality of Language Assistance Services. The Quality Specialist in the Member Services Department will evaluate interactions of Member Services Representatives (MSRs) with our members by monitoring 5-10 calls per MSR per month via our Call Witness audit tool. Call Witness records all call center phone interactions and retains a record of any applications that staff touch or use on their computer to resolve a call. We will also use Call Witness to monitor MSRs' interactions using translator services. We will similarly monitor calls involving bilingual staff. Our call audit criteria include evaluating the accuracy and effectiveness of the interaction, call documentation and overall customer service.

In-Person Services. GSHP will contract with interpretation agencies that provide in-person translation services for member during their appointments with health care providers and during home visits with GSHP's MemberConnections Representatives (MCRs), local health outreach workers, as needed. For member appointments with providers, we strive to ensure availability of **certified medical interpreters,** through the same interpretation subcontractor that provides call center interpretation services. We will maintain a list of certified medical interpreters who provide services on an as-needed basis, including for urgent and emergency care, when members or providers request such services.

Provider Education. GSHP will educate providers on how to schedule interpreters for member appointments. We will encourage providers to notate members' language preference in a prominent way on their medical record and to take the initiative in scheduling a translator, rather than assuming that members will arrange for a translator, by contacting the GSHP call center. We will emphasize to providers that members should not use family and friends, and especially children, to interpret—except on specific request by the member, after knowing that no-cost translation is available.

Member Education. GSHP staff who have direct contact with members also will educate members with LEP about the availability of interpretation services and how to use them so that they can take an active role in removing linguistic barriers to receiving timely health care services. For example, the preferred language designation captured in the MRM system member inquiry history, prompts call center staff to provide the type of member education that is most important and appropriate to each individual member with whom they speak. We also will educate members about the availability of interpretation services through the Welcome Packet, Member Portal, and Member Newsletters.

Recorded messages. GSHP's policies and procedures regarding member materials will also apply to reviewing and developing recorded scripts. On-hold messages and podcasts will be provided in English and Spanish, and include contact information if any translation or explanation is needed.

Written Materials for Members with LEP

GSHP will comply with all DHHS requirements relating to written member materials and for all distribution methods: print, web, advertising, or direct mail. Our Member Handbook, quarterly Member Newsletter, and other member materials will be available in English, Spanish, and other languages that meet the 10% threshold as required—as are other DHHS printed materials for residents seeking health and social services—and upon request in other languages. The GSHP Member Portal will include program content written in English, Spanish and the languages of any other Major Population Group in the service area. Additionally, in the hardcopy and online versions of GHSP's Provider Directory we will list which non-English languages are used by each provider. GSHP member materials will comply with all DHHS requirements.

Accountability for Compliance with Language Requirements. GSHP will submit complete, final drafts of all written materials to DHHS for approval, as required. Before submission, GSHP's Marketing and Communications Manager and Compliance Officer will review the materials for compliance with state and federal requirements, including but not limited to required content and accuracy; DHHS formatting standards, and quality of materials used for printing; readability and comprehension (see below) and cultural sensitivity, including "People-First Language" usage, which emphasizes the person, not the disability.[6] A well coordinated review process includes review by management staff in our Member Services and Provider Services, Medical Management, and Quality Management Departments, as appropriate to the content and proposed use of the materials.

Member Handbook. GSHP will submit a draft Member Handbook and Provider Directory for DHHS approval during the Readiness Review. Prior to the operational start date, GSHP will submit final versions of these and other written materials for DHHS approval. Upon DHHS notification and at least 30 days prior to the effective date of changes in covered services, GSHP will revise its Member Handbook and notify all existing members of changes within this timeframe.

Website. GSHP will maintain the most recent version of the Member Handbook on the member website. GSHP will indicate an updated version has been recently added with a highlighted "update" indicator along with a description of the items that have been updated.

Email. In the later part of 2012, GSHP will have the ability to send emails to members who have provided email addresses to GSHP. We will use these emails to notify members of Member Handbook updates in real time.

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[6] More information about People-First Language usage is available at http://www.thearc.org/page.aspx?pid=2523.

Within 90 calendar days of notice from DHHS, GSHP will translate and make available member materials in a DHHS-designated language when the population reaches the 10% threshold for a Major Population Group. At no charge to members, materials will be available in that specific language to assure a reasonable chance for all members to understand how to access GSHP and network providers, and use services appropriately, as specified in 42 CFR §438.10(c) (4) and (5).

Readability and Member Comprehension. All GSHP member materials will be in a style and reading level that will accommodate the reading skills of New Hampshire Care Management members. The writing will be at a sixth-grade or below reading level, as determined by the Flesch Reading Ease and Flesch-Kincaid Grade Level Index, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy.

When writing member materials, we write the way a person talks: we use a friendly tone, active voice, common words, and short sentences, and we provide examples when words might be confusing. We will include appealing graphic elements and culturally relevant illustrations to reinforce narrative in member materials. In addition, we will ask participants from our Member Advisory Council, Long Term Care/DD Member Advisory Council and Community Advisory Committee to review proposed materials and provide feedback on issues such as readability, clarity, and cultural sensitivity to local norms and expectations.

Language Translation. GSHP will notify members that written information is available in languages other than English and how to request it. On materials where this information is provided, including the Member Handbook, it will be noted in English, Spanish and other languages for populations that reach the 10% threshold for a Major Population Group. For all member materials translations, GSHP will use certified professional translator services such as Inlingua Translation Services, an international language translation and language and intercultural training organization with more than 40 years of experience, or ViaLanguage, a nationally certified, woman-owned enterprise. Both issue certifications of accuracy and completeness for each translation. GSHP also may engage local translators to translate or review specific materials.

Requests for Translation. We anticipate that most requests for translation will be made to our Member Services Representatives in our call center or to MemberConnections outreach staff who meet with members in their homes and the community. Requests entered in the MRM, as described above, alert Communications Department staff, who then order the specific materials, monitor timely production of them, and mail the materials to the member who submitted the request. The MRM system is then updated to indicate the mailing, which will trigger an alert to the appropriate staff (call center or MemberConnections) to contact the member to verify receipt of the materials and answer any questions.

Written Materials for Provider Offices. GSHP will provide member education materials in English, Spanish, and other languages, as required, to providers for their optional use in waiting rooms and offices. Provider Relations Specialists will educate providers on appropriate use of these member materials and encourage providers to post their own office signage in Spanish, and other languages, as appropriate.

Accommodating Members with Special Needs

Q18. Describe how you will accommodate members with special needs, including those who are deaf, visually impaired, persons with mental illness, or persons with cognitive impairments in need of additional assistance to understand information, in member services.

Overview of Services for Members with Special Needs

Ensuring that our members understand the services and benefits available through Granite State Health Plan (GSHP) and how to access them is vital to the success of New Hampshire's Medicaid Care Management Program. GSHP will build on the experience of other Centene health plans in developing and providing information and community resource referrals to members with any physical or cognitive impairment or mental illness regarding the use of equipment options and internet access, including the GSHP Member Portal. GSHP Member Services Representatives (MSRs) will respond to requests received through the Portal within one business day. Most member materials will be available on the GSHP website and Member Portal, which will be designed to be used by persons with vision or other impairments.

> For members with physical, cognitive or communication impairment, GSHP will use a best practice "stay on the line" feature, which will direct callers automatically to an MSR if the caller cannot press phone keys or determine how to respond to the menu options; the member simply **Stays On The Line** for this feature to activate

For members with a physical, cognitive or communication impairment, GSHP will use a best practice "stay on the line" feature, which will direct callers automatically to an MSR if the caller cannot press phone keys or determine how to respond to the menu options; the member simply stays on the line for this feature to activate.

GSHP will also provide home visits to explain benefits to members and/or their caregivers with special needs, through our MemberConnections Program, as described below in response to Question 25.

Additionally, GSHP will educate providers on options for improving communication with members with a physical impairment, including deafness, blindness, and/or cognitive impairment or mental illness.

Members with a Hearing or Speech Impairment. GSHP will draw on Centene's extensive experience in other states serving members with a hearing impairment. As with our affiliated health plans, GSHP will employ a local community member who has a hearing impairment to train our MSRs to use TTY (text telephone or telecommunications equipment for people who have a speech or hearing impairment). Training by a person who has a hearing impairment improves staff understanding of sign language conventions and etiquette distinctive to the use of TTY equipment. The TTY phone number is always listed in the Member Handbook and will be available in other materials including our website.

We also will use New Hampshire Relay, the State's portal to the nationwide 711 relay service. To use the relay service, considered a best practice, members dial 711 to reach a Communications Assistant. The member types in GSHP's toll-free call center number and the Communications Assistant establishes a connection between the member and the MSR and "relays" the confidential discussion back and forth between them. Members also have an opportunity to participate in the New Hampshire Telecommunication Equipment Distribution Program (NH-TEDP). This program was designed to provide free or low cost specialized telephones and accessories to qualifying individuals with hearing, vision, or mobility loss as well as those with cognitive and speech disabilities. MemberConnections Representatives (MCRs) can also help members access this and other resources as needed. Members without TTY equipment who do not qualify for the program usually ask a family member or friend who uses sign language to call the health plan while in the same room as the member, and to use sign language with the member while using voice-conversation with the Member Services Representative. MSRs can also arrange for a face-to-face interpreter to accompany a member to an appointment for covered services to communicate through American Sign Language for members with hearing impairment.

Members who are Blind or have a Visual Impairment. GSHP Member Services Representatives will be trained to use the Telebraille system offered by New Hampshire Relay for members who have a visual and/or hearing impairment. MSRs will offer alternative formats for providing information to members with a visual impairment or multiple impairments as well. GSHP will make all member materials available in formats accessible to the visually impaired as requested, including large print, Braille and audiotapes or CDs.

Members with a Mental Illness or a Cognitive Impairment. The rigorous review and approval processes of written materials and cultural sensitivity training that is part of all Centene health plans, as described above, is conducted to ensure that written and oral communications with Members Services Representatives is appropriate and effective for all of our members, including those with a mental illness or cognitive impairment as well. As needed, GSHP's Member Services Representatives will assist members with low literacy skills or difficulty comprehending materials. Additionally, Centene's Marketing and Communications Department includes staff who have taken health literacy training through organizations such as America's Health Insurance Plans, and this corporate expertise will be available to GSHP. We will also adopt best practices in member communications that our affiliate health plans have developed. For example, Centene's Ohio Plan used input from the local chapter of the National Alliance on Mental Illness (NAMI) to modify materials to be more understandable to members with serious mental illness.

Warm Transfer Calls. GSHP will follow a best practice of our health plan affiliates by allowing members to make one phone call to connect them to the person or persons they need to contact. This service is particularly helpful for members with mental illness or cognitive impairments and other special health needs. When a member calls Member Services and needs to be transferred to an outside entity, such as his or

> Granite State Health Plan's promise
> ***"One Call That's All"***
> Members need to call only **One** phone number and place only **One** call.

her PCP, the Member Services Representative (MSR) will "warm transfer" the call. This means that the MSR calls the appropriate individual for the member while keeping the member on the line and then verbally introduces the member to the new individual on the line to ensure continuity in making an effective connection. GSHP's promise is "One Call, That's All." Members need to call only one phone number and place only one call. **Because GSHP, NurseWise and Cenpatico, our behavioral health services affiliate share the same telephone platform, MSRs can easily warm transfer calls to ensure that callers are not lost or required to call a separate telephone number.**

Accountability for Quality of Member Services for Members with Special Health Needs. The Member Services Director will monitor MSRs' ability to handle calls from members with hearing or visual impairments through ongoing monitoring of reports on requests for TTY and New Hampshire Relay calls and monthly member grievance and appeals. The Member Services Director will immediately implement and monitor needed improvements, as they are identified, and report progress quarterly to the Quality Improvement Committee (described in Section 3.12). To ensure that our materials are culturally appropriate, understandable and meaningful to members, we will obtain input from two local Member Advisory Councils (MACs). One will be focused on members with special health care needs , the SHCN MAC will be comprised of members, parents/foster parents, guardians, medical consenters and caregivers. As with all written member materials, upon GSHP management's review and approval, we will forward documents to DHHS for review and approval. No materials will be sent to members before DHHS has approved them.

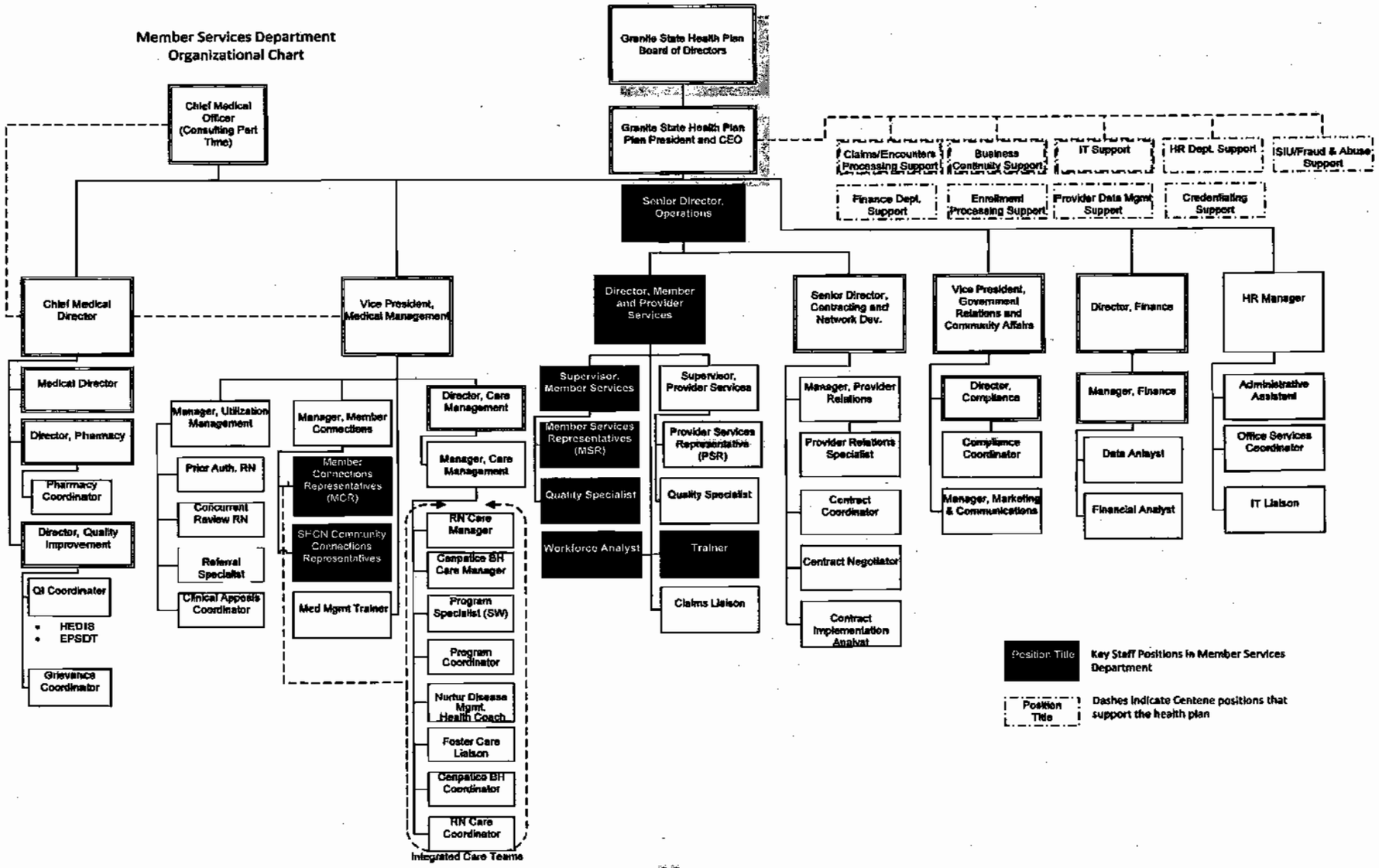
Organizational Chart

Q19. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the MCO's organization and showing the key staff within the Member Services Department.

Granite State Health Plan's Member Services Department organizational chart is shown on the following page. The position shaded in orange are the key staff within Member Services Department.

3.5 MEMBER SERVICES

GRANITE STATE HEALTH PLAN



Curriculum for Training

Q20. Describe the curriculum for training to be provided to Member Services representatives, including when the training is conducted and how the training addresses:

- ***Covered Services, including Behavioral Health Services and Community-based Long Term Services and Supports***
- ***MCO Program requirements***
- ***Special Populations, including those who are deaf, visually impaired, persons with mental illness, or persons with cognitive impairments***
- ***Cultural Competency***
- ***Providing assistance to Members with limited English proficiency.***

Member Services Training

GSHP will implement Centene's comprehensive training program designed to ensure that all Member Services Representatives (MSRs), as well as MemberConnections staff NurseWise staff and care managers are qualified, professional, and equipped to provide outstanding customer service to our members. GSHP's Member Services Department will conduct a four-week training program that consists of three phases: **Fundamentals**, which focuses on the common tools, techniques, and resources available to all staff members of the department; **Programs**, which provides a comprehensive review of Covered Services, DHHS program descriptions and requirements, populations served, and the provider network; and **Job Functions**, which targets the specific roles and responsibilities of MSRs, MemberConnections and NurseWise staff.

GSHP will provide written, auditory and computer based lessons, hands-on demonstrations, role-playing, and written and oral evaluations as part of its training modules. As with our affiliate health plans, Training Coordinators will conduct all training in a classroom setting supplemented by interactive learning management system modules on specific topics.

Fundamentals. The first phase of training will cover the following nine topics, some of which overlap with five topics of focus described below:

1. ***Customer Service Tools.*** Customer service and telephone etiquette; active listening; the Call Management System; the MRM inquiry tracking, documentation and workflow system; call routing/warm transfers to other areas such as Care Management and Prior Authorization; and coordinating three-way calls with our subcontractor for language translation.
2. ***Clinical.*** Prior authorization process; Care Management Programs.
3. ***Claims.*** Reimbursement models; claims review including filing requirements and guidelines; techniques to detect other insurance; resubmission and resolution processes; AMISYS Advance Claims Processing System.

4. ***Provider Processes.*** Credentialing and recredentialing; the medical home; GSHP's Provider Portal; provider complaints and appeals.
5. ***Secure Member Portal.*** Self-service features for members such as how to: order an ID card replacement; update demographic information; complete online health risk screenings or assessments; view the online Provider Directory; change PCP.
6. ***Subcontractors.*** Roles and scope of responsibility; interface protocols.
7. ***Legal.*** HIPAA and confidentiality of member information; detection and reporting of fraud, abuse and waste.
8. ***Resources.*** Internal Intranet site containing GSHP's policies and procedures, quick reference guides, information about statewide programs (such as WIC, fuel and food assistance programs), local community resources (such as homeless shelters and food banks), GSHP's Provider Manual, Member Handbook, and Emergency Management Plan.
9. ***Human Resources.*** GSHP organization structure; Ethics and Compliance; conflict resolution; quality improvement initiatives.

Programs. Understanding of the covered services and program requirements is a critical part of Centene's training protocols, including how to provide information and services that meet the needs of members with physical or cognitive impairments or have LEP in a way that is culturally competent.

Covered Services, including Behavioral Health and Community-based Long Term Services and Supports. The curriculum for covered services, including behavioral health (BH) and community-based long term services and supports (LTSS) will initially address the covered benefits, limitations, and related issues, including screening and preventive services; access to emergency services; indicators of possible behavioral health conditions, or crisis, and referrals to BH Clinicians; and coverage for urgent or emergent needs or complex conditions and referrals. This curriculum also covers Medicaid transportation services for getting to medical and BH appointments.

MCO Program Requirements. The curriculum on MCO program requirements is designed to ensure that new staff learn and will be able to retain their understanding of GSHP services and requirements and can accurately access and convey the information once they are on the job. Member Services Representatives must be proficient at helping members locate, select, and make appointments with providers; educate members about appointment timeframes for preventive, routine, urgent and emergent services; process member identification and demographic updates; make real-time PCP changes and fulfill ID card requests; and educate members on the availability of self service tools on the Member Portal. They must also be able to facilitate three-way calls to assist members with making doctor appointments, intake and document member complaints for referral to the Complaint Unit. Staff must understand the roles and responsibilities of the GSHP Pharmacy Department and US Script; the Formulary, including brand vs. generic coverage rules; and the pharmacy network including national chains and independent pharmacists. They must also learn to identify and guide members who may be experiencing difficulties obtaining or refilling prescriptions or need access to a 72-hour emergency supply of medications.

Special Populations. A central component of staff training for all employees will be Centene's own Disability Sensitivity Training, which includes topics on People-First Language, as described above; issues in health care utilization, types of disabilities, types of needs, using the TTY line, SSI eligibility determination, and the Americans with Disabilities Act; communicating with people with disabilities; and common misconceptions about people with disabilities. GSHP will provide training on how to identify and warm transfer calls to designated staff for members with special health care needs. In addition, we will collaborate with local organizations such as New Hampshire Developmental Disabilities Council to provide additional disability sensitivity training modeled on successful Centene health plan collaborations in other states. For example, our affiliated health plan in Mississippi collaborated with the Mississippi Coalition for Citizens with Disabilities to help train our MSRs on the impact of disability on members, using People-First Language, and viewing the health care system from a member's perspective. Our affiliated health plan in Ohio teamed up with Independent Living Centers, whose staff provided disability sensitivity training. Training also focuses on resources available for members with disabilities and addresses how to respond to members with hearing impairment through Relay New Hampshire.

Cultural Competency. GSHP will require *all* staff, regardless of role or responsibility, to complete our Linguistic and Cultural Competency Training Program upon hire, and annually thereafter. This training is based on the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). The training will address all 14 standards, as listed in Section 3.6 of the RFP. Training emphasizes the impact of culture on health care decisions; the employee's own culture and potential biases, including ethnicity and gender, and the impact of poverty on health, among other topics related to disabilities and LEP.

Training will also include, but not be limited to:

- Centene values and philosophy (diversity, cultural competence, how values and philosophy drive operations, how the cultural competence of operations influences health care utilization and outcomes, how the organization is structured to promote these values/philosophy, how staff are supported and held accountable for cultural competence)
- Community cultural characteristics and access patterns
- Ethnicity and culture (what they are and how they influence utilization of health care)
- Primary and secondary languages (languages our members speak, languages staff speak, accessing interpreters, using the Language Line, the unique skills needed to interpret in a health care environment)
- Alternative family forms
- Dealing with victims of mental/physical trauma
- Professional and respectful phone etiquette
- Working with providers to assist members, such as languages offered and how to help members and providers communicate effectively.

Assistance to Members with Limited English Proficiency. Our training for assisting members with LEP focuses on coordinating three-way calls with Language Service Associates, our interpretation and translation contractor for languages other than Spanish; helping members identify providers who speak the member's primary language, via the hardcopy Provider Directory or Interactive Directory on our Member Portal; responding to callers with hearing impairment through Relay New Hampshire; and providing hardcopy materials such as the ID Card or Member Handbook in the member's primary language. MSR training also includes "warm transferring" members to MemberConnections Representatives, who arrange for face-to-face or telephone translation services for medical and BH appointments through our interpretation and translation contractor. Training also emphasizes linguistic barriers and resources for members with LEP or low literacy.

Job Functions. Near the conclusion of the third phase, trainers will introduce "hands on training" through involvement in real-life and real-time situations for our MSRs and NurseWise staff, and conduct "shadowing", during which they observe new staff members' techniques and competency, and provide guidance and coaching. The duration of shadowing depends on the skills and confidence of each new staff member, who must demonstrate proficiency prior to graduating from the program and independently performing his or her job. Trainers and Quality Specialists begin call monitoring of MSRs via our Call Witness application, described in response to Question 17 in this section.

Coordinating Current Operations with Health Plan Call Center

Q21. Describe how you would coordinate the current New Hampshire call center operations with your call center. Describe your proposed transfer protocols.

GSHP Call Center Coordination with New Hampshire Call Center

GSHP will have the capacity to coordinate our call center with the existing DHHS member services call center. As described in the RFP, this service will continue to operate for the Medicaid fee-for-service program. Each time a Member Services Representative (MSR) identifies during a call that a member needs to contact the DHHS call center the MSR will assist the member in reaching the appropriate customer service line through a "warm transfer," as describe in our response to *Question 18*. This means the MSR will stay on the line until the member is connected to the appropriate party. Call transfers to the New Hampshire call center or any other state or city organization can be conducted as a warm transfer. Before making the warm transfer, MSRs will ask callers if they would like to be connected directly to DHHS or another organization. If the caller only wants information, the MSR will simply provide the information requested. Additionally, we expect to establish a close relationship with DHHS to collaborate in continuously improving our linkages with the State's operations.

Experience Operating Call Centers

Q22. Describe your experience operating member call centers. Provide details with regards to the following metrics from your other operations:

- ***Average call answer time***
- ***Call abandonment rate***
- ***Representative to member ratio***
- ***Average call length***
- ***Interpretation services you are currently providing***

Centene Health Plan Call Centers

Granite State Health Plan's (GSHP's) parent company, Centene, has established a member call center in each of the 13 states with existing health plan affiliates, serving over 1.6 million members. Over its 27 years of experience in full-risk Medicaid managed care, Centene has developed policies and best practices to ensure our call centers meet high standards of professionalism, responsiveness and sensitivity to our members. If for any reason we do not meet our performance standards during a given month, we immediately identify the root cause and address the issue with the appropriate staff or through process or technology enhancements. GSHP will follow this practice.

[redacted]

Over the past year (October 2010 through September 2011), Centene answered nearly 2.6 million calls from members and providers. Approximately 1.8 million of those incoming calls were from members. We are pleased to report that performance at every one of our call centers met or exceeded established call center performance standards. For this same period (October 2010 through September 2011) average speed to answer was 16 seconds for incoming member calls and call abandonment rate for incoming member calls was 1.6%.

Average Call Answer Time, Call Abandonment Rate and Average Call Length. All of Centene's affiliated health plans have a call abandonment rate well below the maximum allowable rate of 5% for the New Hampshire Medicaid Care Management Program; our corporate standard is 4%. Average speed of answer is also well below 30 seconds for all health plans operational since at least January 1, 2011, as shown in the table below. Centene's call center standards also require 99% of calls to be answered by the fourth ring, and no busy signal—ever.

The average call length in minutes is also presented below. We do not impose maximum call duration times; instead, we focus on a high-touch, personal experience for members that reflects our dedication to addressing the unique needs of the Medicaid populations we serve. As often as possible, Member

Services Representatives (MSRs) will spend the time that it takes to resolve members' issues on their first call.

Centene's focus on customer service ensures a smooth transition into Medicaid Managed Care in new health plans, as will be the case with GSHP. For example, our affiliated health plan in Kentucky, which began operating in November 2011, averaged 7 seconds for answering speed and had a 0.69% abandonment rate for member and provider calls combined in November 2011.

Table 4. Call Center Performance Statistics for Centene Health Plan Affiliates, Jan. 1 – Nov. 30, 2011

Absolute Total Care (SC)	:00:14	1.29%	4:17
Bridgeway (AZ)	:00:10	2.45%	1:49
Buckeye Community Health Plan (OH)	:00:11	1.72%	3:39
CeltiCare Health Plan (MA)	:00:06	0.71%	4:56
*IlliniCare Health Plan (IL)	:00:21	3.7%	4:26
*Kentucky Spirit Health Plan (KY)	:00:07	.66%	6:02
Magnolia Health Plan (MS)	:00:10	2.00%	3:39
Managed Health Services (IN)	:00:15	1.76%	3:57
Managed Health Services (WI)	:00:22	2.74%	3:46
Peach State Health Plan (GA)	:00:14	1.56%	4:28
Sunshine Health Plan (FL)	:00:12	0.99%	3:56
Superior Health Plan (TX)	:00:20	1.61%	3:27

*** Illinois operational in May, 2011, Kentucky Operational in November 2011**

To further illustrate our member call center operations, particularly for call center staff to member ratios, we describe our experiences with Superior Health Plan (Superior), an affiliated health plan in Texas, which has Centene's largest enrollment in a Medicaid/CHIP managed care contract, as of January 1, 2011. Membership in Superior includes Medicaid TANF and CHIP members in the "STAR" program (primarily children and pregnant women) and Medicaid foster care children, all served through the El Paso, Texas, call center; and Medicaid Aged, Blind, and Disabled (ABD) members

(primarily adults, including dually eligible members) in the "STAR+PLUS" program who are served through our San Antonio, Texas, call center.

Member Service Representative to Members Ratios. Superior Health Plan developed a Member Service Representative (MSR) call center staffing model of one full-time equivalent (FTE) per members based on years of data analysis from other affiliated health plans. The model factors in call duration; call patterns, including seasonal variation; population characteristics; and MCO program features that drive our scalability planning.

STAR+PLUS member calls are typically longer in duration than other types because Superior is serving members who have disabilities, chronic conditions, and often comorbidities, including behavioral health conditions, that may impact their communication abilities and style. In addition, STAR+PLUS MSRs manage dual and nondual eligibility and coordination issues within a complex benefit structure. The MSR (FTE) per members ratio for this program is 1:3000.

Calls from members in CHIP, although not as long in duration as STAR+PLUS calls, are more complex than STAR (Medicaid/TANF) calls due to the various CHIP benefit limits (such as DME for children and distinctive Perinate provisions), copays, and specific claim filing rules. For Superior's CHIP members, the MSR to members ratio is 1:11,000, and for STAR members, the ratio is 1:15,000.

Our health plan affiliates use a variety of indicators and tools, including, but not limited to performance standards, FTE to members ratios, and marketing data to establish appropriate call center staffing levels, and to monitor performance. During the initial months of an expansion of Medicaid managed care, we will have relatively higher staff levels to meet the initial high volume of member calls typically encountered during implementation. Approximately 90 days after the operational start date, call volumes usually level off and mirror call volume trends of established programs. GSHP will follow this model.

Interpretation Services Provided. As described in our Question 17 response, all of Granite State Health Plan's affiliated health plans, operating in 13 states, have access to Language Services Associates, which provides interpretation services in over 250 spoken languages. After hours, callers reach Centene's 24/7 nurse advice line, NurseWise, which also has access to the same service; approximately 40% of the NurseWise staff are fluent in Spanish. Each affiliate's Call Center and NurseWise have staff who are bilingual in Spanish.

In 2010, Centene health plan affiliates provided 31,054 phone interpretation services in 82 languages. The number of member service calls that included interpretation services, by health plan, are shown below.

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Table 5. Centene Health Plan Affiliates' Phone Interpretation Services, 2011

Absolute Total Care Health Plan	138	1,343	9.2
Bridgeway Health Solutions	99	908	8.7
Buckeye Community Health Plan	735	6,527	8.4
Celticare Health Plan	3,650	36,068	9.4
Cenpatico (Behavior Health affiliate)	883	8,010	8.6
*IlliniCare Health Plan	2,285	28,965	12.2
*Kentucky Spirit Health Plan	176	1,988	10.8
Magnolia Health Plan	342	3.330	9.2
Managed Health Services (IN)	771	10,385	13.0
Managed Health Services (WI)	1054	9,988	9.2
NurseWise (Nurse advice line)	16,980	221,726	12.6
Nurtur Health (Disease Management affiliate)	6,392	84,171	12.7
Peach State Health Plan	1,874	22,179	11.3
Sunshine State Health Plan	2,413	23,408	9.2
Superior HealthPlan	2,630	29,487	10.7
Total	**39,539**	**477,146**	**10.47**

Anticipated Call Center Operation

Q23. Describe your anticipated call center operation for the New Hampshire plan, including: location of operations (if out of state, describe how it will accommodate services for New Hampshire)

GSHP Member Call Center Operations

Overview. Granite State Health Plan's member call center will be located in the Concord/Manchester area. Our hours of operation will be 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

Additionally, to assist with mitigating risk such as weather-based closures or high volume upon start-up, Centene, our parent company, has adopted a virtual call center design that seamlessly integrates call center capabilities across multiple offices in an enterprise-wide Automatic Call Distribution system. This system allows immediate management of geographically dispersed call center resources. Staff can log in from any office, statewide, or even nationwide under certain circumstances. One unified voice messaging system serves the entire organization so that messages can be sent or retrieved by any user at any office. If a center is experiencing extremely high call volume, or needs to close for an emergency, staff in other centers can log into those queues to answer calls. This technology proved its value when Hurricane Ike forced closure of our Corpus Christi and Houston offices in 2008. We rerouted calls to ensure prompt, uninterrupted customer service.

GSHP's call center, nurse advice line, NurseWise, and behavioral health (BH) care affiliate, Cenpatico Behavioral Health (Cenpatico) will ensure sufficient access to local and toll free lines, and a call distribution and monitoring system to meet member and provider needs 24 hours per day for consultation or referral from trained, knowledgeable staff. Both Cenpatico and NurseWise are URAC accredited.

Member Hotline. The GSHP member call center will provide 24/7 access to a MSR or NurseWise staff member, as described above. This toll-free line enables a member to speak to a live person, without ever having a need to leave a recorded message. For the brief time a caller may be on hold, the call center line will provide callers with instructions about what to do in case of an emergency.

Our member call center will share the same call management platform as NurseWise and Cenpatico to enable seamless, efficient call answering and transfer capabilities and reporting. If calls are referred to a clinician with medical or BH expertise, the call is documented in the nationally recognized care coordination and clinical documentation system TruCare. TruCare archives all clinical contacts with a given member in a single place.

Our phone technology allows "warm transfers" (with the three parties on the line) to any phone number; thus, Member Service Representatives (MSRs) will be able to connect members directly, even to external organizations like the local WIC office, so that members will not be asked to hang up and redial. As affiliates, NurseWise and Cenpatico have policies and procedures on staffing, hours of

operation, training, performance standards and quality and compliance monitoring that are compatible with GSHP's.

Standards. GSHP will ensure that 90% of callers reach a live voice within 30 seconds; incomplete calls or abandonment rates should be no more than 4%; a 99% pick up by 4th ring is required; and, callers should never experience a busy signal. We will not impose maximum call duration times, and instead focus on a high-touch, personal experience for members that reflects our dedication to addressing the unique needs of the high-needs Medicaid populations we serve.

Staffing Ratios. When GSHP becomes established, we will follow the same process for determining initial staffing ratio for the call center during the first 90 days of operation and developing staffing levels for normal operations, as described earlier in response to Question 22.

Process to Ensure Proper Handling of Immediate Medical Needs

Q24. Describe the process in place to ensure that member calls pertaining to immediate medical needs are properly handled.

Properly Handling Members' Immediate Medical Needs

GSHP Member Services Representatives (MSRs) are trained to recognize a member's urgent medical and behavioral health (BH) needs and to follow clear protocols to promptly address them. **During all calls, MSRs listen for key emergency words and phrases, member voice volume and tone, and other indicators of stress. If necessary, the MSR will dial 911 for the member while keeping the member on the line.**

For both urgent and non-urgent matters, MSRs have immediate access to physical health and BH clinicians, who are part of the Medical Management Departments of GSHP or Cenpatico. The MSR warm-transfers each call, staying on the line until the next staff person takes the call, and introduces the member and the issue to the second staff person. If the member needs an appointment for urgent care within one day, the MSR will offer to assist in making an appointment with the provider. A member never has to call a second number and is never dropped into a call queue for routing. MSRs are trained to treat members with respect and dignity and to maintain their privacy.

To serve members after-hours, NurseWise staff are similarly trained to listen for indicators that a member is experiencing a medical or BH crisis. In such cases, a NurseWise staff member will immediately warm-transfer the member to a Registered Nurse (RN). The RN will handle the call using nationally approved protocols to determine whether to refer a member for emergency or urgent care services. For urgent or emergent issues, the RN warm-transfers the member's call to 911 or directs the member to an appropriate health care facility, whether or not the member is in the service area.

Each morning NurseWise clinical staff will provide GSHP staff with summary reports indicating any follow-up needed during business hours. For example, Medical Management staff would immediately contact the appropriate provider in the case of a hospital inpatient admission through the Emergency Room (ER). For routine matters, RNs advise on care within established written, clinical guidelines, often avoiding the need for ER care.

Plan for In-Person Member Services Availability

Q25. Describe your plan for in-person member services availability, if any.

- *Location(s)*
- *Services provided*
- *Accommodations for special needs populations*

GSHP's In-person Member Services

Granite State Health Plan's parent company, Centene, has developed an innovative service, called **MemberConnections**® that is available to all affiliated health plans. MemberConnections Representatives (MCRs) are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. Through GSHP's MemberConnections Program, we will provide a high level of in-person interaction in providing information about member services, or as part of care management with an Integrated Care Team, as needed. MCRs receive comprehensive training and become an integral part of our Integrated Care Teams, which increases their effectiveness in reaching members and promoting positive healthy behaviors, particularly those with special health needs for whom reaching or communicating by telephone is difficult, even with telephone-enhanced equipment and services. To address the specific needs of our members with disabilities, we have created a position to focus on Special Health Care Needs (SHCNs). The SHCN Connections Representative will work with our members with SHCNs and/or their caregivers to ensure they are receiving the supports needed from the health plan, social services and their providers.

MemberConnections Representatives are Health Outreach Workers hired from Within the Communities We Serve to Ensure our Outreach is Culturally Competent and Conducted by People Who Know the Unique Characteristics, Demographics and Health Needs of the Local Area.

MCRs will make home visits to members with special needs and to other members that we cannot reach by phone. MCRs will assist with member outreach, coordinate with social services, and attend community functions to provide health education and outreach. MCRs will be available to make in-person visits to members across the entire geographic services area.

As part of our commitment to New Hampshire's Care Management Program and to optimally serve our members with special health care needs, we will co-locate Integrated Care Team RN Care Managers into Community Mental Health Centers (CMHCs) to assist members in facilitating access to physical health services and supports in the community. We will also co-locate RN Care Managers within our provider partner Bi-State Primary Care Association FQHCs to augment the services they already provide, and to offer another level of coordination back to the health plan.

Members with LEP. As described earlier, in response to Question 17 in this section, GSHP will contract with interpretation agencies that provide in-person translation services for member appointments with health care providers and home visits with MCRs. GSHP will maintain a list of certified medical interpreters who can provide in-person services on an as-needed basis, when members or providers request such services.

Consumer Advisory Board

Q26. Describe how you will develop, engage, and utilize a consumer advisory board.

Overview of Consumer Engagement in Granite State Health Plan

Consumer engagement is a resounding theme across all of Centene's affiliated health plans. GSHP will continue to demonstrate the Centene commitment to providing services that offer the greatest value to our members. Consumer input comes directly from consumers and indirectly through advocacy and other community agencies that provide services to their members. We will emulate the best practices of our affiliate Centene health plans by soliciting and acting on consumer input both formally, through advisory committees, and informally, through analysis of and reaction to consumer input we receive during the normal course of our operations.

Our quest to solicit consumer input will begin prior to our operational effective date and continue throughout our participation in the New Hampshire Medicaid Care Management Program.

Member Advisory Council and Community Advisory Committee

Development. Rather than a single consumer advisory board, GSHP will follow the best practice of other Centene health plans by developing both a Member Advisory Council (MAC) and a Community Advisory Committee (CAC) to serve as mechanisms for GSHP to solicit input regarding our operations in the Medicaid Care Management Program (See Section 3.12 response to Question 68 for a description of each). The MAC will be comprised of members, family members, and other caregivers who are randomly selected in accordance with the Managed Care Reform and Patient Rights Act. In Step 2 of the Medicaid Care Management Program, GSHP will start a separate MAC for the Special Healthcare Needs population including those with developmental disabilities and needs for home and community based services (HCBS) and Long-Term Care Services and Supports (LTCSS), separate from the TANF/CHIP/Foster Care population, due to the vast differences in the needs of these populations.

The CAC will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. For example, we have met with New Hampshire-based **Community Support Network Inc. (CSNI) and Easter Seals of New Hampshire, and both have committed to serve on our Community Advisory Committees.**

Engagement. The MACs and CAC will provide feedback to GSHP's Performance Improvement Team (PIT), which reports to the Quality Improvement Committee (QIC). Feedback is intended to be from a member and community perspective, and may include but not be limited to: recommendations for program enhancements, identification of key program issues that may impact community groups, input on service improvements, guidance on effective approaches for reaching members, and other member-related issues. The MAC and CAC will review member and provider satisfaction survey results; evaluate performance levels and telephone response times; review member education materials for relevance, understanding and ease of use; and evaluate access and provide feedback on issues as requested by the QIC. To ensure cross-departmental coordination and integration of this input into QI processes, QI staff will organize meetings, distribute materials to participants, and coordinate post-meeting follow-up activities. The Member Advisory Council will meet in-person quarterly, and regional forums will be convened twice a year during Step One.

MAC and CAC Orientation and Training. GSHP will provide orientation and ongoing training for MAC and CAC members to ensure they have adequate information and understanding to fulfill their role on the Council. At these orientations, GSHP will provide and review the Member Advisory Council Plan and Community Advisory Committee Plan, including the schedule of meetings and our goals for the Council. We will include member perceptions in the development of our goals and submit the plan to DHHS within 30 days of contract execution and annually thereafter. Centene values the collaborative relationships we establish with our State clients and GSHP will include DHHS in any correspondence to the Council including the agenda and minutes. We will also post all agenda and minutes on our GSHP website. GSHP will inform its members and community stakeholders about the Council and Committee, respectively, through various materials such as the Member Handbook, Member Newsletters, and through contacts at community events. We will also make information about the MAC and CAC available on the GSHP website.

Utilization of Feedback. Based on input from the Council and Committee, staff from our Member Services Department and other departments, as appropriate, will make necessary changes. These changes may include staffing adjustments, revision of a policy or process, or revision of member materials to ensure that they are easily understood and relevant to the populations we serve.

Approach for Ongoing Member Communication and Outreach

Q27. Describe your approach for ongoing member communication and outreach.

Ongoing Member Communication and Outreach

All Granite State Health Plan (GSHP) employees and subcontractors recognize that a critical factor to the success of the New Hampshire Care Management Program is members' understanding of program benefits and requirements. This includes knowledge of GSHP operations and its organization; available services; how to access care; member rights and responsibilities (including advance directives); and any copayments, premiums and fees required of members. A clear and easily accessible member education program is vital to achieving the State's goals and assisting members with attaining the best possible health outcomes. GSHP will continue to take a comprehensive approach to developing and maintaining an effective member education program, which will include, but not be limited to the following components:

- In-community education provided by our **MemberConnections Representatives (MCRs)**
- Development of comprehensive member education materials such as our **Member Handbook, Provider Directory, Member Newsletters**, and other written materials
- **New member education** including New Member Welcome Calls, and new member education/health screenings that MSRs will provide
- Education provided by our knowledgeable Member Services Representative (MSRs) when a member calls the **local Member Call Center**, supported by our Member Relationship Manager (MRM)
- Information provided through the GSHP website and all the educational features of our **Member Portal**
- Ongoing education provided to members enrolled in our **care management** programs
- **Community outreach events**, such as our Healthy Lifestyles Program and those provided with community partners such as FQHCs, CMHCs and RHCs.
- **NurseWise**, our 24/7 nurse advice line, which allows members to speak to a registered nurse and ask health-related questions. NurseWise also provides guidance to members related to emergent and urgent care and can help facilitate access to appropriate services.

Member Identification Card. A member's identification card is a vital tool in obtaining access to services and health information. GSHP will issue each member an ID card that includes all of the six minimum information elements listed in Section 3.5 of the RFP. The Member ID card will include a 24/7 toll-free number to reach our call center and nurse advice line after hours. We will reissue a member's ID card after a change in PCP, a name change, or when other information changes, or upon request, when a member reports a lost card.

Marketing. GSHP will follow all DHHS and federal requirements related to marketing, as defined in Section 3.5 of the RFP, to ensure that a potential enrollee has accurate and oral written information to make an informed decision about enrollment. We will not directly or indirectly conduct door-to-door, telephonic or cold call marketing. GSHP will consult with DHHS and the Medical Care Advisory Committee when reviewing and approving marketing materials.

Transparency of Operations. GSHP provides education to our members either directly through one of our affiliate subcontractors such as Cenpatico Behavioral Health, LLC® (Cenpatico), OptiCare Managed Vision® (OptiCare), NurseWise, Nurtur Health Inc. (Nurtur) or non-affiliated subcontractors for transportation, radiology or other services, which GSHP closely manages. All contractors provide outreach and education to members on behalf of GSHP and clearly identify themselves as working for GSHP. Any educational materials used by GSHP subcontractors are developed in collaboration with GSHP, will be approved by DHHS, and comply with State requirements.

Our goal in every member contact is to ensure that members can reach GSHP staff easily and quickly, and that their questions are answered correctly and compassionately. GSHP provides one toll-free Member Services telephone number to its members for all programs and lines of business. When a member telephones GSHP, the member may select prompts to route the member to a subcontractor, but this routing is invisible to the member. This approach is simple for members and ensures that GSHP has direct oversight of all education and outreach functions. We consider every member contact to be an opportunity for outreach and education, thus promoting member empowerment.

Development of Comprehensive Member Education Materials. Centene has extensive experience in developing member information and education materials that GSHP will draw on for its members. We will develop disease-specific information to meet the educational needs of our members and materials that focus on promoting preventive health and general program understanding. All member materials will be developed with the input of DHHS, GSHP providers, GSHP committees, employees (based on interactions with members), members or other stakeholders, as described in Section 3.12 Care Management in response to Question 68.

As described above, in response to Question 17, member materials are written at a sixth grade reading level or below, with appealing graphic elements. Materials are culturally relevant and produced in required languages and alternate formats (e.g., Braille, large print, on audio tapes) upon request. We include footers on most of our member materials to advise members to call us if they need the information in another format.

GSHP notifies members at least annually of their right to request and obtain another copy of member materials via the *Healthy Moves* Member Newsletter and on-hold messages. GSHP prints materials in English and Spanish, or other languages based on the demographics of our population and DHHS direction. Should additional language translations be required, GSHP will make them available.

We also inform GSHP members, in writing, of any program or other change that might affect a member's access to services or benefits at least 30 calendar days before the intended change. State-approved notices are developed and distributed as necessary.

Ongoing Education. GSHP will continuously explore and evaluate the most effective ways to communicate health education information to our membership. We will employ many tools and services to provide and support ongoing member education, including but not limited to our:

Member Services Helpline. Members will be able to call our toll-free helpline with any questions about GSHP, the Care Management Program, their benefits and how to access them. Our knowledgeable local MSRs will use that member contact as an opportunity to provide education.

Member Portal. GSHP will offer members a user-friendly website to access content specifically developed to educate our members and providers on a wide range of up-to-date administrative, medical and wellness topics (also see below).

Care Management Programs. GSHP will encourage members with special health care needs and chronic or complex conditions to enroll in our care management programs, which will provide an opportunity to educate members and their families about their condition(s) and approaches and options that can help them manage their condition and support their own health and wellness goals. Though we enroll all of our pregnant members into our Start Smart for Your Baby® (Start Smart) program—for which care managers educate pregnant members about the importance of prenatal care, and provide ember-specific guidance designed to help ensure a healthy birth outcome—members with a high-risk pregnancy will obtain additional services and support from our Maternal Child Health Integrated Care Team.

Community-Based Member Outreach and Education. GSHP will develop community-based member outreach and education programs to meet members where they are, and provide multiple venues through which they can receive the information they need to make informed health and wellness choices. Through our **Healthy Lifestyles Program** (Healthy Schools, Healthy Homes, and Healthy Congregations), as described in Section 3.12, in response to Question 71, we actively promote healthy lifestyle activities related to disease prevention and health promotion. GSHP will co-sponsor a wide variety of community outreach and education events throughout New Hampshire, such as health fairs, educational events, and prevention screenings, which we call "Health Check Days," which allow us to provide in-person education to our members and the community.

Periodic Member Communications. GSHP will send quarterly Member Newsletters and targeted mailings on preventive care and wellness to at-risk members, such as those enrolled in care management programs. A wide variety of periodic educational materials will also be available on the Member Portal and through Helpline phone queue messaging. As part of our Quality Improvement Program we will also send preventive health reminder postcards for services such as well woman exams, well child visits, and diabetes screening tests.

NurseWise Nurse Advice Line. GSHP members can call NurseWise with any question related to their health, including urgent and emergent situations. NurseWise will provide guidance to members experiencing a potential urgent or emergent situation, and will help facilitate access to the appropriate care setting.

Maintaining an Effective Member Education Program. As part of GSHP's Quality Improvement Program, we will annually review all member educational initiatives and materials (or more frequently if necessitated by a program change) to ensure that our approach is effective, and the content of our materials (in all published languages) is accurate and not misleading or confusing to members. Member feedback is solicited during all member interactions to help us identify where we can improve service delivery. For example, during outbound outreach calls, MSRs will ask members if any materials they received or any information that was communicated during the call was unclear or confusing. The GSHP staff member documents the results of each call, noting any opportunities for member education, policy changes, or process improvements. GSHP also evaluates member satisfaction data (inquiries, complaints, grievances, appeals, CAHPS results, GSHP-administered survey ratings, etc.) to identify opportunities to improve the clarity of educational information, materials, programs, policies, or other aspects of our plan with members.

Internet and Social Media Programs

Q28. Describe your strategy for use of internet member services and other social media programs.

GSHP Website and Member Portal

Granite State Health Plan's (GSHP's) website and secure Member Portal will be specially created for GSHP's New Hampshire Medicaid Care Management members. The website will leverage the expertise of our parent company, Centene, in design, development, integration, implementation, and operations. We will configure the GSHP website to be consistent with DHHS standards and other applicable State laws. The GSHP website will provide user-friendly accessibility to content specifically developed to address our member population. Written content will be available in English, Spanish and the languages of a Major Population Group, defined as reaching a 10% population threshold. The website will contain general information about GSHP, including basic information on eligibility and benefits, information about our provider network, contact information for reaching member and provider services and information about how to file a complaint and how our appeals process works, as well as access to our secure Member Portal, described below. (For information on our Provider Portal and the administrative and clinical functionality we make available to providers, see Section 3.8 in response to Question 36.)

Member Services: The GSHP Member Portal. Our secure GSHP Member Portal will offer GSHP members a variety of informational tools to support their health care needs, including an interactive provider directory. There will also be preventive services and "care gap alerts," wellness reminders, and health information specific to the member. The Member Portal will also provide self-service* support tools such as the ability of the member to choose or change their PCP online, print a temporary ID card, exchange secure messages with our staff, and manage their Member Portal web account information and preferences. Our Member Portal enables our members to access secure,

interactive, member-specific content supplied through our Enterprise Data Warehouse and other supporting business applications.

Figure 1 displays a graphical depiction of the secure interfaces and data content that will support our Member Portal. At the center of this figure is a logged in member "landing" page with access points to other member-specific "transactional" information sources and access to other secured sites.

Immediately below this figure, in Table 3, we list the planned capabilities for our Member Portal, with itemized references corresponding back to Figure 1.

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Figure 1. Granite State Health Plan (GSHP) Member Portal

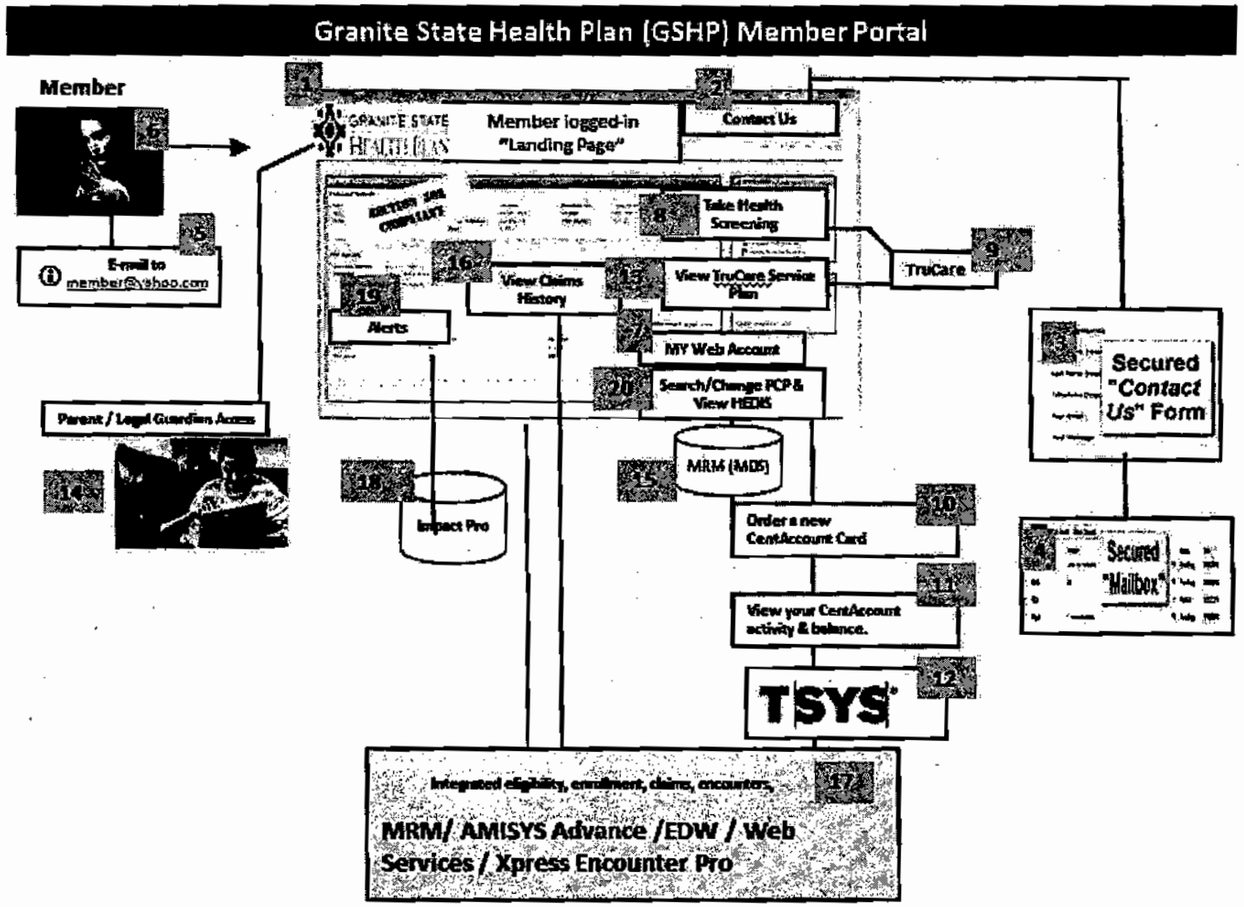

Table 1. GSHP Member Portal Features

Feature	Capability and/or Informative Content
Information	
Plan Information for Members (Item 1 in Figure 1)	All of our Portals provide *engaging health plan* information, displayed in a well-structured manner, and are easy to navigate. We will post our Member Handbook; covered services information; member privacy rights and other member rights and responsibilities; grievance and appeals procedures; contact information; and frequently asked questions and answers. We will also post plan notices, policy changes, and new program information. The main page will also display important contact information including our toll-free customer service Member Call Center telephone number, and TTY (text telephone) number, and a toll free number where current or potential enrollees can call with their questions. For questions about Medicaid eligibility, we will also provide a link to DHHS's website and toll free number.
E-mail Communications, Contact Us and Secure Messaging (Items 2 , 3, 4, 5, and 6 in Figure 1)	Members and visitors to the Portal will be able to fill out a contact form online with a question and phone number as well as an e-mail address (optional) for the response. The secure Member Portal will have secure messaging capability behind the member's login. By having the "Contact Us" function available *after* login to the Member Portal, we can offer members "e-mail alert" functionality. At the member's option, when GSHP responds to the member's Contact Us query, an e-mail alert will be sent to the member's e-mail address with a notice that his/her query has a response from GSHP. The e-mail alert will contain a link back to the GSHP Member Portal, allowing the member to log in to the Portal and view the GSHP response. This function will provide significant tools to GSHP's member outreach and education capabilities. For example, GSHP will be able to e-mail members and request that they log in to the secure Member Portal and retrieve important member-specific health information related to gaps in care. Further, the portal will provide an "inbox" and "outbox" so that a member can securely send and view messages to and receive messages from GSHP while logged in to the secure Portal.

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Feature	Capability and/or Informative Content
My Web Account (Items 5 , 6 and 7 in Figure 1)	We will provide personal Web Account administrative capabilities for our GSHP Member Portal. Members will be able to change their Portal registration information and preferences, such as e-mail and password, and set their preferences for e-mail alerts. E-mail alerts allow the member to receive an e-mail notice at his/her designated e-mail address that certain information is available for the member. These e-mails will not contain any Protected Health Information (PHI), but will have a link for the member to log in to the GSHP member portal to view the information. If a member would like to receive e-mail alerts but needs assistance with setting up an e-mail account, our Member Services Representatives (MSR) will assist members with setting up a free e-mail account with a major supplier (e.g. Yahoo, Google), and offer advice on ensuring that such an account does not inadvertently block GSHP e-mails (e.g., "spaminator" settings).
Wellness	
View CentAccount Status (Items 11 and 12 in Figure 1)	GSHP's CentAccount Program promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors. The CentAccount Program uses industry-leading technology to restrict card purchases to health care related items. Centene provides our members the ability to view their CentAccount incentive status by accessing, through the Portal, on the TSYS Member Portal. TSYS is our second-tier subcontractor for our existing CentAccount™ Program. Our members will thus be able to track their CentAccount activity and their award status via this secure link to the GSHP content hosted on the TSYS Member Portal.
Health Podcasts (Item 1 in Figure 1)	We will offer topical podcasts for members to download and listen to at their convenience. Topics may include areas such as: <u>Start Smart for Your Baby®</u> First Year of Your Baby • Taking Care of Your Baby • How to Get Help • Taking Care of You • Summary – First Year <u>Diabetes Management</u> • Part 1 – Get Started • Part 2 – Be An Active Member • Part 3 – Take Care • Controlling for Life
Local Health Content & News (Item 1 in Figure 1)	Our Portal will contain a variety of health education literature and messages, including, but not limited to: activities for kids, community events, a member blog and Member Newsletters.
Care	

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Feature	Capability and/or Informative Content
Online Health Risk Screen Member Gaps In Care (Items 8 , 9, 18, 19, 5 and 6 in Figure 1)	GSHP members will be able to complete the GSHP Health Risk Screen on our Member Portal. All information collected on the HRS will automatically be populated into our TruCare health services management system. TruCare will be used by GSHP clinical staff to support case and care management, disease management, and utilization management activities. Once HRS data is electronically imported into TruCare, this data will automatically be available to our Centelligence™ Foresight (Foresight) Predictive Modeling application. Foresight will analyze HRS and other clinical data, such as from claims, to identify any potential member gaps in care or in preventive services. Our Member Relationship Management system (MRM) will indicate that an HRS was completed for the member. MRM is our integrated member data management system that will enable coordinated GSHP contacts with our members, both inbound (to GSHP) and outbound (from GSHP), across multiple media (telephone, mail, e-mail, and web). If the member has signed up for e-mail alerts, and a care gap is identified, either from Health Risk Screen (HRS) and/or claims data for the member, our MRM will issue an e-mail alert to the member. The e-mail will instruct the member to contact GSHP for health information, and/or login to the Member Portal to retrieve an important message.
Condition-specific Care Alerts	The GSHP Member Portal will provide access to tailored care alerts for specific diagnoses.
TruCare Service Plan (Item 13 in Figure 1)	Allows read-only access to the GSHP Service Plan maintained in TruCare, our fully integrated care management software. Service Plan data will include member problems, goals, objectives, and other key elements. The Service Plan - viewable from within the Member and Provider Portals - will support collaborative efforts among GSHP, members, and providers in determining and assessing outcomes.
Choose or Change PCP (Item 20 in Figure 1)	GSHP members will be able to choose or change their PCP on the Member Portal. In addition, the member will be able to assess how a potential PCP meets their needs based on geographic proximity, languages spoken, gender, office hours, and other information. Our portals are fully integrated with our Provider Relationship Management (PRM) system that integrates all data pertaining to our contracted providers. PRM will provide one data source for our Member Portal, our claims processing system, provider directories, and other provider data-related processes.
Provider Search (Item 1 in Figure 1)	Members will be able to search for providers by location or by doctor/facility name and refine the search through additional criteria, such as provider specialty and languages spoken. Distance to the provider's facility is calculated in real time. Detailed parameters such as provider name, distance to the medical facility, languages spoken, etc. are also provided. Public transportation access information is included, as well as a map application that provides a

Feature	Capability and/or Informative Content
	travel itinerary from the user's location to the provider (via Google Maps).
Parent/Legal Guardian (PLG) Log-on as Member (Item 14 in Figure 1)	Federal and state regulations stipulate we may not provision a secure portal account for members who are less than 18 years of age. However, we do have the technical ability to provision an account for a member's parent or legal guardian (PLG) - a capability we refer to as our *PLG feature*. We will accommodate the needs of these members (and their parents or legal guardians) with PLG support. Our PLG feature allows a validated parent or legal guardian to access the young patient's health plan information on our Member Portal. Our HIPAA enrollment processing system allows us to receive and process parent or legal guardian (aka "Responsible Person") information in the HIPAA 834 file we receive from DHHS. We propose to review our proposed Parent/Legal Guardian Member Portal provisioning process with DHHS. For example, we would ensure with DHHS that we would be able to consider "Responsible Person" information in the HIPAA 834 enrollment and eligibility file as validated information suitable for provisioning a secure member portal account for the child member. We believe that the PLG feature of our Portal is a very important factor in furthering increased family engagement in our member's care, particularly when the child has special health care needs. This is especially true for all child members in the event of state emergencies (such as severe winter storms like the ice storm of 2008), when ready access to GSHP member information is imperative.
Financial Transparency Tools	
Claims History and Explanations of Benefits (EOB) (Item 16 and 17 in Figure 1)	All GSHP Member Portal users will be able to view medical claims history, including dates of service, and services rendered. Claims history will also include pharmacy claim activity received from US Script.
Accessibility and Technology	
Web Browser Compatibility, Section 508 Compliance	GSHP's Member Portal will be fully Section 508 compliant. GSHP member web applications will have minimal end user technical prerequisites: we require only that the user have a reasonably recent version of the most popular web browsers: Internet Explorer Version 7.0 or above; FireFox Version 2.0 or above; or Safari Version 5.0 or above. This compatibility will be extended and the portal will be viewable/usable on reasonably recent versions of Apple iPhone, Android and all popular personal digital assistants. The Member Portal will also be designed so that users do not require significant memory, disk resources, or special software beyond a web browser.
Integration	Centene Portals are architected on IBM WebSphere standards-based technology, allowing us to develop and deploy web services with a broad range of integration and connectivity options. The result: better access to

Feature	Capability and/or Informative Content
	more timely information from our internal applications and external systems for critical applications - such as our Condition Specific Care Alerts (see above) application for members, which integrates with our Centelligence™ Foresight predictive modeling system and Enterprise Data Warehouse (EDW) to deliver targeted care gap and health risk information on specific members.
Security	
Security and HIPAA compliance	Since 2010, Centene has been deploying secure Member Web Portals for all affiliate health plans. Centene's web architecture allows for the cost effective use of common technologies across all our health plans, including GSHP, but our web portals are rigidly segmented for each health plan in terms of user and data access and sub-network management. We employ rigid HIPAA Security compliant controls, safeguards, policies and procedures throughout our MIS infrastructure, including our web infrastructures.

Updating Portal Information

Ensuring Relevant and Interesting Member Materials. We will take great care in selecting and presenting updated and visually interesting materials for all member communications. Member materials, including those on the GSHP Member Portal will be developed with input from a wide audience, including; DHHS, GSHP providers, various community organizations and committees in which GSHP is involved, and GSHP staff, based on interactions with members, or other stakeholders, and quality improvement measures from various sources, including HEDIS measures and CAHPS surveys. GSHP will also develop informational campaigns around seasonal issues; examples include a Fluvention campaign (described in Section 3.11 Care Management in response to Question 46). Once topics are identified, we will review DHHS priorities and contract requirements to determine what information must be disseminated or if there are any restrictions to the dissemination.

Member Testing and Feedback. GSHP will work directly with our members and our Member Advisory Councils (MACs) to capture what materials members would like to see on the Member Portal, and to ensure that our Member Portal provides the utmost in information accessibility. We will periodically conduct usability testing of our Member Portal by requesting GSHP members to volunteer to try out the Member Portal features and provide feedback to us. We will subsequently use this feedback to enhance the Member Portal, where appropriate. We design our member usability testing to evaluate how easy it is to use our physician and hospital directories, the appropriateness of the Member Portal font size and reading level, intuitive content organization, and ease of user navigation. We provide each member who tests our Member Portal a testing tool that guides them through the features and allows them to score their experience completing various tasks. We also encourage members to provide written feedback and suggestions on how we can improve our Member Portal.

To ensure that our materials are culturally appropriate, understandable, and meaningful to members, we will obtain input from our MAC. The MAC will review and provide feedback on our services, promotions, member materials, policy or operational changes, or any other information on which health plan staff seek a member perspective.

Member Portal Materials. GSHP will use a multi-departmental, inclusive approach for developing member materials, including several approvals and sign offs by our Member Services Department management and GSHP executive leadership, *before* we submit them to DHHS for approval. GSHP will create a policy and procedures document that specifies the review and approval process for materials that are prepared for our members, potential members, and other stakeholders.

The GSHP Manager of Marketing and Communications will have overall responsibility for managing the content on the GSHP Member (and provider) Portal, in conjunction with Centene's Member and Provider Solutions support team in St. Louis, which will support our Member and Provider Portals. When GSHP staff identify the need for new materials or a change to existing materials, the responsible manager will submit draft material and a GSHP *Communication Project Initiation Form* to the GSHP Marketing Manager. This form identifies the appropriate internal and corporate departments that must review the draft document, substantiates the review and approval process, and ensures that all approvals have been made before submission to DHHS for review.

The initial internal review particularly focuses on the following:

- Overall message
- Grammatical accuracy and flow
- Centene/GSHP Style Guide standards
- Compliance, privacy, rights and responsibilities
- Addresses, telephone numbers and Member Portal addresses
- Any State-mandated date stamp and catalog number that may be required
- Easy-to-understand benefits, operating procedures, accessibility and limitations (NCQA Standard Rights & Responsibilities 7, Element A, Items 1 – 7 and Element B, Items 1 – 6)
- Reading level of 6th grade or below, in compliance with State standards
- Availability in alternative formats (Braille, large font, recorded tapes and other supported languages).

Adhering to NCQA Standards. If a draft document contains HEDIS, NCQA or clinical information, it will be reviewed and approved by the Quality Improvement Committee (QIC). The business owner and project coordinator (person who requested the change) will be mutually responsible for ensuring that all information contained in the document is accurate, meets all standards, and is approved. This process complies with NCQA standards.

Provider Directory. Our Provider Network Operations Team will oversee the provider directory feature of our Member Portal. All technical errors will be reported in writing (hard copy or electronically) to the Director of Network Operations with a copy to the Manager of Marketing and Communications to ensure proper communication with the Service Desk or Corporate IT for correction of any issues. (If necessary, an "Experiencing Technical Difficulties" bulletin will be posted temporarily to instruct visitors of technical challenges). Technical errors will also be reported to DHHS.

Translation of Member Materials. To assure the best possible level of usability, our member materials will be written at a sixth grade reading level, with appealing graphic elements. We use the Flesch Reading Ease and Flesch-Kincaid Grade level tests to ensure this reading level, as described earlier in this section in Question 17. Our content and most GSHP member materials will be developed in Spanish, English, and languages of any other Major Population Group. All documents in foreign languages will be translated by a certified translator and will then be reviewed by bi-lingual GSHP staff to ensure that program-specific language is translated properly and that it will be understood by our members.

Member Portal Link Integrity. Any GSHP employee who discovers broken links or Member Portal error messages will be requested to report these in writing (hard copy or electronically) and submit this promptly to the Manager of Marketing and Communications for immediate correction.

DHHS Approval. Additions and changes to documentation will go through all internal approvals up to the Manager of Marketing and Communications before seeking approval from DHHS. Once approved by DHHS, changes will be made to our GSHP Member Portal by our Marketing and Communications team or by Centene IT. Once in production, our Manager of Marketing and Communications reviews and gives approval that production changes are accurate and implemented as designed.

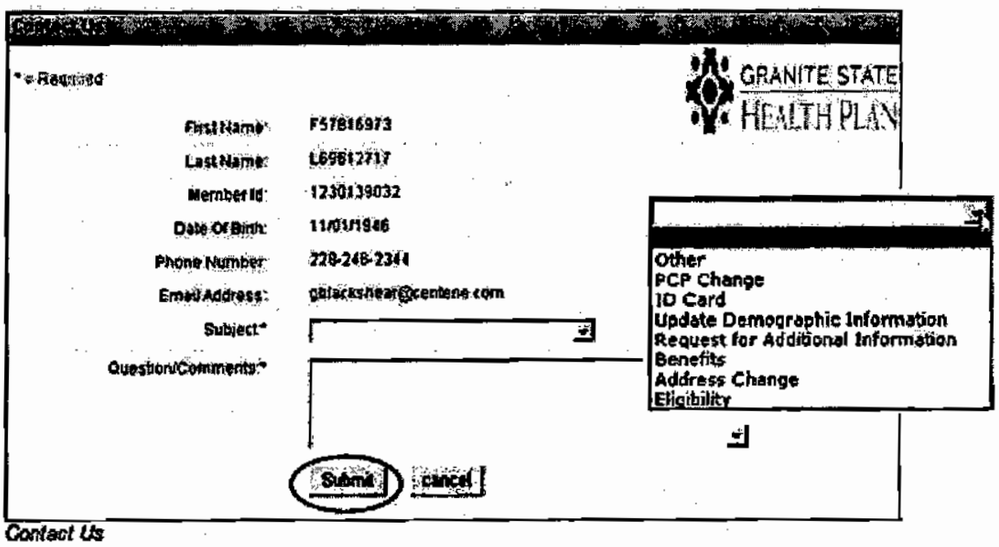
Annual Review. Materials that have been developed and reviewed through the above processes will be reviewed annually (or more frequently if necessitated by a program change) to ensure that the content (in all published languages) is correct and will not defraud, mislead or confuse members. The annual review process follows the initial review process described above. We will also systematically assess member understanding of our operations and policies by meeting quarterly with the Member Advisory Council and assessing the results of our incoming and outgoing member calls. We seek member feedback during all member interactions to improve service delivery and to ensure that members understand our organization, operations and policies.

Monitoring, Tracking, and Responding to e-Mail Inquiries and Other Electronic Member Interactions

We consider our Member Portal an extension of our ability to reach out to and serve our members, and we provide interactive features to engage members in taking responsibility for their health care. We will monitor and track all Internet correspondence to ensure that we are responsive to member concerns and requests.

Contact Us and E-Mail Tracking. Any visitor to our public GSHP Portal or to our secure Member Portal will be able to complete a form online to contact us. Visitors can select the general topic they wish to contact us about using a drop down box in the Contact Us online form; depending on the topic, the visitor's message is routed through our Contact Relationship Management (CRM) software that powers our Member Relationship Management (MRM) system. An example of the Contact Us form is presented in the figure below.

Figure 2. Example Web Portal "Contact Us" Form



Contact Us

Once in the MRM system, the visitor's inquiry is immediately assigned to the correct department, tracked, managed, and followed up systematically through our Dynamics workflow engine. If, for any reason, it is necessary for the responsible department to confer or obtain information from another department, that email, like any correspondence within the MRM system, can be routed to the appropriate party and placed in their call queue. An example of the MRM call queue is shown below.

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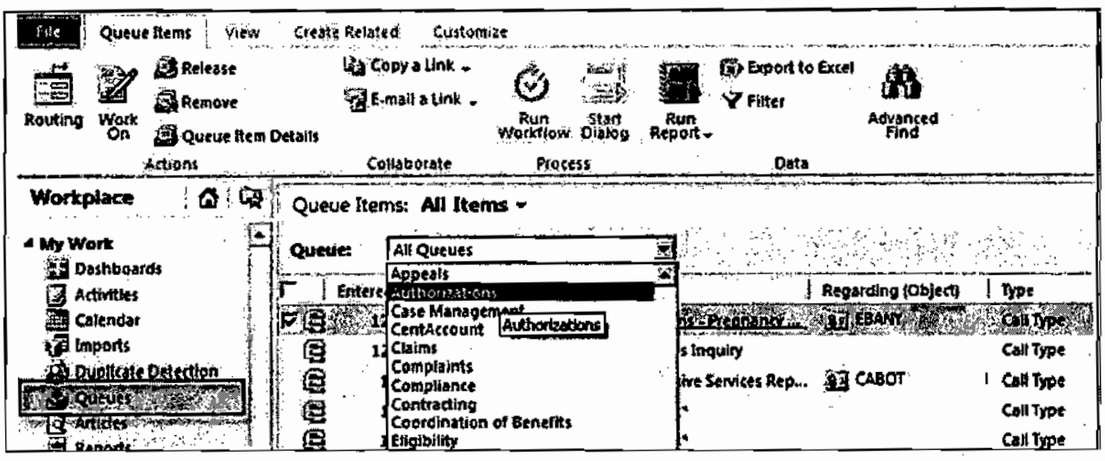
Figure 3. Example MRM – Call Queue



GSHP will carefully monitor all e-mail and all online interactions and inquiries and answer these in the shortest time possible, and at most, within two business days of the date received by GSHP. All e-mail correspondence between our Member Portal and MRM will be sent via secure e-mail; MRM will maintain a history of the e-mail correspondence for operational and regulatory reporting.

In order to ensure we respond to all Internet communications in a timely manner, all Centene health plan Member and Provider Services Departments, including GSHP, must have a policy regarding Internet communications and a procedure for evaluating if the department is meeting the defined standards.

All MSRs and other staff using MRM will have extensive training on the MRM documentation system. This will include but is not limited to documenting e-mail inquiries through the GSHP Member Portal, routing cases to the designated individuals for follow up and resolution (if applicable), and checking queues to ensure all routed cases have been closed in a timely manner. All cases should be closed within 30 days to ensure accurate data for reporting purposes. Member Services Management will conduct monthly audits of open/closed cases by reviewing MRM reports.

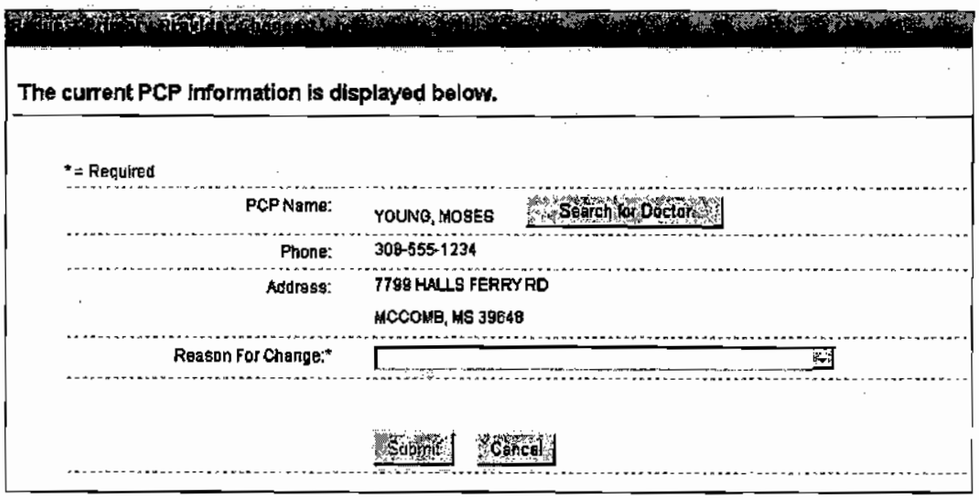
Online Health Risk Screen Monitoring and Follow/up. Our on-line Health Risk Screen (HRS) helps Care Managers identify members with possible health concerns. All information collected on the HRS will automatically be populated into our TruCare clinical management and documentation system. Our Member Relationship Management System (MRM) will indicate that an HRS was completed for the member, and the data will be available in TruCare for *follow up* by our Care Managers, if responses indicate a follow up call from a care manager is necessary.

For reporting purposes and so that we can take advantage of the opportunity to complete an HRS with the member if they should happen to call Member Services, the MRM will record whether a member has completed a Health Risk Screen, or not. Member Services Representative (MSRs) will be trained to review the member's record in MRM for all care gaps, whether the HRS is complete or not, whether the member has special health needs, and other information that helps the MSR respond to the member in a comprehensive and informed manner.

Select/Change Primary Care Provider Requests and Response. Members will be able to request or change a PCP assignment through our Member Portal. This feature is fully integrated with our Provider Relationship Management (PRM) system to ensure provider data is current and accurate.

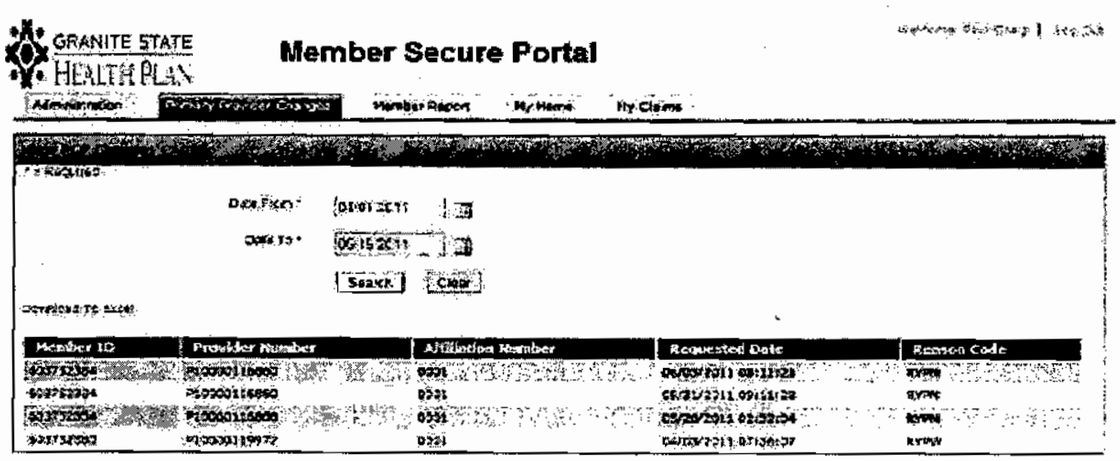
An example of the "Request PCP Change" form is shown in the figure below. The Search for Doctor Link launches our PCP search functionality, allowing the member to choose a PCP that meets their preferences on geographic proximity, languages spoken, gender, office hours, and other information.

Figure 4. Example Web Portal Request PCP Change



All PCP change requests are queued in the Portal Administrative Function for follow up and tracking by the MSR, shown in the figure, below. The new PCP information will load into MRM, AMISYS Advance and the Enterprise Data Warehouse where it will be available for reporting purposes. A new member ID card will be mailed to the member within 10 days.

Figure 5. Example Web Portal Administrative Function – PCP Change

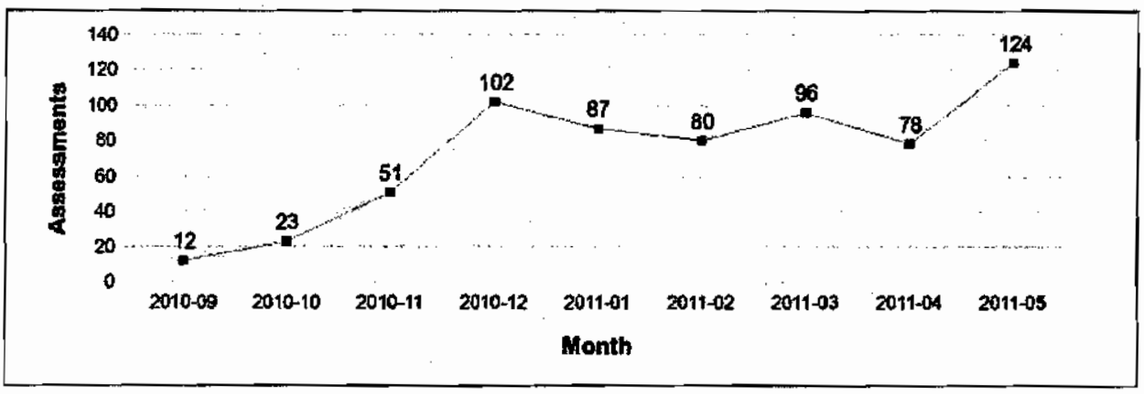


Quality Audits. For quality and training purposes, on a monthly basis, the Supervisor/Manager will monitor a random sample of e-mails; e-mail statistics; HRSs completed, PCP Change Error Report; and all other special projects, as appropriate. The audit consists of checking the percentage of cases

entered, accuracy of documentation, and the number of open versus closed cases. We will capture these results on a monthly performance card, reviewed with, and signed by each employee.

Portal Metrics. The Centene Information Technology (IT) group that supports all affiliate health plans will track metrics on the GSHP Member Portal, such as the number of HRS forms completed on line, number of PCP change requests, etc. We collect and analyze these metrics to ensure that the functionalities we provide on our Member Portal are valued and used by our members, and to identify areas of potential improvement. Our IT group also tracks Member Portal activity using ***Google Analytics*** to help us determine how people find our Member Portals, what pages they visited and consequently, what areas interested them. We use this information to help guide us on content, usability and overall design of the Member Portal. The example, below, illustrates a high-level metric that tracks the number of Health Risk Screenings that were completed for one of our affiliated health plans from month to month, beginning in September 2010 through May 2011.

Figure 6. Example Web Portal Metrics – Assessments



GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.6 Cultural Considerations

GRANITE STATE HEALTH PLAN

3.6 Cultural Considerations

Assuring Cultural Competency throughout the Network

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?

Cultural Competency in Granite State Health Plan

In New Hampshire, a state whose population is 94% Caucasian and highly rural, particularly in the northern half, cultural competency in serving Medicaid enrollees means considering the impact of geographic isolation and poverty on the health care needs of individuals who may also be elderly and/or concerned about their independence and privacy. At the same time, in many of the most urban areas of the state, concentrated in Southern New Hampshire, cultural competence includes providing care that is culturally sensitive and appropriate and linguistically competent for refugees from Somalia, Laos and other countries of Africa and Southeast Asia.

> One of the seven governing Core Values of Centene Corporation, Granite State Health Plan's (GSHP's) parent company, is "**Diversity of People, Cultures and Ideas.**"

We embrace the diversity of New Hampshire's Medicaid Care Management population in all its forms, whether geographical, racial, ethnic, cultural, linguistic, religious, socio-economic, gender, sexual orientation, physical or cognitive abilities, or otherwise. We are committed to providing care that is culturally competent in providing for the health care needs of all GSHP members.

Centene Cultural Competency Mission. The Cultural Competency Mission of Centene Corporation is to develop a culturally competent system of care that acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, and the expansion of cultural knowledge and adaptation of services to meet the needs of our members. To support affiliated health plans in providing culturally competent care to a diverse population of members unique to each state, Centene maintains a national Cultural Competency Committee that meets biannually and includes representatives from all Centene health plans. The Committee facilitates sharing cultural competency strategies and best practices for provider education and linguistic services across plans. GSHP's Cultural Competency Officer will represent GSHP at Centene Cultural Competency Committee meetings.

CLAS Standards and GSHP Cultural Competency

GSHP shall comply with the Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), as listed in Section 3.6 of the RFP. We will ensure that services are provided in a culturally competent manner by addressing members' needs within both GSHP and our provider network.

NCQA CLAS Standards. GSHP will implement the NCQA CLAS Standards, which operationalize the standards of the U.S. Department of Health and Human Services (HHS) Office of Minority Health. These standards are organized by three themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). We will implement and conduct continuous quality improvement for all 14 standards.

Centene NCQA Pilot. Using data from its affiliated health plans, Centene participated as a pilot site for the NCQA CLAS standards in 2009, and as a result, drafted modifications to the overarching Centene Cultural Competency Strategic Plan and policies.

In alignment with CLAS standards, Centene's six cultural competency priorities are as follows:

1. Ensure ongoing strategic plan development, implementation, monitoring, and evaluation of the Cultural Competency Plan.
2. Maintain diverse representation throughout all levels of the company. Staff, providers, and company leadership will mirror the demographics of the communities we serve.
3. Maintain current demographic, cultural, epidemiological profiles of our communities. Conduct needs assessments of the communities enabling health plans to implement services in response to the cultural and linguistic characteristics of our membership. Establish participatory and collaborative partnerships with community organizations through formal and informal mechanisms to facilitate community and member involvement in designing and implementing CLAS related activities.
4. Maintain contracts with vendors to provide language assistance services, including interpreters, translators, signers and TTY services free of charge to our members. Ensure the competence of language assistance services delivered by staff, vendors, and providers.
5. Provide culturally appropriate competent care and services to our members that are understandable and respectful. Members will receive effective and respectful care centered on the individual and provided in a manner compatible with their cultural health beliefs, practices and preferred language. Members will have the ability to resolve conflicts and grievances through process and procedures that are sensitive, linguistically and culturally appropriate, and capable of identifying, preventing, and resolving cross-cultural conflicts and complaints.
6. Deploy collection methods to obtain members' race, ethnicity, and language. This information will be collected and integrated into management information systems for the purpose of improving services. Members will not be compelled to provide such data and the data collected will never be used to deny services or discriminate against members.

We will build on Centene's Cultural Competency Plan to create a GSHP Cultural Competency Plan, tailored to the demographic, cultural, and linguistic profiles of our members in New Hampshire's Care Management Program.

Stakeholder Input and Feedback Structures. GSHP will obtain input and feedback on efforts to ensure we are providing culturally competent services for both urban and rural areas of the state, largely through our Member Advisory Councils, Community Advisory Committee, and Provider Advisory Committee. **To be responsive to the varying needs of our members, GSHP will create two member advisory councils: one for members in TANF/CHIP/Foster Care and one for members with special health care needs (SHCN).** GSHP will seek participation on these committees from members in both urban and rural regions of the state and from each of the major ethnic population groups we serve in the Care Management Program. These two Member Advisory Councils and the Community Advisory Committee will provide input on drafts of member and other materials, performance statistics, propose intervention strategies, which may include community-based outreach and collaboration initiatives, and review effectiveness evaluations and member satisfaction survey results, as described in Section 3.12 Quality Management, Question 68 response.

GSHP will also include providers on the Quality Improvement Committee. Our provider partners Bi-State Primary Care have two board members that have been appointed to Granite State Health Plan's Board of Directors, Quality Improvement Committee and other appropriate committees, such as the Utilization Management Committee, which will analyze utilization and quality of services by key demographic characteristics, such as geographic location, language, age, and other factors, to detect potential disparities. We also will solicit individual provider feedback during provider training sessions and field visits. We have already met with and engaged community and advocacy organizations in New Hampshire such as Community Support Network Inc. (CSNI) and Easter Seals of New Hampshire; both have expressed interest in serving on our Community Advisory Committee.

Monitoring GSHP Cultural Competency. The Cultural Competency Officer will be responsible for monitoring GSHP's programs, our provider network services, the sufficiency of resources to address cultural competency issues, and for reporting to the Chief Medical Director, and Compliance Committee. The Cultural Competency Officer will monitor metrics and activities such as:

- Utilization of telephonic interpretation services, including which non-English languages members request; utilization of TTY and New Hampshire Relay services for members with hearing impairment
- Utilization of in-person interpreter services, including requested spoken languages and American Sign Language
- Member and provider complaints related to cultural competency
- Member and provider satisfaction surveys
- Progress on Cultural Competency Plan initiatives

Promoting Cultural Competence among Staff and Providers

Cultural Competency Training for Staff. Granite State Health Plan will require all staff, regardless of role or responsibility, to complete our Linguistic and Cultural Competency Training Program upon hire, and at least annually thereafter. In addition, cultural competence training is part of our initial and ongoing training for Member Services staff, as described in Section 3.5 Member Services, in response

to Question 20. Our initial training will focus on the impact of culture on health care decisions; the employee's own culture and potential biases, including ethnicity and gender; the impact of poverty on health; resources available for members with disabilities; linguistic barriers and resources for members with Limited English Proficiency (LEP) or low literacy; and viewing the health care system from a member's perspective. GHSP will also collaborate with local organizations to provide training. Our local training model will be based on successful collaborations at other Centene health plans. For example, our affiliate, Buckeye Community Health Plan, in Ohio, partnered with Independent Living Centers to provide disability sensitivity training to the health plan's staff.

Cultural Competency Training for Providers. As with all of Centene's affiliated health plans, GSHP will sponsor provider education and training, and seek provider and community input to establish, maintain and improve the provision of culturally competent care to all of our members.

Training Processes, Content, and Materials. We will provide cultural competency training to providers and their office staff during new provider orientation sessions, or as needed, as issues arise within a provider's practice. During new provider orientation and ongoing training, GSHP will provide information on the CLAS standards and encourage providers to implement applicable CLAS standards that are not already mandatory within their own practices. We will be alert to the need for specialized training. For example, to meet the needs of their small but growing Burmese membership, our Indiana affiliate health plan developed and conducted training on Burmese culture to providers serving Burmese members. GSHP would follow this model in providing specialized training to providers in communities of New Hampshire with significant and growing refugee populations, such as Manchester and Nashua, which are home to Somali resettlements, and Newmarket, with a sizable Laotian refugee population.

We will recommend best practices during in-person training sessions and through our Provider Manual and Newsletters. We will offer culturally appropriate health education materials, such as for our annual "Fluvention" flu prevention campaign, to support providers in educating their patients, our members.

Continuing Education Units. To encourage ongoing and regular participation in training, whenever possible, we will arrange for providers—both physicians and mid-level practitioners—to receive Continuing Education Units (CEUs). GSHP will provide a link on our Provider Portal to online training on cultural competence. Examples include HHS's Physician's Practical Guide to Culturally Competent Care[7], a free, online accredited educational program providing up to nine CEUs, and America's Health Insurance Plans' program on Promoting Culturally Sensitive Health Care,[8] which provides 2.5 CEUs for physicians, and 2.5 CEUs for nurses and care managers. Providers will be able to obtain these CEU credits and training free of charge.

Collaborative Training with Provider Organizations. GSHP will collaborate with key provider organizations and practitioners to customize, develop, and deliver education that meets network providers' needs. For example, with the Texas Association of Community Health Centers, our affiliate,

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[7] See: https://www.thinkculturalhealth.hhs.gov/
[8] See: http://www.ahip.org/disparities/QIModules/

Superior Health Plan, facilitated a statewide training videoconference in December 2010 on using managed care to improve services to diverse populations. Topics included how different racial, ethnic and cultural groups may access and use care, challenges in serving members with LEP, and seasonal migration patterns of farm workers in Texas. Superior Health Plan is initiating a similar statewide provider training initiative with the same association and our behavioral health affiliate, Cenpatico, regarding the importance of PCP screening for behavioral health conditions and integration of medical and behavioral health care. GSHP's relationship with the Bi-State Primary Care Association positions us well to collaborate on similar types of initiatives in New Hampshire.

Provider Monitoring and Support. GSHP will monitor compliance with cultural competence requirements. If we identify providers who are noncompliant, we will require additional training, typically in the provider's office, develop a corrective action plan (CAP) with them, and monitor for improved performance. Although failure to improve could lead to contract termination, the experience of our affiliate health plans is that providers generally recognize the benefits to themselves and their patients of providing linguistically and culturally competent services, and most are cooperative in implementing related practices and procedures.

Practice Support. Through in-person visits as well as calls to our provider call center, Provider Relations staff will monitor providers' satisfaction with their interaction with patients. For example, if providers express frustration with missed appointments and non-compliance with treatment plans, staff will troubleshoot and offer help. A Care Manager may contact members who repeatedly miss appointments to address the cause, perhaps due to a lack of transportation or childcare; additional care management services may also be appropriate to increase members' self-care and compliance with treatment plans. Provider Relations staff will educate providers on how GSHP Care Management and other staff can support their practice, such as linking their patients with culturally appropriate community resources.

Quality Profiling. Our Medical Directors and clinical staff will follow up with under-performing providers to educate them on ways to improve delivery of evidence-based, culturally competent care. Conversely, GSHP will identify high volume providers with strong HEDIS performance to identify best practices in culturally competent care and share such practices with other providers.

Contract Requirements. Additionally, GSHP provider contracts will require compliance with DHHS and GSHP non-discrimination and cultural competency requirements, such as timely use of professional interpreter services and meeting access requirements under the Americans with Disabilities Act to accommodate members with disabilities.

Subcontractors

In addition to network providers, we will contractually require subcontractors to maintain policies and procedures that comply with our cultural competency requirements and ensure that services to members are linguistically and culturally competent. The staff of Centene's specialty affiliates (e.g., Cenpatico, NurseWise, Nurtur Health, Inc., etc.) will complete Centene's initial and annual cultural

competency training. Subcontractor staff will also participate in community outreach activities for cultural minorities.

Ensuring Ethnically Diverse Provider Network

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

Maintaining an Ethnically Diverse Provider Network

Building on the experiences and best practices of our affiliated health plans, GSHP will employ a number of strategies to develop and maintain a diverse provider network that reflects the demographic profile of our members.

Strategies to Recruit a Diverse Provider Network. GSHP prioritizes recruiting community-based providers such as Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs) and Rural Health Centers (RHCs) because they already serve prospective members and understand their needs, and the demographic profile of their staff tend to better mirror that of the patients they serve compared to other types of providers. We have reached out to our provider partner Bi-State Primary Care Association in New Hampshire and will co-locate Nurse Care Managers and Behavioral Health Care Managers in high-volume FQHCs and CMHCs. **All of the FQHCs in New Hampshire have submitted a letter of intent to partner with us.** In addition, we will work with the Association's Recruitment Center to recruit a diverse workforce that complements patients' needs.

Based on our experience in other states, once our network is in place, providers themselves are often the best source for identifying diverse providers and recommending to their peers that they contract with the health plan. In Indiana, for example, providers of Nigerian heritage have helped our affiliate health plan with referrals and also translated selected written materials for the benefit of members of such heritage.

Strategies for Retaining a Network of Culturally Diverse Providers. GSHP recognizes the importance and value of strong patient-provider relationships. One of the successful ways we retain culturally diverse providers in Centene health plans is by including representatives from FQHCs in health plan governance at the highest level of the Board of Directors, as well as throughout major committees and initiatives. For example, the Board of Directors of our affiliated health plan in Georgia includes an FQHC physician and CEO, an FQHC physician and Chief Operating Officer, and the Executive Director of the Georgia Primary Care Association. As our affiliate

Granite State Health Plan will partner with Bi-State Primary Care Association with seats on our BOD, participation in our committees and co-location of our Care Teams within their FQHCs. **Working together we will provide culturally competent accessible care to Medicaid recipients in New Hampshire.**

health plans do, GSHP will solicit and use input from community-based providers on ways to improve delivery of care and administrative processes, and we will encourage participation among ethnically diverse providers on our Credentialing, Utilization Management, and Quality Improvement Committees.

Seeking out ethnically and culturally diverse provider to encourage their participation on our Quality Improvement Committee and other QI committees is another valuable strategy we will use to build and retain a diverse provider network.

Through provider education and training related to our Care Management programs, we also support the retention of a diverse provider network by providing education about our care management programs for their high-risk and high-need patients, and by offering tools, such as telemonitoring and telemedicine to support patient care of certain members in rural areas.

Staff Hiring

Centene strives for cultural diversity among its staff, especially those who have daily contact with members, such as our MemberConnections staff and Member Services Representatives. The experience of our affiliated health plans is that influencing member behavior and providing health education are most successful when members feel they are talking to a person with whom they have something in common. In Ohio, for example, several staff employed with our affiliate, Buckeye Community Health Plan, are former members of the plan. In Georgia, 82% of our affiliated health plan employees are non-white (73% African-American and 9% other) and in Texas, 68% of affiliated plan employees are non-white (59% Hispanic and 9% other).

GSHP will emulate the best practices of other Centene health plans by recruiting and hiring local staff who reflect the demographic diversity of our membership. Hiring from the local area will help to ensure that staffs have a personal familiarity with the region, cultural norms, and how people access health care.

A "Role Model" Company for Hiring People with Disabilities. Centene Corporation's commitment to workforce diversity is exemplified by serving as a "Role Model" company with the Starkloff Disability Institute in a unique program that connects companies with community-based organizations to promote opportunities for companies to hire people with disabilities. Centene participated in a focus group session conducted by the Starkloff Disability Institute to identify solutions that would be effective in opening the hiring process to people with disabilities. One of the most consistent and heartfelt themes emerging from the focus groups was how much participants felt they had learned over the course of these groups.

Hiring people with disabilities gives us unique insight into the obstacles our members overcome on a daily basis while at the same time demonstrating that given the proper resources and support people with disabilities can become some of our most valued employees. For example, our Arizona health plan, Bridgeway Health Solutions, employs two case managers with physical disabilities. They know better than anyone the challenges faced by people with disabilities; members feel better knowing someone truly understands their situation and the health plan staff benefit from "teachable moments" that come from working directly with individuals with a disability.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.7 Access

GRANITE STATE HEALTH PLAN

3.7 Access

Building a Network in Rural Areas

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.

GSHP's success in building a solid provider network in New Hampshire will rely on the expertise and resources that our parent company, Centene, brings to our partnership. It is important to note that Centene stands out from the crowd as a company, since its inception, whose core business has been dedicated to Medicaid managed care. Unlike other organizations that build provider networks from their existing commercial networks, Centene and its affiliated health plans build provider networks from the ground up that are organically grown and nurtured. While GSHP is new to New Hampshire, the experience and dedication we bring - particularly to states transitioning from a fee-for-service to a managed care model - is a continuance of Centene's more than 27 years of Medicaid managed care experience in 14 states. Long before the RFP was released in New Hampshire, our teams of dedicated provider recruiters were "in the field" educating New Hampshire healthcare providers on GSHP and the DHHS initiatives. To date, our provider recruiters have met face-to-face with representatives from most of the local hospitals and provider groups they have identified. In addition to our on the ground field team, we supplemented our network development efforts with an office based team of provider relations representatives who call on providers in the state, gather information, and educate them on GSHP and the DHHS program. **Many providers told us that GSHP was the only plan that came to meet them face-to-face.** We believe our personalized approach to building a network "from scratch" is the most effective way to rouse provider interest in participating with the program and to gain their unwavering commitment and willingness to serve Medicaid beneficiaries. This "on the ground" network building approach has been successfully deployed most recently by GSHP's affiliate health plans in Georgia, Louisiana and Mississippi. These are states that recently transitioned from a fee-for-service to a managed care model. Today, we have robust provider networks in all three of these states. Centene's legacy and its comprehensive and stable provider networks in rural areas are testimonies to the success of its approach to developing provider networks even in the most challenging markets.

Rural Network Development Strategy for New Hampshire

We find the most successful approach to developing networks in rural markets is to engage the rural provider community in developing new partnerships or expanding upon existing partnerships that will lead to increased access to care and better health care outcomes for the people we serve. Every state in the nation has rural access to care issues, yet there is no "one size fits all" solution. For New Hampshire, our approach employs three key aspects: 1.) engaging local providers in rural communities, 2.) filling care gaps, and 3.) removing barriers to health care access. These strategies are described in greater detail below.

Engaging Local Providers in Rural Communities. By working with local providers at a local level, we will succeed in developing cost-effective, innovative solutions that effectively address access to care issues in rural markets. When developing provider networks in rural markets, we start with providers who already serve Medicaid beneficiaries (often referred to as Significant Traditional Providers (STPs)), as these providers and their patients already have established relationships and securing contracts with STPs will ease the transition from fee-for-service to managed care – for both members and providers – and will ensure continuity of care throughout the transition. We prioritize outreach to PCPs (who are STPs) and ask them for the names of providers to whom they normally refer their Medicaid patients so we can build a specialty referral network in line with the PCP's normal referral patterns. We also work with local associations to further identify providers and organizations that serve low-income individuals in the community in order to augment access to care locally and maximize use of local resources. In New Hampshire, we are working with Bi-State Primary Care Association (BSPCA), which is an association of FQHCs currently serving approximately 20,000 Medicaid beneficiaries at clinics located throughout the state. We will also strive to accommodate local patterns of care. For example, in counties lacking physicians altogether, members have no choice but to drive across county lines for care. However, in some cases, members are not aware of health care resources within their communities. Therefore, in rural markets we will reach out to members and inform them of the options closest to their residence. In areas where members access health care services across state lines, we will contract with those providers nearest to them, in such areas as western Maine, northern Massachusetts and eastern Vermont.

Filling Care Gaps. We will use a combination of proven strategies to fill network gaps and ensure access to care in the rural areas of New Hampshire. These activities include:

- **Expedited Credentialing.** Provider Relations (PR) staff will identify potential providers through sources such as listings from the New Hampshire State Medical Association, and local Medical Societies. When access to care is at risk due to a provider's non-participation, we will make an extra effort to expedite credentialing of the provider. For example, our affiliate plan in Texas learned of a new pediatric office opening in a rural area experiencing a physician shortage. With expedited credentialing, the provider began serving members within one month of the initial contact date (versus the standard 90 day credentialing time frame).
- **Encouraging Open Panels.** GPHP Provider Relations (PR) staff will ask PCPs with limited or closed panels to open their panels to new members, or to relatives of members already in their panel. We will encourage open PCP panels and offer incentives to providers who maintain open panels. PR staff will also ask network specialists to expand the number of members they will serve or the scope of their services to accommodate our members.
- **Emphasizing Continued Participation.** GSHP will be proactive in maintaining a stable network. For example, when we learn that a provider has left a group practice, PR staff will contact the provider to encourage continued participation in the network at their new office location.
- **Simplifying Referrals and Authorizations.** We reduce the hassle factor for providers through such strategies as limiting prior authorization requirements, allowing standing referrals for ongoing care, and paying for missed appointments. For example, our Arizona affiliate tried to

recruit a much needed orthopedist in a rural area. The orthopedist did not want to join the network because of his perception of the administrative hassles he would encounter. The plan offered a 'trial run' to the provider so he could have a real-life experience as a participating provider with the plan. When the orthopedist found how easy it was to navigate through the referral and authorization processes and how quickly he was paid, he opted to join the network.

- **Out of Network Approval.** In the event a member needs access to a provider not available within the travel standard, our Medical Management Department will approve medically necessary covered services provided by a non-participating provider until a suitable network provider is available. GSHP staff will help the member locate a provider with an office that is convenient and as close as possible to the member's residence; has no restrictions (such as age limits) that would affect the member; offers the necessary linguistic access; meets the member's cultural needs; and has office hours that accommodate the time it will take the member to get to an appointment. When needed, our MemberConnections™ staff and Case Managers will help members to access transportation services to the out of network provider. Centene plans also have paid for transportation for members who need procedures at nationally-recognized centers such as Pittsburgh Children's Hospital. We find most providers who execute Single Case Agreements eventually become network providers because of our excellent customer service and provider support. In these cases, the member's transition to in-network care is seamless. When a provider chooses not to join our network, we will continue authorizing out-of-network care until an appropriate provider type becomes available in-network. At that time, a Case Manager will work with the member, existing and network provider to ensure a smooth, safe transition to the network provider, within a time frame and following protocols appropriate to the member's condition.
- **Centene Foundation.** The Centene Foundation will consider funding a physician resident program or education loan repayment for a health care practitioner in exchange for the practitioner's agreement to practice in a rural area. We will analyze service gaps for the covered populations, provider and member demographics, and the options for delivery of needed services, for example, through physicians or dentists or mid-level practitioners. This initiative would supplement and complement the existing rural workforce incentive programs used by FQHCs. The Centene Foundation also has funded targeted scholarships to increase access for people with disabilities.

Circumnavigating Barriers to Care. As the general population in America ages while many rural areas are experiencing physician shortages, it has become increasingly necessary for health insurance carriers to find effective yet affordable ways to ensure the provision of health care service for their members in rural settings. Centene has implemented several pilot projects using telemedicine, telemonitoring and member outreach programs which GSHP seeks to implement in New Hampshire. Our support efforts to reduce barriers to care in rural markets are described below.

Timely Utilization Alerts and Information. We will provide timely information to providers about their members' utilization of healthcare services. Physical and Behavioral Healthcare (BH) providers who have registered to access our Provider Portal can access our Enrollee Encounter Report 24/7 to review

enrollee service utilization. In addition, our Care Gaps feature will inform the provider that the member is due or overdue for a check-up, screening, or immunization. These tools will support the medical home relationship and facilitate the provider's outreach efforts.

Rapid Member Outreach After ER Access. When members residing in rural areas seek care at an emergency room (ER) for routine or non-emergent care, it often indicates an underlying barrier or access to care issue. We contact members shortly after learning of their ER visit to discover any barriers that led to the ER use. GSHP staff will contact members subsequent to the ER visit to identify any barriers to appropriate non-emergency care, and provide education about the role and importance of the PCP. We will also remind the member of the availability of NurseWise, our 24/7 toll free nurse advise program, to assist members with their questions about care, and to assist them in finding the most appropriate provider for their health care needs. Members with three or more ER visits within 90 days with chronic or co-morbid conditions and those with evidence of more than one controlled pain prescription, will receive outreach by a Care Manager within seven days of identification. The goal of member outreach in these scenarios is to discover any underlying barriers to care that are more clinical in nature and that can be addressed more effectively by a Care Manager (who is a registered nurse).

In 2010, our 24/7 nurse advice line redirected 82% of calls to a more appropriate level of care

Nursewise Support. We will encourage members to contact NurseWise if they have any questions about appropriate access and determining the potential need for ER services. Nursewise staff will obtain information from the member using direct questions and nationally-recognized and annually-reviewed algorithms to determine the best level of care for the member based on presenting symptoms. If a member's condition appears emergent, Nursewise nurses will warm transfer the enrollee to 911. When the medical condition does not warrant ER care per the protocols, the nurse will advise the member to seek urgent care, immediately contact the PCP, or schedule an appointment with the PCP the next business day. The nurse also will provide self-care alternatives to manage the symptoms at home, such as increased fluids, fever reducing medicine or ice compresses.

Telemonitoring. Coordinated Care will provide in-home telemonitoring services to high-risk enrollees (such as those in rural areas, at risk of readmission or with multiple co-morbidities) for who intensive monitoring is necessary and the condition is amenable to telemonitoring. Our FDA-approved technology is "device-agnostic," interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing landline, cellular (including ConnectionsPlus cell phones), or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as blood glucose level for a diabetic or a blood pressure or weight for an enrollee with congestive heart failure, is transmitted electronically to the Care Manager and evaluated against patient-specific, evidence-based guidelines and analyzed for favorable or unfavorable trends. The system can be set at the enrollee level to alert the Care Manager, trigger an interactive voice response phone call to the enrollee, and/or alert other members of the IC Team or the enrollee's PCP/Health Home or specialist.

For Centene's Ohio affiliate, inpatient admissions and ED visits directly related to the conditions being managed (over the period November 1, 2009 - September 31, 2010) decreased and per-participant per-month costs directly related to the conditions being managed decreased: diabetes by 34.9%, heart failure by 44.5%, heart disease by 30.4%.

Providing Long Distance Transportation. Access to care in rural settings is often impeded by lack of transportation. GSHP is proposing to require Notice of Transportation for trip requests in excess of 50 miles one-way. We find that members' long distance trip requests often indicate underlying access to care issues. By requiring a Notice of Transportation (from our transportation vendor, Access2Care) for long distance trips, we quickly capture data relating to the need for the transportation that enables our Care Managers to become aware of the patient's situation and offer assistance in accessing health care services closer to home, if available. If services are not available closer to home, the Care Manager will continue to research better avenues for the provision of health care services for the member that are closer to home and more convenient for the member.

Telemedicine and Telehealth. GSHP is exploring options for the provision of telemedicine services focused around providing access to primary care services and PCPs in rural areas. Centene's health plans excel at delivering quality health care in rural markets. Part of what makes us successful is our willingness and ability to develop telemedicine networks in largely underserved areas. Our affiliate health plan in Texas, for example, provides covered services to members in 170 rural counties across the state where access to PCP services is limited. In Texas, Centene collaborates with Teladoc Inc. (Teladoc), a telemedicine provider, to reduce overall hospital and readmission rates, reduce in-home visits, and increase member compliance with care protocols. For our members living in the most remote regions of New Hampshire, where access to health care is difficult for everyone (not just Medicaid members), we would like to explore access to telemedicine and telehealth programs through Teladoc to augment members' ability to receive timely and quality health care services in historically underserved markets. Members access Teladoc's network of board certified physicians via our Member Services call center where they are screened to ensure appropriate contact and coordination with their PCP was first attempted. Where appropriate, this intervention guides the member back to their medical home for timely medical care. If the member's PCP cannot be reached, our Member Services representative connects the member with Teladoc via warm transfer. A Teladoc intake specialist conducts a health and medical history of the member to ensure appropriate consultation and treatment can occur. The telephonic consultation is scheduled to occur within 30 minutes of submission of the member's completed health history to the consulting Teladoc physician. A Teladoc "visit" includes medical history and telephonic consultation conducted by a board certified physician and can include prescription of medication if necessary. We look forward to collaborating with DHHS, Teladoc and local providers in this endeavor, which we believe is an effective way to resolve access to care issues that can be challenging in rural areas.

Excellent Results. We are pleased with our provider recruitment activities in New Hampshire to date. Some STPs have opted to delay signing an LOI with any entity prior to the Contract awards, but have told us they will work with us once we get an award. In our experience with transitional markets like New Hampshire, we have found this to be a common practice and we are confident we can finalize agreements with providers upon Contract award.

Recruiting Providers that do not Accept Medicaid

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

Providers who do not accept Medicaid often are the most challenging to recruit for a variety of reasons. Therefore, we take extra care in our approach to increase the odds of our success. To begin, we strive to discover the prospective provider's underlying reason(s) for not accepting Medicaid beneficiaries in his/her practice. This helps us to tailor an approach that will resonate most effectively with that particular provider or provider group. It is important to note that skepticism and uncertainty are inherent among potential providers in a program of this magnitude. All in all, these challenges are typical in the early stages of any network development process. While in the midst of encountering challenges and obstacles, we remain diligent in our efforts to engage providers and continue to "stay the course" by responding to potential providers in a collaborative, respectful and professional way that is ultimately conducive to forging strong network participation and stability long after the early stages of development and implementation have passed.

Strategies for Recruiting Resistant Providers

We work to dispel myths about Medicaid and overcome the preconceived notions providers who do not accept Medicaid often site as their reasons for not participating in our program. We share facts, historical evidence, and recent outcomes data with prospective providers as a way to broaden their perspective of Medicaid and foster a more global understanding of the challenges everyone involved with Medicaid health care encounters. In addition, we offer value added initiatives that support providers and enable them to receive additional reimbursement for driving higher quality, coordinating care and reducing unnecessary costs. As our participating providers gain experience working with us, we enlist their assistance, along with medical societies and colleagues who know the providers to ask them to join the program on our behalf. We furnish references and contacts to providers so they can talk candidly "colleague to colleague" about accepting Medicaid within their practice. Also, when we have a single case agreement with an out-of-network provider, we restate our interest in the provider's participation in our network and ask them to consider participation in light of the "user-friendliness" of our administrative services and quick payment turnaround. In most cases, we succeed in contracting with once-resistant providers after they have gone through a "real-life" experience and are reassured that participation in our program will be a good decision for their practice.

Hospital Network Development. GSHP's parent company, Centene, has always endeavored to build hospital networks comparable to commercial health carriers – in large part to eliminate barriers to care Medicaid beneficiaries often encounter. In our experience, hospital network participation is the key driver in further developing a supporting network of participating providers, and this will be especially critical in New Hampshire given the large percentage of providers that are employed by hospitals. In New Hampshire, our teams of provider recruiters and contract negotiators have been diligently reaching out to all hospitals in the State for the past three months. Our outreach is dedicated to building rapport at this early stage with the goal of securing trust and executing mutually beneficial

agreements upon Contract award. To date, we have met with 23 of the 26 acute care hospitals in the State, covering all counties. These meetings have been cordial and the hospital leadership has been appreciative of our commitment to educate them about our organization. For independent physician practices, securing hospital agreements will greatly influence their decision to participate with our program. Based on the intial feedback, all hospitals we have met with have expressed interest in negotiating an agreement, and we are confident we will have a comprehensive provider network that includes PCPs, key specialist providers and hospitals as well as key ancillary provider types, such as pharmacies and diagnostic service providers (i.e. lab, x-ray) – including providers who previously did not accept Medicaid.

Provider Resistance in New Hampshire. As previously stated, New Hampshire providers are expressing interest in discussing participation agreements with GSHP after the State makes its selections. However, we are experiencing some resistance from providers in terms of obtaining signed Letters of Intent (LOI) for reasons that are consistent with the objections voiced by most providers in the early stages of developing networks with other Medicaid programs Centene manages. Examples of common remarks the New Hampshire medical community has shared with GSHP regarding their hesitation to join our network are:

1. "We want to wait and see which plan is awarded a contract, then we'll join that plan"
2. "We are concerned about the impact this new program will have on reimbursement"
3. "We want to delay our decision pending outcome of current State issues we are working through regarding Medicaid"
4. "We don't want to join any program related to Medicaid"

Provider resistance is most prevalent in the months prior to the posting of bid awards and diminishes during implementation of the new program. We appreciate any support State Medicaid administrators can demonstrate in the form of communicating messages to providers that corroborate with bidding health plans and encouraging all providers in the State to embrace the impending changes and participate with the health plans who are awarded a Contract. These efforts will contribute to a successful transition for the State and to every bidder's overall network development success in New Hampshire.

Provider Recruitment Activities in New Markets. With guidance from our parent company, Centene, GSHP, like its affiliate health plans, activates a variety of outreach efforts designed to raise awareness within the local provider community in preparation of the impending changes to the State's Medicaid program and our interest in serving the state's Medicaid members through the development of provider networks consisting of local providers. Our provider outreach efforts in New Hampshire include:

- Face-to-face introductory meetings to introduce providers to Granite State Health Plan and explain the State's Care Management initiative for its effected Medicaid members.

- Meetings coordinated or arranged by FQHCs to leverage their existing relationships to (a) get team access to key providers and (b) ensure that key providers are aware of our relationship.
- Development of a website for providers to access information on Granite State Health Plan and instructions on how to apply for participation in our network.
- Identifying Medicaid, and other key providers who have not traditionally served Medicaid populations, through various data sources.
- Mailing letters to providers with admitting privileges to newly contracted hospitals to invite them to contract with GSHP, including follow up activities.
- Sponsoring community events for providers or hosting dinners and similar events to educate providers on GSHP's benefits and services.
- Coordinating speaking engagements and meetings with medical societies and provider associations.

GSHP has a complete Network Management and Contracting team ready to negotiate and enter into NH DHHS approved provider agreements. Our Network Management, Provider Relations and Contracting teams constantly monitor and evaluate the provider network from a comprehensive accessibility perspective for members. The team works closely with local providers to build trust and establish long standing relationships. Through these partnering relationships, GSHP will establish network stability and consistency, both of which are critical to long term success in the market. GSHP will further promote loyal, locally-grown provider networks through the development and inclusion of providers on our quality committees including the Quality Improvement Committee, Credentialing Committee, Community Advisory Board and Provider Forums. Local provider representation on these important committees creates an atmosphere of trust and understanding of the challenges and interests of providers and the health plan, which leads to the development of programs that effectively address local health care issues and improve access to quality health care services for our members.

Network Readiness is Centene's Strength. With Centene's guidance and experience in developing provider networks to serve Medicaid populations in 14 other states, GSHP has already identified most key providers in the State and has made great strides in addressing the challenges, objections and obstacles presented by providers and other key stakeholders whenever a new program or change is introduced. By applying Centene's network development "know-how" in New Hampshire, we expect to meet network access standards in critical areas. Close observation of the growth and success of Centene will reveal that Centene has always operated as a commercial carrier business enterprise in terms of how well members are treated, providers are paid and how access to care standards match or even exceed commercial standards.

Provider List

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. (Refer to the GIS Instructions - Appendix A).

The GIS reports are provided in the "Other RFP Requirements Binder" under tab "6.16 Required Attachments", along with a list of Granite State Health Plan's (GSHP) proposed provider network in New Hampshire.

Centene Helps States to Succeed in Serving Their Poorest Citizens

Throughout our response, we've described how Granite State Health Plan (GSHP) will draw upon the experience and knowledge its parent company, Centene Corporation (Centene), will bring to the state of New Hampshire. In this section of our response, we want to impress upon state officials and key stakeholders involved with this bidding process, of the need to take great care in selecting bidders who have demonstrated their successful approach and great care in developing provider networks that are organically grown and locally nurtured. Centene is one of the nation's largest and most experienced Medicaid managed care plan managers for state sponsored Medicaid managed care programs. Since 2006, Centene has helped 6 of its 14 state clients to successfully transition either all or part of their Medicaid populations from fee-for-service to managed care. When it comes to managing health benefits for Medicaid beneficiaries transitioning from fee-for-service to managed care, no company has more recent experience -- or a more successful track record -- than Centene. The common denominator leading to the smooth transition of our nation's poorest and most vulnerable people from fee-for-service to managed care has been our insistence on supporting local providers and building on existing programs within each state.

When it comes to managing health benefits for Medicaid beneficiaries transitioning from fee-for-service to managed care, no company has more recent experience

-- or a more successful track record -- than Centene.

We believe this is the greatest value that Centene brings to states, like New Hampshire, in the midst of great change necessitated by financial hardships. We recognize the difficult decisions that must be made and want to reassure New Hampshire state officials that we have walked down this path with our state clients and we can truly make this change a positive experience for stakeholders, providers, and most importantly, the citizens of New Hampshire.

Organically Grown and Nurtured Provider Networks. The core reason for our success is our commitment to building provider networks starting with local providers who have historically served Medicaid enrollees. These providers are the most valuable resource for us and our state clients in ensuring a smooth transition for members because:

1. They already serve Medicaid members
2. They have long-standing, established relationships with other Medicaid providers
3. They have an awareness of resources within the community that serve underserved populations

4. Their motivation to serve Medicaid members comes from their heart rather than what is to be gained financially
5. They practice cultural competency every day.

These attributes are common among providers who have served Medicaid members over the years. The underlying theme is that traditional Medicaid providers have provided more than health care services to Medicaid members – they have performed a public service for the entire community and deserve recognition for their work. It is for these reasons that we first seek to build our provider networks with traditional Medicaid providers as the foundation of our program.

Our Network Development Strategy for New Hampshire. We have used a layered approach in developing our provider network in New Hampshire that includes our staff of Network Development Representatives who are based in the northeast region, provider outreach activities, and a partnership with Bi-State Primary Care Association (BSPCA). Each strategy is described more fully below.

Provider Recruiters on the Ground. Our Network Development Representatives lead the network development campaigns in our new or expanding markets. Their mission is to gain commitment from local hospitals and provider groups for participation in our network. To date, our representatives have succeeded in meeting with 23 of the 26 acute care hospitals in the State. Additionally, over the past three months our Network Development Representatives have been on the ground and traveling throughout New Hampshire meeting with local providers, sharing information about the impending changes to the DHHS program and how it will impact providers and members, and establishing rapport with providers and community leaders who will also be impacted by the state's decisions regarding the New Hampshire Medicaid population. As a result of their efforts in New Hampshire, we have obtained Letters of Intent (LOI) as well as verbal commitments from providers across the state.

Glenridge Healthcare Solutions. We also enlisted the help of Glenridge Healthcare Solutions (Glenridge), a leader in network development and data management tools for the management and program development needs of health plans and provider organizations. Glenridge facilitates seamless integration of provider data with our systems, processes and staff. We selected Glenridge to assist us with our development and expansion efforts in New Hampshire because they are uniquely experienced at connecting Medicaid health plans with experienced providers in a time of massive regulatory reform, managed care upheaval and deep division between payer and provider. Glenridge has been sending mailings, conducting phone surveys, gathering provider data and reaching out to local providers via telephone to engage their interest in participating with GSHP. Their provider outreach efforts have resulted in the collection of nearly *750 LOIs and verbal commitments* from hospitals, FQHCs Federally Qualified Health Centers), primary care and key specialist providers that translates into more than *3,500 individual providers* who are interested in participating with GSHP in New Hampshire.

Partnership with Bi-State Primary Care Association (BSPCA). GSHP is pleased to have formed a unique partnership with the Bi-State Primary Care Association (BSPCA). We believe this partnership will greatly benefit the Medicaid beneficiaries in New Hampshire by ensuring the provision of health care services – now and in the future - through a comprehensive, well-coordinated network of FQHCs. *Our main objective in forming this partnership is to increase provider capacity levels and to build upon our access to high quality, cost effective care for our members.* Currently, the FQHCs have the capacity to provide

health care services for approximately 20,000 Medicaid beneficiaries. By working together, we are maximizing resources and building infrastructure for the future. We expect to double the FQHC's capacity to serve 40,000 Medicaid beneficiaries. The program we will create together is based on the following five areas of partnership:

- Shared planning and execution of quality programs between GSHP, BSPCA, and the FQHC. GSHP will provide needed technical assistance in using data to drive continuous improvement, helping to select and measure appropriate clinical protocols, and developing QI plans;
- Developing on-site case management capabilities to assist patients in meeting their health care goals and needs and creating jobs within the local communities being served;
- Collectively identifying underserved communities and patients, and working together to develop primary care capacity and workforce to serve these areas;
- Developing technical assistance capabilities that will ensure effective patient-centric operations and strategic and financial planning for growth at FQHCs; and
- Developing a technology infrastructure, workforce, and methodologies to effectively manage population health costs.

BSPCA member FQHCs will contract directly with GSHP to better manage patient costs and to capture utilization data and provider performance metrics that are measurable and meaningful to the success of each FQHC's ability to serve as the Medical Home for GSHP members. We believe that this program has the potential to be an industry-recognized best practice for how managed care organizations and health care providers can and should partner in the best interest of GSHP members, BSPCA member FQHCs, and the local communities we collectively serve.

Provider Recruitment Activities: Performance Metrics. Our provider recruitment teams have been very active in New Hampshire over the past few months and we will continue reaching out to prospective providers for as long as is necessary to ensure our compliance with DHHS travel distance and our own stringent access to care standards are met. The table below depicts the performance metrics regarding our provider recruitment campaign in New Hampshire through December 12, 2011:

SUMMARY OF PROVIDER OUTREACH ACTIVITY (# of Touches)				
	Hospitals	FQHCs/RHCs	Physicians	Total
Face-to-Face	45	21	1528	1594
Outbound Calls	62	47	1055	1164
Fax/Email	36	10	189	235
Outbound F/U	40	105	1005	1150
Inbound Calls	1	10	116	127
Re-Mailings	0	8	86	94
Mass Mailing				805
Org. Contacts	27	15	776	818
Doc @ Org Contacts	2977	134	1213	4324
Ave Contact per Org	5.5	6.4	3.8	3.9

Access to Care Initiatives for Coos, Grafton and Carroll Counties. The rugged and remote region of northern New Hampshire coupled with harsh winter weather creates difficult and challenging dilemmas in terms of access to health care services for local residents. We believe providers are willing

to practice in the northern reaches of New Hampshire, but the resources they would need to deliver the full spectrum of primary care services are simply not available. To address these access to care concerns in the most remote and rural regions of New Hampshire, which include Coos, Grafton and Carroll Counties, GSHP will implement the following initiatives:

- *Co-location of GSHP employed clinicians at FQHC and CMHC sites*. By embedding our employees with clinical experience within each clinic, we help to alleviate some of the administrative burdens and patient overload situations that rural providers often experience while improving access to quality healthcare services for our members
- *Telemedicine services* provided through Teladoc and coordinated with GSHP member Services and NurseWise to facilitate 24/7 access to PCPs for members who cannot travel to their PCP for care. Our telemedicine program is described in the response to Question 31 herein.

Recent Examples of Centene's Success Helping States to Manage Medicaid Programs

Throughout our proposal, we have described Centene's Medicaid managed care experience in 14 states. Below, we highlight our most recent implementation experiences for five of our newest State clients in Illinois, Mississippi, Louisiana, South Carolina and Georgia. We've provided historical background in order to show the relevance of our network development approach in helping our State clients to achieve their goals for the Medicaid programs in their respective states.

Centene's Success in Illinois. Our recruiting effort for the state of Illinois' Integrated Care Program highlights our ability to develop provider networks from scratch, in the midst of competition with a large commercial carrier (for our Illinois affiliate, IlliniCare Health Plan (IlliniCare)). The competing carrier had a sizable commercial network already operating in the pilot areas that they proposed for the ABD population to be served, despite the fact that many commercial providers do not have experience with or wish to provide health care services to special needs members. Our contracting team, made up of internal and external Provider Recruiters, worked to build a network from scratch in anticipation of delivering health care services to 20,000 members in suburban Cook County and the five counties surrounding Chicago. Despite the heavy competition we faced, we succeeded in obtaining approximately 5,000 LOIs to submit with our proposal. We were pleased to be awarded a contract and began operations in January 2011. We believe our successful bid was a direct result of our network development approach in Illinois wherein we engaged local provider interest in participating with IlliniCare by telling the Centene story (see below) and educating providers on how we are better able to take care of special needs members.

The Centene Story in Illinois. Our successful network development approach in Illinois resonated with the providers we recruited in several ways. To begin, because Medicaid managed care is our only business, our Illinois staff was able to dedicate 100% of its attention to the Medicaid populations and providers we serve and was not distracted by other products such as commercial or Medicare offerings. Additionally, Centene's commitment to and partnership with local FQHCs and health clinics gave us a huge advantage over our competition, as we were able to secure an exclusive agreement with the largest FQHC provider in the Chicago area because of our vast Medicaid experience and our successes with ABD (Aged, Blind and Disabled) populations in other markets. Another factor in our success was our Member Connections program wherein we were able to offer free cell phones to high

risk members through Connections Plus as well as our Healthy Rewards Account Program to encourage healthy behaviors (which our commercial competitor could not match). We also found that our local approach was very well-received by the providers who expressed their satisfaction with IlliniCare offices and personnel actually being in the same communities as our providers. Another unexpected benefit of our "Medicaid only, on the ground approach" was that we were able to obtain agreements with several key provider systems and groups who shared with us that they would not sign with the commercial carrier due to existing service and contractual issues. Our solid reputation within the larger provider community gave IlliniCare a huge advantage due to the fact that we did not bring baggage from other lines of business to these new provider relationships.

Centene's Success in Mississippi. In 2010 Magnolia Health Plan (MHP) was awarded a state wide managed care contract by the Division of Medicaid in Mississippi to serve the ABD Medicaid population. Consequently, MHP was required to build a network throughout Mississippi to meet the needs of this unique population. MHP understood that health care is delivered locally and that we needed to be on the ground in the market, using and establishing local connections, in order to construct a cohesive provider network. It was also clear that, although there were urban centers in Mississippi, such as Jackson and Gulfport, the state was predominantly rural.

The Centene Story in Mississippi. In order to fully understand the local provider community, MHP's approach was to engage providers directly, face to face, with seven Provider Recruiters "in the field" full time. Several of our Provider Recruiters had extensive experience working in the Mississippi provider community. These recruiters were supplemented with six full time recruiters contacting providers via telephone to obtain participation agreements and, where appropriate, setting up face to face meetings for the field team. We also developed a formal relationship with the Mississippi State Medical Association, and through them engaged their wholly owned provider network organization, Mississippi Physicians Care Network, as a significant resource and influence in developing our statewide physician network. This relationship still exists today. These strategies allowed us to blanket the State of Mississippi, including the historically challenging rural region of the Mississippi Delta, to ensure comprehensive coverage for all services. In fact, over 140 Rural Health Clinic (RHC) locations are participating in our network today. We also understood and focused our strategy on providers that were the traditional caregivers for the Medicaid population in Mississippi. As such, we developed a rapport with the Mississippi Primary Care Association and all twenty-one (21) of the existing FQHCs in Mississippi are participating in MHP's network. As of today, there are over 4,000 providers participating in MHP's network in Mississippi. That includes 71 hospitals covering all corners of the State as well as key health systems such as Hospital Corporation of America (HCA), University Hospital and Health Systems – University of Mississippi Medical Center, Health Management Associates, Inc. (HMA), and Baptist Health System.

Centene's Success in Louisiana. Like New Hampshire, the state of Louisiana is a brand new entrant into the Medicaid managed care environment with its Medicaid fee-for-service populations in the midst of transitioning to managed care effective February 1, 2012 -- for the first time in the State's history. Our network development efforts in Louisiana began two years before the State of Louisiana issued their Request for Proposal (RFP) for its Coordinated Care Networks program. The transition will occur in three phases with the first two phases covering five of the nine Medicaid regions. In June 2011, our Centene affiliate in Louisiana, Louisiana Healthcare Connections (LHC) was awarded a statewide

contract and has been assisting the State with the transition process for months. To date, all FQHCs, RHCs and School Based Health Clinics in the regions have joined LHC. Our first members will be enrolled February 1, 2012, and we have already demonstrated our network readiness by exceeding the State's network adequacy requirements with over 3,000 executed agreements with over 500 PCPs and several health systems, including Tulane University Medical Groups, Children's Hospital and their PHO, and Baton Rouge General Hospital.

The Centene Story in Louisiana. In Louisiana, Centene wanted to introduce a provider/owner model as part of its strategic solution for a successful and smooth transition from fee-for-service to managed care for the State. We initially met with a number of provider groups to find the right partner for a shared ownership model. We were pleased to form a joint venture partnership with 19 of the 25 FQHCs in the State. Using this innovative structure, we firmly established LHC as a provider-centric company both with the State and its provider community. This was especially important in Louisiana where 40 of the 64 parishes (counties) are classified as rural and the state has a large geographic footprint. FQHCs and RHCs play an essential role in serving the underserved in these communities. Our shared ownership opened doors within a provider community that is wary and skeptical of managed care organizations. With a team of nine full time Provider Recruiters "in the field" and another ten telephone provider outreach staff, we made contact with providers in all nine of the State's Medicaid regions during the time leading up to the RFP release date. We were repeatedly told by providers that we were the only MCO that had met with them. As with all State expansions or transitions to managed care, the purpose of our advanced and exhaustive outreach efforts with providers is first and foremost to introduce ourselves to the providers, teach them about our approach, programs and initiatives, and in most cases teach them about the initiative the State is preparing to introduce. The good will generated through our early relationship building in Louisiana has translated into a successful network build through the first phases of their roll-out.

Centene's Success in South Carolina. When state officials in South Carolina decided to issue an RFP, the program had a rough start because during that time the State was contending with unresolved issues presented by hospital stakeholders regarding the Upper Payment Limit and year end reconciliations. Also, the State allowed any bidder who could show intent to do business in the State by building a provider network, to participate in the program. This created a complicated bid process and led to over 10 contract awards and as many new payors entering the market; each seeking a contract from providers in the State. Providers were so overwhelmed with the number of new payors approaching them for an agreement that they limited the number of contracts they would sign. This led to several of the new plans electing to leave the market due to network inadequacy. However, our South Carolina affiliate, Absolute Total Care, continued to operate and increasingly helped the State pull through the turmoil that ensued by consistently delivering high quality member and provider service.

The Centene Story in South Carolina. The Medicaid managed care program in South Carolina is divided into four regions, and the implementation was phased in by region over the first year. The State required winning bidders to obtain network adequacy approval for each county prior to allowing the payors to have members in that region. From the initial implementation, our active practitioner panel grew from 75 credentialed practitioners to nearly 6,500 within 3 years. Today we have over 7,300 active practitioners in South Carolina. This represents over 45% of the total number of available

practitioners in the area we serve in South Carolina. Despite the initial challenges other payors experienced, we have consistently met South Carolina provider access requirements.

Centene's Success is Georgia. In 2005, Peach State Health Plan (PSHP) was awarded a managed care contract by the Georgia Department of Community Health in Georgia to serve several categories of its Medicaid population in three regions of the state. PSHP was required to build provider networks in the regions of Atlanta, Central and Southwest, which encompassed more than half of the counties in the State of Georgia, to meet network adequacy standards for nearly 800,000 enrollees. Our team of Provider Recruiters was on the ground in Georgia and quickly constructed a cohesive provider network in all regions in time for the January 2006 start date.

The Centene Story in Georgia. We developed a formal relationship with Choice Healthcare; a consortium of FQHCs based in the Atlanta area and through them we were able to quickly develop our physician network for the Atlanta region. Through our own network development efforts in all other regions, we have a very large and stable provider network in Georgia that includes over 15,000 providers, comprising 90% of the total number of providers in the state. In 2011, we were awarded the remaining 3 regions (there are 6 regions in the State) and are prepared to serve the entire state of Georgia on the program expansion start date of January 1, 2012.

Granite State Health Plan is Ready, Willing and Able to Serve New Hampshire. Unlike commercial carriers that tend to use a "one size fits all" approach to network development, Centene recognizes that special needs populations require a customized network that is experienced and willing to provide quality care to our members. Therefore, we first seek to build our provider networks from the ground up – at a local level - with traditional Medicaid providers as the foundation of our program. The list of providers from whom we have received LOIs in New Hampshire depicts only a small part of our exhaustive network development efforts in New Hampshire that we know will lead to a fully qualified and fully functioning provider network that is ready to serve DHHS and its citizens from day one. It is our great desire to serve the state of New Hampshire. We look forward to being selected by DHHS to serve your Medicaid beneficiaries and continuing the legacy of dedication, kindness and care that the people of DHHS have shown to their fellow citizens in the provision of health care services.

Projected Ratio of Providers to Members

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

Ratio of PCP and Specialty Providers to Members

The Member and Provider Ratio Report is located following this narrative.

Capacity Limits for PCPs and Specialty Providers. Granite State Health Plan (GSHP) will comply with state mandated requirements or apply accepted industry standards for patient capacity among providers. Standard capacity limits for PCPs vary from plan to plan. For New Hamphire, we would take into consideration local providers' current capacity levels and realistic abilities to accept new patients in order to establish reasonable limits.

Rationale Used to Determine Network Sufficiency. Our standard practice for determining network sufficiency starts with obtaining the number of members within a given geographic region and comparing the total number of members against the total number of in-network primary care providers serving the same geographic region. We also take into account those providers who have reached the capacity limit and adjust calculations in order to get a true picture of network capacity for each geographic region. In New Hampshire we define "geographic region" as each individual county within the state. In new markets, like New Hampshire, where we do not yet know how many members we would have in any given county, we apply reasonable assumptions regarding expected enrollment levels, or we follow any enrollment assumption instructions provided by the state.

Our Methodology for Determining Network Sufficiency in New Hampshire. In order to develop a meaningful provider-to-member ratio analysis to verify that GSHP had received commitments from an adequate number of PCPs and specialists, it was necessary to define certain data resources and criteria as follows:

- Since DHHS plans to award 3 contracts, GSHP assumed 33% of the eligible population in each county for our member count. The member counts are reflected in the table below.
- In defining provider types to be measured, we targeted 18 core physician specialties, known through our national experience to represent the high volume Medicaid specialties, and all PCP types. The specialties are reflected in the table below.
- Since DHHS did not provide specific provider to member ratios, we utilized ratios used by Centene in other markets. Due to the smaller geographic footprint of New Hampshire, and the often difficult travel conditions, we tightened the Centene ratios for GSHP (for example, instead of one provider per 20,000 members, we reduced it to one provider per 2,000 members). The ratios are reflected in the table below.
- Provider counts included for each county in the below table include all providers falling within industry standard mileage parameters for the members in the county.
- Since we do not have actual member locations, for this analysis we utilized census data derived from a CMS enrollment file as a proxy for member locations. This allows us to calculate distances from our contracted provider locations to the actual population centers in each zip code within each county.

As the table below demonstrates, with the exception of areas like Coos County where providers are sparse in general, GSHP's provider network far exceeds the minimum ratios developed for New Hampshire.

Ongoing Measurement and Reporting to DHHS. During the first year of operations and at least annually thereafter, GSHP will conduct an access and availability evaluation to ensure our provider network meets network and access requirements in New Hampshire and we will submit the ratio report to DHHS as required or requested. At a minimum, this evaluation will analyze compliance with travel distance standards, appointment availability, after-hours access standards, and cultural competency for key provider types, which include PCPs (including FQHCs and RHCs), OB/GYNs, and

selected specialist physicians. For DHHS, GSHP will prepare a report showing the ratio of PCP and Specialty Care Providers to members using the enrollment data files supplied by DHHS. Typically, after the first year of operations with a new health plan, we include additional provider types, such as hospitals, urgent care providers, home health and other ancillary providers, pharmacies, and vision care providers, in our evaluation. Quality Improvement (QI) staff complete the evaluation and then incorporate its results in the comprehensive, semi-annual, plan-wide Quality Evaluation Report.

GRANITE STATE HEALTH PLAN

County	Medicaid Beneficiaries	Estimated Enrollment	Primary Care Provider Ratio 1000:1	Servicing Providers	Allergy & Immunology Ratio 10000:1	Servicing Providers	Cardiac Surgery Ratio 7500:1	Servicing Providers	Cardiology Ratio 2000:1	Servicing Providers
Belknap	6747	2247	2	289	1	18	1	15	1	65
Carroll	4840	1612	2	259	1	17	1	15	1	76
Cheshire	6882	2292	2	164	1	12	1	15	1	51
Coos	4281	1426	2	55	1	0	1	9	1	2
Grafton	7249	2414	3	382	1	11	1	15	1	41
Hillsborough	35683	11882	12	587	1	9	2	7	4	51
Merrimack	12529	4172	4	823	1	18	1	15	1	81
Rockingham	15676	5220	5	600	1	14	1	7	2	51
Strafford	11510	3833	4	192	1	12	1	5	1	7
Sullivan	4770	1588	2	334	1	13	1	15	1	42

County	Medicaid Beneficiaries	Estimated Enrollment	ENT Ratio 3000:1	Servicing Providers	Gastroenterology Ratio 3000:1	Servicing Providers	General Surgery Ratio 1500:1	Servicing Providers	OB/GYN Ratio 3000:1	Servicing Providers
Belknap	6747	2247	1	26	1	34	2	75	1	153
Carroll	4840	1612	1	25	1	33	1	94	1	149
Cheshire	6882	2292	1	23	1	35	2	39	1	126
Coos	4281	1426	1	2	1	1	1	6	1	18
Grafton	7249	2414	1	14	1	25	2	57	1	128
Hillsborough	35683	11882	4	15	4	22	8	40	4	90
Merrimack	12529	4172	1	25	1	39	3	96	1	149
Rockingham	15676	5220	2	18	2	21	4	47	2	110
Strafford	11510	3833	1	17	1	16	3	21	1	82
Sullivan	4770	1588	4	15	1	30	1	55	1	133

GRANITE STATE HEALTH PLAN

County	Medicaid Beneficiaries	Estimated Enrollment	Infectious Disease Ratio 2000:1	Servicing Providers	Nephrology Ratio 5000:1	Servicing Providers	Neurology Ratio 3000:1	Servicing Providers	Neurosurgery Ratio 7500:1	Servicing Providers
Belknap	6747	2247	1	24	1	23	1	56	1	17
Carroll	4840	1612	1	24	1	23	1	56	1	17
Cheshire	6882	2292	1	24	1	19	1	49	1	17
Coos	4281	1426	1	17	1	0	1	1	1	11
Grafton	7249	2414	1	24	1	17	1	37	1	17
Hillsborough	35683	11882	6	11	2	11	4	22	2	7
Merrimack	12529	4172	2	24	1	25	1	59	1	17
Rockingham	15676	5220	3	11	1	15	2	28	1	7
Strafford	11510	3833	2	11	1	11	1	22	1	6
Sullivan	4770	1588	1	24	1	19	1	47	1	17

County	Medicaid Beneficiaries	Estimated Enrollment	Oncology Ratio 8000:1	Servicing Providers	Ophthalmology Ratio 2000:1	Servicing Providers	Orthopedic Surgery Ratio 1500:1	Servicing Providers	Podiatry Ratio 3000:1	Servicing Providers
Belknap	6747	2247	1	67	1	18	2	52	1	29
Carroll	4840	1612	1	61	1	38	1	74	1	29
Cheshire	6882	2292	1	63	1	21	2	35	1	23
Coos	4281	1426	1	0	1	1	1	6	1	5
Grafton	7249	2414	1	47	1	12	2	40	1	15
Hillsborough	35683	11882	2	35	6	24	8	37	4	23
Merrimack	12529	4172	1	71	2	42	3	89	1	32
Rockingham	15676	5220	1	39	3	26	4	53	2	29
Strafford	11510	3833	1	30	2	9	3	26	1	23
Sullivan	4770	1588	1	55	1	15	1	86	1	16

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County	Medicaid Beneficiaries	Estimated Enrollment	Pulmonology Ratio 3000:1	Servicing Providers	Rheumatology Ratio 3000:1	Servicing Providers	Urology Ratio 3000:1	Servicing Providers	Vascular Surgery Ratio 7500:1	Servicing Providers
Belknap	6747	2247	1	33	1	25	1	42	1	31
Carroll	4840	1612	1	31	1	25	1	42	1	31
Cheshire	6882	2292	1	31	1	25	1	41	1	31
Coos	4281	1426	1	0	1	12	1	0	1	17
Grafton	7249	2414	1	19	1	25	1	22	1	31
Hillsborough	35683	11882	4	22	1	14	1	31	2	22
Merrimack	12529	4172	1	35	1	25	1	46	1	31
Rockingham	15676	5220	2	24	1	10	1	33	1	22
Strafford	11510	3838	1	18	1	6	1	28	1	19
Sullivan	4770	1588	1	25	1	25	1	38	1	31

Providers Knowledgeable About Genetic or Chromosomal Conditions

Q35. Describe how you will ensure that members have access to providers who are knowledgeable about genetic or chromosomal condition(s) and 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).

Overview

Granite State Health Plan's (GSHP) parent company, Centene Corporation (Centene), has experience providing care management and care coordination services for developmentally disabled and underserved populations. Like our Centene health plan affiliates, we will use a holistic, member-centric approach to serving members with development disabilities (DD) that incorporates strengths-based assessment, support of the provider community, and integration of covered services with community resources to assist members in the least restrictive, most appropriate way to ensure their physical and mental well being. Our innovative approach to serving disadvantaged populations has improved health care outcomes for our members while improving their level of functioning and reducing unnecessary use of health care services.

Community Support Network (CSNI) and GSHP. We recognize that state institutions for the seriously mentally ill and developmentally disabled have been eliminated in New Hampshire and Medicaid beneficiaries obtain services through Community Support Network, Inc. (CSNI), which is comprised of ten area agencies located throughout New Hamphire. These agencies provide acute and long term care services to individuals with developmental disabilities and assist their families in accessing additional caregiver support services. *All ten agencies are in the process of signing Letters of Intent (LOI) with GSHP.* Additionally, GSHP has invited CSNI to be a member of GHSP's Community Advisory Committee. Both CSNI and GSHP are enthusiastic about working together to serve the developmentally disabled residents of NH in a way that supports and encourages Consumer Directed Services and brings family members, caregivers and the community together to assist members in achieving their life goals.

GSHP's Care Coodination Program for DD Members. GSHP's holistic care coordination approach is based on Centene's core Coordinated Care Model, which our affiliate health plans use to manage cases for members with traumatic brain injury, serious mental illness, autism, bipolar disorder, ADHD, seizure disorder, cerebral palsy, congenital defects and other chronic, complex, co-morbid and co-occurring conditions. Our approach will reflect lessons learned by our affiliate health plans serving similar populations in other states. For example, we have learned that effective case management and care coordination for persons with physical and cognitive disabilities and/or mental health issues must go beyond a clinical determination of needs to include and address each member's functional status and fully investigate any barriers to care they encounter. We also recognize that while some members have complex or co-morbid medical conditions, others may require a more functional approach to

their care rather than the traditional medical model. Because the experience of our affiliate Centene health plans demonstrates that active member direction and engagement are key factors in compliance and improved outcomes, GSHP will encourage and support active member direction (Consumer Directed Services) and caregiver engagement, which we find are key factors in compliance and improved outcomes in the care plan process. Our goal for each member is to help them live in a healthy, safe environment. Maintenance and/or improvement of health, behavioral health and functional status are prerequisites for this goal and not merely ends in themselves. This core philosophy drives our approach to providing services and support for our DD members.

Using this model, Centene's affiliate health plans have coordinated acute, behavioral, pharmacy, nursing facility, and long term care services as well as non-covered community resources. This approach has earned Centene recognition as a best practice in serving special needs members in managed care.[9]

Effective case management and care coordination for those with physical and cognitive disabilities and/or mental health issues must go beyond purely clinical determination of needs to identify and address functional status and barriers to care.

Care Management Approach to Eliminating Health Disparities. Our Case Managers (CMs) spend their time in the field, getting to know members and their families/caregivers. They develop and maintain strong relationships with the member's provider(s) to meet each member's needs and quickly identify and address issues. CMs support caregivers by connecting them to respite services and community resources to help prevent burnout and strengthen the informal support system. By taking the time to learn about our member and their daily challenges, our CMs can more effectively assist the member with their social and functional needs – which is often an important link to meeting their medical and behavioral health care needs.

Additional Service Support for Providers Serving DD Members. Our approach to care management for DD members involves additional service support programs to assist the providers who serve our DD members. In many cases, providers who serve patients with DD diagnoses are highly specialized and limit their practice to DD patients. Therefore, in order to ensure continuity of care and relieve these specialized providers for the need to serve the general population, we will enter into single case agreements or allow closed panels to further augment the provider's ability to serve our DD members. Also, our Provider Recruiters and Care Managers work together to canvas local advocacy groups to obtain referrals to providers who treat DD patients, including those who do not accept Medicaid. Our assigned Care Managers address and monitor the incidence of a DD member appointment no show by coordinating appointments and transportation service for both members and their caregivers/attendants. We also offer interpreter services and other non-medical support services that are conducive to the member's and provider's abilities to effectively communicate with one another regarding care treatment plans and follow up treatment or appointments. All of these activities are

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[9] SCHIP Innovations for Children with Special Needs in Managed Care. *Center for Health Care Strategies Resource Paper. Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus. February 2003.*

designed to enable the providers to better serve our DD members in support of the additional assistance DD members need to have their health care needs fully addressed.

How Informatics Reduces Care Gaps. Our CMs are supported by Centene's informatics tool, Centelligence™, which is part of Centene's family of integrated decision support and healthcare informatics solutions. Centelligence enhances the CMs ability to anticipate, identify, monitor and address issues and opportunities for improvement. For example, CMs can use Foresight, our predictive modeling and care gap/health risk identification application, to

- track member conditions;
- monitor member care gaps (health risk alerts);
- identify members with co-morbid conditions
- identify persons at risk of developing chronic conditions;
- identify persons in need of additional services or higher levels of case management.

Armed with this data, the CM can take immediate action and assist the member. CMs and other clinical staff access this information with one click through TruCare, our member-centric health management platform for case management, behavioral health (BH), disease management, and utilization management. TruCare allows us to integrate utilization, BH care, case management and disease management efforts; proactively monitor members; efficiently document the impact of our efforts; pinpoint where care is needed; and implement customized intervention strategies. Additionally, we maintain data for Medicare Special Needs Plan (SNP) members within the same system, providing us a more holistic view of the needs and services of all member, regardless of their status as Medicaid, Medicare, or dually eligible. Our CMs' outreach efforts will also be supported by Centene's Member Relationship Management (MRM) system, which integrates information from several case tracking systems into one repository that links all systems related to member file management.

Care Coordination with Providers. Each CM works with the DD member's PCP to review the assessment, care plan, member preferences, goals and needs. With member or appropriate caregiver consent, the CM shares clinical information and care options with all applicable providers, and shares each provider's input with other treating providers to ensure coordinated input into the care plan. Additional expertise and input may also be obtained from our multidisciplinary Case Review Team (CRT) for members with complex situations. The CRT is comprised of the Medical Director, Vice President of Case and Medical Management, CM Supervisors, BH Coordinator, and CMs. A CM Supervisor evaluates all moves from home and community based settings into an assisted living facility for appropriate level of care prior to the move.

Innovative Care Management Strategies. GSHP's care plans will incorporate innovative services that go beyond covered services to assist members in living safely at home and enhance our ability to monitor their health conditions. Our Integrated Care Program (ICP) will support providers to ensure timely access to care, manage costs and improve outcomes for members with severe and persistent mental illness (SPMI). We will include Medicare-certified medical and BH providers who are accustomed to working with DD and SPMI patients in our provider network. Our Care Managers will

provide technical assistance to ICP providers to develop local integrated service delivery connections between medical and BH providers. As part of the ICP in other markets, our affiliate health plans have been transforming certain behavioral health clinics into a Medical Home with behavioral expertise. We will place a CM onsite to facilitate coordination of care, discharge planning and community re-integration. The hospital will contact our crisis line when a member presents in an acute behavioral health crisis in the ER so we can quickly work to resolve the crisis and avoid unnecessary hospitalizations.

Initial Assessment of New Members. CM Supervisors review information from Centelligence™ Foresight (including TruCare), such as eligibility and claims as well as information obtained from the State, previous Contractors, BH providers, or other sources to identify members with existing services or immediate needs. New members receive a Welcome Call from a Program Coordinator (PC) who helps the member complete a Health Risk Screening (HRS) to identify diagnoses, hospital and emergency room use, mental health conditions, substance use issues, and use of medical equipment and supplies. The PC enters HRS data and other information gathered during the call into TruCare. The CM Supervisor uses this information to assign a CM and a timeframe for the initial assessment visit. Depending on the member's condition and needs, the CM may be a nurse, BH clinician or social worker. If enrollment or HRS information indicates unmet critical needs, the PC immediately contacts a CM, who assesses criteria for urgent initiation of services and schedules an immediate home visit. If there are no unmet critical needs, the PC works with the member to schedule a home visit. When scheduling the visit, the PC or CM asks who else they would like to have participate, encouraging inclusion of caregivers and informal supports. For dual eligibles, the CM coordinates the initial assessment with the other health plan carriers.

Developing a Care Plan. To ensure our members can make informed decisions, CMs use Motivational Interviewing and other strategies to engage members and their families in the planning process, and provide comprehensive education about services and support available through GSHP. For dual eligible members, CMs discuss differences between long term care, Medicaid and Medicare, and how we coordinate both sets of benefits, including how CMs interface with Medicaid and Medicare Plans. CMs shares information with DD or Special Needs members living in their own homes about options (if available) to choose their spouse as a paid attendant caregiver and the need to consider how that choice may influence eligibility for other publicly funded programs. The CM also provides applicable disease management education to enhance the member's control over their own condition and care.

Case Management Resources. GSHP will rely on the expertise of our case management staff as well as that of our Centene affiliate disease management subcontractor and on sophisticated technology solutions to support our case management activities. We will also implement innovative programs to enhance each Member's care. These resources will enable us to effectively integrate the full range of medical, behavioral health, long-term and other services each member's needs.

Specialized Integrated Care Teams. GSHP will serve our special needs members using specialized ICTs, each with targeted experience and background relevant to the specific subgroup. Our Vice President of Medical Affairs and Director of Care Management advises each team on how to overcome obstacles, helps to identify high risk members and recommends interventions. GSHP will establish three

specialized types of ICTs to serve members with a focus on their specific health care situation. These specialized ICTs are described below.

1. Physical/Chronic Illness (PCI) ICT will provide care coordination and disease management services to members whose primary condition is a physical disability or chronic/complex medical condition(s). A registered nurse will serve as the lead Care Coordinator, while a behavioral health clinician Care Coordinator will be available to provide input and oversight on secondary behavioral health needs. Other team members, including a Program Specialists, Health Coach, Transition Coordinator and Program Coordinator will also support the Primary Care Coordinator. People with physical disabilities and chronic illnesses tend to be less active due to their physical limitations. This inactivity can lead to decreased cardio-respiratory fitness, osteoporosis, and an increase in dependence on others, a decrease in social interactions, and secondary complications. Primary physical activity goals of the PCI ICT for this population are to improve physical functioning and enhance well being.

2. Serious Mental Illness (SMI) ICT will be led by a licensed behavioral health Care Coordinator, a clinician who has experience in nursing and a psychology background. This ICT will also include RN Care Coordinators who have expertise in managing chronic and complex disabling conditions common among the SMI population such as diabetes, cardiovascular conditions, complications of obesity, congestive heart failure, chronic renal failure, brain injury and physical disabilities. SMI ICT staff have awareness of the special social, behavioral and educational needs of members with SMI, and are experienced in effectively communicating with family members, medical consenters, and agencies and providers (including Certified Mental Health Clinics (CMHC)) that serve SMI members. Care Coordinators manage referrals and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices. Care Coordinators, along with the Medical Director and Pharmacy Director, will work with the CMHC and/or behavioral health Provider and PCP to address medication compliance, drug interaction, multiple medication prescribing issues and psychotropic medication management. Follow up by the SMI ICT Team occurs daily or less often, depending on the member's social supports and physical health needs.

3. Developmental Disabilities (DD) ICT focuses on chronic care and life skills that include services similar for long term care populations, but are geared toward serving younger individuals and their families. These services include education and training regarding Consumer Directed Services and life skills and how to secure employment (Work Force program). Additionally, the DD ICT serves as a key resource for caregivers by encouraging and coordinating respite care to alleviate some of the stress and strain caregivers experience when taking care of their loved one. Staff also has expertise with receptive and expressive language challenges, mobility, and other issues related to developmental disabilities attributable to a physical or mental impairment, other than the sole diagnosis of mental illness. This may include a combination of mental and physical impairments, and the inability to live independently without continuing and regular assistance. The DD ICT will complete a determination of need (DON) for primary functional needs as well as medical care needs.

Supporting Living in the Community. GSHP's approach to care coordination will help members achieve the highest possible levels of wellness, functioning, independence and quality of life. Our processes will ensure integration of covered and non-covered services. Our ICTs will build relationships with members and their families, assisting them with issues that assessment tools may not identify. The Care Coordinator will continuously monitor the member to determine if the service plan appropriately meets their needs and to be aware of changes in the member life (such as move to a new residence or loss of a family member) that may indicate a need for revision of the service plan.

Determining and Addressing Member Needs and Preferences. The Care Coordinator (CC) will work with the member to assess functional abilities; physical and behavioral health conditions; social, environmental and cultural issues; ability to live independently; mobility; expressive language; economic self-sufficiency; medications; and other needs that form the basis of our integrated, holistic care plan. For members desiring to remain in their own home, the following assessments will be completed: an environmental assessment of the member's home; the Minimum Data Set for Home Care (MDS-HC); a Client Needs Assessment Questionnaire and Task/Hour Guide to assess the determination of need (DON); and a comprehensive ADL and IADL needs assessment. Care Coordinators will discuss Consumer Directed Services (CDS) with members and will help them complete a Self-Assessment Form to determine their level of readiness and desire to receive CDS. In addition, the Care Coordinator will administer a simple depression screen, and a brief mental status exam and confusion/dementia assessment. GSHP recognizes that home visits are highly important in serving individuals with chronic illness or disabilities. We believe that "meeting members where they are", through home visits, is an effective approach to building supportive relationships and provide an opportunity to observe members and their behaviors in a familiar and comfortable setting. With that in mind, an GSHP ICT member will conduct an in-home visit for all members at least annually and more often if the member experiences a significant change in their condition. This approach allows our multidisciplinary ICT to establish stronger relationships with our members than is possible by telephonic contact alone. Also, by conducting an environmental risk assessment we are better able to identify any barriers to improved health status that may exist in the member's home. Our ICT will use initial and ongoing contact with the member/family to establish a trusting relationship in order to understand all factors that affect member condition and care.

Strategies to Mitigate Risk. GSHP will implement innovative strategies to assist members in maintaining home or community based placement.

1. ConnectionsPlus. All Centene affiliates have implemented this innovative program, which provides high-risk members who lack reliable phone access with a pre-programmed direct dial cell phone (at no cost to the member) that facilitates communication with the ICT, providers and caregivers to ask questions, request assistance and report medication side effects and new or changed needs. The phone will also preprogrammed with other important phone numbers such as our 24 hour nurse advice line (NurseWise), and 911. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The cell phones also help care coordinators maintain contact with members for things like reminder calls, coaching and education, and to send text messages with health information targeted to the individual member's condition. This program received *URAC's 2009*

Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award and was a *2009 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree.* GSHP will offer several different styles of phone to accommodate the special needs of our population such as headsets or optimum texting keyboards for hearing impaired members and voice recognition for members with visual impairment.

2. Telemonitoring. For certain high risk members, we also offer telemonitoring services that allow for more frequent monitoring of high risk conditions, and also reduce travel to an office, which is frequently an issue for those with physical and cognitive disabilities and multiple co-morbidities. The CC will keep the provider updated on results of the monitoring data. This patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level for a diabetic or a blood pressure or weight for a member with congestive heart failure, will be transmitted electronically to the CC and evaluated against patient-specific or national guidelines and analyzed for favorable/unfavorable trends. The system can then be set at the member level to alert the CC, trigger an Interactive Voice Response phone call to the member, and/or alert the ICT or the member's PCP. The technology is entirely web-enabled and the devices will allow CCs and treating providers to easily monitor key health indicators, providing opportunities for real-time "teachable moment" interventions. The technology represents a quantum leap forward – and sets GSHP apart from its competitors in the area implementing real-time biometric monitoring capabilities on a large scale. We will also evaluate members for personal emergency response systems such as *Lifeline or Lifefone.* These programs enable seniors and persons with disabilities to remain in their homes with independence and safety. By pressing the button on their personal monitor (neck chain or wristband models), the member is linked to a 24 hour monitoring center and allows a two-way conversation with a trained professional. The monitoring center can contact emergency service or designated family/caregiver contacts as indicated.

3. Home Visits. GSHP recognizes the important role home visits play in serving individuals with chronic illness or disabilities. Without home care, members who are home-bound or who have a physical or cognitive disability that make visits to a doctor's office challenging will often go without necessary health care services. Compounding the problem, cognitive or physical disabilities may also impact an individual's verbal communication, making telephonic assistance and education difficult. Individuals who are home-bound or disabled are also at increased risk for abuse, neglect and exploitation. Home visits provide an opportunity for GSHP staff to observe the member's interaction with their caregivers and to look for potential warning signs. To meet the physical and behavioral health care needs of home-bound members, GSHP will contract with or coordinate the provision of services with local community organizations that provide in-home care and services (such as local Meals on Wheels).

4. Contingency Plans. A Contingency Plan will be an integral part of our care plans to ensure members receive critical services in their home such as attendant care, personal care,

homemaker, and respite care. The term "critical services" is inclusive of standard daily living tasks and other special needs. Because these services are, by definition, critical to the member's ability to maintain maximum function in a home or community setting, contingency plans are developed that enable the member as well as the ICT to take prompt action in order to prevent a crisis when there is a gap in critical services. The GSHP ICT will work closely with the member and their caregiver to develop the contingency plan so it aligns with the member's care plan, ensuring both plans reflect the member's choice to remain in the least restrictive setting while receiving appropriate and cost effective services for their needs.

Engaging Family Members or Other Caregivers. A family's support of maintaining the member's home placement is important to the member's success in maintaining that placement. If the family is anxious about the plan of care, the member may also become uneasy and worry about their ability to succeed. GSHP's holistic, "boots on the ground" model is a more personal interaction between the member, caregivers, family and the ICT. The CC will make special effort to ensure members' families are comfortable and in support of the care plan. The CC will reassure the member's family that our primary concern is the member's safety and well-being. The CC will talk with the family, listen to their concerns and specifically point out the interventions in the care plan that addresses those concerns. The CC may add additional service supports that were not originally part of the member's care plan to explicitly address family concerns, such as our pre-programmed cell phone through the ConnectionsPlus program or personal emergency response system. The CC will explain the implementation and review process for ensuring services are initiated in a timely manner and that the plan of care is reviewed frequently, through telephone and home visits, to ensure it continues to meets the member's needs.

At other times, family apprehension may be due to a lack of confidence in their ability to assist the member with certain wound care activities (such as handling feeding tubes or changing dressing). In these cases, the CC will arrange for training through a home health agency so the family member feels comfortable in performing the function. We will also offer to link the family and member (as applicable) to local support groups. Through this holistic, personal, transparent approach, GSHP's ICT will often be able to put the member's family at ease about the placement and support services to be implemented to meet our common goal of providing the member with the least restrictive home environment while maintaining their safety.

Preventing Abuse, Neglect, and Exploitation. GSHP will implement a proactive approach to preventing abuse, neglect and exploitation of our members by monitoring and, if necessary, reporting cases to the appropriate authorities. Our credentialing process will work to ensure agencies that provide services for our members are licensed by CMS and the state to provide services and have not been listed with Office of the Inspector General's (OIG) exclusion list. Through our credentialing process, we will also check ensure agencies have appropriate policies and processes in place to ensure their employees are appropriately trained and monitored. We will check OIG monthly to ensure no GSHP provider has been added to the exclusion list. Our clinical model will call for frequent interaction with members including telephonic and face-to-face visits either in the home or physician offices.

Our ICT are trained to detect signs of abuse and neglect and on reporting requirements and procedures at initial training and at least annually thereafter. This training will include the definition of abuse and

neglect, signs of potential abuse, the CC's duty under the contract and State law for reporting suspected abuse/neglect, and contact information for OIG, Department of Public Health and Department of Aging responsible for handling adult abuse, neglect or financial exploitation. We also contract qualified organizations that conduct home medical visits and monitor for signs of neglect or abuse during their onsite visits. We will also educate our members, their families and caregivers on the definition, signs and reporting of suspected abuse/neglect. The CC will report all suspected abuse/neglect to the appropriate agency according to State requirements. The CC will document suspected abuse/neglect, including the date of the report and the agency staff to whom the report is made, in a confidential file separate from the member's case file. The CC will report member quality of care issues to and coordinate resolution with GSHP's Quality Management Department.

Transition Back To The Community. GSHP's Transition Coordinator (TC) will routinely assess members residing in nursing facilities to determine their ability to transition back to the community. When potential for transition is identified, the TC will begin discharge planning immediately, working with the member and family to determine long term placement options and develop a care plan to ensure a safe transition to home/community placement. Some members may need significant modifications to a current home in order to accommodate new needs. The TC will work with local community agencies to research options and work with the member and their family/caregiver to develop a care plan that may include locating a home, temporary placement until the home is ready, setting up utilities, locating resources for home furnishings or for home modifications. We also empower our staff to be creative and think outside the "covered services box" to meet member needs. For example, Centene's Arizona health plan paid for a homeless member to live in an extended stay hotel following hospital discharge until wounds healed completely, to avoid the need for readmission. GSHP's approach to transitioning members out of facilities and back into the community is built on the experience and successful strategies used by other Centene health plans. For example, Superior Health Plan, our Texas affiliate, participates in the State's "Money Follows the Person" program, which facilitates transition by allowing members currently residing in a facility to access 1915c waiver and other community services without first being placed on the waiver waiting list. Superior serves approximately 300 members who formerly resided in a facility and were able to transition to a community setting as a result of this program.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.8 Provider Network Management and Requirements

3.8 Provider Network Management and Requirements

Provider Communication and Outreach

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.

Granite State Health Plan, Inc. (GSHP) will use a variety of communications mechanisms, coupled with carefully developed, well-tested content, to ensure that providers receive the information needed to work with us successfully, maintain high performance standards, and achieve optimal outcomes for our members. We will draw on the expertise of our parent company, Centene Corporation (Centene), whose affiliate health plans have been partnering with Medicaid providers since 1984 and continually enhancing and refining their provider education processes and materials. Our provider education and training will be the cornerstone of communications, as it provides a forum within which to receive feedback and answer questions in real-time. To reinforce our training, we will provide written manuals and guides for providers and their staff to use as reference materials, and we will use web-based communication, standing committees, and a local provider call center to round out a communications system that has proven to be highly successful in all of our sister health plans.

Granite State Health Plan's provider network development staff has already been in contact with over 4,000 providers in New Hampshire

GSHP understands that during the initial first year of the Medicaid Care Management Program, all current Medicaid eligible providers shall be deemed as enrolled and credentialed. We will adapt our provider communication and outreach procedures to accommodate this requirement. GSHP's policy is to offer the same robust training to all providers who join GSHP's network, whether they are joining before or after program implementation or before or after being credentialed (during the first year). This training begins during initial recruitment activities and continues throughout the provider's participation with GSHP.

Pre Implementation Provider Outreach

For the past 90 days, GSHP has been meeting with providers across New Hampshire to educate and familiarize them with GSHP, Centene's experience in Medicaid managed care and the New Hampshire Medicaid Care Management Program. We have provided written materials on GSHP and Centene. Providers have received our letter introducing GSHP and the integrated care management model and its benefits. During our meetings, we explain the process for bringing providers into our network and provide case studies illustrating how coordinating services facilitates better outcomes. Pre-contracting

materials focus on how we support providers in caring for Medicaid populations including TANF, CHIP, ABD and Foster Care as well as members with special healthcare needs.

Interactive training for providers is critical in establishing good relationships and ensuring use of the most effective preventive care and disease management strategies and best practices. Partnering with the state medical society, physician groups, primary care association or hospital to host Orientation sessions encourages a broader attendance, as does using convenient, familiar locations. GSHP appreciates that providers have multiple demands on their time, so we will use geomapping to ensure training is accessible to rural area providers within no more than 60 miles or minutes. GSHP also will offer supplemental online interactive and presentational training to all providers and staff 24/7.

Initial Training and Orientation. Once a provider has contracted with GSHP, we will provide comprehensive education that addresses all aspects of plan operations, the Medicaid Care Management program and the Department of Health and Human Services (DHHS) requirements.

Provider Welcome Packet. Within five days of completing initial credentialing, GSHP's Provider Services Department will mail all new providers a Provider Welcome Packet. This packet contains all of the materials and information a provider will need and is required by DHHS in order to participate in GSHP's network, including the following:

- Welcome Cover Letter
- Provider Manual
- Provider Quick Reference Guide
- Prior Authorization Requirements List
- MemberConnections® Brochure and Referral Form
- Pregnancy Notification Form
- Medical Prior Authorization Form
- EPSDT Tools
- PaySpan Brochure (Information and registration for electronic transactions)
- Referrals for Case Management Services
- Panel Requests (Prebirth, Full, Hold, and Disenrollment)

Provider Orientations. In addition to the written materials sent to all new providers, GSHP Provider Relations Specialists will conduct office orientations with providers and their office staff ***within 30 days of placing a provider in active status.*** Orientations may be conducted in various ways, including but not limited to:

- Individual meetings in the provider's office according to the provider's availability (the most common means for completing orientations following program implementation)
- Group Workshops in a community location such as a local hospital, FQHC, primary care association or community center during several days and different times.
- Webinars during several days and different times

During these orientations all aspects of GSHP and the DHHS requirements are addressed, including but not limited to:

Medicaid Care Management Program	GSHP Guidelines	GSHP Benefits
• Program goals and objectives • Covered services • Program Eligibility and Benefits • Limitations on provider marketing • Requirements around identification of special needs members • Quality improvement	• Prior authorization and referral guidelines • Billing and reimbursement • Reporting requirements • Reporting, and records reviews, for quality purposes • Practice requirements, as applicable to the provider type (e.g., 24 hour access, covering physician)	• Claims adjudication performance • Pay-for-Performance • Member outreach services • Credentialing and recredentialing • Disease Management Program (population-based interventions, case management)

Reference Materials. GSHP offers our providers several written resources that provide information about GSHP and the Medicaid Care Management Program. We distribute these materials in Provider Welcome Packets and during initial orientations, both in hard copy and on CD, and providers are informed that they may obtain copies through our website free of charge.

GSHP's Provider Manual (approved by DHHS during the readiness review or prior to publication if changes are made) describes the manner in which GSHP manages its Medicaid program as well as operational procedures followed by our company. It covers a broad array of topics, included but not limited to:

- A Description of the Medicaid Care Management Program
- Member and Provider Grievance System information
- Medical Necessity standards (DHHS and practice guidelines
- Medical record standards
- Claims submission protocols and standards
- Provider Rights & Responsibilities
- Cultural competency information
- Value added services and benefits
- Primary Care Physician responsibilities
- Prior authorization and referral procedures
- ICT Prompt pay requirements
- Medical Management Programs (including guidelines for treating chronic and complex conditions)
- Eligibility verification process
- EPSDT standards
- Credentialing and re-credentialing information
- Quality Improvement program

The Provider Billing Manual is GSHP's guide for providers that describes the manner in which providers are expected to bill for services covered by our program. The Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements.

GSHP's Provider Quick Reference Guide is a "cheat sheet" summarizing the operational policies and procedures that govern our program that includes information about billing requirements. Please see the following page for a sample of a quick reference guide used with GSHP's Illinois affiliate health plan. We will develop a similar reference guide for New Hampshire providers.

Clinical Practice Guidelines. GSHP educates providers on clinical practice guideline (CPG) application, how our Care and Disease Management Programs support use of CPGs and how these guidelines dovetail with ongoing clinical initiatives such as NCQA. CPGs and related educational materials are available on our website and upon request. Examples of clinical practice and preventive guidelines we will provide include ADHD, adult preventive care, asthma, bipolar disorder, diabetes, major depressive disorder, pediatric preventive care, schizophrenia, sickle cell and congestive heart failure.

IlliniCare Health Plan

Provider Quick Reference Guide

Provider Services

Contact the Health Plan Provider Services Department at 1-866-329-4701 for assistance with the following services:

- Answer questions regarding claim status
- Provider education/ orientation
- Network participation
- Member eligibility/ verification
- Change, update or correct demographic information

Providers can visit IlliniCare Provider Portal at www.IlliniCare.com to access the following:

- Provider Manual
- Provider Forms
- Billing Manual
- Companion Guide for Electronic Transactions
- Wellness Information
- IlliniCare News
- Clinical Guidelines
- Provider Newsletter (If you are not able to access the newsletter via web, please contact Provider Service)

The following information is available via the secure portal at www.IlliniCare.com:

- Member Eligibility
- PCP Verification
- Submit Claims
- Claims Inquiry
- Request Prior Authorization for Services
- View PCP Panel (patient list)

Claims Services

Electronic Claim Submission:
For claim processing efficiency and cost savings to the providers, IlliniCare encourages its providers to file claims electronically. IlliniCare's Payor ID is 68066. Please visit our website at www.IlliniCare.com for our electronic *Companion Guide* and our *Billing Manual* which offers more detailed information regarding claims billing instructions. Our Clearinghouse vendors include Emdeon, Envoy, WebMD, and Gateway EDI. Participating providers may receive electronic funds transfers (EFT) and electronic remittance advice (ERA) from IlliniCare, but to do so the provider must register with PaySpan by contacting 1-877-331-7154 or at www.payerformance.com.

Paper and Corrected Claims:
Providers may submit paper claims and corrected claims to the following address. Corrected claims must be clearly marked as such to avoid denials as duplicate claim submission:
IlliniCare Health Plan
ATTN: Claims Department
P.O. Box 4020
Farmington, MO 63640-4402

Claim Requests for Payment Reconsideration:
To request payment reconsideration, providers may contact the Claims Provider Services Unit at 1-866-329-4701, or they may submit a written request to:
IlliniCare Health Plan
ATTN: Claims Department
P.O. Box 4020
Farmington, MO 63640-4402

If the payment request for reconsideration is unsuccessful, providers may submit a Provider Claim Dispute Form (found in our website under Provider Forms) to:
IlliniCare Health Plan
PO Box 3000
Farmington, MO 63640-3800

Timely Filing Guidelines
180 Days (the date to file are from the DOS to the received date)
45 Days to receive a corrected claim, Request of Reconsideration or Claim Dispute (date of EOP to the received date.
* Please see provider or billing manual for more detailed information

IlliniCare Health Plan
1-866-329-4701
www.IlliniCare.com

GRANITE STATE HEALTH PLAN

Medical Management

IlliniCare Medical Management team provides oversight for utilization management, care coordination/case management, and disease management. Authorization must be obtained prior to the delivery of certain elective and scheduled services. For more information on services that require prior authorization, please refer to the list attached or visit our website at www.IlliniCare.com. To secure an authorization to provider services, providers may call 1-866-329-4701.

Member Services

Members can visit our website to access our Member Handbook and learn more about our programs and services. Member Services is available Monday thru Friday from 8:00 a.m. to 5:00 p.m. CST to answer questions regarding the following issues for your patients:

- Find a Doctor
- Benefits Eligibility
- ID Card Replacement
- PCP Changes

Member Service Line (Monday thru Friday 8:00 a.m. to 5:00 p.m. CST.
1-866-329-4701 or 1-866-811-2452 TDD/TTY

Value Added Member Benefits

IlliniCare provides the following value added benefits to our members to enhance their benefits and improve their healthcare:

NurseWise®
1-866-329-4701

NurseWise is a 24 hour free health information phone line. The nurse triage service provides access to a broad range of health-related services including health education and crisis intervention.

MemberConnections® is an educational outreach program designed to educate members about how to access healthcare services and benefits. The program conducts one on one education with members to ensure they understand their benefits, the role of the Medical Home (PCP) and why it's important to establish and maintain a relationship with the Medical Home. Contact Member Services if you have a patient that needs help understanding the program.

Start Smart for Your Baby®
is our special program designed to educate women who are pregnant.

Nurtur® provides a full spectrum of Disease Management outreach and education to members with chronic conditions such as:

- Asthma
- Congestive Heart Failure (CHF)
- Diabetes
- Hypertension
- Obesity
- COPD
- Coronary Artery Disease (CAD)

Vendor Services

Behavorial Health
Cenpatico Behavioral health
Phone: 1-866-329-4701

Pharmacy Benefits Manager
US Script
Prior Authorization:

- Phone: 1-866-399-0928
- Fax: 1-866-399-0929
- Help Desk Line 1-877-861-5724

Non-emergent Transportation
First Transit
Phone: 1-866-329-4701

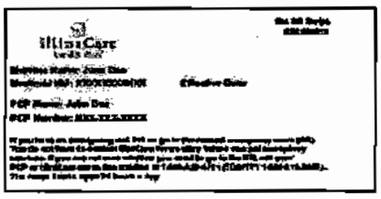
Dental Services
DentaQuest
1-866-912-6285

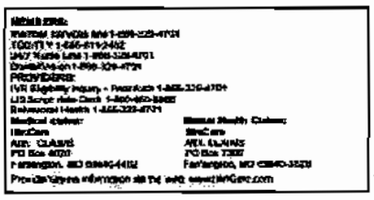
Optocare
Customer Relations:
1-800-334-3937

CVS Caremark:
Phone: 1-800-237-2767
Prior Authorization Fax line:
1-800-323-2445

Radiology Services
National Imaging Associates (NIA)
1-866-329-4701
www1.radmd.com

Sample Member Card (Front and Back)





Secure GSHP Provider Portal

Our Provider Portal is an increasingly important and strategic component in our ongoing efforts to collaborate with medical and behavioral providers for efficient administrative, coordinated care and clinical quality processes. Our GSHP provider portal will have well organized reference content as well as multiple transactional functions for submitting claims, authorizations, checking eligibility, and viewing care gap alerts.

Content for all Providers. Wherever possible, our provider website content is available on the non-secured (public) portion of our site. Please see *Table 3.8-A: Provider Portal* for a list of our provider website features available to all users that do not require a log-in.

Table 3.8-A: Provider Portal

Content	Description
Administrative function	Online registration to obtain a secure login from GSHP. We validate providers who apply online with their Tax Identification Numbers (TIN) and National Provider ID (NPI), and other practice information we have on file for that provider.
Provider Search	Online provider directories with multiple search options, including location or name; type; specialty; gender; language spoken; whether accepting new patients; and medical and hospital affiliations.
EDI	Information for providers on submitting HIPAA professional, institutional, and encounter transactions electronically to GSHP, as well as receiving electronic Explanations of Payment (EOP) from GSHP via HIPAA formatted transactions (the HIPAA 835).
Formulary List/E-Prescribing	Our online interactive formulary with drug information and NDC code or description search ability. Providers have the option of utilizing other e-prescribing vendors.
Contact Us Form	Allows any user to complete and securely submit an online form with an inquiry to GSHP.
Training Information	Training program topics, schedules, and locations.
Provider Manuals	Online Provider Manuals.
Quality standards	Clinical Standards and Practice Guidelines.

Content	Description
Downloadable forms	Forms such as "Prior Authorization Forms," "Full Panel Adds," and others.
Links	To GSHP and other areas that DHHS specifies.
Prior authorization Information	Information on services that require prior authorization (PA) and the process for requesting prior authorizations; and PA submission forms.
Claims Dispute resolution information	Process for disputing claims payment.
Appeal process	Process for appealing claims and medical necessity decisions.
HIPAA	HIPAA Policies and Procedures.
Section 508 Compliance	Centene Provider Portals are Section 508 compliant. We adhere to web design guidelines that ensure information we present is readily accessible and easy to understand for our provider user audiences. Our approach includes: • Having textual description alternatives for informative images displayed • Ensuring that information conveyed with color is also available without color • Allowing our providers to use assistive technology to fill in online forms • Other guidelines to ensure that all our providers are able to use our websites to the fullest. Our provider websites and portals are designed so that users do not require significant memory or disk resources or special software beyond a web browser.
Web Browser Compatibility	Today, our Provider Portals support Internet Explorer and Firefox browsers. The Provider Portal will also be viewable/usable on reasonably recent versions of Safari, Apple iPhone, and popular Personal Digital Assistants (PDA's).

Secure Functionality via our Provider Portal. Our GSHP network providers will be able to register online for access to our secure GSHP Provider Portal. We will also provision secure access to our Provider Portal for authorized DHHS staff or designated individuals for case specific information. Please see *Table 3.8-B: Provider Portal – Secure Functionality* below for a summary list of the secure transactional functions our providers will be able to perform via the Portal.

Table 3.8-B: Provider Portal – Secure Functionality

Content/Function	Description
Adjustments for Prior Authorizations and Claims Adjustments	Ability to submit supporting documentation for prior authorizations and claims.
Member Search (Eligibility Verification)	Verify member eligibility; search for member by last name, date of birth, date of service; or by member ID and date of service.
Pre-Authorization Requirements and notification	User can search by procedures to view pre-authorization requirements and submit request online with immediate acknowledgement.
Patient (aka "Panel") Roster	View, print, or export to Excel all members under the provider's care. GSHP providers will be able to quickly review summary and detailed information on all members under their care through this functionality.
Claims status search	Search for claim status by member information, claim information, and/or provider name.
Online Claims entry and adjustments	Submit and request adjustment to professional and institutional claims online.
Emergency Room Flag	Allows providers to indicate if eligibility inquiry is related to an Emergency Room visit.
Authorization/referral requests & status inquiry	Submit and search recent web-submitted authorization requests, and view authorization approvals.
Online Explanation of Payment	View and download EOP information.
Payment History	View and download EOP and payment history information.

Content/Function	Description
Batch claims submission	Submit HIPAA 837 claims files. Providers can submit HIPAA 837 claim submissions via any of several nationally recognized claims clearinghouses. Our batch claims submission capability will allow providers to submit their HIPAA 837 claims directly to GSHP as an additional submission option.
Interactive Formulary	View drug information by search with NDC code or description.
Electronic Funds Transfer (EFT) Payment Support	GSHP will offer several options for Electronic Funds Transfer (EFT) and/or Electronic Remittance Advice (ERA), either directly to our providers through ACH direct deposit, through a clearinghouse, or through two additional payment options, **EMDEON ePayment** and **Payformance**, (without the provider being required to share bank account information with GSHP). Providers will be able to review the payment options on our Provider Portal and we will educate our providers on these options and the benefits of each so they can make the best selection for their practice. Below is a brief description of each solution: • **EMDEON ePayment (ePayment).** Our providers will be able to go to the ePayment site, register, and set up their bank account for EFT. Once set up, the provider can view remittance information online on the ePayment site and/or download a HIPAA 835 ERA for import and processing as payable information into the provider's practice management system. • **Payformance.** Payformance offers our providers a comprehensive payment management solution which is "clearinghouse agnostic." Payformance supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, and provides online capability for viewing detailed remittance information.

Content/Function	Description
Secure Messaging	We are building on our existing online "Contact Us" capability for providers and enabling a secured two-way online communications capability for our Provider Portal users. GSHP provider users will be able to sign up for "email alerts" (see Web Account Administration feature). If the provider leaves a message for GSHP via a secured "Contact Us" web form, GSHP will send the provider an e-mail to the address they specified in Web Account Administration (above). This e-mail will NOT contain Protected Health Information (PHI), but will provide a link back to the Provider Portal where the provider can log in and view GSHP's response. Further, we are building an "inbox" and "outbox" capability on the Provider Portal so that a provider can securely view messages to and from GSHP while logged on to the Portal.
Clinical Content and Resources	Access to clinical practice guidelines and resources, medical policies, and other content resource links that contain content specific to the Medicaid Care Management Program.
Online Care Gap Notifications (OCGN) via Eligibility Inquiry	Online Care Gap Notification will notify providers about the potential need for interventions, diagnostic tests and labs for certain conditions, or for preventive services whenever any provider office checks eligibility via our Provider Portal. We will monitor provider use of our Care Gaps system to determine whether and how to improve provider awareness and use.
Online Care Gap Notifications (OCGN) via PCP Member Panel	Online Care Gap Notification will notify a GSHP PCP about the potential need for interventions, diagnostic tests, and labs for certain conditions, or for preventive services and EPSDT whenever that PCP checks his/her Member Panel in our Provider Portal.
TruCare Service Plan	Used by GSHP's Care Managers, and other clinical professionals on our Integrated Care Team (ICT), TruCare is our member-centric health services management platform for collaborative care coordination and case, behavioral health, disease, and utilization management. The TruCare Service Plan displays the member's identified health problems, treatment goals and objectives, milestone dates, and progress in an engaging, well-organized online format.

Content/Function	Description
Member Health Record	This online summary Member Health Record (MHR) offers a well organized view of a member's care gaps as well as a cursory clinical "face sheet", along with other clinical detail information, for each member for whom we have supporting data. Our MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in our Enterprise Data Warehouse (EDW).

Ongoing Education and Training

Training Modalities. GSHP's efforts to educate our providers does not stop once orientations have been completed. We offer our network providers an ongoing training curriculum that ensures that providers remain updated on GSHP and DHHS requirements and any changes in clinical guidelines.

- ***Office Site Visits*** which are conducted by our local Provider Relations Specialists based on a set schedule and frequency by provider specialty and member volume.
- ***Summit Meetings/Open Invitation Trainings.*** GSHP will hold trainings for our providers and their office staff throughout the year. Ongoing training targets new and revised program requirements, incorporates feedback from provider surveys or advisory committees or may address a particular need for further education.
- ***Ad Hoc/Customized Training.*** This is conducted when we determine that a provider needs additional or customized training, for example, based on a provider request, monitoring, claims submission errors, member complaints, or provider profiling or a provider specialty. These trainings usually are held in provider offices or by teleconference.
- ***Quarterly Newsletter.*** Because clinical and non-clinical staff needs vary, our "Provider Watch" is targeted to office managers, administrative, and billing staff. Topics include administrative support information such as billing and prior authorization changes, updates on key DHHS programs and indicators, and NPI and EPSDT information. The "Provider Watch" is posted on the website.
- ***Webinars.*** More interactive than on-demand web-based training, this e-learning method includes audiovisual and action features and is conducted in real-time. With webinar meetings, GSHP will share our desktop files and computer applications with participants. To participate, the provider simply needs a fast Internet connection and either conference-call-enabled telephones or VoIP (voice-over Internet protocol).
- ***BlastFax and Customized mailings containing billing information and updates.*** GSHP will follow the best practice of other affiliate Centene health plans, who have found BlastFax to be especially efficient and effective in reaching providers with urgent information about

regulatory, contract, or other changes. Short faxes work best. We include a return phone and fax number and other appropriate contact information so that providers can readily ask questions and ensure that communication is a two-way street.

- ***Explanation of Payment (EOP) Stuffers.*** GSHP's affiliate health plans have used EOP stuffers a number of times over the past few years as an easy way to quickly circulate information to out-of-network as well as network providers. We will use this medium for reminders and information that are not specific to a certain provider type. For example, to encourage providers to move towards submitting claims electronically we included a stuffer on EDI information with the paper checks.

Tracking Provider Training. GSHP will use our Contact Relationship Manager (CRM) to track all provider education and training. Built based on best of class contact relationship management and provider data management technologies, our Provider Relationship Manager (PRM) will allow us to more efficiently coordinate communications with our providers no matter the media (in person group trainings, phone, Interactive Voice Response (IVR), fax, email, or web). One PRM component is ProviderReach, our automated outbound provider campaign management application for efficient and coordinated launch of provider communications and notices. For example, we will use ProviderReach for an outreach campaign to recruit providers to submit claims via EDI and encourage claims payment through Electronic Funds transfer (EFT). PRM will integrate with our other provider service applications, such as the Provider Portal.

Provider Advisory Board

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.

Engaging Providers in Program Development

GSHP believes strongly in active involvement of its providers in designing and implementing a clinical and quality program that has value to providers, members and the plan. In order to build this collaborative foundation, GSHP will act on Centene's experience starting up new health plans in other states by eliciting provider participation early in the planning, design, and implementation process as well as on a long term basis. **GSHP has developed a partnership with Bi-State Primary Care Association and its 22 members which include 11 FQHCs and one FQHC Look-Alike (representing 30 sites) and others, and plans to actively engage them in the planning and design of our clinical and quality model, placing particular emphasis on our approach to physical and behavioral health integration. Providers from several FQHCs have already committed to serving on several of our committees.**

In each state Centene operates Medicaid managed care plans, while remaining acutely aware of the multiple demands on providers time, we institute a multipronged approach to ensuring that we

develop relationships with the providers in our network, engage them in providing feedback and actively utilize the input they provide. Our approach in New Hampshire will mirror our approach in other states and will be centered around our Quality Improvement Committee, and its related subcommittees, the Provider Advisory Committee, Hospital Advisory Committee, Pharmacy and Therapeutics Committee, Credentialing Committee and the Utilization Management Committee, all of which actively involve a broad range of providers. Findings from these committees guide our mechanisms for provider education, feedback, and monitoring activities.

Quality Improvement Committee (QIC). The purpose of the QIC is to promote a system-wide approach to quality assurance, provide oversight and direction in assessing the appropriateness of care and services delivered, encourage provider participation, and to continuously enhance and improve the quality of care and services provided to members. In addition, the QIC has the responsibility for developing and implementing the QAPI program. This will be accomplished through a comprehensive, plan-wide system of:

- Ongoing, objective, and systematic monitoring
- Identification, evaluation, and resolution of process problems
- Identification of opportunities to improve member outcomes
- Education of members, providers and staff regarding the Quality Assurance, Utilization Management, and Credentialing programs.

The QIC is chaired by the CMD. Other senior management staff on the QIC will include the Vice President of Medical Management, Director of Quality Improvement, VP of Compliance & Regulatory Affairs, Director of Provider Relations & Network Development, and Director of Member Services. Subcontractor representatives may also attend the QIC as appropriate.

The QIC will actively engage in its quality activities participating network providers who represent the range of specialties across the State (e.g., Family Practice, Internal Medicine, Behavioral Health Provider, Long-Term Care Providers, Cardiologist, Neurologist, Geriatrics, dentists and other high-volume specialists as appropriate), to the extent that there is not a conflict of interest.

Current New Hampshire providers who have committed to serve on the QIC include:

- Chris Heatherton, M.D. – Lamprey Health Care
- Dr. Robert Slocum, Medical Director – Families First Health and Support Center

Provider Advisory Committee (PAC). The PAC is comprised of the CMD or a Medical Director, network practitioners from across the contracting area, the Director of Contracting and Network, and Provider Relations staff as appropriate. The Medical Director chairs the PAC. The committee provides input on GSHP's provider profile, incentive programs and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance. GSHP will align its performance incentives with DHHS's Quality Incentive Program. Granite State Health Plan has already identified two providers to participate

on this committee: Dr. Jennifer Koop Families First Health and Support Center and Frederick S. Kelsey, M.D., F.A.C.P. of the Mid-State Health Center.

Hospital Advisory Committee (HAC). The HAC is an advisory group made up of key administrative hospital leaders and GSHP staff to address concerns of hospital networks with regard to prior authorization, concurrent review, discharge planning and coordination of care and payment. The Committee will meet on an ad hoc basis as determined by GSHP executive staff.

Pharmacy and Therapeutics Committee (PTC). The PTC will be a standing subcommittee of the QIC, with oversight of and operating authority over GSHP's Pharmacy Program. The P&T Committee will be multidisciplinary and include representation from a range of network physicians and pharmacist(s), clinical pharmacist(s), and a psychiatrist. GSHP executive leadership and Pharmacy/QA staff will also participate as appropriate. The PTC will be responsible for the development and annual review of the Pharmacy Program Description and associated policies, as well as activities such as reviewing pharmacy utilization; specific drug utilization review studies, particularly on the polypharmacy risks of SSI members; and drug interaction reports. Paul Friedrichs, MD of Lamprey Healthcare will be one of the providers sitting on our Pharmacy and Therapeutics Committee.

The PTC will also be responsible for evaluating and recommending drugs for inclusion on or removal from the Preferred Drug List; reviewing and recommending formulary management activities such as prior authorizations, step therapies, age restrictions, quantity limitations, mandatory generics, and other activities that affect access and patient safety; and making recommendations regarding drug utilization review activities such as targeted prescriber and/or member education initiatives. The PTC may also assist with the review of complaints and grievances regarding pharmacy issues, and have oversight of US Script, our Pharmacy Benefit Manager.

Credentialing Committee (CC). The CC will be a standing subcommittee of the QIC, and will oversee and have operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities will be communicated to the Board of Directions (BOD). The CC will be responsible for development and annual review of the Credentialing Program Description and associated policies and procedures. The CC will have final authority for review and appropriate approval of licensed physicians, other licensed healthcare professionals, and certain facilities that will have an independent relationship with GSHP. Credentialing activities are performed in compliance with NCQA standards as well as State and federal guidelines, as applicable. The Credentialing Committee is chaired by the CMD or Medical Director and includes representation from a range of practitioners across the contracting area to include the specialty and types of practitioners it reviews. As the Committee member leadership develops, the Committee may be chaired by a network physician at the discretion of the CMD.

Utilization Management Committee (UMC). The UMC, also a standing subcommittee of the QIC, will have oversight of and operating authority over the Utilization Management (UM) Program, including among other things monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization of services and coordination of care, including the appropriate integration of physical and behavioral health services. To ensure behavioral health is

integrated throughout the medical management program, a behavioral health provider will be included as a standing member of this Committee.

Soliciting Provider Feedback

Provider Satisfaction Surveys. GSHP will conduct an annual comprehensive provider satisfaction survey and new provider surveys to get regular feedback from providers in our network. The annual survey is conducted in all Centene plans by The Myers Group. The survey includes questions on satisfaction with credentialing, utilization management, claims processing and the professionalism and knowledge of GSHP staff. In addition, within 90 days of a new contracted provider's effective date the new provider will be sent a short survey designed to identify concerns that can be addressed early in the relationship.

Provider Complaints and Appeals. At Centene affiliate plans, a majority of provider complaints received have been appeals of actions to deny or reduce authorizations for services. The GSHP staff will log and track the appeals in addition to reporting them to DHHS. GSHP's Complaints and Appeals staff will monitor appeals on at least a monthly basis and Medical Management staff will also monitor the frequency and types of actions as additional indicators of potential provider dissatisfaction. Tracking this data may also identify possible changes in practice patterns within the network, or inconsistencies in how Medical Management staff applies medical necessity criteria. GSHP's staff will present action and appeal data to the Provider Advisory Committee and the Quality Improvement Committee for review and recommendations. Provider complaint data can, for example, drive changes in the process of adopting clinical criteria or practice guidelines, as well as changes in the criteria or guidelines themselves. They can also change the process of provider education regarding criteria and the process of training and testing inter-rater reliability for Medical Management staff.

Provider Turnover. Our relationships with and retention of our providers is a hallmark of Centene's success in administering programs. GSHP Provider Services staff will monitor contract terminations as well as retention of individual and organizational providers. Credentialing staff will record reasons for provider departures from the network in the credentialing tracking database using reason codes. The QIC will regularly review turnover data, with input from the Provider Advisory Committee, and develop recommendations to improve network consistency and promote network provider retention.

Direct Provider Feedback. Based on the experience of our affiliate Centene health plans we also anticipate receiving direct feedback from providers on network issues through face-to-face visits with Provider Relations Specialists, the local provider services call center and the secure email on our Provider Portal.

Training Evaluations. GSHP will ask attendees of face-to-face trainings to complete a seven to nine question survey, with space for comments. Feedback will be aggregated and reviewed by our Provider Relations staff quarterly to identify needed revisions to training. Web-based training will include a similar online form.

Monitoring Performance Measures. We will conduct daily, weekly and monthly monitoring of key provider satisfaction indicators, including claims processing and call responsiveness. Centene will monitor indicators quarterly. Claims staff will produce monthly reports that include at a minimum turnaround time, average days receipt to paid; adjustments processed, claims denied as percentage of paid claims, pending claims, percentage electronically submitted, and the top five deny reasons. Call center indicators will include call volume, average speed of answer, abandonment rate and average wait time. GSHP will track and trend provider complaints by functional area and measure the number of complaints against established thresholds. Our cross-functional Performance Improvement Team will review these and other performance measures monthly, require action from the appropriate functional area staff as needed, and report results to the QIC quarterly. Centene's executive for each functional area review performance measures for all Centene health plans.

Subcontractors with Provider Networks. For subcontractors that maintain accreditation GSHP will require the subcontractor to fulfill all accreditation requirements for assessing provider satisfaction. For other subcontractors, GSHP will monitor performance measures, such as for claims payment accuracy, timeliness, and call center responsiveness, as well as provider complaint trends, and may require specific corrective actions, including targeted assessment of provider satisfaction and subsequent interventions.

Provider Surveys

Q38. Describe your experience with conducting provider surveys and your provider survey methodology. Also summarize the results of the provider surveys for other state's managed care programs you administered.

Experience Conducting Provider Surveys

Granite State Health Plan (GSHP) will build on the experience and expertise that Centene has developed in working with Medicaid managed care programs in 13 states to engender strong provider relationships, and work collaboratively with providers to design, monitor and improve all aspects of plan operations. Centene plans go the extra mile to provide excellent customer service, education and support to our providers. This requires a focus on identifying and reducing the 'hassle factor' that can result in provider dissatisfaction. By regularly conducting annual provider surveys, surveys of new providers, tailoring surveys to special needs and combining insights gained from supplementary survey efforts, Centene affiliates have been able to consistently improve provider relations and

expand our provider networks. This experience is particularly important when transitioning providers from fee-for-service Medicaid to managed care as we have done in six states since 2006 and what we will be doing in New Hampshire. Our provider surveys have helped the Centene plans understand what is important to providers. **This information proved invaluable when we transitioned over 13,000 physicians to Medicaid managed care in Georgia.** We have also recently transitioned providers in Kentucky, Mississippi, Illinois, Florida and South Carolina. We understand the critical importance of starting a new program off on the right foot. This requires constant attention to provider concerns and reliable responsiveness during implementation as well as ongoing.

Provider Survey Methodology

Comprehensive Annual Survey. Centene has contracted with The Myers Group to conduct annual provider surveys for all Centene plans. The Myers Group has conducted our provider satisfaction surveys for the past five years, providing continuity in survey methodology and consistency across plans regarding the topic areas assessed. This enables Centene plans to not only see how well they are performing in their operating area, but gives each plan feedback on how their performance compares to other Centene plans across a wide variety of factors.

Staff who collaborate with The Myers Group include the Centene Director of Quality Improvement (QI), the VP of Member and Provider Solutions, and for each health plan, the executive responsible for Provider Relations (PR) and Provider Services (PS). The survey includes questions on satisfaction with the knowledge of provider service and provider relations staff, continuity/coordination of care, the network, utilization management, finance (including claims processing), and overall satisfaction:

- ***Call Center/Provider Services Staff.*** This section of the annual survey measures the process of obtaining member information, the helpfulness of Medical Management staff in obtaining specialist referrals for patients and the helpfulness of Provider Services staff in resolving claims issues.
- ***Provider Relations.*** The responsiveness and courtesy of the representative and the timeliness of the representative response to answer questions and/or resolve problems are addressed in this section of the survey. Respondents also evaluate the quality of the provider orientation process, of practitioner educational meetings/inservices, and of written communications as well as the distribution of information regarding Quality Improvement initiatives and results.
- ***Continuity/Coordination of Care.*** In this section respondents are asked to rate the timeliness and frequency of feedback/reports from Specialists and Behavioral Health Clinicians for patients in their care.
- ***Network.*** This section of the survey asks respondents if the specialist and behavioral health networks have an adequate number of high-quality specialists/practitioners to whom they can refer their patients. Respondents also rate whether the health plan takes physician input and recommendations seriously.

- ***Utilization & Quality Management.*** In this section, respondents evaluate the process of obtaining pre-certifications/referrals/authorizations; timeliness of pre-certification process; the availability to request authorizations by phone, fax, or web portal; the extent to which Utilization Management staff share review criteria and reasons for adverse determinations; the consistency of review decisions; the timeliness of the Utilization Management appeals process; and the timeliness of resolution requiring Medical Director intervention. The health plan's encouragement/support of provider participation in QI activities, administration of the PCP's referrals to specialists, facilitation/support of appropriate clinical care for patients, and the phone access to Case/Care Managers are also referenced in this section. In addition, providers evaluate the alternative care and community resource options available, their satisfaction with the referral process to disease management programs, and the degree to which the plan covers and encourages preventive care and health wellness.
- ***Finance Issues.*** This section addresses the reimbursement rates for provided services, the accuracy and timeliness of claims processing, and the resolution of claims payment problems or disputes.
- ***Overall Satisfaction and Loyalty.*** Respondents are asked to rate their overall satisfaction with the health plan and all other plans in which they participate. They are also asked whether they are likely to recommend GSHP to other physicians and patients. Two open-ended questions will allow respondents to comment on what they like best about GSHP and what could be done to improve the plan.

The annual survey tool can also be modified to include questions and concerns of specific interest to each state. The sample size is designed to achieve 95 percent confidence in results for each health plan. No later than 120 days after the end of the plan year, GSHP will submit a provider satisfaction survey report to DHHS that summarizes the survey methods and findings and provides analysis of opportunities for improvement. GSHP QI and staff from the appropriate functional area will use provider satisfaction data to identify what is important to network providers, design interventions, measure their effectiveness, and increase provider satisfaction. In addition, our semi-annual QI Evaluation will include provider satisfaction survey results, interventions, and assessment of their success. Provider Newsletters will publicize results to demonstrate GSHP's responsiveness to survey results.

Satisfaction Survey of New Providers. GSHP also will use Centene's proven, best-practice technique of surveying new providers within 90 days of each provider's contract effective date. GSHP will survey 100 percent of new providers to promote a high response rate. The survey will be short –six or seven questions – and designed to identify potential concerns that can be resolved early in the relationship. The survey will enable GSHP to supplement training, educate providers on operational matters, correct misunderstandings, obtain prompt feedback on problems, and identify needed follow-up activities. Both provider relations (PR) staff in the field and provider services (PS) staff at the provider call center will play a role in the survey. For large physician practices, certain traditional Medicaid providers such as FQHCs and RHCs, and key hospitals, our Provider Relations (PR) Representatives will conduct the survey as part of an in-person meeting with provider leadership. GSHP will also mail the survey to practitioners, place it on our Provider Web Portal, and notify providers who are registered with the

portal by secure email. PS staff will make or follow up with outbound calls to survey certain providers. The type of contact will vary based on such factors as provider type, size of practice, and geographic location. PR staff will tabulate survey results weekly for at least two months after implementation, and monthly after that.

Prompt staff follow-up on issues identified by providers through the survey, including onsite, customized provider education, is critical to maintaining high satisfaction levels. Call center staff will document calls with providers and flag needed follow-up. Managers will conduct weekly review of tickler lists, performance data, tracking reports, and web portal reporting, and follow up with staff to maximize response rate and ensure prompt response to identified concerns.

Other Survey Opportunities. In addition to the annual and the new provider surveys, GSHP may conduct other provider satisfaction surveys as circumstances warrant, such as when a major program, systems or operating change is implemented that affects GSHP interfaces with providers. GSHP also will supplement its various provider satisfaction surveys with other provider feedback activities including assessing provider satisfaction through co-located staff in high volume provider offices like FQHCs, RHCs and Community Mental Health Centers, our standing committees including Credentialing, Pharmacy and Therapeutics, Utilization Management, and Grievance and Appeals and, as noted in response to question 38, training evaluations, monitoring key performance measures and subcontractor provider satisfaction surveys.

Provider Survey Results

The chart below summarizes the results from the 2010 comprehensive annual survey of Centene's 8 Medicaid plans conducted by The Myers Group. The results are summarized by survey section/attribute. The total survey included 40 questions. The chart includes the results for the percent of responses rated excellent or very good. For example, on the line titled Provider Relations, the Centene Aggregate column shows that overall 34.3% of respondents rated their satisfaction with the Call Center/Member Services Staff as *excellent or very good*. Not unexpectedly the highest rated plan in this category is our Texas plan which has been in place since 1999. The lowest rated plan in this category was Massachusetts which had only begun operations the year before the survey. The "h" designation means the plan had a score that was significantly above the trend rate or benchmark. The "b" designation shows the results were significantly below the trend.

Table 1 2010 Comprehensive Annual Survey Results

Call Center/ Member Services Staff	39.4%		37.5%		41.5%	h	39.0%		38.6%		37.7%		39.1%		43.7%		NA***
Provider Relations	34.3%		33.2%		31.6%	h	35.3%		30.8%		34.1%		37.2%	b	40.2%		27.1%
Continuity/ Coordination of Care	34.8%		33.5%		34.7%		40.0%		34.9%		30.3%	b	37.6%		39.8%		22.8%
Network	24.1%		25.6%		21.3%	h	26.0%		21.6%		22.3%		23.7%		30.7%		19.8%
Utilization & Quality Management	27.0%		24.7%		24.4%	h	27.9%		27.1%		26.2%		26.9%		33.8%		22.4%
Finance Issues	26.8%		29.3%		23.9%		26.9%		27.6%		26.1%		26.8%		31.0%		23.9%
Pharmacy and Drug Benefits	19.1%		16.7%		19.9%	h	18.7%		NA		20.6%		20.1%		NA		12.5%
Overall Satisfaction and Loyalty	77.3%		71.5%		76.6%	h	82.8%		73.1%		79.5%		73.2%		84.5%		65.9%

As a result of the annual survey each plan each plan develops an action plan to address areas where the plan scores were significantly different than the benchmark for that attribute. For example, following the 2010 Provider Survey, Celticare, Centene's Massachusetts affiliate developed a multi-pronged plan for immediate action addressing provider and member appeals, prior authorizations and denials. They also identified longer term initiative's to address payment policies, the formulary and tertiary referrals.

The annual survey also helps to provide direction for implementation and ongoing priorities. Based on their analysis of survey results, **The Myers Group identified the following three items as "strengths,"**

and significant predictors of overall physician satisfaction, for the Centene health plans: (1) Degree of improvement to eliminate "hassle factor"; (2) Obtaining pre-certification/ referral/ authorization information, and (3) Timeliness of Utilization Management's pre-certification process.

An example of how Centene affiliates use survey results successfully was a Peach State survey conducted initially in 2007. Based on feedback gained from the survey, the Plan implemented several new processes to build collaborative relationships and enhance communication with provider groups, improved reporting analysis and follow through of service metrics, and more frequent updates to provider orientation materials. The Plan conducted regular Practice Manager Advisory Group meetings to share information and identify opportunities for improvement. A new Provider Portal with enhanced capabilities was implemented with easy access to member rosters, authorization requests, claims processing, and communication capabilities. A Provider Tool Kit was distributed to ease access to forms and Plan processes. The provider call center updated policies, procedures, call scripts and workflows to improve on response timeliness.

As a result, in subsequent follow up surveys in 2008 and 2009, the Plan saw statistically significant improvement in all four attributes evaluated. *Timeliness to answer questions and/or resolve problems* rate scores in 2007, 2008 and 2009 were 15.8%, 28.0% and 32.3%, respectively. The percentage change in rates between 2007 and 2009 was 104.4% and was statistically significant ($p<0.0001$). *Quality of provider orientation process* scores in 2007, 2008 and 2009 were 14.2%, 24.1% and 31.0%, respectively. The percentage changed in rates from 2007 to 2009 was 118.3% and was statistically significant ($p<0.0001$). *Health Plan takes physician input and recommendations seriously.* Scores in 2007, 2008 and 2009 were 10.7%, 15.2% and 24.5%, respectively. The percentage changed in rates from 2007 to 2009 was 129.0% and was statistically significant ($p<0.0001$). *Accuracy of Claims Processing* scores in 2007, 2008 and 2009 were 12.1%, 16.0% and 29.8%, respectively. The percentage changed in rates from 2007 to 2009 was 138.0% and was statistically significant ($p<0.0001$).

Another example of a successful provider survey process conducted by a Centene affiliate took place in 2008. In Arizona, Bridgeway Health Solutions (Bridgeway) conducted provider satisfaction surveys prompted by the implementation of a major systems update that required modification of several claims and prior authorization processes, including processes for Case Manager authorized services. The survey questions focused on satisfaction with those processes. Bridgeway sent the survey to 67 network long term care and home and community-based providers, with a 55% response rate. Based on the survey results, the QIC implemented changes including a temporary increase in staffing, and process redesign encompassing systems analysis, supplemental software and improved accountability. Demonstrated improvement included increases in positive responses from 2008 to 2009: timeliness of claims payments from 65% to 75%; prior authorizations process from 61% to 85%; ability to receive information from Member Services about eligibility from 79% to 94%; and assistance received from Case Managers from 86% to 95%.

Using Input to Inform Change

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

GSHP, as do all Centene affiliates, relies on its Quality Improvement Committee (QIC), which is chaired by the Chief Medical Director (CMD), to assure a system-wide approach to Quality Improvement. The GSHP QIC will provide oversight and direction to assure that there is an ongoing, objective and systematic identification and evaluation of provider, member and staff feedback. The QIC will receive regular reports from all subcommittees and organizational units. The results of the annual survey, new provider surveys, and specialty surveys, as well as Provider Advisory Committee (PAC) and Utilization Management Committee (UMC) data analyses and recommendations, will be channeled through the QIC. The QIC will use the input to provide direction on the appropriateness of care and services delivered, including service integration; to encourage provider participation; and to continuously enhance and improve the quality of care and services provided to members.

GSHP CEO and executive staff, with departmental support, are responsible for converting committee recommendations into specific interventions, tailored to the subject matter or deficiency; measuring the effectiveness of interventions at appropriate intervals; adjusting interventions that are not effective and re-measuring; and ensuring accountability for interdepartmental actions and for annual evaluation of improvement efforts and results. To ensure effectiveness, regular reports and updates on the results of recommendations and actions taken will be fed back to the QIC, PAC, UMC and other standing committees.

Following are examples of interventions taken by Centene health plans operating in other states as a result of input derived from our system-wide approach to advisory committees, surveys and other feedback processes:

Example 1. At Centene's health plan in Indiana, the UMC noted that one PCP had an Emergency Room (ER) utilization rate lower than that in most PCP practices. The plan learned that he had extended office hours beyond normal business hours and developed effective ways to educate his patients on appropriate ER use and the importance of the medical home, including through calls to all new patients. The plan asked him to speak with other PCPs in their network and published information on his practice in the Provider Newsletter.

Example 2. A Provider Advisory Committee member of our Arizona affiliate, Bridgeway, related his difficulty in obtaining the Five Wishes form for his patients. To supplement the distribution of the forms to members by our Case Managers, we implemented a link to the 5 Wishes (Advance Directives) forms on the Provider Portal within one week of the meeting. We also implemented a dedicated toll-free "live person" provider inquiry line for authorization and claim status in response to Provider Council members' request for a single point of contact at the plan.

Example 3. Practitioners with Superior HealthPlan, Inc. (Superior), our affiliate Texas health plan, expressed their difficulty in knowing when one of their patients has been to the emergency room. Superior was able to partner with some of its high-volume hospitals to obtain daily listings of members

who had been to the emergency room on the previous day and developed a process to share this information with their provider network in order to facilitate continuity of care and follow-up with the medical home after an emergency room visit.

Example 4. In March 2010, a network provider submitted a complaint about repeated denials of prescriptions for medication for hepatitis C. The Centene affiliate's prospective pharmacy utilization criteria required that confirmation of hepatitis C should include a positive HCV RNA. The provider's position was that a positive HCV RNA was superfluous if the member had a documented positive liver biopsy and an elevated viral load. Using the provider's input and a review of the evidence base, the Bridgeway Pharmacy and Therapeutics Committee revised their criteria for this medication and removed the requirement for HCV RNA confirmation when the patient had a positive biopsy and viral load.

Example 5. As a result of routine monitoring of provider appeals by the staff and of direct feedback from network hospitals, the Centene Medical Management/Utilization Management Committee noted an upward trend in denials, appeals and overturned denials of Bridgeway LTC members' inpatient stays. Assessment by the Committee determined that the major contributors were poor communication with and insufficient information from the inpatient facilities to their Concurrent Review staff. The corrective action approved by the Committee was the implementation of onsite Concurrent Review Nurses at higher volume network hospitals. Concurrent Review Nurses promptly coordinated with hospital staff to arrange access to workspace, patient records, and hospital clinical staff. In some cases, they have received hospital authorization to interact directly with hospitalized members to facilitate transition of care planning for hospital discharge. **As a result of this change, the number of denied inpatient admissions has steadily declined from a total of 17 in the fourth quarter of 2009 (4% of admissions) to eight in the fourth quarter of 2010 (1% of admissions).** For example, Yuma Regional Medical Center had six denials in the fourth quarter of 2009, but has averaged three per quarter since then; the John C. Lincoln Hospitals in Phoenix had two denials in the fourth quarter of 2009 and none since. The plan is continuing onsite concurrent review to maintain this improvement.

Example 6. Peach State Health Plan developed interventions to increase the level of provider satisfaction after conducting their annual provider satisfaction in 2007 and then reassessing in 2008 and 2009. Based on a barrier analysis, the Plan implemented several new processes to build collaborative relationships and enhance communication with provider groups, improved reporting analysis and follow through of service metrics, and more frequent updates to provider orientation materials. The Plan conducted regular Practice Manager Advisory Group meetings to share information and identify opportunities for improvement. A new Provider Portal with enhanced capabilities was implemented with easy access to member rosters, authorization requests, claims processing, and communication capabilities. A Provider Tool Kit was distributed to ease access to forms and Plan processes. The provider call center updated policies, procedures, call scripts and workflows to improve on response timeliness.

The Plan saw statistically significant improvement in all four attributes evaluated. *Timeliness to answer questions and/or resolve problems* rate scores in 2007, 2008 and 2009 were 15.8%, 28.0% and 32.3%, respectively. The percentage change in rates between 2007 and 2009 was 104.4% and was statistically

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Our relationships with and retention of our providers is a hallmark of Centene's success in administering its programs. We are committed to ensuring that similar feedback processes and follow up actions are taken in the implementation and operation of provider relations in New Hampshire.

Credentialing Experience

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.

Centene's Successful Implementation Track Record

Granite State Health Plan's (GSHP) network development efforts in New Hampshire are supported and provided by its parent company, Centene Corporation (Centene), which operates 13 Medicaid managed care plans. Our pre and post implementation outreach efforts have been highly successful in developing expansive provider networks in the states in which we operate. By explaining our process for bringing providers into our networks and providing information on how we support providers in caring for ABD, TANF, CHIP, Developmentally Disabled and Foster Care Medicaid populations, we have been able to recruit a broad array of provider's willing to serve our members. We have been able to retain those providers by using carefully developed, well-tested materials, to ensure that providers receive the information they need to work with us successfully. We also use, and plan to use in New Hampshire, peer support, web-based communications, standing provider inclusive committees, and a local provider call center to round out a provider communications system that has proven to be most effective in preserving provider loyalty to our plans. It is Centene's practice to invite as many providers as possible in the areas it serves to participate in the network, starting with providers who have historically served Medicaid beneficiaries. Our goal is to provide members the broadest range of quality providers as possible, particularly to ensure a smooth transition for members and providers who are new to managed care. It is also critical to demonstrate that we are there to support our providers over the long term.

Examples of Centene's Implementation Successes. Most recently, we assisted providers in Georgia, Illinois, Kentucky, Louisiana and Mississippi during the transition from fee-for-service to managed care. We have taken our experiences and applied lessons learned to continue to improve upon the process, improve our communications and ensure our interactions with providers are efficient in order to

reduce undue administrative burden on providers whose time would be better spent providing care to Medicaid members. We have already begun outreaching to providers in New Hampshire where we have sent letters to providers throughout the state and have Network Development teams on the ground following up in each area. **To date, we have held face to face meetings with all 26 acute care hospitals in New Hampshire and obtained letters of intent (LOIs) from 23 of them.**

The credentialing process for Granite State Health Plan (GSHP) is the same for all Medicaid programs affiliated with Centene and the administrative process of credentialing providers is done by Centene with oversight of GSHP Board of Directors and Quality Improvement Committee. GSHP's policy is to complete the initial credentialing process for each applicant within the NCQA standard of 180 days after signature date of the provider attestation on the completed credentialing application. **Over the last 12 months, our average turnaround time from receipt of complete applications was less than 30 days for initial credentialing.** To ensure that our process is provider friendly our credentialing specialists, from the early stages in the credentialing process, look for discrepancies or omissions in the application or required documents and call, fax or email the provider or his/her office manager to obtain any missing information. This outreach occurs up to 3 times, or for 30 days, whichever is longer, until the requested information is obtained.

Success in South Carolina. Our experience in South Carolina demonstrates the success of our approach. In South Carolina, **our active practitioner panel grew from 75 credentialed practitioners at implementation to over 6,481 within 3 years. Today we have 7,380 active practitioners in South Carolina.** This represents over 45% of the 16, 515 available practitioners in the area we serve in South Carolina. We have consistently met the South Carolina provider access requirements. During the first three years, 760 providers in our South Carolina program have been terminated; the majority of those were voluntary terminations related to change in practice locations, retirements or death. Less than 1% of these providers were terminated for cause. Similarly, practitioners who initiated termination of their agreement with our Ohio health plan affiliate, Buckeye Community Health Plan (Buckeye) only did so due to factors unrelated to their commitment to or satisfaction with the plan (i.e. loss of licensure, a state decision to terminate their Medicaid participation, retirement, death).

Ohio is A-Okay. Even when providers have indicated they may be considering terminating, we have been able to address their concern and avoid provider initiated contract terminations. Only one provider out of 1,509 who left our Ohio program between March 2009 and December 2010 was terminated by Centene. Today, there are 12,273 providers participating with Buckeye either directly or through a delegated entity. This represents approximately 87% of the available practitioners in the areas we serve in Ohio. We also have 2,223 facilities enrolled in Ohio including hospitals and Skilled Nursing Facilities. As a result, we are in compliance with the provider network access requirements in Ohio. In the rare instances when we have encountered provider network challenges, we have received state approval for the variance. For example, in Ohio we were unable to meet access standards for a general surgeon in one rural county due to the only general surgeon in that county moving out of state. In this case, we received state approval to enable members to receive care in the neighboring county.

Georgia is Good-to-go. Our Georgia affiliate, Peach State Health Plan (Peach State), was extremely active in enrolling providers prior to start up and has consistently met state mandated provider access

requirements. On the program start date, Peach State had a very robust network of more than 15,000 providers, including practitioners and facilities. **Today there are 15,957 providers participating with Peach State. This represents 90% of the providers available in our service area.** During the first three years of operation, 854 Peach State participating providers network were terminated. The majority of those were voluntary terminations related to change in practice locations, retirements or death.

Network Adequacy and Stability for the Long Haul. The table below shows the percent of providers credentialed versus eligible providers in our health plan service areas. Due to recent program start dates for our Illinois and Kentucky affiliates, we do not yet have meaningful data available for individual practitioners and will be glad to share this data after the first ninety days of their start dates have passed. However, we are pleased to share that to date we have approximately 78 hospitals, 1573 PCPs, and 3928 specialists in our network in Kentucky and 46 hospitals, 1438 PCPs, and 2254 specialists in Illinois.

Centene Health Plan Affiliate	% of Eligible Providers Credentialed	Eligible Providers* in Health Plan Service Area
Absolute Total Care (SC)	45%	16,515
Bridgeway (AZ)	81%	257**
Buckeye Community Health Plan (OH)	87%	14,500
CeltiCare Health Plan (MA)	32.3%	30,248
Magnolia Health Plan (MS)	62.5%	12,000
Managed Health Services (IN)	26%	32,000
Managed Health Services (WI)	60%	6,931
Peach State Health Plan (GA)	90%	15,957
Sunshine Health Plan (FL)	71%	7,080
Superior Health Plan (TX)**	67%	126,747

*Eligible Provider defined as individual practitioner; Provider Population defined as Medicaid Providers within regions or service areas where the health plan operates; In counties/service areas where our health plans operate – we may not be contracted with all eligible providers.

**10% allowance for incomplete data and 5% for provider types which SHP does not provide services

***Represent Medicaid Acute Care PCP providers in Yavapai County

A History of Network Readiness. It is worthwhile to note that raw numbers alone do not fully reflect a new health plan's readiness and ability to ensure the provision of health care services and access to care in terms of other operational functions the new health plan must have in place to support access

to health care services for members and providers transitioning from a fee-for-service to a managed care model. In this regard, GSHP is ready. With Centene's vast network of business units and system support capabilities, GSHP has the administrative functions and staff needed to support members and providers during the transition process. These supporting operations include 24/7 member and provider customer service center availability, relaxed requirements for prior authorization for out of network services, and expedited credentialing for key providers. It is much more critical – and more conducive to a successful transition – for the health plan to have these functions operational and able to handle the volume of network service support needs on the program start date than how many providers participate with the health plan on the program start date. While we always strive to meet network adequacy requirements by the program start date, the bottom line is that we always ensure uninterrupted access to health care services for our members and providers (regardless of their participation status) during the initial phase of new plan implementations and as long as is necessary to ensure continued access to health care services for our members.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.9 Payment Reform

GRANITE STATE HEALTH PLAN

3.9 Payment Reform

Implementing Delivery System and Payment Reform

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

Granite State Health Plan's (GSHP) affiliated health plans strive to deliver the right care at the right time in the right place. We stay on the cutting edge of health care delivery by constantly keeping informed of health care industry and government initiatives. These initiatives are dynamic and sometimes complex as federal and state lawmakers seek to provide healthcare coverage for all Americans. GSHP's parent company, Centene, has dedicated resources to the development and implementation of state and federal government initiatives, Patient Centered Medical Homes (PCMH) and Health Homes (HH), being two of them. We are committed to supporting Granite State Health Plan and our contracted primary care providers (PCP) in delivering comprehensive, evidence-based, and culturally sensitive health care services for their patients in coordination with specialists, facilities, ancillary providers, and the families or caregivers of patients.

While the traditional fee for service model creates incentives for providers for the quantity of services provided, our New Hampshire Payment Reform Plan will reward providers for behaviors that drive high quality, cost effective care. Creative structuring of provider incentives enables us to engage providers in both cost containment and quality improvement initiatives through various payment reform models geared toward achieving the right care in the right place at the right time. Payment reform approaches need to be responsive to the local providers and delivery systems and accountable to the members and the State for achieving high quality care. Such transformation is obviously an evolutionary process that becomes more sophisticated as partnerships, synergies and technological solutions mature. We have been very successful with pay for performance and Patient Centered Medical Home payment reform programs and are prepared to work with New Hampshire's providers to develop other responsible and accountable payment reform methods such as bundled payments, accountable care organizations and other aligned payment methods not just at program inception but over time to continually drive towards quality care that is effective and efficient.

Delivery System & Payment Reform Plans

Granite State Health Plan will ensure the provision of covered services as specified in the New Hampshire Medicaid Care Management Program Request for Proposal. GSHP's approach to developing and managing the provider network begins with a thorough analysis and evaluation of the NH Department of Health and Human Services' network adequacy requirements for the Medicaid Care Management Program. GSHP will develop and maintain a network of qualified providers in sufficient numbers and locations throughout the State to provide required access to covered services and a geographically convenient flow of members among network providers. The provider network will be

designed to reflect the needs and service requirements of GSHP's member population and to maximize the availability of community based primary care and specialty care access.

GSHP's comprehensive network will ensure its membership has access at least equal to, or better, than community norms and will include non-emergent after-hours physician or primary care services.

The approach to building the delivery system is consultative with a multi-pronged value proposition to attract target network providers.

Starting with this goal of maintaining network adequacy, GSHP's Delivery System & Payment Reform Plan will be centered on aligning provider incentives to reward for high quality care that will reduce waste, slow the growth of health care costs and improve the health of our members. We will be implementing a combination of Pay-for-Performance, Gain Sharing, Bundled Payments and where applicable Accountable Care initiatives. Upon selection as an MCO in the Care Management Program and receiving the State's detailed claims files, GSHP will work with DHHS to finalize the Payment Reform Plan and establish the quantifiable metrics for measuring the ongoing success of the Plan. Below are a sample of delivery system and payment reform initiatives that Centene affiliates have in place and will be considered in New Hampshire.

Pay for Performance (P4P). In order to provide an opportunity to reward all PCPs and Specialists, including those who do not meet high volume thresholds (such as rural providers), we have established a per encounter incentive payment to encourage appropriate and timely preventive health and disease monitoring services per evidence-based clinical practice guidelines. The P4P Program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as CMS-AMA Physician Consortium, NCQA and the National Quality Forum ("NQF").

GSHP researched various measures as published and supported by national agencies while taking into consideration its internal strategic goals as well as those of the New Hampshire Department of Health and Human Services; its membership demographics; and the clinical practice guidelines it has adopted. Indicators may include, but are not limited to HEDIS preventive care measures or disease specific practice guideline measures in categories such as:

- Well Child Visits & Immunizations
- Appropriate Medications for Asthma
- Routine Diabetic Screenings
- Timeliness of Prenatal and Postpartum Care
- Breast and Cervical Cancer Screenings
- Semi-Annual Chronic Disease Maintenance Visits
- After Hours Services

PCPs and specialists shall receive a financial incentive per eligible claim/encounter submitted and paid, regardless of PCPs participation duration. In addition, the P4P indicators will be aligned with member

incentives offered by GSHP in order to ensure that providers and members are aligned in obtaining and delivering the appropriate preventative healthcare services.

Clinical incentives through the P4P program are paid in addition to fee-for-service payment at time claim is processed. Participating providers are automatically eligible for this program.

Bonus Payment Incentive Program. This provider incentive program is premised on GSHP's belief that our success in driving the highest quality, efficient care requires strong Plan/Provider partnerships and the rewards of these efforts should be shared accordingly. By inviting providers to share in our success financially, we earn their trust, commitment and support in ensuring our members are receiving the right care, in the right place at the right time. Through this program, GSHP will share financial savings with eligible providers who achieve an overall reduction in medical costs for GSHP members assigned to them. Specifically, the provider shall be eligible for bonuses based on medical cost reductions that are achieved by health care professionals whom the provider employs, contracts with, or refers patients to. The provider is eligible for a bonus based on the provider's ability to improve health outcomes resulting in lower medical expenses if the provider: (1) has achieved the specified medical expense thresholds as set forth in the provider incentive agreement; (2) meets all other thresholds and requirements set forth in the agreement; and (3) is in compliance with the terms and conditions of the agreement; 4) has a minimum of 100 GSHP members; and 5) maintains open panels throughout the incentive program year. GSHP will support providers in this program with critical resources, tools and processes such as: reporting, member compliance innovations, predictive modeling, and care management tools.

Patient Centered Medical Homes and Health Homes. GSHP-affiliated health plans have had experience with medical home and health home models (collectively referred to as HH) at different stages of development, and this pattern is consistent in New Hampshire, with Dartmouth Hitchcock Health System achieving level three PCMH certification in all of its PCP practices to rural providers without such resources. In New Hampshire, we have already engaged Bi-State Primary Care Association, multi-specialty PCP-centered medical groups and PCP offices which are interested in becoming Medical Homes, to aid them in the transition driven by Healthcare reform. GSHP will take a flexible approach, based on our assessment of each Medical Home's capabilities. Smaller offices are more likely to require all care coordination services be done by GSHP staff while larger ones already developing medical home skills may only require supplemental support and integration. With approximately 90% of the PCPs in New Hampshire employed by hospitals or health systems, there are tremendous opportunities to support the Medical Home and truly coordinate care across the entire continuum of health care services. GSHP will encourage all of our providers, regardless of size, structure or degree of development, to continuously improve their capabilities for accessible, continuous, comprehensive, coordinated, compassionate and culturally effective patient-centered care.

Bundled Payments. GSHP and Centene intend to partner with selected providers in developing new payment reform options including bundled payments. The objective of bundled payments is to transition away from a purely fee-for-service model of paying for health care services to a model that sets a fixed price for a collection of health care services, or bundles, that are related to an episode of care. Bundles of health care services would include most health care services provided during the

patient's episode of care including professional, facility and ancillary services as well as any pre- and post-discharge services including readmissions. Bundled payments give providers the potential to be rewarded for providing efficient and consistent evidenced-based care. By offering providers a single bundled payment for an episode of care, providers become jointly accountable and may realize a financial gain or loss based on how they manage resources and the total costs associated with treating the patient throughout the episode.

The unique structure of the New Hampshire provider environment, where a significant number of the PCPs and specialists are employed by hospitals or hospital systems, is ideal for piloting bundling payment approaches. Bundled payments are best implemented for medical conditions and episodes that have significant variations in clinical practice and/or outcomes, require substantial post-acute care services and also for a number of chronic diseases. Potential examples include joint replacements, cardiac surgery, transplants, and cancer care. Chronic disease conditions that could be applicable to bundled payments include diabetes, renal failure and CHF. A detailed analysis and assessment of the state's claim and clinical experience is critical to understanding the potential conditions to focus on. In addition, GSHP will need to collaborate with providers on developing an effective payment model and to identify clinical areas of improvement.

Accountable Care Initiatives. GSHP and Centene understand that there is growing interest by federal and state governments in understanding and participating in accountable care models including "accountable care organizations" (ACOs). These models provide the potential to compensate providers according to their ability to improve the health of the populations they manage (instead of fee-for-service). They also require the coordination of services and care among different provider organizations and types. The key elements of an ACO model include joint accountability for the full continuum of health care for patients, a portion of provider payment that is contingent upon improving the overall quality and coordination of care, and the responsibility to manage medical costs with a target budget. The key program components of an ACO model include an effective governance model (it must be physician lead and driven), specific and measureable performance measures (some examples include key HEDIS and preventive care measures, member access and availability standards and meaningful use of electronic health records) and include meaningful financial incentives for improving the efficiency and cost of health care. GSHP will engage and collaborate with providers regarding their interest and commitment to participating in an ACO model.

Creating Provider Partnerships to Support Health Care Reform

Assessing Partnerships. Through organizations including Bi-State Primary Care Association, Dartmouth Hitchcock Medical Center, Health Partners PHO, Granite Health Network, and virtually all the hospitals in the State, GSHP has introduced the above reform initiatives in face-to-face meetings and received favorable responses. Our initial investment in introducing GSHP to the provider community has started building the foundation of trust that is at the core of successfully implementing our programs and initiatives. It is important to recognize that payment reform is not static and our Reform Plan will need to evolve over time. Again this is where our provider partnership model plays a critical role in our long term success. GSHP will continue to gather as much information as possible regarding national

initiatives and current initiatives under way in New Hampshire. We will also work closely with providers to find out their level of knowledge regarding national and local health care reform initiatives, their level of commitment to working within a reformed model, and their ability to perform well within that environment. Compiling this information will help us to discover partnership opportunities and uncover challenges early in the process and guide our approach to developing strategies and goals that are measurable, achievable and, most importantly, tailored to the unique needs of the providers.

Now, there are even more opportunities to reduce costs and improve quality and reform our health care system. We have made recent investments in technology that we will make available to our provider partners. These tools will allow providers more insight into member care gaps and claims history, and by sharing both this information and structuring contracts to allow providers to share in any savings and to reward providers for improvements in quality measures, we can reduce overall costs and improve quality. We know from our experience in other markets that when this data is shared with providers, they gain the additional insight into what services are driving costs that could be provided in an alternative, less expensive but equally or more effective setting. As providers identify new opportunities, we can modify contracts and incentives accordingly to accommodate new delivery models. In addition, we have identified other quality metrics that relate to the providers' accessibility and to patient satisfaction and believe that payment models can be used to incent improvements in those measures that may also result in improved compliance and health outcomes.

Even with the technology and other investments in resources, we understand the journey to implement health care reform has some challenges. In order to begin addressing some of the challenges we will more carefully design the measures to evaluate the effectiveness of our payment models, work to refine our contracts with providers to make sure that the incentives are meaningful and driving the appropriate outcomes, continue to develop our IT resources to make sure that the data we present is shared in a way that is actionable, evaluate how that data is shared with our providers, refine how patients are attributed to providers, review our quality metrics to make sure that the data is easy to define and capture and that the measures reflect quality outcomes. We plan to continue to build on the work done in our existing states with select provider groups and identify providers who might be interested in innovative payment models and who have adequate member volume to allow for credible measurement of performance.

Centene wants providers to succeed in their quest to improve health care access and outcomes for their patients. Therefore, we will augment the provider's ability to deliver enhanced services for members by coordinating care through a number of our tools, services and personnel resources. We will support their transition from traditional practice to patient-centric care by "wrapping around" their capabilities with services provided by our Integrated Care Teams (ICTs). Recognizing the impact of mental health and substance use on other chronic conditions and vice versa, Centene health plans educate PCPs on how to screen for, identify, and refer members with behavioral health conditions for services. We require PCPs serving as a Designated Provider to further integrate behavioral health treatment into their medical practices to include initial diagnostic assessment, development of a treatment plan, and monitoring and follow-up care. We also recruit and pay for PCPs to schedule regular onsite appointments at Community Mental Health Centers (CMHCs) serving as Designated

Providers to provide coordinated care for members with severe mental illness (SMI), since these members are likely to be non-compliant with care for co-morbid medical conditions.

This approach to managing health plans ensures that members, providers, state agencies and community resource agencies are able to partner with trusted individuals from their communities and that our stakeholders have direct access to local, accountable health plan staff. To reinforce this commitment, GSHP has partnered with Bi-State Primary Care Association. Through this partnership we will provide support enabling Bi-State to increase access to care by recruiting additional providers enhancing their ability to serve additional Medicaid recipients physical and behavioral health needs as well as access to social services, community outreach and support services. We will work with Bi-State to target the barriers to accessing care and will collaborate with them to provide solutions; Bi-State will have two board members on the GSHP Board of Directors as well as participation on our Quality Committees ensuring feedback and opportunities to improve the quality of care and access to care for our Medicaid members.

Integrated Care Teams. To complement and augment the capabilities within our provider network, Granite State Health Plan will employ Integrated Care Teams (ICTs); a multi-disciplinary team comprised of registered nurses (RNs), behavioral health (BH) clinicians, social workers, Disease Management Health Coaches, and non-clinical Program Coordinators. ICTs ensure that members, often with multiple co-morbidities and changing needs, receive fully coordinated care. For provider groups with only limited ability to coordinate care, our ICTs work closely with the provider group staff and the member to develop an individualized care plan and then to coordinate all the covered and community services in the plan. For groups who have more developed care coordination capability, the ICT co-manages their care plans, overseeing them, complementing their coordination and adding physical and behavioral health, social service and disease management expertise to ensure all services are delivered and all needs are met.

Provider-based Support for Care Coordination. For FQHCs, CMHCs and other PCMH with many assigned members, Granite State Health Plan will embed Care Managers onsite to maximize cooperation with and support of the PCMH comprehensive care coordination. For example, our Care Managers play a key role for CMHCs in facilitating access to comprehensive physical health services for enrollees with serious mental illness. A recent review discussed the benefits of locating an RN Care Manager in a CMHC to facilitate access to primary care services off-site, citing evidence for increased receipt of evidence-based services and for increased likelihood of having a usual source for primary care services.[10] In fact, without appropriate coordination of care and identification of a Medical Home, individuals with serious mental illness may be forced to seek routine care in the emergency room. Embedded Care Managers build face-to-face relationships with these members while they are in the familiar environment of the CMHC. They ensure access to the most appropriate medical and ancillary services for member needs and encourage compliance with care plans with such measures as arranging escorts or translators for medical visits.

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[10] Alakeson V, Frank RG, Katz RE, Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders, Health Affairs 29(5) 2010; 867-873

The Centene Foundation for Quality Healthcare. The Foundation for Quality Healthcare was established to improve the quality, access, effectiveness, and value of healthcare for low-income families and individuals, focused on activities that identify and address core causes of unequal access and treatment in healthcare. Building on Centene's long-standing commitment to deliver healthcare at the local level, the Foundation develops partnerships to implement innovative approaches to promote healthy communities. In 2009, The Foundation funded a $50,000 grant to the Louisiana Primary Care Association (LPCA) to help support their initiative for member FQHCs to become NCQA recognized as Patient-Centered Medical Homes. This initiative built on the FQHCs' strength as community-oriented providers of comprehensive care to go the next step to achieve and be recognized for fully coordinated, patient-centered care, and accountable for improving the health status of their patient population.

Value-Based Payment Arrangements

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.

Centene Corp has had a wide array of experience creating value-based payment arrangements, sub-capitation arrangements and incentive programs. With the concept of paying for performance being a relatively new concept in the Medicaid market we have reported good preliminary results. We have moved to a value-based payment arrangement with most of our states, but we have many LOAs that allow for flexibility to reward providers for quality care delivery in limited markets.

All our payment initiatives are focused on impacting quality and reducing cost, most of our programs have value-based and incentive based pay for performance components. Our largest value-based payment arrangements reside in the states of Texas, Louisiana and Massachusetts. In Massachusetts, as they move towards a global payment model, there is a component of sub-capitated payment. We also have a value based payment arrangement in our Wisconsin, South Carolina and Georgia markets with FQHCs and CMHCs that serve a large portion of our population.

Superior HealthPlan – Texas

To better align provider reimbursement with improvement in healthcare quality, our Texas affiliate, Superior HealthPlan, Inc. (Superior), in collaboration with their network providers, developed an innovative provider partnership model called Preferred Networks (PNs). These PNs more closely align acute care hospitals and primary care physicians (PCPs) through a model of shared accountability for providing efficient quality care for assigned members. The model includes a multi-tiered incentive plan with gain sharing and quality-based components. While first conceived as a pilot, this model has received such a positive response from Superior's providers that they intend to implement it, with Health and Human Services Commission (HHSC) approval, in all areas with enough membership density to support it.

The collective challenge in developing the PNs was to develop a model that both aligned networks of providers with shared accountability for service delivery and adequately motivated them to improve the efficiency and quality of care. It quickly became apparent that hospitals had the resources to form the core of an accountable network and potentially play a key role in reducing readmissions. Superior also viewed PCPs as having the greatest potential for providing holistic, integrated, coordinated, and accessible care; particularly if motivated to transition their practices to become recognized Patient-Centered Medical Homes. The PNs include hospitals and PCPs, and use performance data and a package of financial and non-financial incentives to motivate providers; including direct sharing of savings resulting from improved efficiency and quality of care. To best focus on members with co-morbid chronic conditions and at highest risk for future resource utilization, Superior collaborated with their PNs to encourage PCPs to go beyond PCMH status and become Designated Providers for their Health Home Program. Superior also encourages PNs to provide the team of health professionals required to support their Designated Providers as Health Homes. Superior further compliments these efforts by providing all required Health Home services that are beyond the current capabilities of particular Designated Providers or PNs. They also work closely with PNs to ensure that their providers have the communication and data functionality needed to coordinate care among themselves, and to continuously improve quality of care and outcomes.

Superior collaborates with PNs on initiatives similar to Coleman's Care Transitions Model (industry recognized process for reducing inappropriate readmissions) designed to reduce inappropriate utilization. Though Superior expects quality-based incentives to drive savings in the long term, we expect direct reduction of inappropriate utilization such as inappropriate admissions and readmissions to have a more immediate impact. Their model links gain sharing incentives to hospitals successfully meeting or surpassing specific benchmarks related to metrics such as reduction of preventable ER visits (which can result in admissions) and preventable readmissions.

Incentive Strategy. Superior has carefully crafted an incentive strategy that:

- Respects natural referral patterns for hospitals
- Aligns financial performance with appropriate utilization
- Is sensitive to MCO premiums and will not require frequent, complex contracting changes
- Provides transparency to the PN providers
- Aligns financial performance with quality outcomes
- Aligns Superior's goals with HHSC's performance goals for quality, cost effectiveness, and access

Superior used HHSC's Performance Indicator Dashboard, Performance-Based Capitation Rate Indicators, and Quality Challenge Award Indicators, as well as their Provider Profiling Program measures, other HEDIS Medicaid measures, Texas Association of Community Health Centers Performance Improvement data elements, and NCQA Patient-Centered Medical Home requirements as resources for developing the initial quality metrics for this incentive. They have established targeted categories of quality measures for PN PCPs and a separate set of cost and quality measures for hospitals. These measures are in line with Centene's Medical Home requirements and performance tracking as defined previously.

CeltiCare Health Plan - Massachusetts

Created as a result of Massachusetts legislation 305 CML 30 creating PCMHI Massachusetts Health Demonstration Project, this project is a three year Multi-payer initiative modeled after similar initiatives in other states, yet redesigned to fill the gaps where other states have found short falls. The State's goals for this initiative were to achieve accessible high quality primary care, increase available resources, attract new PCPs to the state and demonstrate cost effectiveness to justify sustainability beyond the initial three year pilot.

The initiative has 12 Core Competencies required in 3 categories: Practice redesign, Consumer engagement and Care Management. The state is supporting this initiative with a Medical Home Facilitator who will work 1:1 with practices, establish learning collaborative with expert faculty, best practice sharing and ongoing online collaboration forum and Patient Registry technical assistance.

A diverse set of providers across Massachusetts are participating. These providers must be contracted with MH PCC plan or a MH Managed Care Plan and must have Broadband Internet connection in the office. Additionally, they must meet the following mandatory practice requirements:

- Learning Collaborative participation
- Use Patient Registries (either via EMR or dedicated tool)
- Become NCQA recognized at the "Level 1 PLUS" category for PCMH by 7/3/12
- Care Coordination/Care Management
    - Hire a licensed nurse (Monthly pmpm payments do not start until this occurs)
    - Identify high-risk patients
    - Provide intensive monitoring, follow-up and clinical management
- Submit reports

Provider Reimbursement Strategies. With a move to a global payment model, provider payments are adjusted to a mix of incremental administrative fees and a shared savings model. Shared savings are tied to provider's ability to generate cost savings or trend reduction relative to a control group.

Louisiana Healthcare Connections (LHC) – Louisiana

As part of the recent launch of its Medicaid managed care program, Coordinated Care Network (CCN), the state of Louisiana wants to engage its contracted Medicaid managed care plans in promoting the development of Health Homes, recognized by NCQA or JAHCO, as soon as possible. Therefore, Centene's health plan affiliate in Louisiana, Louisiana Healthcare Connections (LHC) will implement a PCMH program in conjunction with the CCN program start date on January 1, 2012. The state of Louisiana has several components to its provider payment reform. Recognizing that maintaining a network of providers is critical to the success of the CCN program, LHC is committed to paying certain providers who meet specified guidelines above the current Medicaid fee schedules and to reward providers for providing quality care to members. Additionally, LHC's commitment to enrolling Significant Traditional Providers (STPs) in its network is not only apparent in its organizational structure (that has 19 FQHC owner-partners in LHC), but also in our belief that STPs deliver high quality and

often otherwise unavailable healthcare services to Louisiana's Medicaid population. LHC recognized and wished to continue supporting the long-standing relationships between FQHC STPs and members. Therefore, LHC structured reimbursement with these providers to foster the patient-provider relationship that has been formed within the FQHC STP community.

LHC is implementing two incentive programs for providers: 1) a bonus program based on the efficiency of care, and 2) a pay-for-performance program based on specific measures that the State and LHC deem essential in delivering high quality care. The provider is eligible for a bonus based on the provider's ability to improve health outcomes resulting in lower medical expenses if the provider: (1) has achieved the specified medical expense thresholds as set forth in the provider incentive agreement; (2) meets all other thresholds and requirements set forth in the agreement; and (3) is in compliance with the terms and conditions of the agreement. LHC has researched various measures as published and supported by national agencies while taking into consideration its internal strategic goals as well as those of the Louisiana Department of Health and Hospitals; its membership demographics; and the clinical practice guidelines it has adopted. LHC's indicators include a variety of HEDIS preventive care measures as well as disease specific practice guideline measures. LHC will produce and distribute provider-specific reports containing meaningful, reliable and valid data for evaluation by LHC and the provider.

This provider incentive program is premised on sharing financial savings with primary care providers who achieve an overall reduction in medical costs for Louisiana Healthcare Connections members assigned to them. Specifically, the provider shall be eligible for bonuses based on medical cost reductions that are achieved by health care professionals whom the provider employs, contracts with, or refers patients to.

The provider is eligible for a bonus based on the provider's ability to improve health outcomes resulting in lower medical expenses if the provider: (1) has achieved the specified medical expense thresholds as set forth in the provider incentive agreement; (2) meets all other thresholds and requirements set forth in the agreement; and (3) is in compliance with the terms and conditions of the agreement.

For the purposes of calculating the bonus LHC will, on a quarterly basis, compare the cumulative medical expense ratio (based on the applicable effective date) of the primary care provider's assigned members, through the most recent calendar quarter to a baseline medical expense threshold. If the comparison indicates that the provider has delivered more efficient care resulting in medical expenses that are less than the target threshold as set forth in the incentive program agreement, then the incentive bonus shall be equal to fifty percent (50%) of the difference between actual medical expenses and the target threshold.

Bonus incentives earned are distributed on a quarterly schedule with an annual reconciliation based on the primary care provider's year end results. In any calendar quarter and/or contract year, a provider's bonus shall not exceed thirty-three percent (33%) of total claims payments made by LHC to the provider and/or it's professionals during such time period for services rendered by the provider and/or its professionals.

LHC will support providers with critical resources, tools and processes such as: reporting, member compliance innovations, Predictive Modeling, care management tools, etc.

Wisconsin

Managed Health Services, GSHP's affiliated health plan in Wisconsin, created a Pay for Performance bonus pool by contributing a per member per month capitation amount to the fund, measuring provider performances based on HEDIS and Administrative measures. Providers receive quarterly progress reports and the bonus is payable following the close out of the previous year.

Mississippi

GSHP's affiliated health plan In Mississippi, Magnolia Health Plan, created a pay for performance model to provide real-time rewards for PCPs that performed preventive services that support better health outcomes such as immunizations, well baby care, diabetic monitoring and foot care, and after-hours access in lieu of Emergency rooms. Magnolia identified 48 CPT codes for these services and increased the fee paid for these codes. There is no waiting for claims run outs and bonus pool calculations; the payment for performance is real-time.

All Plans

Notification of Pregnancy. Early identification of pregnancy and assessment of risk factors and potential complications is so important we provide an incentive for providers to complete and submit the form. This enables the plan to assign a proprietary risk score and engage the member using the most appropriate level of care management. In 2010, GSHP's affiliated health plans have saved a combined $14 million due to the reduction in NICU days based on early notification of pregnancy and our care management efforts.

New Hampshire has been a leader in the development of patient centric care delivery models, and much of the success is due to the coordinating role that the state has played. Centene will work collaboratively with the state and other payers to explore opportunities to support payment and delivery system reform and to further align incentives and standards in order to achieve common goals. In New Hampshire, Centene will work in partnership with the state and local providers to create comprehensive and sustainable payment reform initiatives.

Behavioral Health Delivery System and Payment Reform

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

Granite State Health Plan's (GSHP) approach to Behavioral Health delivery system and payment reform is to provide managed behavioral health services that deliver *functional* outcome results, *high* member satisfaction, intensive quality management based for thoughtful program and product design with

exceptional customer service. Our staff and programs leverage clinical efficacy with culturally appropriate, seamless wraparound services that look beyond the immediate service request to provide the most appropriate services at the right time. As an integrated team, GSHP and our behavioral health affiliate Cenpatico Behavioral Health, LLC (Cenpatico), use an enterprise approach that reduces redundancy and fragmentation. We internally provide behavioral health coordination, disease management, pharmacy support, 24/7 nurse helpline services, utilization management and telemonitoring as one entity with a single centrally located care plan and record of services.

Integrated Service Delivery System. Our experience and understanding of managing BH care is the foundation for our population specific treatment protocols, training methodologies, and overall program design that will become a best-in-class model for New Hampshire.

These efforts will build on Centene's experience in other markets establishing a Health Home model that is inclusive of behavioral health services and supports and addresses the needs of members with serious mental illness (SMI) or severe emotional disturbance (SED). This forward looking development ensures New Hampshire long term success for members. GSHP will provide an unbiased quality driven program that exceeds expectations for timeliness, access to all covered services, medical appropriateness of services and successful functional outcomes. Our experience with our integrated healthcare approach to Behavioral Health service delivery and payment reform includes but is not limited to:

NCQA Accreditation Behavioral Health Care Organization

- Physical health/mental health/substance abuse service integration through Integrated Care Teams (ICT);
- Working with providers to develop payment methodologies such as Cenpatico's block payment technique for comprehensive service providers;
- Development of Sub-acute levels of care, for step down after hospitalization or to avoid need for hospitalization;
- Crisis services, including 24/7 hotline support services with access to care assessments and services;
- Interagency systems coordination, including child welfare and homeless lead agencies, law enforcement, and other state and local agencies and resources;
- Discharge, peer support, wrap around, and crisis intervention planning for high needs populations with emphasis on decreasing readmissions;
- Community outreach for hard to reach members through our MemberConnections Representatives; and
- Unprecedented member and family voice and involvement; where people can recover and have the right to be involved in their care.

Cenpatico serves over 1.7 million Members nationwide; has nearly 7,500 providers enrolled to provide care; and is Accredited by NCQA.

Network Development

GSHP will draw on the experience of its affiliate Cenpatico, and consider current and anticipated utilization and demographic data, including the cultural and linguistic characteristics of Members, to determine the requirements for network Providers. We use quantitative and qualitative methods to analyze and monitor network adequacy and sufficiency in all our current markets. Quantitative analyses are performed to evaluate any changes in the demographics of those we serve, geographic characteristics and capacity of our network, availability of appointments and out-of-network authorizations. Through qualitative analyses, we assess the adequacy of specialized programs and services by analyzing Member and family guidance data, as well as data on complaints, grievances and appeals. As a result, we have successfully included all CMHCs located in each of our eleven state markets. Nine of the eleven States served by Cenpatico include Aged, Blind and Disabled (ABD) populations, including adults with severe mental illness (SMI) and children with severe emotional disturbances (SED) in their managed care plans are Arizona, Florida, Illinois, Indiana, Ohio, South Carolina, Texas, Wisconsin, and more recently Kentucky.

Comprehensive Service Delivery. Cenpatico has successfully developed networks and provided for the delivery of the full continuum of behavioral health services, as covered in each or their eleven markets. While more fully described in response to Q45, our experience delivering a full continuum of services includes the full array of community based services. All markets include delivery of psychiatric, psychological, counseling, and medication support. Markets serving the ABD populations include evidenced based, community services that assist with the resiliency and recovery needs of its Members such as supported employment, illness management, day treatment, partial hospitalization, and peer supports. Inpatient care and residential services are also included in most markets.

Payment Reform in Other States

GSHP's behavioral health affiliate, Cenpatico, has used a variety of payment approaches, including traditional fee for service (FFS), block payments, and payment for performance incentives. FFS arrangements typically include provider specific, negotiated rates for covered services delivered to enrolled Members.

In Arizona, Cenpatico uses a block payment methodology to pay their CSP (CMHC) providers while retaining a fee-for-service system for non-CSP Medicaid providers, including Medicaid specialty providers and acute care facilities. Block payment reimbursement is a strategy that empowers larger multi-service providers in the overall care of those they serve. CSP receive lump sum payments by fund type each month and manage the dollars to cover services. CSP are accountable for their spending and are required to submit encounters for services to be equal to or greater than their contract amounts. The primary advantages to this payment strategy are that it improves care and outcomes by allowing the provider to coordinate waiver and wrap around services in relation to traditional outpatient services. The coordination of care is centralized with the CSP. It brings more of the right services to bear for each individual. It gives the providers flexibility in determining the right service mix for their communities, leading to better outcomes for each individual served.

Cenpatico has worked with Arizona to establish appropriate measures; incentives for each measure; and monetary amounts for each incentive to create a mutually acceptable set of performance based incentives. As a proven best practice, incentives earned by Cenpatico of Arizona are shared with providers. In an effort to achieve our goal of quality care, Cenpatico provides incentives to CSP Intake Providers to improve and sustain performance in three key areas: Employment, Annual Assessment Updates, and Peer and Family Involvement. Cenpatico offers Service Incentives to providers who meet the specified requirements.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.10 Behavioral Health Services

3.10 Behavioral Health

Developing Partnerships with CMHCs

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.

Overview

Granite State Health Plan's (GSHP) behavioral health affiliate Cenpatico Behavioral Health, LLC® (Cenpatico), has extensive experience contracting with a full continuum of behavioral health providers including Community Mental Health Centers (CMHCs) and non-traditional providers such as peer support organizations. We are keenly aware of the importance of maintaining existing relationships between providers and our members and highly respect the knowledge and experience of safety net providers in serving vulnerable populations such as those who will be enrolled in the New Hampshire Care Management Services Program. These safety net providers will already know and be familiar with our members; they are located in the neighborhoods in which our members live; our members will know and trust them; and involving safety net providers minimizes the need for transition of care when members join GSHP. This commitment to and understanding of the role of safety net providers is demonstrated by the fact that Centene, through Cenpatico, currently contracts with 307 CMHCs in 981 locations, in eleven states. In New Hampshire, we have already begun the process of building collaborative relationships with the CMHC providers through outreach meetings with the Community Behavioral Health Association and member CMHCs to learn about their programs and begin contracting efforts.

GSHP will offer all ten Regional CMHCs within the State the opportunity to participate in our network. Given our experience in all other markets, we expect those efforts to be successful. Following the best practices of existing Centene health plans, we will:

- Place priority on CMHC providers during our network development activities;
- Develop unique relationships with CMHCs that position them to serve as Health Homes for our highest-risk members with serious mental illness (SMI) or serious emotional disturbance (SED); and
- Actively solicit input from CMHCs regarding GSHP's model for care coordination, quality improvement initiatives and other aspects of our operating model.

Partnering for Innovation. Cenpatico has worked to develop innovative partnerships with CMHCs across the country. In Indiana, we have worked with CMHC, the Bowen Center, to improve communication between the health plan and the clinicians for members with complex needs through integrated joint rounds. Additionally, Cenpatico partnered with the Bowen Center to offer a children's

crisis respite benefit to help reduce unnecessary inpatient hospitalizations for children. In Texas, Cenpatico has partnered with the Center for Health Care Services, a San Antonio based CMHC, to increase awareness of Assertive Community Treatment (ACT) services at local inpatient facilities. Management from both Cenpatico and the CMHC provided joint outreach and training to alert the hospitals that members of the ACT program had on the ground case managers who were available for discharge planning. In Georgia, Cenpatico has partnered with local Community Service Boards (CSBs), which are their CMHCs, to enhance evidence based practices available to members. Utilizing an internationally-recognized, evidence-based approach to care, the Strengthening Families Program (SFP), Cenpatico developed a Pilot Program designed to engage high-utilizing community-based service providers in a way that would improve their treatment practices and member outcomes. Three Georgia CSBs were selected and Cenpatico contracted with Lutra Group, Inc., the sole authorized source for SFP staff training, to provide a two-day on-site training for SFP service development and delivery to the three identified pilot providers.

Results from the first Lutra Group SFP Georgia Outcomes Report stated, "The children enrolled in the SFP Pilot at two Atlanta sites had significant behavioral and mental health problems that were almost twice as severe as those children who generally participate in SFP, resulting in a particularly high-risk population and therefore appropriate for the SFP intervention... 100% of the five family change variables were improved significantly." The report also stated, "Hence, it appears that the SFP programs are having a dramatic impact on the overall family environment, beyond that found normally in other SFP sites nationally. This is a very positive effect and a tribute to the Cenpatico strategy."

In addition to positive member outcomes for members and their families, SFP parent graduates reported favorable responses to the program. One parent said, "It helped me to build a closer relationship with my son." Another parent stated, "It was nice to be with other mothers who had similar issues, and we could share different techniques for handling the same problems." And a third parent said she was initially resistant about attending the weekly SFP training sessions, but by graduation was better at expressing her own feelings and was able to get her son to communicate more with her instead of "keeping things bottled up inside."

Fully Coordinating Care

Integrated Care Teams. GSHP will use comprehensive Integrated Care Teams (ICT) to ensure that members, often with multiple co-morbidities and changing needs, receive fully coordinated care. Our ICT approach started in Ohio where our physical health and behavioral health care management and coordination staff were organized into teams with one lead care manager assigned based on the primary health concerns of the member. The team approach allows for streamlined communication to members and providers with expert case consultation available for co-morbid conditions. This approach has achieved further success in GSHP's affiliate plan in Illinois, IlliniCare, where we have woven the ICT approach into our work with Health Homes. For example, in Illinois when a Health Home provider has only limited ability to coordinate care; our ICT will work closely with the Health Home staff and the member to develop an individualized care plan and then to coordinate all the covered and community services in the plan. For Health Homes who have more developed care

coordination capability, the ICT will co-manage their care plans, overseeing them, ensuring clear roles and responsibilities, complementing their coordination and adding physical and behavioral health, social service and disease management expertise to ensure all services are delivered and all needs are met. Similar to our experience in other markets, Cenpatico's Care Managers and Care Coordinators on the ICT will play a key role for CMHCs in facilitating access to comprehensive physical health services for members with SMI and SED. This population commonly has significant medical co-morbidities with adverse outcomes due to poor engagement in primary care services and low compliance with treatment plans. In fact, without appropriate coordination of care and identification of a Health Home, individuals with SMI and SED frequently seek routine care in the emergency room. We will build on current successes in the State, such as those experienced in Nashua where Lamprey Health Care has co-located physical health providers in the local CMHC.

GSHP, drawing on the experience of IlliniCare and their Texas affiliate, Superior Health Plan (Superior), will facilitate coordination and communication among the Health Home, behavioral health providers, PCPs and Members by encouraging use of our On-Line Clinical Portal as a shared source of behavioral health visit, medical, immunization, prescription drug and other historical member data.

Integrating Care Management Staff with Local Providers. A recent review recognized the embedded care coordinator approach as a valuable alternative for providing a Medical Home for people with serious mental illness, citing evidence for increased receipt of evidence-based services and for increased likelihood of having a usual source for primary care services.[11] When possible and appropriate GSHP will embed Care Coordinators with high volume providers; in all cases our ICT will be available for on-site consultation when necessary. This approach strengthens rapport with members and fosters collaborative relationships with providers. Our ICT will ensure access to the most appropriate behavioral, medical and ancillary services for members' needs and encourage compliance with care plans with such measures as arranging escorts or translators for health care visits.

Facilitating Communication for the Health Home. GSHP will facilitate coordination among the Health Home, other providers and members by encouraging use of our On-Line Clinical Portal and Member Health Record as a shared source of health visit, immunization, prescription drug and other historical member data. Our Connections Plus® program, offered by all Centene plans, will provide pre-programmed cell phones to high-risk members who lack reliable phone access. This innovative program will allow them to make calls to and receive calls from their Health Home and other providers, care coordinators, other GSHP personnel, award winning NurseWise (our 24/7 nurse advice line, crisis line), and 911. Members in areas without adequate cell phone service will still be able to access GSHP services via any public telephone using our toll free member and NurseWise numbers.

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[11] Alakeson V, Frank RG, Katz RE, Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders, Health Affairs 29(5) 2010; 867-873

Soliciting Input from CMHC Providers

Centene health plans have extensive experience in every market working with CMHCs as network providers, committee members, and partners in innovation.

Provider Advisory Committee. GSHP will implement a Provider Advisory Committee (PAC). The PAC will be composed of the Medical Director, network practitioners from across the contracting area, the Director of Contracting and Network, and Provider Relations staff as appropriate. GSHP has already recruited two providers to actively participate on the PAC: Dr. Jennifer Koop Families First Health and Support Center and Frederick S. Kelsey, M.D., F.A.C.P., Medical Director of Mid-State Health Center.

When recruiting additional providers to participate on the PAC, we will target safety net providers, including CMHCs. The Committee will provide input on GSHP's provider profile and incentive programs, and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data and effective means of helping providers improve their performance.

Annual Plan. GSHP will engage CMHCs, along with other stakeholder groups and organizations, in the development and revision of an annual plan to address New Hampshire's unique service and program needs. Regional service and treatment needs of people with SMI and children with SED will be specifically addressed in the planning process, creating local solutions.

Subcontracting

GSHP, through its behavioral health affiliate Cenpatico, contracts with a full continuum of behavioral health providers to fulfill the health care service needs of its members. We do not otherwise subcontract behavioral health functions or services.

Serious Mental Illness and Serious Emotional Disturbance

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.

Overview

Granite State Health Plan (GSHP) will leverage the experience of Centene health plans across the country and our behavioral health affiliate Cenpatico Behavioral Health, LLC® (Cenpatico) with contracting Community Mental Health Centers (CMHCs), and other safety net providers, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), other Health Centers (such as White Mountain Community Health Center-Conway and Child Health Services-Manchester),and the 15 Public Health Networks. As noted in Q44 above, CMHCs, are an integral component of our network.

For individuals with serious mental illness (SMI) and children with serious emotional disturbances (SED) in need of long term care support and services CMHCs are often the only providers who offer the comprehensive community based care. Cenpatico has extensive experience providing services to adults with SMI and children with SED in eleven states.

Centene health plans have extensive experience providing long term care services to aged and disabled members. For example, in Arizona, Centene subsidiary Bridgeway Health Solutions (Bridgeway) provides long term care services that include facility-based and home and community-based services (HCBS) such as home modifications, personal attendants, and adult daycare to older persons and people with disabilities on SSI. Superior HealthPlan (Superior), our affiliate health plan in Texas, has provided long term care support services to the ABD population since 2007.

While covered benefits may vary from state to state; Cenpatico has extensive experience providing a wide array of evidenced based services to support people with SMI or SED. Some of those services include:

- Assertive Community Treatment.
- Crisis Intervention.
- Person Centered Treatment Planning
- Community Support
- Comprehensive Mental Health Services.
- Case Management: Mental Health, Transition Linkage and Aftercare
- Services for people with Visual Impaired and Hearing Deficits
- Inpatient Services
- Short-Term Diagnostic and Mental Health Services
- Supported Employment: Job Finding, Retention and Termination Supports
- Mental Health Assessment
- Intensive Outpatient Service
- Outpatient Service
- Peer and Family Supports
- Psychological Evaluation
- Psychosocial Rehabilitation and Support (PSR)
- Psychotropic Medication Administration, Monitoring and Training
- Intensive Family-Based Services
- Therapy/Counseling – Individual, Group and Family
- Treatment Plan Development, Review and Modification

Direct Experience in Service Delivery

Achieving a behavioral health delivery system that meets the needs of individuals with SMI and SED long term care service and supports needs includes offering a broad continuum of behavioral health services. Cenpatico's experience working with behavioral health providers across the country to deliver covered services informs our approach to long term care. ***We have experience in, and are prepared to deliver all community mental health services provided through designated Community Mental Health Providers.*** Covered behavioral health services differ from program to program and state to state. We have seen greater success for SMI and SED members enrolled in programs with a richer benefit, which offers adequate step-down services that encourage member-directed recovery and resiliency in the least restrictive environment.

Understanding Behavioral Health Benefits. Providing a broad continuum of care effectively addresses behavioral health issues and improves access to care by more appropriately meeting members' treatment needs. We believe so strongly in the benefits of a continuum of care, that we have implemented services as value-added benefits to members in programs with limited benefit packages to ***improve access to sub-acute levels of care*** that help members stabilize and maintain their recovery in the community. In Indiana, we recently implemented Crisis Respite services for children to help prevent unnecessary inpatient admissions. In many programs we have used services like intensive outpatient (IOP), which provides an integrated program of rehabilitation, counseling, education, and therapeutic and family services in a concentrated series of meetings per week. Members engaged in IOP will have an individualized treatment plan. Services range from one and one-half hours per day, and at least six hours per week. Treatment goals include reduction in symptom severity and improvement in levels of functioning so that the member may proceed to less intensive forms of outpatient treatment. For example, a Texas member diagnosed with Bipolar Disorder with psychotic features who had been hospitalized several times began partial hospitalization services in June 2009. Cenpatico staff facilitated transitioning her to step down to IOP services later that month, and she continues to participate in her individualized treatment plan. The coping skills, treatment and other supports she has received from these services have allowed her to enroll in college and achieve greater stability and productivity in the community.

Cenpatico has successfully ***implemented diversionary services*** such as Targeted Case Management activities, bus passes where available, and telemedicine in more difficult to reach rural areas. In Ohio, we offered such Diversionary Services as an outpatient eating disorder program to prevent inpatient hospitalization for members. Diversionary Services are flexible, individually tailored, culturally competent interventions that are provided in addition to Covered Services to help stabilize members with BH disorders, reduce or avoid inpatient admissions, and increase their tenure in the community. Diversionary Services include clinical and non-clinical services such as respite, residential care, BH wrap-around services, medication compliance assistance, skills training and other non-Covered supports or interventions to meet unique individual situations and conditions.

We see the impact of severe mental illness (SMI) such as disabling schizophrenia or high-risk bipolar disorder in our members, most impacted are SSI and Aged, Blind and Disabled (ABD) populations. People with an SMI diagnoses are often at high risk for discontinuation of treatment, homelessness and frequent acute care. At times traditional outpatient services are not enough to help them stabilize in the community. In one of our Texas programs, the standard benefit package limited access to certain diversionary services. We knew that better step down services were needed, so we went outside the benefit package to contract with providers who offered specialized services such as Assertive Community Treatment (ACT) and Cognitive Adaptive Training (CAT), another evidence-based treatment approach for members with disabling schizophrenia or high-risk bipolar disorder. This program addresses the needs of a small targeted population, very high-risk members, but the impact is significant. The first recipients enrolled ***experienced a 16% reduction in inpatient admissions and a 25% reduction in readmissions*** comparing the 90-day periods before and after initiation of treatment.

To keep high-needs members that are hard to reach connected to care, our Connections Plus® program, offered by all Centene plans, will provide pre-programmed cell phones to high-risk members

who lack reliable phone access. This innovative program will allow them to make calls to and receive calls from their providers, care coordinators, other GSHP personnel, their award winning NurseWise (our 24/7 nurse advice line), and 911. NurseWise's Rapid Response – Behavioral Health Case Management 2011 - Case In Point Platinum Award - Most successful and innovative case management programs working to improve healthcare across the care. We encourage members to call promptly for advice rather than waiting until their next appointment.

Bridgeway Health Solutions® (Bridgeway): GSHP's Long Term Care health plan affiliate in Arizona uses a holistic, member-centric approach that incorporates strengths-based assessment, support of the informal network, and integration of covered services and community resources to maintain members in the least restrictive, most integrated setting appropriate to their preferences and needs. Our Case Managers (CMs) spend their time in the field, getting to know members/families and maintaining strong relationships with providers to meet member needs and quickly identify and address issues.

Assessment. Case Management (CM) Supervisors review information from the State, previous contractors, BH providers, or other sources to identify members with existing services or immediate needs. New members receive a Welcome Call from a Program Coordinator (PC) who helps the member complete a Health Risk Screening (HRS) to identify diagnoses, medications, hospital and emergency room use, activities of daily living, pain, mental health conditions, substance use issues, and use of medical equipment and supplies. The CM Supervisor uses this information to assign a CM and a timeframe for the initial assessment visit, based on the member's needs.

The CM works with the member and family/caregiver to complete a comprehensive assessment of physical and BH conditions, functioning, social needs, living environment, cultural considerations, informal support system, and financial needs. The CM also administers a depression screen, assesses for medication non-adherence and reviews any psychotropic medications. We require CMs to document medication regimen in TruCare, including purpose, effectiveness, and any adverse side effects. CMs also assess for history and treatment of substance abuse, psychiatric issues (including hospitalizations), suicide attempts, and aggressive or threatening behavior; as well as legal history, vocational history, ability to care for self, and strengths and goals. We assess the member's existing system of care and how it is working for them, and help identify providers with specific expertise as needed. If members have strong relationships with non-network providers, our Provider Services Representatives will attempt to contract with them to ensure continuity of care and expand availability of expertise within the network in areas such as pain management services.

Care Planning. To ensure that our members can make informed decisions, our CMs uses Motivational Interviewing and other strategies to engage members and their families in the planning process, and provide comprehensive education about services and support available through Bridgeway.

The CM uses all assessment information to help the member articulate physical health, BH, functional, social and other goals that form the basis of the care plan. Goals are measurable and the CM and member identify a plan of action (including timeframes, roles and responsibilities, and service options) to achieve each goal. The CM encourages member self determination, honoring preferences in types,

frequencies and settings of services, emphasizing their right to services provided in the most integrated, least restrictive setting appropriate for and acceptable to them.

Clinical Input. The CM contacts the PCP in a timeframe consistent with member needs to discuss the assessment, member preferences, goals and needs, and the care plan. With member consent, the CM shares clinical information and care options with all applicable providers, and shares each provider's input with other treating providers to ensure coordinated input into the care plan. To obtain additional expertise and input into the care plan, CMs may present complex situations to our multidisciplinary Case Review Team (CRT), comprised of the Medical Director, VPs of Case and Medical Management, CM Supervisors, BH Coordinator, and CMs.

Coordination and Monitoring. Once the care plan is finalized and agreed to by the member/family, the CM enters authorizations into TruCare and ensures service initiation. The CM alerts all treating providers as appropriate to changes in the member's physical, BH or functional status, including any emergency room or inpatient admissions. The CM ensures that any physician who has prescribed medications for the member is made aware of all member prescriptions and how to contact the CM and the PCP to ensure medications are coordinated. For members on psychotropic medications but not stable, or when these medications are being adjusted, the CM reviews the situation with the BH Coordinator at least quarterly. The BH Coordinator contacts the prescriber to discuss and resolve any concerns. Our psychiatric consultant conducts poly-pharmacy reviews with the Medical Director, Pharmacy Director, BH Coordinator and nurse CMs to identify unneeded, ineffective, or contraindicated medications.

Centelligence Foresight

- **Predictive modeling**
- **Care gap/health risk identification application**
- **Track member conditions**
- **Health risk alerts**
- **Identify members with co-morbid conditions**
- **Identify Members at risk of chronic conditions**

Our CMs are supported by our state-of-the-art Centelligence™ family of integrated decision support and healthcare informatics solutions. Centelligence™ enhances CM ability to anticipate, identify, monitor and address issues and improvement opportunities. For example, CMs can use Centelligence Foresight™ (Foresight), our predictive modeling and care gap/health risk identification application, to track member conditions; monitor member care gaps or health risk alerts; identify members with co-morbid conditions and persons at risk of developing chronic conditions; identify persons in need of additional services or higher levels of case management; and take action. CMs and other clinical staff access this information with one click through TruCare, our member-centric health management platform for case management, behavioral health (BH), disease management, and utilization management. TruCare allows us to integrate utilization, BH care, case management and disease management efforts; proactively monitor members; efficiently document the impact of our efforts; pinpoint where care is needed; and implement customized intervention strategies.

Payment for Services

Cenpatico, as noted earlier, has used a variety of payment approaches, including traditional fee for service (FFS), block payments, and payment for performance incentives. FFS arrangements typically include provider specific, negotiated rates for covered services delivered to enrolled Members. Details can be found in the response to Q43.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.11 Care Management Overall Approach

GRANITE STATE HEALTH PLAN

3.11 Care Management Overall Approach

Overall Approach to Care Management

Q46. Describe your overall approach to care management and how you integrate wellness, prevention, and chronic care management into one seamless program.

Overview

Granite State Health Plan's (GSHP) parent company, Centene Corporation, has experience providing case management and care coordination services to populations similar to those covered by the Care Management Program. Nine of GSHP's affiliated health plans (AZ, FL, IL, KY, MS, OH, SC, TX and WI) provide services to approximately 223,000 SSI/ABD members with over 45,000 of those members part of the dually eligible population. Our affiliates also serve TANF, Foster Care, DD/SMI, Dual Eligibles and LTCSS.

GSHP will implement a GSHP Model that each Centene affiliate has adapted to the unique needs of the local population, integrating the full range of services each member needs into a seamless, holistic experience of care that improves outcomes and enhances quality of life. Using this model, Centene plans have coordinated acute, behavioral, pharmacy, nursing facility, and home and community based services as well as non-covered community resources. This includes coordinating consumer-directed home and community based services (HCBS) with other services to meet member needs, goals and preferences.

> High-risk members enrolled in case management achieved **21.3% higher savings.**

Centene health plans use this model to manage such conditions as cancer, organ transplants, spinal cord injury, para/quadriplegia, amputations, HIV/AIDS, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, serious mental illness, autism, bipolar disorder, ADHD, seizure disorder, cerebral palsy, congenital defects and other chronic, complex, co-morbid and co-occurring conditions. Our approach will reflect lessons learned serving similar populations in other states. For example, we have learned that effective case management and care coordination for those with physical and cognitive disabilities and/or mental health issues must go beyond purely clinical determination of needs to identify and address functional status and barriers to care. We also understand that while many in this population have complex and/or co-morbid medical conditions, others may require or want a primarily functional approach to their care rather than the traditional medical model. Because our experience demonstrates that active member direction and engagement are key factors in compliance and improved outcomes, GSHP will encourage and support member self-determination in the care plan development and implementation process. The ultimate goal, however, is for each member to live a fulfilling life. Maintenance and/or improvement of health, behavioral

health and functional status are prerequisites for this goal and not merely ends in themselves. This core philosophy drives our approach to providing services and supports to members.

- Our approach to care will be **holistic and functional** rather than diagnosis-driven. Each member will receive the education and support they need to self-manage chronic conditions as well as make decisions about their care plan and delivery of care.
- Our unique **integrated approach** to serving people with cognitive impairment, including serious mental illness, includes **co-locating** RN Care managers and BH Care managers onsite at FQHCs, CMCHs and other high-volume provider locations. Recovery and resilience outcomes are achieved by addressing both behavioral and functional needs, thereby supporting physical health status improvements.
- We will **support the physician** community through reducing the "hassle" of managed care by asking for the lowest level of required authorizations possible, accepting out of network care episodes, reducing no-shows by facilitating transportation, arranging specialist appointments, offering electronic interfaces, and identifying member needs related to disabilities prior to the treatment visit.

GSHP staff will ensure that the full range of covered and non-Covered Services is integrated into a seamless experience of evidence-based care that improves outcomes and enhances quality of life. This approach has earned Centene plans a reputation among member populations for understanding how to meet special needs.

Care Management Approach

Historically, the health care industry geared case management toward individuals who were either at the threshold of an acute episode or actually having an acute episode. Members were managed through the acute episode then discharged from case management. To have a more meaningful, lasting impact on member outcomes and health care costs as well as quality of life, case management should focus not solely on acute episodes, but on the greatest opportunities for improvement; individuals for whom a case management program that recognizes and incorporates wellness and prevention and chronic case management can have a significant impact. With this approach we have the greatest opportunities in preventing, delaying or reducing the occurrence of acute need. GSHP will implement a program that expands the boundaries of traditional Care Management, focusing on preventive care; self-management of chronic conditions; integration of medical, behavioral health and other services; and an "outside the box" approach to innovative, community-based solutions. Successful strategies we will build on and adapt for New Hampshire include the following.

- Centene's **enterprise approach** reduces fragmentation. We can internally provide case management and coordination, disease management, pharmacy supports, 24/7 nurse helpline services, traditional managed care, and telemonitoring as one entity with a single centrally-located care plan and record of services.

- On-the-ground, **locally-based** call center, community outreach workers, Case managers, and hospital based discharge nurses ensure each member is supported by someone who understands the local culture and available community resources.
- We will **engage members**, families/caregivers and advocates in the way services are provided and how we communicate. We will achieve member-centric care and service outcomes by including members in treatment planning, through participation on advisory councils and other methods of ongoing engagement such as advocacy group participation in staff training and suggestions for network development.

Clinical Practice Guidelines. GSHP's case management programs will be based on clinical practice guidelines (CPGs) promulgated by the leading academic and national clinical organizations such as the American Diabetes Association (ADA), American College of Obstetricians and Gynecologists (ACOG), National Institute of Health (NIH) or as otherwise defined by the Department of Health. Guidelines are reviewed and updated at least annually or upon significant change. The specific clinical practice guidelines used for our case management programs include but are not limited to the following:

- *Asthma* Diagnosis and Management Guidelines, National Heart, Lung and Blood Institute (NHLBI)
- *Chronic Kidney Disease* – Guidelines for evaluation, classification and stratification, National Kidney Foundation
- Depression - Treatment of Patients with Major Depressive Disorder, American Psychiatry Association; Assessment and Treatment of Child and Adolescents, AACAP
- *Diabetes*- Standards of Medical Care 2009, American Diabetes Association (ADA)
- Hemophilila - Guidelines for the Management of Hemophilia (2005), World Federation of Hemophilia.
- *Perinatal Care*, Sixth Edition, 2007, American College of Obstetricians and Gynecologists
- *Sickle Cell* Management, Fourth Edition, National Institutes of Health. National Heart, Lung, and Blood Institute.

Provider Engagement. We will conduct a pre-implementation 'train the trainer' education campaign that includes an emphasis on completing the initial primary care visit and following the EPSDT periodicity schedule for screenings, immunizations and diagnostic testing. The campaign will target municipal agencies, advocacy groups and key community organizations and local municipality health programs that serve the member populations. GSHP will request a meeting with the mayor or mayor representative to establish the local contacts and begin to develop strategies for activities. GSHP is also developing a **partnership with Bi-state Primary Care Association of New Hampshire**, which is a nonprofit corporation that serves as a liaison, representative and support of the network of 330 providers including FQHCs, RHCs, hospital based CHCs and other primary care providers whose goal is to achieve access to quality preventive primary health services to the populations in greatest need in New Hampshire. The train-the-trainer campaign, which will include non-branded "Managed Care 101"

materials, and will enable these groups who regularly see our members to answer questions and assist members with access.

Centene was recognized as the *top* Managed Care company in Information Week's **2011 500 Most Innovative Business Technology Organizations.**

Centelligence™: Award Winning Technology Support

At the heart of our information capabilities is our Centelligence™ platform, which is our award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal *and* external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports. The Centelligence™ family includes:

- **Centelligence™ Insight** – our web-based reporting and management KPI Dashboards capability. In late 2010, we enhanced Insight with advanced capabilities for provider practice pattern and utilization reporting – supporting both our clinical staff as well as our providers with summary and detailed views of clinical quality and cost profiling information. This capability gives our providers the practice and peer level profiling information needed for continuous clinical quality improvement. Insight also supports both HEDIS and hybrid HEDIS reporting.
- **Centelligence™ Foresight** – our predictive modeling (PM) system combining best in class PM applications with Centene proprietary predictive modeling and Care Gap/Health Risk identification applications to identify and report potentially significant health risks at multiple population, provider, and member levels. Foresight also powers our Online Care Gap Notification functionality, allowing our providers and members to securely access care gaps and health alerts securely via our web based Provider and Member Portals.
- **Centelligence™ Enterprise Data Warehouse (EDW)** - Supporting both Insight and Foresight, EDW will receive, integrate, and continually analyze an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and member and provider information as required by any of our QI Programs.

Best in Class Software Supports Centelligence™. Centene's transaction systems are integrated with Centelligence™– and supply relevant data to the Centelligence™ EDW in near real time. These applications include:

- **Member Reach Management (MRM).** MRM receives, validates, integrates, manages, transmits, and reports on all levels of member demographics, member preferences (e.g. preferred contact information, preferred communication methods), and other member information. MRM is our "system of truth" for all member information. In addition, MRM provides information on member outreach efforts or campaigns, family linkages and other information such as wellness visit or appointment scheduling status. We also use MRM to capture, track, report and manage member grievances, and reasons for termination of enrollment for other than loss of eligibility (information that is then integrated into Centelligence™ for subsequent reporting and analysis).

- **Provider Relationship Management (PRM).** Integrated with MRM for the best possible service functionality across GSHP and Centene departments, PRM provides a single data repository for all of Centene's provider functions, including prospecting, recruiting, contracting, network enrollment, credentialing, financial affiliation configuration, data management, and Provider Directories(online and paper). PRM also captures provider complaint information for immediate action and follow/up – and reporting via Centelligence™.
- **AMISYS Advance** is our claims processing engine with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate member and provider data systematically from MRM and PRM; receives service authorization information in near real time from TruCare; and is integrated with our encounter production and submission software.
- **TruCare** is our member-centric health management platform for collaborative care coordination, and case, behavioral health, disease, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows our medical management staff to capture utilization, care and population-based disease management data; proactively identify, stratify, and monitor high-risk members; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions. TruCare also houses an integrated Appeals Management module, supporting the appeals process from initial review through to resolution, and reporting on all events along the process.

Care Management Staff

GSHP will rely on the expertise of our **locally-hired** case management staff as well its Centene owned disease management and behavioral health management subcontractosr and on sophisticated technology solutions to support our case management program. Our program encompasses 1) general prevention and wellness member education and coordination of services, 2) disease management and 3) complex case management programs that will include innovative tools to enhance each member's care. GSHP will use a multi-faceted approach to implementing its CM program including telephonic and **face-to-face** interactions with staff that are locally hired and are familiar with the geography and resources available to our members. These resources will enable us to effectively integrate the full range of services each Member needs.

Integrated Care Teams (ICT). Recognizing that multiple co-morbidities often exist in chronically ill individuals and that the level of support required by these individuals is likely to change over time, GSHP will deliver case management services through an Integrated Care Team (ICT) approach. The Chief Medical Director (CMD) will oversee and ensure integration of all clinical programs, including wellness, disease management and case management, and will have overall responsibility for the proper authorization and provision of care and services to members. The CMD will be a full-time physician with an active unencumbered license in accordance with state laws and regulations. The VP, Medical Management (VPMM) will also provide oversight for our clinical programs, working with the CMD to effectively implement clinical policies and procedures and ensure integration of care. This

team will include **co-located staff** from GSHP, Nurtur (our affiliated disease management company), and Cenpatico (our affiliated behavioral health company) in **New Hampshire**. Co-location of the ICT facilitates regular, in-person communication about the member's care and achieves a level of coordination and integration that voicemails and emails among multiple case managers cannot. Our GSHP Integrated Care Teams will be comprised of the following staff:

- ***Case managers*** will be licensed clinicians with case management experience (including but not limited to Registered Nurses (RNs); Licensed Practical Nurses (LPNs); Licensed Clinical Social Workers, Master's in Social Work). ICTs will be supported by both an RN case manager (RN-CM) and a behavioral health case manager (BH-CM). Each member enrolled in case management will be assigned a primary case manager based on primary condition (physical health or behavioral health) who will be responsible for overseeing the member's entire plan of care. This will include, but not be limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers. Case managers will perform assessments, develop care plans, provide educational resources and follow up in conjunction with the team.
- ***Health Coaches*** from Nurtur, our disease management affiliate, will promote a coordinated, proactive, disease-specific approach to case management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. All health coaches are licensed clinical staff, such as respiratory therapist, certified diabetes educator, registered dietician, exercise physiologist, with a minimum of one year of experience in a clinical setting.

> Effective case management and care coordination for those with physical and cognitive disabilities and/or mental health issues must go beyond purely clinical determination of needs to **identify and address functional status and barriers to care.**

- ***Program Specialists*** will be non-licensed social workers with one to three years of community, or non-profit experience in directly managing and integrating the social/community needs of members. Social workers will assist with non-medical aspects of the member's care, including referral to community resources.
- ***Foster Care Coordinator*** will be a nurse or social worker with knowledge and experience in working with children and youth involved in the child protection and/or juvenile justice systems or children in foster home/group home/residential placement. The FCC is the primary contact for DHHS case manager, member, guardian and providers for these children.
- ***Program Coordinators*** (PCs) will have a minimum of a high school diploma and experience in a clinical office setting is preferred. PCs will support other ICT staff as needed and determined by the team lead. Under the direction of the lead case manager, the PC will help implement the non-clinical aspects of care plans developed by the case managers and follow up on progress. PCs will maintain contact with members in non-urgent situations, such as appointment reminder phone calls and assistance arranging transportation, and facilitate service contacts for

those who have immediate clinical needs. PCs will undergo robust training and operate under strict oversight protocols.

- ***MemberConnections® Representatives*** (MCRs). The MemberConnections Program allows us to provide a level of **in-person, "boots on the ground" interaction** with our members that many other health plans do not. MemberConnections Representatives (MCRs) are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and become an integral part of our Member Services and Care Management teams, which benefits our members and increases our effectiveness. MCRs will make home visits to high risk members we cannot reach by phone. They will assist with member outreach, coordinate with social services, and attend community functions to provide health education and outreach. For example, MCRs will work with providers to organize Healthy Lifestyles events and work with other local organizations for health events. MCRs will work with providers to organize **Health Check Days** which promote preventive services and **Baby Showers** for education and outreach to pregnant members; and work with local organizations such as churches and social services agencies to organize **Healthy Lifestyles** events and other preventive care and health-focused events. Upon inclusion of the waiver services and long term care services membership during Step 2 of the Care Management Program, GHSP will add a Special Healthcare Needs MemberConnections Representative to assist our members with special healthcare needs in accessing services. Often our members with cognitive and physical disabilities require different interactions not only with members but with caregivers and require a different level of support. We want to assist those members/caregivers in "connecting them" to appropriate social and community supports so they can spend that time providing care to the member – not trying to maneuver through the system.

The ICT will be supported by the following key personnel:

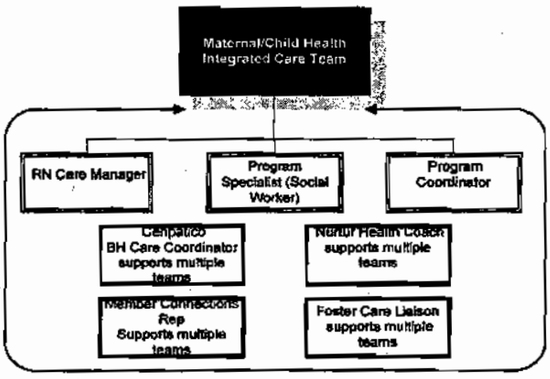
- ***Medical Directors*** will support the ICT during weekly case rounds and as-needed by providing input and answering questions about the clinical needs of complex members.
- The ***Pharmacy Director*** will review weekly drug utilization reports to identify under-utilization, over-utilization, and noncompliance. Working with the ICT, the Pharmacy Director will address these needs in the care plan and share suggested changes with the member's PCP. The Pharmacy Director will work with case managers to ensure that appropriate prescribing, utilization, and compliance are achieved.
- ***Physician Advisors*** are available to ICT staff to answer questions about the clinical needs of complex members. As needed, GSHP Medical Directors may consult with the Centene Corporate Pediatric Medical Director or Obstetric Medical Director or will consult with local external network specialists for recommendations.

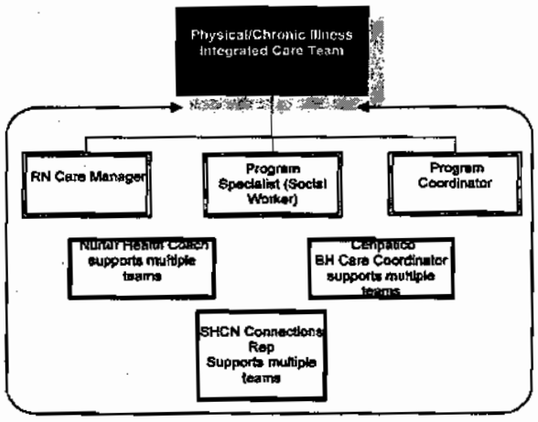
The teams will support and complement the medical home provider, specialist medical providers and the behavioral health Provider or CMHC in the following ways:

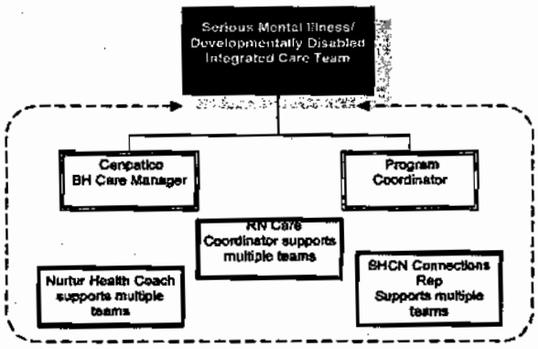
- Support the Provider's treatment plan
- Improve client appointment show rate
- Facilitate communication and integration between behavioral health and medical providers
- Coordinate discharge planning
- Coordinate wrap-around health services
- Facilitate member access to non-covered community resources

Each member in case management will be assigned an ICT lead. For example, a member whose primary condition is major depression will be managed by a team that is lead by a BH-CM. An RN-CM will be available for consultation if the member has an acute medical condition or is identified as having a controlled co-morbid clinical condition. Members with a primary physical health condition will be managed by a team that is lead by an RN-CM. Due to the unique needs and expertise needed to manage particular populations, GSHP will develop specialized ICTs as noted below.

Integrated Care Team Structure







Integrating Care Management Staff With Local Providers. Through our partnership with the Bi-State Primary Care Association, GSHP will work FQHCs such as the Coos County Family Health Services, Avis Goodwin Community Health Center and Lamprey Health Care to co-locate our Integrated Care Teams where appropriate and feasible.

Our CMs will support and supplement provider staff, building on and enhancing the existing service infrastructure within the service area.

Our partnership with Bi-State will be based on the following five areas of partnership:

- Shared planning and execution of quality programs between GSHP, BSPCA, and the FQHC members. GSHP will provide needed technical assistance in using data to drive continuous improvement, helping to select and measure appropriate clinical protocols, and developing QI plans for the FQHCs;
- Developing on-site case management capabilities to assist patients in meeting their healthcare goals and needs and creating jobs within the local communities being served;
- Collectively identifying underserved communities and patients, and working together to develop primary care capacity and workforce to serve these areas;
- Developing technical assistance capabilities that will ensure effective financial management, patient-centric operations, and strategic planning for growth at FQHCS;
- Over time, collectively developing a technology infrastructure, workforce, and methodologies to effectively manage population health costs. FQHCs will partner directly with the Plan to better manage patient costs.

As we evaluate our membership including access needs and higher acuity populations, we also plan to expand into additional FQHCs and co-locating RN Care Mangers in certain CMHCs to facilitate access for members with physical health needs. The on-site CMs will work with provider case management staff to complete assessments on members we have been unable to reach including homeless members, collaborate on care plan development, provide member education and participate in case conferences with Providers' staff. These field-based staff will carry laptop computers, enabling them to stay connected to other ICT members and to document their case management efforts in our TruCare integrated clinical documentation system.

Identifying Members for Case Management

Quick accurate identification and assessment is essential to reaching the member before an acute episode occurs to implement interventions that improve outcomes. GSHP will begin risk assessment and stratification at the time of enrollment, using information from the **Health Risk Screening** (HRS) tool which we will ask all new members to complete within 30 days of enrollment. Our standardized tool is an initial, high level screening that consists of questions to identify conditions currently under treatment, problems with taking medications, recent emergency room or inpatient services, use of

home health care services or home medical equipment, and identification of special needs. We will encourage all new members to complete the HRS at the time of their enrollment. GSHP will make at least 3 outreach attempts on different days and at different times to contact members for the Welcome Call and to complete the HRS. If telephonic contact attempts are not successful we will investigate multiple alternative sources such as PCP, Internet search, and reverse phone number look up to identify a current phone number. If we are not able to contact the member telephonically and there is indication that the member is at high risk, such as information received from PCP or through pharmacy data, a GSHP MemberConnections Representative may go to the member's home to complete the HRS, conduct an environmental assessment or evaluate the need for enrollment in the ConnectionsPlus Program which provides free cell-phones to our highest-risk members without reliable phone access (This program is described further in the narrative below).

Our innovative Member Reach Management (MRM) system will allow us to track completion of the HRS so that all staff with member contact are immediately aware of which members still need to complete one. For example, if an member calls GSHP with a question about their care or a provider, the staff answering the call will encourage completion of the HRS during the call. In addition, our staff may complete the HRS with the member during face-to-face encounters onsite at FQHCs/CMHCs, or Care Coordination staff at the Member's place of residence. A 'yes' response to any question on the HRS indicates potential risk for complications or a potential unmet need and will be referred to the ICT's RN or behavioral health Case manager (BH-CC) for comprehensive assessment and as indicated, care plan development.

- **Notification of Pregnancy (NOP).** The NOP process is a well-organized approach that aims to identify pregnant members at risk for pregnancy complications as early in pregnancy as possible in order to establish a relationship between the member, provider, and health plan staff. Pregnant members may be identified through many avenues including GSHP staff, providers, or NurseWise our 24/7 nurse advice line. A standard Provider 'Notification of Pregnancy' (NOP) form will be used to facilitate notification as well as aid in early and consistent risk stratification and appropriate intervention. Providers must notify GSHP of all known pregnancies as early in the pregnancy as possible - as soon as the provider becomes aware of the member's pregnancy. Providers may notify the plan of a pregnancy via fax, mail, telephone or Web. Members may also complete the form on our Member Portal or by calling our toll-free Member Services call center. Any GSHP employee who identifies a pregnant member will work with the member to fill out the NOP assessment. All NOPs received will be entered into CaseNet Trucare (TruCare), our clinical management system, to enroll the member in our *Start Smart for your Baby*® program (described further in our response to Q48). The NOP form indicates the member's current contact information, provider information, Estimated Date of Confinement (EDC), and obstetric history. Based on this information, we will stratify and assign a risk score that determines the course of action taken in regard to the member's pregnancy.
- **Predictive Modeling.** GSHP will use Centelligence Foresight, our multi-dimensional, episode-based predictive modeling and case management analytics tool, which uses clinical, risk, and administrative profile information obtained from medical, behavioral and

pharmacy claims data and lab value data (received from network lab vendors) to identify members who may need clinical management. This will allow us to identify members who may not yet have a diagnosis or identified condition that would trigger assessment for case or disease management, but are at risk for future utilization. With appropriate management and monitoring, we may prevent, delay or reduce the disease process and the need for high utilization by ensuring these members access to appropriate preventive and primary care, long term services and supports, and non-covered services and community resources.

We use predictive modeling to identify members who may be at risk for high future utilization and assign a risk score.

- **Member and Provider Contact.** Because identification helps improve opportunities for positive outcomes, we will capitalize on every interaction with member and providers to identify member needs. For example, member contacts to our Member Service Helpline to change PCP or inquire about mental health services may indicate an issue or unmet need. In the community, our MCRs may be asked questions that indicate needs, such as questions about benefits. When staff identify a member with a potential unmet need, the staff will send a referral through our TruCare system to alert the ICT of the need for follow-up. GSHP's affiliated 24/7 nurse advice line NurseWise will also serve as a resource for identifying member needs from those who call with benefit questions or requesting triage for appropriate care utilization. Practitioners, nurses, other clinical or social service staff treating the member in the office, hospital or home may identify potential member needs. Many times these needs or inquiries will be able to be addressed during the same interaction with the member and our staff will do so; other times the need will be referred to the ICT for member assessment or reassessment.
- **Utilization Management Activities.** GSHP will use utilization management activities as a way to identify members with complex conditions and/or high costs. ICT staff will monitor member for new diagnoses or exacerbations of a previously well controlled condition that would trigger initial or reassessment of a member's needs. With appropriate management and monitoring, we may prevent, delay or reduce the disease processes, inappropriate utilization, and/or the need for higher levels of care, by ensuring these members access appropriate preventive and primary care, as well as non-covered services and community resources. Our onsite discharge planning process, initiated as early in the stay as possible, will involve ICT staff and concurrent review nurses working with physicians and hospital discharge staff to evaluate member needs related to placement and services required at time of discharge from the facility.

Assessment and Care Plan Development

The case manager will work with members identified through the HRS or other methods (such as predictive modeling, described below) to complete a comprehensive assessment to assess functional abilities; physical and behavioral health conditions; social, environmental and cultural issues;

medications; informal support system; and other needs that form the basis of our integrated, holistic care plan. In-home assessments may occur in such situations as follow up to emergent services, when assessment could not be completed prior to care delivery; inability to reach a high risk member by phone; high utilization; or upon provider or member request. For low risk members, our Health Coaches will conduct condition-specific assessments as well as assessments for co-morbid conditions and readiness to change.

Process. The case manager will use the information gathered through assessments and during member interactions, along with other information such as utilization data, to help the member articulate desired physical health, behavioral health, functional, social and other goals (as discussed above). The case manager will also provide education on available service options and settings. The member and case manager will develop a plan to achieve each of the member's goals, which will be measurable and will include milestones to evaluate progress.

For members with co-morbid physical/behavioral health conditions, the case manager will obtain input from the other ICT clinician on appropriate services and integrating the full range of needed care. The plan will contain, at a minimum, timeframes, the member's role and action steps, the types, date ranges and authorized units of services, standing referrals to specialists, community resources and informal supports to be accessed, and ICT responsibilities. The case manager will provide applicable health education and help the member identify barriers to articulated goals and suggest acceptable approaches for overcoming barriers.

The goal of our case management program is to **Facilitate Access** to and **Coordinate Services** to assist the member/family in maximizing outcomes, and achieving goals, independence, and improved quality of life.

The care plan will include personal or cultural preferences such as types and amounts of services, providers and their characteristics (such as preferred gender or language), and living arrangements. The care plan will also include both covered services and non-covered services to address each identified need, such as non-covered Medicaid services, WIC, Food Stamps, housing services, or services provided through local social services organizations such as assistance with utility bills.

Cultural Competency. GSHP recognizes cultural competency as a key factor in engaging and retaining Members in care and providing services that meet their needs and is a critical component in building and sustaining our wellness, prevention and case management programs. Culture includes linguistic and disability-related needs as well as beliefs, expectations, assumptions and preferences due to ethnicity, racial, religious or national background. We understand that New Hampshire is fairly homogenous population but has some significant pockes of diversity in such areas as southern New Hampshire. Often, we find that rural regions have a culture of strong independence influencing access to and provision of health care. We have designed our assessment, care planning, and care delivery processes to identify and respond to what is important to each individual, including strengths, goals and cultural considerations, so each member understands how and why to access appropriate care and

feels comfortable and empowered to do so. In developing outreach and engagement strategies, we take into account all cultures.

Translation, Interpretation and Literacy. GSHP technologies will support culturally competent communications with Members. We will load ethnicity and language information provided on the state's enrollment file into the Member Relationship Manager (MRM) system so that outreach staff are prepared with the appropriate resources when contacting an Member, such as arranging for an interpreter or using a bi-linugual Member Services Representative when we are aware of an Member who speaks another language. Our Member materials will be written at or below a 6th grade reading level and pre-approved by DHHS.

Communications Supports and Assistance. For some members, such as those with severe cognitive and/or communication impairments, obtaining accurate information about their goals and preferences is a challenge. We will work with the centers and workshops that serve people who have developmental disabilities to incorporate service goals into self-direction supports.

Community-Based Supports. Based on Centene experience with similar populations in other states, we understand that engaging advocacy organizations and peers is often the most effective way to provide mnrollee support. GSHP will work with local advocacy groups and peer organizations such as Access for Living to provide support to Members in directing their own care, including but not limited to care plan development.

Reassessment. The ICT will regularly monitor the member and services to ensure the care plan continues to meet their needs. If needs are not being met or Impact Pro indicates an increased risk, the case manager will reassess the member and revise the care plan as appropriate. Reassessment will occur at least every six months, or more frequently based on changes in the member's condition and/or development of new needs.

Integration of Wellness and Prevention

GSHP will provide a variety of general education to support member self-direction of care plan development. This will include but is not limited to information provided in the Member Handbook about the member's right to direct their own care and the process and support we provide for doing so. We will also provide a brochure in the New Member Welcome Packet about Member self-determination that includes this information as well as information about Consumer-Directed Services. In addition, we will provide written information about recommended care for a variety of health and behavioral health conditions. For example, Health Coaches will provide condition-specific material when Members are first assessed and enrolled in disease management.

Member Connections. GSHP will implement Centene's intensive, grassroots outreach program, MemberConnections. Through this program, we will hire MemberConnections Representatives (MCR)s from within the communities we serve and train them as outreach and health education workers. For members who request or need further education, the MCR can meet the member at home or at a community location or provider office. Case managers will also educate those new and other members

who may require case management assessment about scheduling the initial primary care visit and ongoing EPSDT visits during the assessment process, and will provide assistance with scheduling and accessing transportation if needed. Through the MemberConnections program, we send MCRs into the community to work with members one-on-one in their homes and other community locations, such as FQHCs, to educate them and address barriers to appropriate access specific to EPSDT services. MCRs also work with our community partners to organize and staff health fairs and other community events that promote health and wellness and provide screenings and vaccine administration at locations frequented by members.

> We have found that this program effectively builds upon and enhances outreach efforts of existing safety net providers.

Care Gap Alerts. Using Impact Pro, our predictive modeling software, we will identify necessary preventive services that an member needs to schedule in the near future (Care Opportunities) or services that the member is past due to receive (Care Gaps). With this knowledge, the case manager will be able incorporate these needs into the care plan. Care Opportunities and Care Gaps are customized for each Member based on age, gender and identified health conditions (such as annual HgA1c testing for an Member with diabetes). Making this information easily accessible allows us to take advantage of every member contact to provide education about and assistance with scheduling appropriate services.

Engaging Member Supports. Through our experience with members on SSI, with serious mental illness (SMI) and in foster care, we have learned the importance of outreaching to the caregiver and other supports that the member looks to for assistance or guidance. For example, ensuring that members with SMI or other cognitive impairments receive needed preventive and EPSDT services often requires involvement of their 'influencer', such as a Community Mental Health Center case manager or guardian. Members with chronic or complex physical conditions may look to the caregiver or a family member. For foster care members, we will outreach to foster parents, medical consenters, DHHS case workers and, as appropriate, biological parents. We will educate these supports about the initial visit and how we can help address barriers to access. We will also identify ways these supports can help the member address barriers, recognizing that some members may be more willing to accept guidance and assistance from people they know and trust.

Member Education Program

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

Wellness, prevention and case management at GSHP are completely integrated, personally and technologically, to help members help themselves. We know that to *effectively* influence individual behaviors, we need to *meet members where they are*, and that means proactively and retrospectively assessing members' health, health risks and patterns of care to tailor interventions and education

appropriate to their situation and communicating in ways that are culturally sensitive. We need to partner with members, caregivers, families, community groups and providers to put timely and effective resources in the hands of our members to support their healthy decisions as they take responsibility for the health and health care.

Education Supporting Overall Wellness

We know that member health education must be provided in multiple formats (such as print, online, phone and in-person), using multiple strategies (such as case management-based, Provider-based, mail, phone calls, and community events) and incorporated as an ongoing, reinforcing set of approaches, instead of a one-time or annual effort. We will tailor best practices developed by Centene health plans to effectively meet a wide variety of cultural and linguistic needs. In short, our approaches will align with evidence-based guidelines and best practices to empower members to access needed services and to have confidence in self-care and self-directed care, assist network providers in educating their patients, and encourage the support of caregivers, family members and communities in healthy lifestyles, care plan follow-through and service access.

Written Information. GSHP will give a New Member Welcome Packet to each member upon enrollment. The packet will contain the Member Handbook, which includes information about primary care and how to contact us for assistance. The packet will also contain a brochure which explains the concept of comprehensive primary care and encourages them to schedule the initial visit within 90 days of enrollment and EPSDT visits per the periodicity schedule. We will also include a flyer on our NurseWise 24/7 nurse assist line, Emergency Room Services, and Case and Disease Management programs. Our quarterly Member Newsletter will include preventive health services such as EPSDT, flu vaccines, well woman exams, and wellness topics such as handwashing. Newsletters will also contain information about disease states such diabetes, asthma, depression, and hypertension.

Newsletters. GSHP will distribute quarterly member Newsletters that include health education and our events calendar listing health fairs, screening days and other GSHP-sponsored or organized health activities. The Newsletter will include general health topics and specific topics relevant to member subpopulations. For example, topics for members on SSI may cover the use of home medical equipment, fostering good caregiver interactions, care for wounds and skin, and the symptoms of depression. Topics for members with SMI and other cognitive impairments may include the importance of medication compliance and accessing the health home to ensure physical health needs are addressed.

On-hold Messaging. Our Member Services telephone line on-hold messaging will include health education briefs and general reminders and GSHP benefits and services information. We will periodically change the messaging to meet identified member trends or topical issues, such as flu prevention.

Online Information. We will provide members on their member Portals with information using podcasts that members may download and listen to at their convenience, and briefs on health news

and local activities that they may print out or read online. For example, our podcasts may cover such topics as:

- Exercise and Diabetes
- Chronic Kidney Failure
- Things to Do to Control Your Diabetes
- Diabetes ABCs
- Diabetes and Eye Exams
- Taking Your Medicine the Right Way
- Tips for Healthy Eating
- Advance Directives
- What are Generic Drugs?
- When You Have Diabetes

Our news briefs may inform them of such news as a recently developed breakthrough approach to cancer care or upcoming community health fairs or other events.

Innovative Strategies for Health Education

Member Portal. We will use the Member Portal to allow members to send a secure message to GSHP and receive secured response, receive consumer friendly preventive and condition-specific care gap alerts, view information on claims for services rendered and view their TruCare service plan online. TruCare is our member-centric health management platform for collaborative care coordination and Care, Disease, and Utilization management, and is used by GSHP case mangers and other members of our Integrated Care Team.

Health Podcasts and Health News. We will provide our members ongoing and periodic education online and in our member Newsletters on health-related topics relevant to their daily lives and medical, behavioral health and functional conditions. We will inform members of this information via our New member Welcome Packet, member Handbook and websites, and in Member Services and ICT conversations with members.

Healthy Lifestyles Program. GSHP's community-based Member education and outreach program strategically meets members where they are. Unlike point of service and home visits, which rely on the Member to access services, our community outreach events are free, informal gatherings open to the public and attendees have the opportunity to win health-related giveaways, talk to the GSHP staff, and receive healthy tips and information. By getting involved "on the ground," we meet the members we serve and show our support in helping them to improve their health.

GSHP's Healthy Lifestyles Program identifies regional community health education needs, improves outreach and communication with GSHP and community-based organization members, and actively promotes healthy lifestyles such as disease prevention and health promotion. The Healthy Lifestyles Program includes the following:

- ***Healthy Habits***: GSHP staff will visit local Group Homes or day programs to teach Members, such as Members with developmental disabilities about healthy eating (including cooking demonstrations) and other healthy habits such as safety and hygiene education.

- ***Healthy Congregations:*** This program focuses on bringing health education to faith-based organizations, such as churches. Healthy Congregation sessions occur after church services (such as bible study or Sunday services), and offer attendees preventive screening services such as blood pressure checks, body mass index (BMI) measures, glucose or cholesterol testing. They also include health education and healthy cooking demonstrations (cooking healthy on a budget). Our Healthy Congregation events are free and open to the public, and attendees have the opportunity to win health-related giveaways, talk to the GSHP staff, and receive healthy tips and information.
- ***Healthy Schools/Adopt a School*** – Plan staff visit local elementary schools to participate in school assemblies led by the author of a Thumbs Up Johnnie book about healthy eating, with a reading and a discussion about healthy habits.
- ***Kids Club/Childhood Obesity*** –Health plans outreach to members aged 5 to 9 identified as obese with a newsletter, healthy recipe and other contests, and other events, and distribute the Thumbs Up Johnnie healthy eating book and a book of healthy recipes from program contests.
- ***Back to School Fairs.*** GSHP will coordinate and provide support to community Back-to-School fairs that involve health promotion, well child screenings, and immunization administration. MCRs will play a key role in supporting these efforts by coordinating the fairs, contacting members in need of services and notifying them of the fairs, and providing staff support the day of the fair.

Start Smart for Your Baby. All pregnant members, are eligible to participate in Smart Start programs that will educate them about how to ensure a healthy pregnancy and first year of life for their babies. Centene offers Start Smart in all 11 affiliated health plans. Start Smart for Your Baby promotes education and communication between pregnant members and their case managers to ensure a healthy pregnancy and first year of life for their babies. Start Smart offers a range of case management techniques, including health screenings, educational literature and MP3 players with educational podcasts designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well child visits.

- ***Smart Steps for Your Baby®*** is a program that educates members on the benefits of exercise during pregnancy, and provides information on how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer
- ***The Start Smart® Baby Shower Program*** educates pregnant members about prenatal and postpartum care for themselves and their newborn. "Baby Showers" are conducted in a class environment by health plan staff. Led by a registered nurse and assisted by Member Connections staff, the classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a

review of the GSHP Start Smart® and MemberConnections programs. Upon completion of the class, participants may take part in a raffle, and the winner will receive a basic infant car seat.

- ***Start Smart® Birthdays Program.*** The Start Smart ® Birthdays Program this event is designed to outreach to children (newborn through school-aged) and provide them with a Start Smart Birthday Party while engaging them in learning about healthy living and taking care of themselves. MemberConnections Representatives provide a quarterly event with health and parenting education, explanation of member benefits for parents and children, targeting information on well child checks and other HEDIS related needs. Events target various age groups. Guest speakers and/or topics are chosen and publicized for the event. Such topics can be Crisis Care, Physical Fitness, Healthy Eating, Ask the Pediatrician, Child Safety, Meet the School Nurse, etc. Free diapers and other give-away itens to encourage healthy living are included for participants depending on the target group. Items we have given away include: jump ropes teddy bears hackey sacks soccer balls, bracelets healthy snacks water bottles.

Targeted Outreach. GSHP will send members an annual birthday card reminder about EPSDT visits due or the annual physical exam as applicable, and instructions for accessing assistance with transportation and scheduling. GSHP will also monitor compliance with the initial primary care visit and EPSDT appointments through claims data as well as data collected through GSHP staff interaction with members. The Quality Improvement (QI) staff will send reminder post cards to identified members who are in need of recommended services, such as the member parents of children listed on monthly reports as not having received timely immunizations or blood lead screening. MCRs will personally call persistently non-compliant members, encouraging them to make an appointment, and offering to assist with scheduling. The QI staff will set up automated Televox reminder messages for the remaining members identified as noncompliant. MCRs will also meet individually with members in the community and in their homes, particularly when we have been unable to contact a member by telephone.

Chronic Care Management Education

Member engagement is critical for preventing exacerbations or complications of chronic conditions. Centene's GSHP Model, which has been implemented by all health plan affiliates, provides Care Management services designed to engage members in all aspects of their care. Case managers encourage and support member self-determination in assessment, care plan development and implementation processes. These processes integrate the member's and case manager's review of the member's strengths and needs, resulting in a mutually agreed-upon, appropriate, and cost effective care plan that meets the medical, functional, social and behavioral health needs of the member.

Clinical care and disease management staff will educate members about their specific illnesses and conditions upon their enrollment in an ICT and as often as necessary to respond to member questions and changes in health and functionality. For example, a case manager could educate an member with diabetes about the disease and its possible progression and the importance of annual physical, podiatry and nephrology exams. Case managers will use an member's health assessment information and stated health goals to determine the appropriate information to provide. For example, an member in case management who also wants to quit smoking will receive different information and follow-up

calls than an member who does not have those goals or who smokes but lacks interest in taking self-care initiatives. Health education also often plays a leading role in the development of an individualized Care Plan, so that the plan meets member needs in a way that ensures member understanding of their conditions, reflects their preferences and goals, and encourages their compliance with care guidelines. Case managers will additionally reach out telephonically or in person to the member's caregiver or other informal supports, recognizing the influence these individuals may have on member engagement in healthy behaviors, appropriate service access and treatment compliance.

The case managers who we will locate within selected FQHCs can educate and reinforce education given by other GSHP ICT staff and Providers. On-site case management may also identify members who could benefit from disease or case management and help coordinate care with the FQHCs and other Providers to meet the member's need for services. Face-to-face health education and care coordination is especially useful for members who have serious mental illness or cognitive impairments, which may limit their understanding of educational information delivered by telephone and written contacts. MCRs, who often visit members in their homes or encounter members at community events, may identify members who need case management and at that time provide basic education about the member's condition. For example, MCRs may provide basic asthma education, conduct a home environment assessment, and refer the member to the Asthma Disease Management Program.

Wellness and Prevention Services

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 the outcomes of those strategies.

Granite State Health Plan's (GSHP) approach to engaging members in use of wellness and prevention services begins wtih an expansive set of health education programs that use comprehensive outreach and communication methods to effectively educate members, their families and communities about their health and self-care and how to access plan benefits and supports.

Our health education approach starts when members join our plan. In our new member materials and during all new member education, GSHP will not only explain health plan benefits and services but also emphasize the importance of selecting a PCP, establishing a health home relationship, accessing preventive health services, understanding health conditions and self-care and describe where to go and who to contact for assistance with questions about health and accessing services. Our outreach and education strategies focus heavily on direct member contact, since our experience shows phone or in-person contact is more effective than relying on written and online materials.

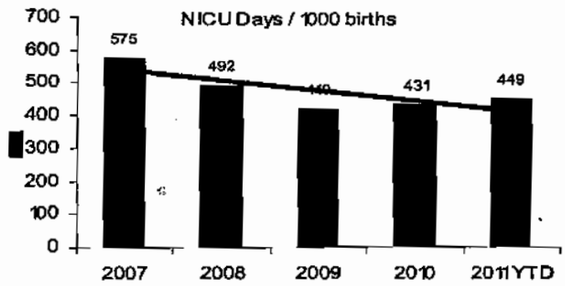
> We believe that health education paired with incentives, assistance or information on how to access needed services provides the strongest supports for member health and functional maintenance and improvements

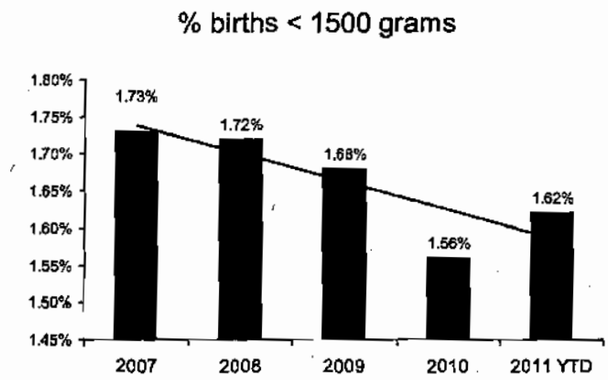
Improvement Plans Implemented

GSHP's affiliate health plans have achieved improvements in outcomes through programs addressing topics such as asthma and diabetes management, children with special health care needs, women's preventive health, depression, well child care, prenatal, postpartum and neonatal care, and coordination of medical and behavioral health care. For example, as a result of targeted programs, our Texas affiliate increased cervical cancer screening 85.5% in ABD/SSI members from 2007-2010, and, through a discharge planning initiative, improved the inpatient readmission rate by 20.6% for Foster Care members from 2009-2010. Centene disease management programs have also achieved significant improvement in outcomes. Over the period 2008-2010, members who participated in our child asthma program had a 25% lower rate of asthma-related ED visits than matched non-participants. Those who participated in our adult diabetes program had a 26% lower rate of diabetes-related hospital admissions than matched non-participants. The following table summarizes our current programs and initiatives. These activities have been incrementally improved over time, and typically are piloted in one health plan and rolled out over time to the others, adapted for the needs of their members.

Year	Improvement Activity	Year	Improvement Activity
1999	• Member Newsletters	2008	• Provider Summit Awards
	• Member Handbook		• Auto-dialer Reminder Calls
	• Call Center Queue Messaging		• Provider Fax Blasts
	• Provider Handbook	2009	• Integrated Care Teams
	• Provider Newsletters		• *Thumbs Up Johnnie* Children's Book Series
2004	• Reminder Postcards		• CentAccount
2006	• Start Smart for Your Baby®		• Adopt-a-School Program
	• Live Telephonic Outreach Campaigns		• Healthy Living Girl Scout Badge
	• Member Raffles		• Secure Member Web Portal
	• Employee Incentives		• Secure Provider Web Portal
	• Chart Reminder Stickers	2010	• Provider Incentives
	• Member Non-Compliance Lists	2011	• Online Care Gap Alerts
2007	• Provider Profiling		• Member/Provider Relationship Manager
	• Disease Management Programs		• Online Clinical Health Record
	• MemberConnections		
	• Connections Plus		

Below we describe specific programs and their associated outcomes.





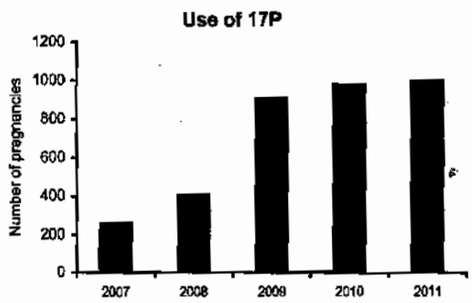
Start Smart for Your Baby®

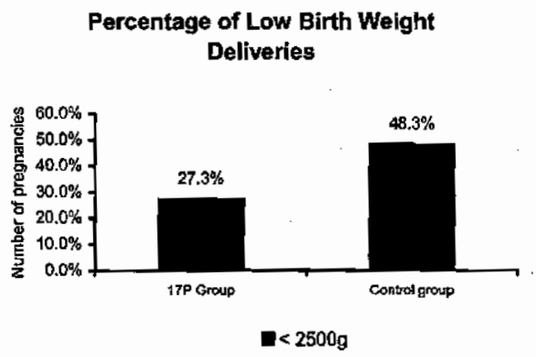
In 2006, Centene initiated our Start Smart for Your Baby® Program to improve birth outcomes by focusing on early identification and risk screening, and member education and empowerment. Start Smart is a comprehensive pregnancy and postpartum management program, extending into the child's first year of life, which incorporates the concepts of case management, care coordination, and disease management. Our multi-faceted approach to prenatal and postpartum care is a team effort with our providers, and includes enhanced member outreach, health screenings, wellness materials, intensive case management, and member and provider incentives. Educational materials reinforcing healthy behaviors and adherence to recommended preventive care include MP3 players with educational podcasts. The Start Smart Program has succeeded in improving key indicators of birth outcomes, including statistically significant decreases in our NICU admission rate and NICU days/1000 births, and decreases in all three measures of low birth weight, all from 2007 to 2010. We obtain birth weight information on over 90 percent of our births each year.

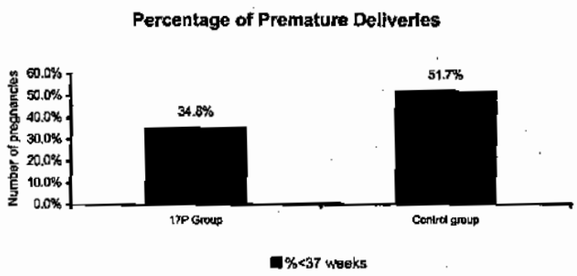
In 2010, Centene's Start Smart for Your Baby Program won a Platinum Award for Consumer Empowerment at the URAC Quality Summit, and the inaugural **URAC/ Global Knowledge Exchange Network International Health Promotion Award.** In 2009 it was named an NCQA Best Practice.

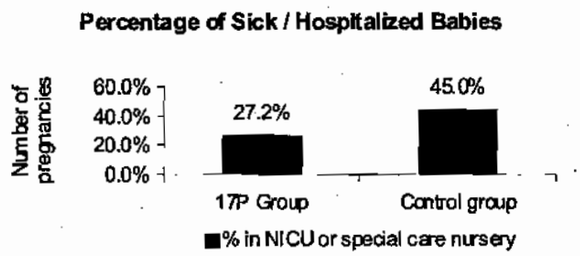
Prevention of Premature Birth. Among our most effective interventions in managing high risk pregnancy, our **17P Program** identifies women less than 28 weeks gestation who may qualify for weekly injections of 17 alpha-hydroxyprogesterone caproate (17P). The American College of Obstetrics and Gynecology recommends use of 17P to prevent preterm delivery in women with a previous spontaneous preterm birth. Through our early adoption of this Program, we provided high-risk pregnant members and their providers with ready access to this custom compounded medication and significantly improved health outcomes. Centene's long experience with 17P and its impact on birth outcomes was recently reported in the journal Managed Care.i From 2004 to 2009, Centene members receiving 17P had a statistically significant 36.6% lower rate of premature birth (less than 35 weeks

gestation) than a control group. The NICU admission rate was 25.2% lower for recipient offspring than controls.

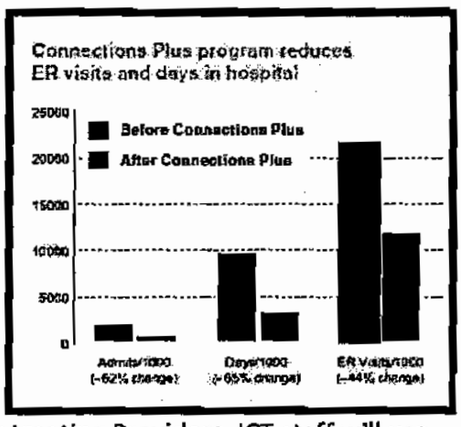








Connections Plus



Centene's experience with the Medicaid and SSI populations has shown that many of these members lack reliable telephone access. This hampers the member's ability to contact a case manager or Provider with questions or to report a change in condition. It also impedes the ability of GSHP plan staff and Providers to reach the member with education, reminders and other information critical to their care. GSHP will offer the Connections Plus program (where cell phone coverage is available), which provides restricted-use cell phones to certain high-risk members participating in case management. The phones will be pre-programmed with numbers for the case managers, NurseWise, 911, PCP and other treating Providers. ICT staff will use the phones to contact members for education, appointment reminders and ongoing coaching and support for wellness and compliance. We will also send text messages with health information targeted to the member's condition. For example, pregnant members will receive text messages about healthy eating, avoiding alcohol and obtaining prenatal care. Several phone models are available with

options such as large print and numbers and Spanish translation to accommodate our members who may have visual impairments or language barriers. Our Connections Plus program will also provide podcasts loaded onto MP3 players for blind and other selected members.

URAC, NCQA and Medicaid Health Plans of America (MHPA) have all recognized Centene's Connections Plus program as a best practice.

CentAccount™

The CentAccount™ member incentive program is widely used by Centene health plans and promotes personal health responsibility and ownership by offering financial incentives that we load onto an GSHP-issued CentAccount MasterCard® debit card. The CentAccount program also helps educate members about their health and self-care by identifying targeted healthy behaviors and by fostering needed and timely member contacts and communications with their Health Home and other Providers. Eligible members can earn rewards for completing annual preventive health visits; attending a follow-up visit with seven days of discharge of an admission for mental illness; and completing other recommended preventive health and chronic disease care screening. Rewarding members for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement. members can use their CentAccount cards at many popular retailers, such as Walgrens, CVS, Rite-Aide and Wal-Mart stores, supermarkets such as Shaw's Supermarket, Market Basket, Shop and Save, and other stores throughout the state. members may use the funds on their CentAccount cards to buy a wide variety of health-related items including some over-the-counter medications not covered by Medicaid. Goods and services qualify for card purchases if they are recognized by U.S. Internal Revenue Service as health care expenses for a Flexible Spending Account and flagged by the retailers' Inventory Information Approval System. We will inform members of this program via our New Member Welcome Packet, Member Handbook and websites, and in Member Services, MCR and ICT conversations with members.

Since implementing CentAccount, PCP visits within 90 days of enrollment have **increased 19.1%**, chlamydia screenings have **increased 26.1%**, and well visits have **increased as much as 115%** in some plans.

Healthy Lifestyles Program

As described above, Health Lifestyles identifies regional community health education needs and improves outreach and communication between GSHP and community-based organization and member such as the FQHCs and CMHCs that are implementing the New Hampshire Wellness Incentive Program. The Program actively promotes healthy lifestyles such as disease prevention and health promotion. We will support the CMHCs and work with schools, public agencies, churches and faith-based organization to improve education and access to EPSDT services such as screenings and immunization administration for our members.

Health Check Days. At these events, we collaborate with provider offices to identify members who have missed certain preventive care services, including EPSDT services, such as vaccines and diagnostic or screening tests. We outreach to the members to encourage them to make an appointment for the needed service on a certain day set aside by the practice, and assist them with transportation needs. We have outreach staff in the providers' offices on these days to reinforce the importance of preventive care and answer questions about the member's health plan benefits.

Back to School Fairs. GSHP will coordinate and provide support to community Back-to-School fairs that involve health promotion, well child screenings, and immunization administration. MCRs will play a key role in supporting these efforts by coordinating the fairs, contacting members in need of services and notifying them of the fairs, and providing staff support the day of the fair. One specific example of this occurred in Centene's Wisconsin Plan (MHS-WI). MHS-WI donated $25,000 to sponsor the Milwaukee Public Health department's first Child Health Week, leading to the Back-To-School Health & Resource Fairs held in August 2009 at South Division High School and Fitzsimonds Boys & Girls Club. More than 5,200 individuals and families participated and many children received needed dental screening, vision screening, immunizations, blood lead testing, and other services. MHS also provided educational materials on flu prevention, immunizations, blood lead testing, nutrition and physical activity in English, Spanish and Hmong. MCRs helped schedule EPSDT visits for non-compliant members in Milwaukee and promoted the Back-To-School Fairs through phone calls. MHS nurses staffed a live-broadcast phone bank to answer parent questions on child preventive care, wellness, immunization schedules, and flu prevention.

Smoking Cessation Program

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

Granite State Health Plan and Nurtur, our affiliated disease management company, will implement a tobacco cessation program for our members using evidenced-based clinical guidelines from the American Cancer Society, American Lung Association, American College of Obstetricians and Gynecologists (ACOG), the Agency for Healthcare Research and Quality (AHRQ), and the U.S. Public Health Services. Smoking cessation program components include proactive identification of smokers; targeted member outreach initiatives; provider engagement through education and support; targeted programs for pregnant members; participation in Tobacco Quit Lines; and our Tobacco Cessation Registry, which we use to track and document the effectiveness of our efforts.

Identifying Members Who Smoke. The first step is to identify members who smoke, particularly those at risk for more immediate negative health outcomes such as pregnant members or those with comorbid respiratory conditions. We will identify these members through the Health Risk Screening (HRS) completed by new members, our Notice of Pregnancy (NOP) form, Centelligence Foresight reporting based on claims data received, information obtained during case and disease management

assessments, referrals from other all GSHP staff, providers, or during other member interactions, and direct referrals from members requesting assist with smoking cessation.

Initial Outreach. We will send an information packet to members identified as smokers explaining covered tobacco cessation benefits; a comparison grid showing the cost of tobacco versus getting help to quit; a Secondhand Smoke Fact Sheet; a bookmark and card with Quit Line information; and how to enrolle in our tobacco cessation program. We use educational pamphlets, member handbooks, health fairs, case and disease management programs, contacts with Member Services call center staff, health risk assessments, and Quit Lines to engage members in understanding the health impact of smoking. We develop targeted information for specific age cohorts and cultural/ethnic populations at high risk for tobacco use.

Health Coaches. We will partner with Nurtur, our affiliate and a national disease management leader, to proactively link members to Health Coaches (Coaches). These Coaches are certified tobacco treatment specialists trained in tobacco cessation coaching. They will outreach telephonically to members to explain the program; confirm eligibility; and conduct an Initial Health Assessment to determine tobacco use status, readiness to change, and nicotine dependency level. Call frequency is based on member need for education and support, and typically averages two to four calls per month, but is not limited. We will work with members interested in smoking cessation to develop individualized quit smoking care plans based on the member's readiness to change.

Coaches also make referrals to other programs or services as needed. When members enroll, decline enrollment, or cannot be reached, Coaches notify the PCP by fax. They also send a Tobacco Fax Progress Report when members successfully abstain, fail to abstain, or voluntarily disenroll from the program.

Provider Engagement. Providers play a key role in educating members and engaging them about tobacco cessation. We inform providers about how to access information (such as ACOG's A Clinician's Guide to Helping Pregnant Women Quit Smoking) and support from the Health Coach or plan case manager, including assistance with member monitoring.

Fact Sheet. We developed a Second Hand Smoke Fact Sheet that Provider Relations Representatives (PRRs) distribute to pediatrician offices during network orientation and ongoing visits. PRRs and other staff encourage providers to distribute the Fact Sheet to parents who smoke

Reference Guide. We created a culturally appropriate and age-specific reference guide which includes smoking cessation materials such as posters and brochures targeted to different populations. PRRs distribute these materials to providers during orientation and ongoing visits, during which training on appropriate coding and billing of smoking cessation counseling occurs

Coding Education. In 2008, our behavioral health affiliate and subcontractor (Cenpatico Behavioral Health) developed educational materials on proper billing codes for smoking cessation counseling to distribute to behavioral health providers and post on Cenpatico's provider website. In March 2009, we sent a targeted mailing to all primary care physicians (PCPs), educating them on proper billing codes for providing tobacco cessation treatment. The mailing included a pocket sized laminated reference card

that included appropriate billing codes. PRRs provided training on appropriate coding and billing of smoking cessation counseling during orientation and ongoing visits

Other Affiliate Approaches. Other approaches used by affiliates include the following:

- Our Arizona (Bridgeway) affiliate covers smoking cessation drugs and nicotine replacement therapy, including over-the-counter products.
- Our Indiana affiliate, Managed Health Services (MHS), uses its website to offer providers and members information on tobacco use, tips on quitting, and links to the Indiana Quit Line. The plan's hold messages on the Member Services Line and Provider Services Line include the "Two Simple Questions: Do you use tobacco products? And may we help you?" messaging. During "Health Check Health Days" events, the plan's Community Relations Liaison staff distributes a one-page *Using Tobacco Products/Tobacco Cessation* education flyer to members. The Provider Portal provides tools and resources for providers to help their patients stop smoking.
- Our South Carolina affiliate, (Total Carolina Care) uses the pharmacy vendor to identify members who have accessed smoking cessation products and refers them to the tobacco cessation program.
- Our Texas affiliate, Superior HealthPlan, implemented a tobacco cessation pilot program in Bexar County for Medicaid only members on SSI in November 2008. To be eligible, the member must currently use tobacco products, agree to participate, and set a quit date to occur within thirty days of program enrollment. The program population is randomized into three groups: control group (not offered an intervention) who were asked only to participate in a study to answer questions about their tobacco use; a telephonic intervention conducted by the American Cancer Society; or a face-to-face support group meeting once per week for six weeks. A Nurtur Health Coach who is a Registered Respiratory Therapist and Certified Tobacco Cessation Specialist administers the program. Participants are part of a study being conducted by the Institute for Child Health Policy (University of Florida) and receive incentives for participating in four telephone surveys during the year about their health, tobacco use, physical activity, and other health issues.

Evaluating Tobacco Cessation Activities and Data To Support Outcomes. We evaluate our tobacco cessation activities using HEDIS measures, cessation program participation statistics, and Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS) tobacco cessation measures. Our Quality Department reviews results monthly, and our Quality Improvement Committee reviews results five times a year and recommends additional interventions and program improvements.

HEDIS Measures. We use the following HEDIS measures to evaluate tobacco cessation programs annually: Advising Smokers and Tobacco Users to Quit; Discussing Cessation Medications; and Discussing Cessation Strategies. For CY 2008, MHS changed survey vendors and survey administration protocol. The new protocol resulted in a response rate that does not meet NCQA's 45% threshold for validity. Thus, 2008 results are not comparable. To improve the response rate and ensure valid, comparable results, we will add automated Televox calls to survey recipients four to ten days after the survey is mailed. We will continue to mail a replacement survey to non-respondents; this will occur approximately 35 days after the original mailing. In addition, we will add NurseWise telephone follow

up approximately 21 days later for non-respondents. This enhanced process is based on the NCQA follow-up process.

Puff Free Pregnancy. GSHP will implement Centene's Puff Free Pregnancy program to address the increased risk of pre-term birth, low birth weight, and post-natal lung problems. Several Centene health plans have implemented the Puff Free Pregnancy program that is customized to encompass health outcomes of both mother and baby. Women identified as pregnant and smoking on the Notification of Pregnancy Form will be contacted for enrollment in the program. If the member is interested, they will receive educational information and a pregnancy customized quit smoking tool kit. The program will also include tobacco cessation counseling and follow-up by Nurtur's Health Coach by phone and mail to monitor progress and provide additional resources/support. The member's physician will be notified of the member's enrollment in the Puff Free Pregnancy program, sent a resource kit and updated by fax on the progress of their patient. To date, analysis of all Centene health plan members enrolled in the program indicates a positive reduction of low birth weight babies in pregnant women who quit smoking compared to those who did not. We evaluate the Puff Free program by measuring member-reported outcomes. For example, 2009 results indicate that about a quarter of the participants in our Indiana affiliate's program quit smoking, while those who did not quit reported reducing the number of cigarettes smoked per day by over half, on average. Our Ohio affiliates' results for August 2008-October 2009 indicate that about a fifth of participants quit smoking, while those who didn't quit also reported reducing the number of cigarettes smoked per day by over half on average. Helping members quit smoking can improve birth outcomes, as shown in the following table of outcomes for the three affiliate plans operating Puff Free with at least one full year of data (Arizona-Bridgeway, Indiana, Ohio). The results below encompass the three plans combined, from the point of each affiliate's program inception (AZ – 10/8; IN – 2/08; OH – 9/08) through 12/21/09.

Outcome	Quit	Didn't Quit	Left Program	No Response	Unknown
Birth wt < 2500 g	13.79%	19.40%	20.00%	9.78%	55.56%
Birth wt < 1500 g	1.72%	4.48%	0.00%	1.09%	0.00%
Birth wt < 1000 g	0.00%	1.49%	0.00%	0.00%	0.00%
Delivery < 37 wks	14.29%	18.18%	20.00%	14.10%	50.00%
Delivery < 32 wks	3.57%	4.55%	0.00%	3.85%	12.50%
Seriously Ill	13.56%	14.93%	0.00%	6.52%	66.67%
Stillborn/Expired	3.39%	4.48%	0.00%	0.00%	0.00%

GRANITE STATE HEALTH PLAN

Strategy to Reduce Childhood Obesity

Q50. Describe your strategy to reduce childhood obesity. Provide information on the outcomes of similar programs you have deployed.

Approximately 12.5 million or 17 % of U.S. children and adolescents ages 2 to 19 are obese.12 This is a national issue faced by every state and it must be approached in a broader context than just children. Children are part of families, schools and communities. We have developed comprehensive programs to help our young members learn the value of healthy eating and staying active and to reinforce this message with those that can reinforce children's healthy choices.

Healthy Schools/Adopt a School Program

Through this initiative GSHP partners with local schools to provide health outreach and education for children and supplies and support for School Nurses. The program includes:

- **The Kids' Club**, which educates children on a variety of health topics, focusing heavily on obesity prevention, using newsletters, contests (such as healthy recipe contests) and other events.
- **"Thumbs Up Johnnie" Program,** which is designed to raise community awareness about the dangers of childhood obesity and preventing the spread of germs through proper hand washing. We use "Thumbs Up Johnnie," a child-friendly, nationally recognized character to help educate children. Author Michelle Bain visits students in our adopted schools to read, "*Super CENTEAM 5, The Adventures of Thumbs Up Johnnie*" and *"Super Centeam5 Cookbook."* Students receive copies of the book, a character-themed bracelet or spatulas and a healthy snack. Children take pre/post presentation tests about healthy eating habits.
  Teachers who turn in their post-presentation tests receive a set of Thumbs Up Johnnie books for their classroom and

[12] NCHS Health E-Stat: Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008, CDC, Atlanta http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.htm accessed 6/9/2011

bookmarks for their students. We also donate a set of autographed books to that school's library. A review of our test outcomes shows that after testing more than 5,000 children in our adopted schools we see an impressive increase in correct answers to our standard five questions. The average is 33.6% increase in correct answers with a range from 73% to 13% depending on the question.

- **Off the Chain** is a book developed solely for our teenaged members that provides general information about teen-related issues, such as smoking, self-esteem, domestic violence, pregnancy, drugs, and personal hygiene.
- **Healthy Choices Brownie Badge.** Centene expanded the Kids Club Program with the Healthy Choices Brownie Badge, which is, designed to educate kids on making healthy choices. Centene has already met with the Girl Scouts of America and received their full support to move forward with this initiative. Brownie troops must complete at least 4 of the following health-related components to receive their Thumbs Up Johnnie "Try It" Badge:
    - Breakfast - Discuss its importance
    - Lunchtime - Discuss and design a healthy lunch
    - Fast Food – Learn how to use moderation
    - Recipe collection – Write down and exchange 3 healthy snacks
    - Water – Learn the need for hydration and measure out 8 glasses of water
    - Exercise – Create an exercise routine with a jump rope
    - Tell your friends – Design and draw a poster

Because childhood obesity is about more than just the children, we extend our efforts to parents, caregivers and community groups as well through various programs:

Healthy Lifestyles Program

Our ***Healthy Lifestyles Program***, identifies regional community health education needs in collaboration with community-based organizations and includes childhood obesity related program components. Centene health plans are working to raise awareness with its members and the community concerning the dangers of childhood obesity.

Healthy Congregations. This program, modeled on the successful program of our Indiana affiliate, focuses on bringing health education to faith-based organizations such as churches. Healthy Congregation sessions occur after scheduled church services and offer attendees preventive screening services such as blood pressure checks, body mass index (BMI) measures, and glucose or cholesterol testing. They also include health education and demonstrations such as cooking healthy on a budget. Our Healthy Congregation events are free and attendees have the opportunity to win health-related giveaways and talk to the GSHP staff. These events give us an opportunity to connect with the local community and conduct outreach especially in rural areas.

Healthy Choices. This program focuses on removing barriers that make it difficult for our members to make healthy food choices. Centene offers Healthy Choices in other states, and tailors the program to meet local circumstances. For example, our Texas affiliate partnered with the Sustainable Food Center

in Austin to provide its members a monthly $10 voucher to the Austin Farmer's Market (a local 501(c)(3) non-profit) to encourage healthy eating habits. The voucher allows the member to purchase fruits and vegetables from local farmers at three different locations. In Louisiana, through marketumbrella.org – the parent organization for Crescent City Farmers Markets – and Kingsley House, 500 vouchers redeemable for $10 in market tokens at any of the three, weekly Crescent City Farmers Markets held in New Orleans were distributed at GSHP's Fresh Foods Health Fair on June 10, 2011. Head Start, Kingsley House Summer Camp participants and Adult Services seniors may use the vouchers on field trips to the farmers markets where they can exchange them for seasonal, locally grown fruits and vegetables, eggs, dairy, meat, seafood, and fresh bread. Participants included more than 400 summer camp participants (age 5-12), Head Start members, seniors with varying degrees of ability/mobility, and parents and other adults. We provided a box garden; various lesson, activity, display and tasting stations where participants could learn about making healthy choices.

Healthy Cooking Demonstration. A balanced diet is important to maintaining a proper weight and preventing disease. As part of our Healthy Lifestyles Program, GSHP will hire a professional nutritionist, cook or chef to conduct a one-hour healthy eating and food preparation class at a local community center, church, or other facility equipped to provide such a class. The class will focus on healthy eating and choosing nutritious foods while on a tight budget. The use of food stamps and the WIC program will also be highlighted in the presentation.

Web Based and/or Telephonic Tools

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

Engaging our members in their health care is a critical component in the overall care and wellness model Granite State Health Plan (GSHP) facilitates with our members. We take every opportunity to educate and inform our members about general and condition specific health care issues and provide them with personal wellness and care information through care gaps and care plans posted on our secure Member Portal. We have developed our technology to assist us with this process, so that each moment of contact with a member, whether on the phone with our Member Services Representatives, or other GSHP staff member; or on line through our member portal; relevant, member specific information is available to educate, inform and guide our members towards healthy choices.

Telephonic Tools Offering HealthCare Solutions

The Member Relationship Management System (MRM). Our call center staff and 24 hour Nurse Line (described below) will use our Member Relationship Management (MRM) system. MRM enhances support for all informational aspects of our Members' relationship with GSHP. MRM will enable GSHP to **identify, engage,** and **serve** our New Hampshire members in a holistic and coordinated fashion, across the breadth of their wellness, clinical, administrative, and financial matters. For example, MRM will receive Care Gap and Health Risk information from our Centelligence™ Foresight product (See

Addendum 2.4.3 MIS Overview), allowing us to systematically anticipate care needs for our members. For example:

- ***MemberReach.*** The MemberReach component of our MRM automates, manages, tracks, and reports on our workflows for *outbound and outreach* member campaigns, as well as targeted outbound interventions (such as engaging high risk or other members in our Disease Management Program).
- ***MemberConnect.*** The MemberConnect component of our MRM greatly expands the efficiency and extent of Member and Caregiver information that we can collect, transmit, display, route and use. MemberConnect also supports *inbound campaign management*. If a Member or Caretaker we have been trying to reach happens to call us for any reason, our GSHP Member Services Representatives (MSRs) can address the Member's immediate issue and subsequently resolve the original issue for which we had been trying to contact the Member. For example, when a member contacts our customer service department, our MSR addresses the immediate need of the member, and while doing so, reviews the member record in MRM for possible care gap alerts generated by our Centelligence™ Foresight reporting platform. A care gap alert may indicate, for example, that based on the claims data we have available for that member, that our records indicate it is time for the member's yearly doctor visit. The MSR can then assist the member in making an appointment with the member's PCP. Alternatively, MRM may indicate that we do not have a health risk assessment for the member, so the MSR may offer to transfer the member to our case management team to complete the assessment.

Member Hotline. GSHP will provide a toll-free hotline that members can call 24 hours a day, seven (7) days a week. This hotline is supported by NurseWise, a sister company, also wholly owned by Centene. NurseWise provides 24-hour telephonic medical triage and has conducted outbound call programs for our affiliated health plans, nationwide. NurseWise triage nurses are experienced professionals who have the knowledge to help patients with immediate health concerns make informed decisions.

Connections Plus. All Centene affiliates have implemented our Connections Plus Program®, which provides pre-programmed cell phones to our high-risk members who lack reliable phone access. This innovative program provides 24-hour instant access for our members, allowing them to make calls to and receive calls from their providers, case managers (including behavioral health case managers), GSHP staff, NurseWise, and 911. The overall objective of the program is a reduction in preventable adverse events such as inappropriate ER use or hospital admissions through improved access to health care information and treating providers. High-risk members receive a cell phone (at no expense to the member) that has pre-programmed direct dial to the member's PCP or other treating provider, Case Manager, NurseWise (our 24/7 nurse advice line), and 911. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The cell phones are also used so that case managers can send the member a text message with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members. As part of the program, Centene health plans also provide members MP3 players loaded with podcasts in Spanish and English, relevant to a member condition. The podcasts are also available for members to download from the website. Examples of podcast topics includes diabetes, alcohol abuse, chronic

kidney failure, COPD depression, headaches, health weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives. ***This program received URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award and was a 2009 Medicaid Health Plans of America (MHPA Best Practices Compendium Honoree.***

In Home Telemonitoring. GSHP will provide telemonitoring services to the highest-risk members (with multiple co-morbidities), for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. This patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modern utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as blood glucose level or a diabetic or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the member's case manager and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the case manager, trigger an Interactive Voice Response phone call to the member, and/or alert other members of the ICT or the member's provide. The technology is entirely web-enabled; all members are provided a login card that enables them, their family, or their physician to acc3ess their biometric information from anywhere in the world at anytime, as long as they have access to the Internet. The technology represents a quantum leap forward – and set GSHP apart as having the only device-agnostic, real-time biometric monitoring capability among its competitors. Three other Centene health plans have already implemented this program and initial data indicates that it is impacting health outcomes for members.

Interactive Voice Response. Our Avaya Voice Portal IVR platform with voice recognition capabilities and Avaya Communication Manager (CM) Version 5.2.1, will allow callers (strictly at their option should they choose to not talk with a live operator) to use our automated and secure self-service telephonic features and to select or speak menu choices and identification information, to receive information over the phone via IVR in automated fashion, and/or to direct their call accordingly to the appropriate live person or queue to be answered by qualified staff. In addition to options to directly speak to a staff representative, our IVR has systematic options for such services as claims status, Third Party Liability, Authorization Request, etc. In this way we blend the speed of automation for those who prefer that to immediate access to a live person.

Our phone technology allows warm transfers (with the three parties on the line) to any phone number; thus, Member Service Representatives (MSRs) can connect members directly, even to external organizations such as a Primary Care Physician office, members are not asked to hang up and redial.

Web-Based Solutions Promoting Wellness and Engaging Members in Their HealthCare

The GSHP Member Portal. Another key component of our MIS support for member service is our GSHP Member Portal, which will offer a number of self-service, wellness and care features specifically tailored for GSHP members. Our GSHP Secure Member Portal will equip our members with the ***administrative, wellness, care,*** and ***financial transparency*** information they will need to help them stay engaged in their health care with their providers. Please refer to Question 51 for additional information on the GSHP Member Portal.

In the table below we have listed out the planned capabilities for our GSHP Member Portal that assist members with their health care choices. ***Please also see our response to Question Q.28 for more features of our Member Portal.***

Feature	Capability and/or Informative Content
Wellness	
View CentAccount Status	GSHP's CentAccount Program promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors. The CentAccount Program uses industry-leading technology to restrict card purchases to health care related items. Centene provides our members the ability to view their CentAccount incentive status by accessing, through the Portal, GSHP branded web pages on the TSYS Member Portal. TSYS is our second-tier subcontractor for our existing CentAccount Program. Our members will thus be able to track their CentAccount activity and their award status via this secure link to the GSHP content hosted on the TSYS Member Portal.
Health Podcasts	We will offer topical podcasts for members to download and listen to at their convenience. Topics may include areas such as: StartSmart for Your Baby® First Year of Your Baby • Taking Care of Your Baby • How to Get Help • Taking Care of You • Summary – First Year Diabetes Management • Part 1 – Get Started • Part 2 – Be An Active Member • Part 3 – Take Care • Controlling for Life
Local Health Content & News	Our Portal will contain a variety of health education literature and messages, including, but not limited to: activities for kids, community events, a member blog and Member Newsletters.
Care	
Online Health Risk Screen/ Member Gaps In Care	GSHP members will be able to complete the GSHP Health Risk Screen on our Member Portal. All information collected on the HRS will automatically be populated into our TruCare health services management system. TruCare will be used by GSHP clinical staff to support case and care management, disease management, and utilization management activities. Once HRS data is electronically imported into TruCare, this data will automatically be available to our Centelligence™ Foresight (Foresight) Predictive Modeling application. Foresight will analyze HRS and other

Feature	Capability and/or Informative Content
	clinical data, such as from claims, to identify any potential member gaps in care or in preventive services. Our Member Relationship Management system (MRM) will indicate that an HRS was completed for the member. MRM is our integrated member data management system that will enable coordinated GSHP contacts with our members, both inbound (to GSHP) and outbound (from GSHP), across multiple media (telephone, mail, e-mail, and web). If the member has signed up for e-mail alerts, and a care gap is identified (either from HRS and/or claims data) for the member, our MRM will issue an e-mail alert to the member. The e-mail will instruct the member to contact GSHP for health information, and/or login to the Member Portal to retrieve an important message.
Condition-specific Care Alerts	The GSHP Member Portal will provide access to tailored care alerts for specific diagnoses.
TruCare Service Plan	Allows read-only access to the GSHP Service Plan maintained in TruCare. Service Plan data will include member problems, goals, objectives, and other key elements. The Service Plan - viewable from within the Member and Provider Portals - will support collaborative efforts among GSHP, members, and providers in determining and assessing outcomes.
Choose or Change PCP	GSHP members will be able to choose or change their PCP on the Member Portal. In addition, the member will be able to assess how a potential PCP meets their needs based on geographic proximity, languages spoken, gender, office hours, and other information. Our portals are fully integrated with our Provider Relationship Management (PRM) system that integrates all data pertaining to our contracted providers. PRM will provide one data source for our Member Portal, our claims processing system, provider directories, and other provider data-related processes.
Formulary Look-up	GSHP members will be able to access the GSHP formulary. Our formulary look-up provides the member with a description of the pharmaceutical, and the ability to sort by NDC (National Drug Codes).
Provider Search	Members will be able to search for providers by location or by doctor/facility name and refine the search through additional criteria, such as provider specialty and languages spoken. Distance to the provider's facility is calculated in real time. Detailed parameters such as provider name, distance to the medical facility, languages spoken, etc. are also provided. Public transportation access information is included, as well as a map application that provides a travel itinerary from the user's location to the provider (via Google Maps). Our provider search is powered by PRM.
Parent/Legal Guardian (PLG) Log-on as Member	Federal and state regulations stipulate we may not provision a secure portal account for members who are less than 18 years of age. However, we do have the technical ability to provision an account for a member's parent or legal guardian (PLG) - a capability we refer to as our *PLG feature*. Our PLG

Feature	Capability and/or Informative Content
	feature allows a validated parent or legal guardian to access the young patient's health plan information on our Member Portal. Our HIPAA enrollment processing system allows us to receive and process parent or legal guardian (aka "Responsible Person") information in the HIPAA 834 file we receive from the Enrollment Broker. We propose to review our proposed Parent/Legal Guardian Member Portal provisioning process with DHHS. For example, we would ensure with DHHS that we would be able to consider "Responsible Person" information in the HIPAA 834 enrollment and eligibility file as validated information suitable for provisioning a secure member portal account for the child member. We also propose, that if DHHS or the Enrollment Broker cannot establish the parent or legal guardian (the member's "Responsible Person"), then GSHP will attempt to establish this information - and we will use that validated information to provision the child member's web account, and we will report that information back to DHHS as required. We believe that the PLG feature of our Portal is a very important factor in furthering increased family engagement in our member's care; particularly when the child has special health care needs.
Financial Transparency Tools	
Claims History and Explanations of Benefits (EOB)	All GSHP Member Portal users will be able to view medical and behavioral health claims history, including dates of service, and services rendered. Claims history will also include pharmacy claim activity.

Identifying Members Needing Care Coordination

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

Granite State Health Plan (GSHP) will identify members for care coordination and case management using medical and pharmacy claims, utilization, and health screening data and referrals. Integrated Care Team (ICT), a multidisciplinary team of health proffesionals, will review information from new member Health Risk Screenings; monthly reports from our Centelligence™ Foresight (Foresight) predictive modeling system for members identified as at risk for developing a qualifying condition; monthly claims-based reports driven by diagnosis, procedure, and pharmacy codes that indicate or are associated with qualifying conditions; monthly ED utilization reports and daily logs from NurseWise, our 24/7 nurse advice line; and assessments conducted by case managers. Potential candidates for case management may also be identified through concurrent review of members receiving inpatient treatment; review of pharmacy data to identify members utilizing drug classes that indicate a qualifying condition; referrals from providers, staff, community organizations, and member self-referral; and in-person contact with IC Team staff located at high volume provider sites.

Identifying New Members

Enrollment Information. Using the member's historical claims and eligibility data provided by DHHS, as well as category of need indicators provided on the enrollment file, case management staff will identify members for care coordination and case management. In addition, we will use any other information that may be provided by DHHS, such as existing authorizations for specialty services, non-emergency transportation, and certain supplies including oxygen and enteral nutrition.

Health Risk Screening (HRS). We will proactively contact new members to complete a HRS to identify those who may have care coordination or case management needs. GSHP will make at least three reasonable attempts on different days and times of the day to contact a new member and complete an HRS, which will include questions about physical, behavioral health and developmental conditions and needs. We will mail all new members a New Member Welcome Packet which will contain the HRS and a stamped, return envelope. NurseWise, our nurse advice line affiliate, will place Welcome Calls to all members within 30 days of enrollment to assist them in completing the HRS if they have not already done so. As part of our outreach efforts to complete the Welcome Call and HRS, GSHP will use our predictive dialing capability to deliver audio-postcards asking the member to call our Call Center for information about their health care.

In other states, we have found that a small number of members will either refuse the HRS, or we will not be able to reach them. If the member's contact information is wrong, a MemberConnections Representative (MCR) will attempt to identify the correct information through alternative resources such as the Internet, PCP office, WIC office, as applicable, or reverse telephone lookup. We may also locate members when they call the Call Center, upon inpatient admission, and when filling prescriptions. When we locate the member, we will request updated contact information and attempt to complete the HRS. GSHP will locate ICT staff onsite at certain provider locations such as high-volume practices and FQHCs, so they can complete an HRS for new members when they access the provider office. We will document all attempts to contact a member for the screening, including dates and times of attempted contacts, in TruCare, our integrated medical management system.

Identifying Pregnant Members. We will identify pregnant members via DHHS enrollment information and monthly claim reports that indicate pregnancy diagnoses or prenatal vitamin prescriptions. Using our predictive dialing capability, we will send audio postcards to these members describing Start Smart and encouraging them to call our toll-free number if they are pregnant. Our Notification of Pregnancy (NOP) process will identify pregnant members at risk for complications so we can establish a relationship among the member, provider, and health plan staff as early as possible. We will incentivize providers to notify us via fax, mail or telephone as soon as they become aware of a pregnancy. Members may also complete the NOP form by calling our call center. We will maximize self-identification by educating all members about the positive benefits of early prenatal care and our Start Smart for Your Baby Program.

Any Medical Management or Member Services staff who identifies a pregnant member will help them complete the NOP form, which assesses more than 20 obstetric history factors. We will use this information to stratify and determine intensity of interventions.

Direct Referrals. GSHP will identify members who may need Care Management through referrals from members, families, caregivers, providers, community organizations, and GSHP personnel. Referrals may be made via phone, fax, mail, email or through our Member or Provider Portal. We may also receive referrals in person through GSHP staff, such as MCRs, at community outreach events, Care Managers onsite at FQHCs, and concurrent review nurses onsite at network hospitals. When we receive a referral, IC Team staff will attempt to contact the member by phone within the timeframes described below for high risk members, unless the referral is from a provider who indicates a lower risk level. In this case, we will use the outreach timeframe for moderate or low-risk members.

MemberConnections® Program. The MemberConnections Program allows us to provide a level of in-person, "boots on the ground" interaction with our members that other health plans cannot. MemberConnections Representatives (MCRs) are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and become an integral part of our Member Services and Case Management teams, which benefits our members and increases our effectiveness. MCRs will make home visits to members we cannot reach by phone. They will assist with member outreach, coordinate with social services, and attend community functions to provide health education and outreach. For example, MCRs will work with providers to organize Healthy Lifestyles events and work with other local organizations for health events.

Centelligence™ Foresight: Predictive Modeling Technology

GSHP will use Centelligence™ Foresight (Foresight), our multi-dimensional, episode-based, predictive modeling and Care Management analytics tool to identify members who may need our Care Management program. Foresight, an improved process and supporting software tools that we began implementing across health plans in 2010, will allow us to identify members who may not yet have a diagnosis or identified condition that would trigger assessment for Care Management, but are at risk for future illness and utilization.

Risk Stratification. Our risk stratification approach will involve the following key steps:

- Identify the clinical risk markers observed for an member. Clinical risk markers describe a member's array of clinical conditions and their use of health care services in the context of those conditions. Risk markers are important in defining an member's clinical profile and how that clinical profile can be used in differentiating their risk versus the risk of other members. Examples of risk markers include: congestive heart failure (CHF) with co-morbidity; CHF with co-morbidity, recent inpatient stay last three months; and CHF with co-morbidity, significant episode clusters (a measure of unique physician encounters), over the last three months. Other risk markers may be assigned according to member age and/or gender, prescription drug use and the use of significant services such as durable medical equipment.
- Assign risk weights to each clinical risk marker. The risk weights describe the incremental contribution to risk of having a clinical marker. A risk weight is assigned to each marker of risk for the member.
- Calculate member risk. An member's risk score for an outcome is the sum of the risk weights for all their markers of risk observed.

Centene health plans that have fully implemented our improved predictive modeling process have **increased identification of high-risk members by 17.5%.**

We will add additional risk markers or adjust the risk weights to support the unique characteristics of our enrolled population. For example, our affiliate plans have added risk markers and weights to stratify pregnant members. GSHP will evaluate the range of risk scores and assign a range to high, medium and low stratification levels. Our stratification approach will be based on algorithms from predictive modeling approaches we use in other states, all of which are industry validated. Our Care Management staff will use risk stratification and primary condition to determine timeframes for assessment and for initial assignment to the appropriate IC Team and clinical team lead. Because a member may receive a new diagnosis or have an exacerbation of a previously well controlled condition after the initial stratification, we will generate reports from Impact Pro on a bi-weekly basis to frequently reassess risk levels and identify additional high risk/high cost members.

Ongoing Review to Identify Care Management Needs

We will identify existing members who need or desire Care Management when members contact our member Call Center; when our Medical Management Department receives an authorization request; when an member is admitted to the hospital; or when an member seeks care in the emergency department. Identifying members at these contact points is possible through our Member Relationship Management (MRM) system and TruCare.

GSHP will use utilization management activities as a way to identify members with complex conditions and/or high costs. ICT staff will monitor member for new diagnoses or exacerbations of a previously well controlled condition that would trigger initial or reassessment of a member's needs. With appropriate management and monitoring, we may prevent, delay or reduce the disease processes, inappropriate utilization, and/or the need for higher levels of care, by ensuring these member access appropriate preventive and primary care, as well as non-covered services and community resources. Our discharge planning process, initiated as early in the stay as possible, will involve ICT staff and concurrent review nurses working with physicians and hospital discharge staff to evaluate member needs related to placement and services required at time of discharge from the facility.

If the contact comes through a provider, we will obtain and forward member information to the IC Team so they can contact the member and complete the IHS. If an member's first contact with us is through a hospital admission or ED visit, TruCare will indicate the IHS and/or Care Management status to the concurrent review nurses (CRN) who will monitor all inpatient members. Identified members will receive a comprehensive assessment as described below.

Care Management staff will use monthly Trigger Diagnosis reports, monthly ED Utilization Reports to identify members, and the monthly NurseWise Care Management Reports to identify members/families whose calls to our Call Center after-hours (to NurseWise) may indicate a need for case management. Our Pharmacy Benefits Manager (PBM), US Script, will provide drug utilization review reports allowing the Medical Directors and Plan Pharmacist to identify members with multiple or conflicting drug regimens that may indicate the need for case management.

Community Resources

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.

We understand that success in delivering high quality GSHP means engaging with traditional Medicaid/CHIP providers, locating in communities where members live and work, and collaborating with community-based organizations to serve the whole individual in the context of family and informal supports. We are creating not only a formal network of providers and programs to support member health and wellness, but we also are actively investing in community relationships to coordinate care and well being, including for non-covered services such as help with home safety.

Understanding Available Resources

The first step in assisting members with accessing community resources is to understand and have established relationships in place with these resources. GSHP has already begun identifying available resources and establishing collaborative relationships to ensure our ability to take a holistic approach to case management, incorporating both covered and non-covered services. For example, we met with Rich Crocker of Community Support Network Inc. (CSNI). CSNI is a not for profit organization that works in support of the 10 Area Agencies throughout the state of New Hampshire that provide services to individuals with developmental disabilities and acquired brain injury and their families. We will reach out to Family Centered Early Supports and Services who provide services for children birth through age two who are at risk of substantial developmental delays or are currently experiencing developmental delays. Additionally, we will coordinate services with the New Hampshire Partners in Health program is a community-based program designed to address the needs of families with children that have chronic health conditions.

We will also collaborate with organizations that advocate for people with mental illness and substance use disorders such as NH Behavioral Health Association, New Futures, NH Alcohol and Other Drug Providers Association, NH Alcohol and Other Drug Counselors Association. Many of our Bi-State partner providers already have established relationships with these and other local agency's serving the residents of New Hampshire.

On-the-ground, **locally-based** call center, community outreach workers, Case managers, and hospital based discharge nurses ensure each member is supported by someone who understands the local culture and available community resources.

We will explore innovative ways to partner with or leverage local resources, similar to what our affiliate plans have done in other states, for example:

- Our Mississippi affiliate has partnered with Kids of Katrina Art Camp.
- Our Georgia affiliate has partnered with the Child Abuse Prevention Coalition.

- Our Ohio affiliate collaborated with an FQHC in Akron to provide primary care for members with primary behavioral health disorders and a carved out behavioral health benefit. The program was named a Pinnacle award-winning best practice by the Ohio Association of Health Plans.

Like our affiliates, we will take a hands-on approach: our Connections outreach staff assist in event planning and will participate, in person, throughout the events themselves. We also provide financial support such as paying for event promotion and signage, but our primary goal is to connect personally with members and their families and peers in their own community settings.

Coordination Through the Medical Home

A key way in which we will ensure members receive appropriate services that are well-coordinated is to link them to a medical home provider who is appropriate to their needs, will deliver primary care and coordinate all the member's services. The Patient-Centered Medical Home (PCMH) takes a team approach to health care and places the patient at the center of that team. Our member-centered model emphasizes the role of primary care providers in coordinating their patients' care across multiple locations and settings and over time. Several of our Bi-State partner providers have achieved Level III Patient-Centered Medical Home (PCMH) recognition and many others are at varying stages of implementation and application for their PCMH recognition.

Co-Located Integrated Care Teams. GSHP understands that primary care providers, particularly those recognized as PCHM, will most often be the member's case manager and have established processes in place to coordinate services through local community agencies that may provide services that the managed care program does not cover, but which support the member's overall healthcare needs and goals. Our intent to actively support existing patterns of care and referrals through co-location of our case management staff within FQHCs, CMHCs and other high volume provider locations. These staff will serve as our grassroots community liaisons; among other things, the they will work with community-based organizations that provide non-covered services to members to establish streamlined processes for member referrals.

GSHP and Centene Community Involvement – Proven Approaches

Community collaboration and investment are trademarks of Centene health plans. In New Hampshire, GSHP will follow Centene's proven community engagement and feedback approaches and continuously identify local and regional needs and the organizations and individuals that are actively addressing them. Each state is unique, and our approaches to supporting member health and wellness will be tailored for New Hampshire with help from a range of advisors in the communities we serve, such as FQHCs, our locally-hired staff, and the GSHP Community Advisory Committee, Member Advisory Council, and Provider Advisory Committee. We will leverage all of our award winning and proven expertise to improve the overall health and well- being of our New Hampshire members. Centene's expertise in community collaboration on healthy baby education is demonstrated by the award won by our Ohio

Our locally based model and partnership with Bi-State gives us invaluable knowledge about geographic disparities and available resources.

affiliate, the Community Outreach/Partnerships Pinnacle Award for the program, "Community Care: A Partnership in Nurturing," and a Healthcare Programs Pinnacle Award for its 17P Program. Our success in collaborating with communities to improve member health was recognized in June 2011 at the Communities in Action National Asthma Forum by the U.S. Environmental Protection Agency (EPA), which recognized Centene and its Disease Management specialty affiliate, Nurtur, along with two other organizations, with the National Environmental Leadership Award. Criteria for winning the award included implementing strategies to deliver positive health outcomes, forming strong community collaborations, exhibiting committed leadership, and conducting effective environmental interventions to improve the lives of people with asthma.

Members who are Transient, Difficult to Locate, Homeless and Difficult to Engage

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.

GSHP realizes that without Member contact, we are rendered ineffective in impacting the Member's health and well-being. Accordingly, ensuring that we have mechanisms in place that support our ability to maintain Member contact is a high priority for GSHP. We understand that ongoing effective communication between Members, Providers and health plan staff is essential to the successful delivery of integrated care and needed services. Contact is necessary to educate Members about services and benefits under the plan, to engage them in self-care, guide them on how to get assistance and to deliver care and disease management; all of which help foster improved health outcomes, health maintenance and quality of life. Finally, Member contact provides GSHP feedback to design and improve upon systems and approaches to enhance service delivery.

Members Who Are Mobile, Homeless or Difficult to Locate

Member Information and Tracking. GSHP's Member Relationship Management system (MRM) is a powerful contact management system specifically designed for Member related data and processing workflow needs in health care administration. MRM enablee GSHP to systematically identify and engage our Members and their families in a coordinated fashion, connecting administrative, financial, and personal health information in one location. MRM will have three core integrated components:

- The Member Demographics System provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting and distributing Member data throughout our organization to ensure consistency and control in the ongoing maintenance and application use of Member data
- MemberReach will automate, manage, track and report on our workflows for outbound call and in-person outreach Member campaigns as well as targeted outbound interventions (such as engaging high risk Members in disease management programs)

- MemberConnect will support inbound campaign management offering a solution for alerting the GSHP staff person who answers the call if another department has been trying to contact the Member, such as ICT for disease/case management assessment.

Using this system, GSHP maintains comprehensive and up-to-date contact information for Members including phone numbers and home addresses. Unlike demographic information received through the eligibility process, the MRM will maintain all historical and current contact information for each Member with the ability to note the primary or preferred method of contact. MRM will also allow GSHP staff to record multiple addresses (i.e. physical address and mailing address), multiple phone numbers (i.e. daytime phone number, evening phone number, or neighbor's phone number) and email addresses. GSHP staff will reconfirm contact information with Members during each telephonic interaction, regardless of whether the Member is calling into GSHP Member Service Center or our Integrated Care Team (ICT) staff is calling out to the Member. The MMR system will also

Point of Service Connections. Often the best place to reach Members who are mobile, hard to reach or homeless is at the point of care such as a doctor office, pharmacy, mental health service center, or during a home health or physician home visit. GSHP has identified three homeless health care programs among the FQHCs that are well positioned for assisting with the homeless. The following FQHCs are 330(h) homeless programs in NH:

- Families First Health and Support Center (Portsmouth)
- Harbor Care Clinic (Nashua)
- Health Care for the Homeless Manchester

As mentioned previously, our co-location model will enable us to establish a relationship with the Member and conduct assessments and care plan updates, provide education, answer Member questions and assist the Member with accessing needed services when a Member comes in for a scheduled appointment or as a walk-in. If the Member is homeless the case manager can also link them to available community resources and assist the Member with scheduling needed referrals and transportation to the visits as needed. The CM will also use this opportunity to identify the best way to reach the Member and if needed, schedule a follow-up meeting at the point of service or other location of the Members choice. If the Member is high risk and does not have reliable phone service, the CM can refer the Member for the ConnectionsPlus program as described below. The following methods have also proven successful in Centene health plans:

- track pharmacy prescriptions to identify approximate refill dates and ask the pharmacy to notify us when the Member is there

- identify approximate location of the Member and interview local community service staff, homeless shelters and area residents
- conduct onsite visits when Members are admitted to the emergency room or hospital

This face-to-face interaction with the Member builds trust, lets the Member know GSHP is here to help, and encourages the Member to keep contact with the ICT.

MemberConnections® Outreach. MemberConnections Representatives (MCR) are locally hired and familiar with the communities and service challenges encountered by our Members and play an important role in locating and engaging Members. They will assist with telephonic outreach campaigns, arrange community events, and conduct Member education in various settings. MCRs will also help locate hard to reach individuals. Because they are part of the community, they are familiar with and know the local businesses and church representatives who in turn are more likely to share with us the potential location of the Member. If telephonic and point of service outreach attempts are unsuccessful or if we fail to find a valid telephone number for the Member, a MCR will go to the Member's home to provide initial education on benefits, programs, importance of our ability to reach the Member and to complete the Health Risk Screening (HRS). MCRs will also go to Members homes to provide targeted education, such as appropriate use of the emergency room, and to conduct home assessments to identify potential barrier to accessing needed services. If the Member is not home, the MCR will leave a door hanger with a request that they call GSHP's toll-free number to discuss their health care. If the address is wrong, the MCR will notify our Eligibility Specialist who will initiate contact with State/HFS to obtain a current address/phone number for additional outreach attempts.

Telephonic Outreach. GSHP will implement a telephonic outreach program to educate and assist Members in accessing services and managing their care. Calls will be conducted by GSHP staff or by Nursewise®, our 24/7 nurse advice line, to new Members and to targeted populations such as Members who are identified or enrolled in disease or case management, who have frequent emergency room utilization or who are due or past due for services. To improve our chance of contacting our Members we will also use Televox's SmartAppend™ service that utilizes an FTP server to append, retrieve, verify and update Member contact information (telephone and/or address) using

SUCCESS STORY

Soon after Centene's Illinois affiliate, IlliniCare, began operations, we received a call from Provena Mercy Hospital in Aurora, letting us know our enrollee was about to be discharged from the emergency department.

Toni, an IlliniCare Care Manager, went to the hospital to visit with and begin discharge planning for the enrollee the same day we received the call. The hospital case manager was surprised at the prompt response, and indicated she had never known or heard of any Medicaid health plan to make hospital visits.

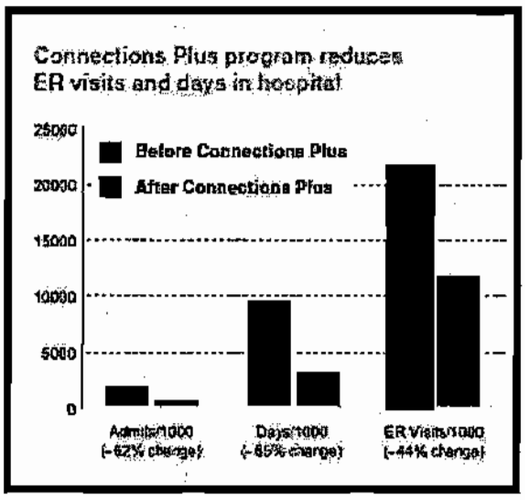
The enrollee was a homeless man with chronic COPD who required a great deal of care coordination. He let Toni know that he had refused to go to the doctor, until finally he had to call an ambulance to be taken to the emergency department. Toni spent two hours working with the enrollee on his discharge plan. The enrollee was so grateful for the personal attention and care for his needs that he was crying.

Toni and other members of her Integrated Care Team visited the enrollee during his stay in a rehabilitation facility to monitor his condition and address his questions and concerns. They helped him access housing and establish a medical home to ensure his ability to access regular medical care.

data from over 700 telephone companies. For Members who do not answer the phone or whose phone line is busy, we will make at least three phone call attempts, with calls placed at least five days apart and at different times of the day. If the number is found to be the wrong phone number for the Member or is disconnected, the MCR will conduct research to identify an alternate phone number using reverse look-up systems, searching the Internet, checking with Providers who last saw the Member, or pharmacies who last dispensed medicine to the Member, etc.

GSHP will also subcontract with BEP certified vendor, Awakened Alternatives to make outbound Health Risk Screening calls and to conduct Member searches.

Connections Plus®. ConnectionsPlus is an innovative approach that uses cell phone technology to facilitate communication with Members and improve health outcomes. Lack of reliable telephone access hampers their ability to contact a case manager or Provider with questions, or to report a change in condition. It also hampers GSHP's and a Provider's ability to reach the Member with education, reminders, and other information critical to their care. With approval from the State, GSHP will provide restricted-use cell phones to certain high-risk Members who lack reliable phone access (i.e. homeless, mobile, no home phone), have serious mental illness, or have other chronic and complex needs. The phones will be pre-programmed with important numbers such as the PCP, other treating physicians, the GSHP Case manager/ICT, NurseWise (our after-hours nurse advice line), and 911. By providing an Member with reliable phone access, we provide them with the means to contact critical members of their health care team and empower them to accept more personal accountability for their health care needs. There are over 1190 prepaid cell phones currently in circulation in other Centene health plans.



A review of 680 aged, blind, and disabled Members compared to a similar population (control group) demonstrated significant improvement in health outcomes including a reduction in Emergency Room visits by 19%, reduction in inpatient admissions by 38%, and a decrease in length of inpatient stay by 29% after receiving the phone.

Community Outreach. GSHP's community-based Member education and outreach program strategically meets Members where they are. Unlike point of service and home visits, which rely on the Member to access services, our community outreach events are free, informal gatherings open to the public and attendees have the opportunity to win health-related giveaways, talk to the GSHP staff, and receive healthy tips and information. By getting involved "on the ground," we meet the Members we serve and show our support in helping them to improve their health. Members will be informed of special programs we offer, such as ConnectionsPlus, Healthy Lifestyles and others.

Members Who Are Difficult To Engage

The experiences of our affiliate Centene health plans has taught us that even the most creative education strategies may not motivate members with chronic conditions to access appropriate care. GSHP will implement strategies and then continually looks for ways to address this barrier. We will solicit input from our Member Advisory Committee and Community Stakeholder Committee to help develop strategies to increase motivation.

GSHP's approach to interventions recognizes that the best way to draw difficult-to-serve Members into care is by:

- Providing an active, high-quality, responsive platform of intervention methods, beginning with the first Member interaction, to ensure active engagement from the start.
- Providing Member-centric information in easy-to-understand formats and context through a variety of methods to meet preferred learning styles
- Helping Members identify health-related goals they see as important to their quality of life (such as losing weight, going to work, or remaining in their own home);
- Designating action steps that Members agree to take responsibility for in the plan of care (such as getting their prescriptions filled on time and taking medications as scheduled, or calling the CC in advance if they think they might not be able to get to a Provider appointment);
- Asking Members to evaluate their own progress on action steps;
- Discussing barriers to and alternative steps for achieving goals.
- Minimizing repetitiveness where possible, especially for those with multiple co-morbid conditions

Encouraging and supporting active Member involvement with an underlying emphasis on personal accountability for their own health and wellness

Care Management Outreach and Engagement. GSHP will use a multifaceted approach to contact Members. Our experience in other states treating similar populations, has shown that successfully reaching Members requires continual, integrated documentation, culturally competent communications, repeated contact attempts using multiple strategies (written, telephonic, online, and in-person) and a strong method for tracking contact attempts and member contact information. GSHP will capitalize on every mmber contact to engage members in case management.

Member outcomes are more positive when members and (as appropriate and with required consents) their families and informal supports are engaged in planning, directing, and evaluating their care. Member education is the primary tool for encouraging Member participation in case management, which requires that Members understand their health condition, service options, and the role of the care plan. A population that includes the elderly, disabled, and Members with serious mental illness (SMI) and developmental disabilities poses an even greater challenge. GSHP's wellness, disease and case management programs are designed to encompass strategies to address these challenges and support the goals of improved health outcomes. When Members who have been unmanaged receive support to make informed health care decisions and the tools to take responsibility for managing their

own decisions, they show an average 51% improvement in healthy behavior (Burke, Arkowitz, & Menchola, 2003).

GSHP's ICT staff are highly skilled in identification and discussion of barriers to compliance, and adept in facilitating a readiness for change, obtaining true buy-in for behavioral modification, and encouraging solution-oriented problem solving. The CC will use Member assessment tools that include questions to determine the Member's readiness to change, a key predictor of participation in their own care. CCs use the results of these tools to identify health information geared to the individual Member's readiness to change and willingness to participate. For example, an Member who wants to quit smoking or lose weight will receive different information and follow-up calls than an Member who clearly lacks interest in taking such initiative. Members with SMI or developmental disabilities often require additional outreach strategies and support to engage in their own care. Control of the BH condition can be a critical factor in the Member's willingness to engage. Case managers will work with the CMHC to monitor service delivery and Member compliance, and determine optimal points to reassess the Member's readiness to change. This information is then documented in our TruCare system so that it is available to all case management staff during future interactions.

The key to successful initial and ongoing engagement of a population is a relentless commitment to creativity and persistence. GSHP's affiliate health plans and Nurtur, our disease management subcontractor, have successful track records in engaging Members in programs. In fact, Nurtur has a long-standing track record of engaging 75-90% of individuals it is able to successfully reach. While we are proud of these past successes, we recognize that we must consistently reevaluate our programs to account for changes in cultural dynamics, barriers, peer pressures and community norms.

Trigger Events. GSHP will utilize bi-weekly disease management identification reports from Impact Pro, our predictive modeling software, not only to identify potential new participants, but also to identify certain trigger events for our existing participants. Examples of these events include an inpatient admission, an emergency room visit, a heart attack or a stroke. The experiences of our affiliate health plans have taught us that significant health events such as these often motivate a person to make life-style changes that they had not previously been willing to make. When such an event is identified, a member of the case management team will outreach to the participant by phone for a brief call to check on their condition, ask about any current unmet needs and determine if the care plan needs updating. It has been Nurtur's experience this type of proactive outreach following a significant event demonstrates our concern for the participant, which results in a desire to remain with the program.

Home Visits. GSHP Health Plan (GSHP) recognizes the important role home care, including home visits and telehealth or telemonitoring, plays in serving individuals with chronic illness or disabilities. We believe that "meeting Members where they are", through home visits, is an effective approach to building supportive relationships with our Members and providing an opportunity to observe Members and their behaviors in a familiar and comfortable setting. This approach allows our multidisciplinary Integrated Care Team (ICT) described below to establish stronger relationships with our Members than would be possible by telephonic contact alone and to conduct a more thorough assessment, by observing symptoms or non-verbal communications that may indicate the need for additional questions and by conducting an environmental risk assessment to identify any barriers to improved

health status that may exist in the Member's home. GSHP's home care program is one component of the comprehensive set of services provided through our Integrated Care model

Extra Effort. The experiences of our affiliate Centene health plans has taught us that even the most creative education strategies may not motivate Members with chronic conditions to access appropriate care. GSHP will implement strategies and then continually looks for ways to address this barrier. We will solicit input from our Member Advisory Council and Community Stakeholder Committee to help develop strategies to increase motivation.

GSHP's approach to interventions recognizes that the best way to draw difficult-to-serve members into care is by:

- Providing an active, high-quality, responsive platform of intervention methods, beginning with the first Member interaction, to ensure active engagement from the start.
- Providing Member-centric information in easy-to-understand formats and context through a variety of methods to meet preferred learning styles
- Helping Members identify health-related goals they see as important to their quality of life (such as losing weight, going to work, or remaining in their own home);
- Designating action steps that Members agree to take responsibility for in the plan of care (such as getting their prescriptions filled on time and taking medications as scheduled, or calling the CC in advance if they think they might not be able to get to a Provider appointment);
- Asking Members to evaluate their own progress on action steps;
- Discussing barriers to and alternative steps for achieving goals.
- Minimizing repetitiveness where possible, especially for those with multiple co-morbid conditions
- Encouraging and supporting active Member involvement with an underlying emphasis on personal accountability for their own health and wellness

Member Incentives and Supports. The CentAccount™ Member incentive program is widely used by Centene health plans and promotes personal health care responsibility and ownership by offering financial incentives that are valued and appreciated by health care consumers. Rewarding Members for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement.

Development of Care Plan

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

GSHP will encourage members to participate in Care Management and engage in their own care using successful strategies of other Centene health plans for similar populations in other states. Member

participation contributes to a greater level of compliance, optimal health outcomes and quality of life. However, many Medicaid members require intensive support and education to do so effectively and to sustain their involvement. To address these needs, GSHP will provide multiple levels of support, information and interaction to engage and support member (and family/guardian or caregiver, as appropriate) participation in Care Management. A fundamental aspect of providing this support will be to proactively seek member and family/guardian input on whom to include in the process and to ensure active engagement in service plan development.

We know that one-on-one and in-person support is more effective for Medicaid and CHIP members than written materials. Thus, while we will provide a variety of written educational materials, our strategies will focus heavily on direct member contact. For example, GSHP staff providing education in person will immediately determine whether and to what extent the member understands the information being provided, and will allow staff to quickly ask if the member has questions, or repeat information as needed to ensure understanding. Our staff will also establish personal relationships with the member and their families/guardians, because these members often need a relationship of trust to be established before they can feel comfortable asking questions or consider health advice that conflicts with cultural beliefs about health and health care.

In addition, GSHP will leverage our relationship with the Bi-State Primary Care Association and their membership of primary care providers (including FQHCs) to provide credibility for and confidence in our Care Management outreach efforts. There is a high likelihood that members eligible for Care Management may already be in treatment, have previously sought care from, or be familiar with one of the Bi-State Primary Care Association health centers. Since these health centers are woven into the fabric of the communities they serve, GSHP's efforts to identify, outreach to, and engage members in Care Management will benefit from their **established relationships** with social service and community-based organizations that may have existing relationships with these members.

GSHP's affiliate health plans and Nurtur, our disease management subcontractor, have successful track records with engaging members in Care Management. For example, Nurtur has a long-standing track record of engaging 75-90% of individuals their staff are able to successfully contact. GSHP's Care Management Program will use strategies our affiliates have successfully used to ensure that members are engaged and active participants in the program. Because different people prefer different methods of communication, our program will use multiple communication strategies, including written materials, telephonic outreach, web-based information, and in-person interactions as described above. During our initial conversations with our members we will attempt to gauge which methods and style of communication the member prefers. The Care Manager will document this information in TruCare so that it is available to all ICT and other clinical staff during future member interactions.

Integrated Care Team (ICT) Support. Care Managers and other members of the ICT who work with members on assessment and service planning will educate them about the importance of and their right to participate in and direct service plan development, and that member self-determination is a guiding principle of our Care Management Program. Because some members may not be familiar with these concepts, our staff will describe the types of activities involved in directing service plan development, such as deciding who else the Care Manager should include in discussions about assessment results and development of goals and preferences; deciding which available service options

the member thinks will best meet their needs; and selecting their own providers. We will also educate the member about the support available through the ICT, including that the member can reach a Care Manager by phone at any time 24/7 if they have questions or concerns. If the member's assigned Case manager is not immediately available via phone, the call will never be sent to voicemail. Instead the member will always have the option of speaking to another Care Manager.

Participation in Care Plan Development. Care Plans are developed with members who are placed into Care Management and/or Disease Management. Upon referral, or at any time there is a change in services or needs, Care Managers will complete all assessments and discussions of needs and services with the Member, and will involve family, caregivers, and others as requested by the member. If the Member is not capable of making his/her own decisions, the Care Manager will work with the family member, caregiver or other legal representative. Specific processes that encourage member participation will include helping members identify goals related to health, functioning and community participation that they see as important to their quality of life (such as losing weight, going to work, or remaining in their own home); designating action steps that members agree to take responsibility for in the plan of care (such as getting their prescriptions filled on time and taking medications as scheduled, or calling the Case manager in advance if they think they might not be able to get to a Provider appointment); asking Members to evaluate their own progress on action steps; and discussing barriers to and alternative steps for achieving goals. In addition, Care managers will work with members to complete assessment instruments that include questions to determine the member's readiness to change, a key predictor of member participation in their own care.

As these goals are identified and evaluated, the Care Manager (CM) will work with the member and family to identify placement choices for services, what services are needed to meet the members goals in the most integrated setting appropriate for the member and the availability of those services within the community. Evaluation and assessment is made of any Durable Medical Equipment (DME) which members may require or need repaired, these are reviewed with the member's PCP for appropriate approval when required. The CM educates the member regarding their covered services, and discusses the process for coordinating services, access to services and who the point of coordination for the member will be. Care Managers also use the results of these tools to identify health information geared to the individual member's readiness to change and willingness to participate. For example, a member who wants to quit smoking or lose weight will receive different information and follow-up calls than a member who clearly lacks interest in taking such initiative. Members with SMI often require additional outreach strategies and support to engage in their own care. Control of the behavioral health condition can be a critical factor in the member's willingness to engage. Care Managers will work with CMHCs to monitor service delivery and member compliance, and determine optimal points to reassess the member's readiness to change.

During the care plan development/revision process, the CM discuss the member's right to select providers and determine whether or not the member wishes to remain with their current provider, including their CMHC, FQHC, PCP or other providers. Specifically, the CM with the assistance of other Integrated Care Team (ICT) staff, work with members with special conditions or need for locating specialists who are willing to meet their unique needs Once the CM and member determine the most appropriate placement and finalize a mutually agreed upon care plan the member will receive a copy of the Care Plan, which will be entered into the TruCare system, our integrated clinical documentation

system on a platform shared by GSHP affiliates, Nurtur and NurseWise. With the Member/family consent, a copy of the Care plan will also be sent to the service providers. The CM verifies that needed services are available in the community, if not the CM and or Program Coordinator works with the member to determine substitute services until services become available or a temporary alternative placement is made to meet the members needs safely.

For services requiring PCP approval, the CM will contact the PCP to provide necessary information and obtain the physician order to include frequency, duration and scope of the services. GSHP will ensure continuity and comprehensive care planning for members transitioning into GSHP and with any transition of care. GSHP MemberConnections Representatives are knowledgeable about available resources within the community and understand how to locate those resources and coordinate them with covered services; they will work closely with the CM as the care plan for a member-centered approach that gives preference to member choices.

Behavioral change readiness. All GSHP care management staff will be trained in Motivational Interviewing with initial training provided by Paul Cook, PhD, a leader in the field of implementing psychologically based behavior-change techniques to help members self-manage chronic conditions. GSHP's evaluation of members' behavioral readiness to change is based on research conducted by Dr. James J. Prochaska, as published in his authoritative work on the topic titled "The Transtheoretical Model of Health Behavior Change"[13]. In accordance with this evaluation paradigm, individuals' behavioral change readiness is classified as pre-contemplative, contemplative, preparation, action, or maintenance phase and is a key factor utilized in determining coaching intensity level. Case managers use conversational "interview" methods designed to elicit information regarding educational level; unmet social needs such as housing, transportation, sufficient food or other issues; family environment or issues; and other similar issues. Most importantly, this training will enable our staff to understand the *individual Member's* goals. This understanding enables them to seek common ground and an attainable goal that the individual seeks, which can serve as the foundation for subsequent goal setting and importantly, a caring sense of trust that the member begins to develop the with care manager and the Integrated Care Program overall.

Health Literacy. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is a key determinant in the *style* and *pace* of education provided by GHP's case managers to ensure that we are keeping them engaged and interested in participating in the program. Individuals with low health literacy will be provided simple information about their disease and how to self-manage, while individuals with high health literacy may be provided more advanced information, perhaps even through the provision and discussion of more focused articles regarding emerging therapies for a given condition.

Member Support to Ensure Compliance. Development of the care plan includes educating the member of the importance of meeting their identified responsibilities. Members' education will occur through telephone contact, face-to-face contact, education groups, and educational mailings/teaching

[13] Am J Health Promot 1997 Sep-Oct;12 (1):38-48

tools. Members will be educated about their disease condition(s) and addressing symptoms. Education includes information about monitoring daily disease-specific indicators; other actions specific to their condition(s), and the actions to take when these measurements indicate a potential health risk; medication compliance, side effects and how they are specific to their health condition(s) based on each Members care plan. If appropriate and available, the CM links the members/family with community-based disease-specific educational programs and support groups. As described in our response to Q47, we will implement a multi-faceted educational program. Activities and programs unique to GSHP's case management program include:

- ***MemberConnections® Program*** is our boots on the ground health education workers.
- ***Connections Plus®*** provides pre-programmed cell phones to our high-risk Members who lack reliable phone access.
- ***Appointment Reminder Calls*** including calls about annual preventive care, specialist appointments and follow up appointment after emergency room visits or inpatient admissions.
- ***Online Care Opportunities and Care Gaps*** to ensure our members are aware of needed services.
- ***NurseWise***, our 24/7 nurse advice line is available to them to answer questions. It will also remind them that they have the ability to earn financial incentives when they receive certain necessary screenings and preventive care. We will also include with each reminder, information about a needed preventive service or screening, whether in writing or by phone, a reminder about the risks associated with progression of their disease and about any available incentives for receiving the service.
- GSHP's ***Healthy Lifestyles Program*** identifies regional community health education needs, improves outreach and communication with GSHP and community-based organization members, and actively promotes healthy lifestyles such as disease prevention and health promotion.

Trigger Events. GSHP will utilize bi-weekly reports generated by Impact Pro, our predictive modeling software to identify certain trigger events for our members participating in care management. Examples of these events include an inpatient admission, an emergency room visit, a heart attack or a stroke. The experience of our affiliate health plans has taught us that significant health events such as these often motivate a person to make life-style changes that they had not previously been willing to make. When such an event is identified, a member of the ICT will outreach to the member by phone for a brief call to check on their condition, ask about any current unmet needs and determine if the care plan needs updating. This type of proactive outreach following a significant event demonstrates our concern for the participant, which results in a desire to remain with the program and comply with care plan interventions.

Tracking Member Compliance. GSHP will use multiple methods to monitor member compliance with care plans, including but not limited to, utilization reporting, TruCare documentation and member and provider feedback. Using Impact Pro, ICTs will generate member-centric reports that compare expected services to services received. Impact Pro will utilize both medical and pharmacy claims to generate these reports. These reports will allow care managers to ensure that members are attending

scheduled appointment and refilling prescribed medications. GSHP will also use available lab data to determine if members are adhering to care plan requirements such as dietary modifications, which should result in improved HgA1c values for members with diabetes or lower cholesterol levels for members with previously reported high cholesterol levels.

Member care plans are documented in TruCare, including member responsibilities. This information is available to all ICT members during each member interaction. During conversations with members, care managers are able to review the information and ask Members if they are complying with expected receipt of services, such as provider visits or medications, and with agreed upon behavior modifications, such as dietary changes or stopping smoking. ICT members may also contact an member's PCP directly to confirm that they are attending scheduled visits or to inquire about vital signs such as blood pressure or weight as a means to assess care plan compliance.

Provider-Based Assistance. GSHP will encourage providers to support members in actively participating in their own care as well as participating in the Care Management Program when applicable. We will provide a copy of the member's service plan to the PCP so they can review and discuss it with the member as needed during appointments. It will also include providing access to the member's care opportunities and care gaps online through our Provider Portal. This feature will enable providers to outreach to the member as needed to schedule appointments and discuss needed care during appointments. We will also educate providers about the support and information we will provide members to direct their service planning. In addition, we will contact providers for assistance when the ICT is unable to reach the member. More information on the technology and other support we will offer providers to influence member behavior and engage them in Care Management and their own care is provided below.

PCP Assignment, Using Assigned Provider, Keeping Appointments

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.

Assigning all Members to a Primary Care Provider

GSHP and its affiliate health plans have extensive experience in delivering member choice while ensuring that all of our members are assigned a Primary Care Physician (PCP) in a timely manner. Our experience shows that many of our new members already have established relationships with our network providers and that members who select their own PCP are more likely to access their medical home; GSHP will ensure that all members have a PCP who provides an ongoing source of primary care appropriate to the member's needs, and GSHP staff will assist members in the PCP selection process.

Centene has 27 years in the Medicaid managed care business and through this experience we have developed and refined an auto-assignment algorithm that analyzes claims history, family member PCP assignment, and finally, geo-access methodology to auto-assign a PCP if one has not been selected by

the member. Across our 11 health plans, we have varying degrees of auto-assignment. For instance, in our Illinois affiliate, GSHP, all members come to the plan with an assigned PCP. However in other states, such as Mississippi, our Magnolia Health Plan, even though members are encouraged to select at PCP at upon enrollment with the enrollment broker, many members have not and we perform auto assignment for members the majority of the time.

Encouraging Member Choice. GSHP will employ a comprehensive outreach and education process to encourage our members to be active participants in the selection and timely assignment of their PCP. Members are encouraged to select a PCP upon enrollment. However, if one is not selected, GSHP will deploy its PCP auto-assignment process to ensure members are assigned a PCP in a timely manner.

Member Selected PCP Assignment. GSHP will leverage existing Centene's standard member load logic that validates the member's chosen provider, if included in the enrollment file, is participating in our network, is appropriate for the member's age, gender and that the provider has not exceeded their panel capacity. The member will be assigned the PCP of their choice unless the selected PCP has reached their maximum physician/patient ratio or the member has selected a PCP whose practice is limited to groups to which the member doesn't belong. GSHP will confirm the member's PCP selection via the member's ID card. GSHP' enrollment department will use an exception report to identify any member PCP selections that cannot be completed and the Eligibility Specialist (ES) will research the reason the selected PCP could not be assigned and resolve issues if possible. If the ES is not able to resolve the issue, the member will be auto-assigned and GSHP will assist the member to select another PCP during our welcome if the auto-assigned PCP does not meet their needs.

No Member Selected PCP indicated in Enrollment File. New GSHP members who have not proactively selected a PCP during the enrollment process or whose choice of PCP is not available will have the opportunity to select a PCP within GSHP that has entered into a subcontract with GSHP; and is within a reasonable commuting distance from their residence.

PCP Auto Assignment. To ensure that every GSHP member is assigned a PCP in a timely manner, GSHP plans to assign a PCP to all members who have not made a selection by the enrollment effective date. For those members who have not proactively selected a PCP upon enrollment we will use the auto assignment algorithm, matching returning member to their previous PCP; then using a family Case Number if provided to identify family members and assign their selected PCP; and finally, using a geo-access methodology that matches the member's age, sex and address zip code with the nearest available appropriate PCP within DHHS's required access standards. To qualify for member auto-assignment, a PCP must be configured in our system as a current provider with effective contract start and end dates, and be accepting new patients. Our system will assign members only to PCPs with available capacity to comply with contract service availability and accessibility standards.

GSHP will monitor PCP assignments to ensure completeness and accuracy of member/PCP designations. GSHP' enrollment department will monitor PCP error reports to ensure all members are able to be matched to a PCP. Members who are unable to be matched to a provider through the auto assignment logic will be manually matched to a PCP.

Communicating with the Member about PCP Assignment, Ensuring/Encouraging Members to Use Their Assigned Provider, and Keep Their Appointments

- GSHP will confirm the PCP through the new member welcome packet mailing which includes identification of the PCP and the phone number on the member's identification card. The new member welcome packet will also include a notice informing members of the process for changing the PCP assignment and encouraging them to make their own choice about the provider who will serve them.
- The Member Handbook will state "it is important to call your primary care physician when you need care" and "you can choose your primary care physician." The Member Handbook will outline the role of the PCP as a medical home. We will emphasize the importance of using the PCP as first contact for needed care, as well as for preventive care visits, especially highlighting immunizations, smoking cessation, and care related to chronic conditions such as HbA1c and LDL testing for diabetes. We will emphasize appropriate use of the emergency department, the availability of NurseWise, our 24-hour nurse advice line, and we will emphasize the importance of coordination of care between the PCP and specialists. GSHP will encourage Members to keep their scheduled appointments by offering them **incentives** through our comprehensive Member incentive program.
- New Member Welcome calls will, stress the importance of seeing their PCP for preventive care, remind the Member about appropriate use of the ER and the 24-hour availability of NurseWise, and provide information about how to contact GSHP for questions or concerns . All GSHP staff with Member contact will reinforce the importance of getting needed services and keeping appointments.
- Members can earn incentives for completing annual well visits and other preventive health services.
- Members may utilize Member/Member Services or MemberConnections staff at any time for assistance in making appointments.
- Members who receive care coordination or disease management services will receive assistance in making appointments, as well as appointment reminders and attendance follow-up, as appropriate. GSHP MemberConnections Representatives assist Providers upon request to follow up with Members who have missed scheduled appointments.

NCQA Patient Centered Medical Home Certification

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

Granite State Health Plan (GSHP) is committed to supporting providers in its network in achieving recognition as Patient Centered Medical Homes (PCMH) and will promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, patient-centered and coordinated care management processes. GSHP will actively partner with our providers, with community organizations, and groups representing our members to increase the numbers of providers who are recognized as PCMHs, or committed to becoming recognized, and who achieve the meaningful use of health information technology (HIT). Beyond that, we will support the development of medical neighborhoods that expand beyond the PCMH to include other clinicians providing health care services

to patients and that include community and social service organizations and state and local public health agencies.

Provider Readiness Assessment

The first step in building the network of PCMH primary care providers is to identify providers who are already recognized as PCMHs or who have many of the necessary qualities of a PCMH. GSHP's strategic partner Bi-State Primary Care Association's members Ammonoosuc Community Health Services, Coos County Family Health Services, Concord Hospital Family Health Centers, Families First Health and Support Center, Lamprey Health Care, Mid-State Health Center all have achieved NCQA Level 3 accreditation. All the other FQHCs are in the process of reaching Level 1 NCQA accreditation. GSHP is in the process of reconciling its other provider network registry with NCQA listings of recognized providers and will continue to do so periodically in the future.. GSHP has developed a PCP survey tool to evaluate providers' readiness to meet NCQA's medical home standards. When GSHP is entering into provider contracts, the Credentialing Packets will require providers to complete a preliminary readiness survey that can be completed either on paper or via an online survey tool. The survey will focus on NCQA's must-pass elements to gauge providers' readiness to achieve PCMH recognition.

Provider Education and Training

Centene will hire a Medical Home Coordinator dedicated to the state of New Hampshire. Among other accountabilities, this coordinator will make sure Medical Home staff is fully educated on the process of attaining PCMH recognition. GSHP will offer provider staff education through local seminars, in-services and webinars provided through such organizations as NCQA, New Hampshire Primary Care Association and Centene Corporation. GSHP will conduct educational outreach to providers in our network who have not yet made the commitment to become PCMHs. This educational outreach will consist of mailings to providers, one-on-one training and support, education sessions and webinars.

GSHP will work with those providers who have made the commitment to conduct a more in-depth assessment and develop individualized work plans to implement change. We will encourage them to use the Primary Care Development Corporation (PCDC) online self-assessment tool *"Obtaining Patient-Centered Medical Home Recognition: A How to Manual and the PCDC"* to supplement NCQA materials. Our staff work with the providers to review their self-assessment and develop a work plan encompassing, for example, revised patient flow and work redesign with supporting policies and procedures and job descriptions for crucial roles, especially the front desk. Once the plan is developed, we may assist them in developing a time schedule for training staff and implementation of new or changed policies and procedures. Once the plan is implemented, Centene staff may assist providers in conducting chart audits and gathering documentation for submission with their NCQA application. In our most recent experience working with providers in Louisiana through our Louisiana Healthcare Connections health plan, one of GSHP's affiliate, this entire process can take as little as 6 month or as long as 18 months to complete.

Provider Clinical Quality and Technology Tools

For FQHCs, CMHCs and other provider groups with many assigned members, many of Centene's health plans embed Care Coordinators onsite to maximize cooperation with and support of the medical home's comprehensive care coordination. This support will further assist them in achieving a high level of patient-centered performance and improve quality of care for high needs members, particularly in integrating medical and behavioral health care and documentation of care for members with co-morbid physical and behavioral health conditions. GSHP is currently working closely with Bi-State Primary Care Association's members to identify the centers and understand required case management staffing needs.

A Suite of Technology Solutions: Pursuant to the American Recovery and Reinvestment Act (ARRA) and Health Information Technology for Economic and Clinical Health Act (HITECH) Act of 2009, incentives are available to certain providers ("eligible professionals" and "eligible hospitals") to help in their adoption and implementation of certified EHR technology deployed for meaningful use. GSHP will work with the Regional Extension Center of New Hampshire and our Information Technology (IT) professionals to help providers identify the best IT solutions for them, and to capitalize on the available incentive funds.

In working to achieve recognition as a PCMH, providers will also need technology solutions to help them with workflow and operations. Our work plan templates will help providers work to achieve the PCMH standards, and we will offer other resources such as a reminder postcard system, and documentation templates. In addition to having resources to help providers with these operational needs, from an information technology perspective, we will be offering several HIT applications for our network providers who are either recognized PCMH's or are committed to becoming NCQA accredited medical homes. They will also have access to the other levels of IT support that we will offer to all providers.

Beyond this support, our Chief Medical Officer, Chief Medical Director and Vice President of Medical Management will work with our providers to ensure that we are enabling wide-scale, secure, timely, and appropriate exchanges of electronic health information; meaningfully used for the treatment of our members.

For all network providers, through our CenTraCare offering of clinical web applications (delivered via our secure Provider Port) offers tools that help support PCMH accreditation elements:

- **Online Provider Directory:** with multiple search options, including location or name; type; specialty; gender; language spoken; whether accepting new patients; and medical and hospital affiliations. Unlike the features discussed below, our Online Provider Directory is also available to members – and to any visitors on our public website. Our interactive, searchable Provider Directory ensures that our Provider Portal users have up-to-date information on GSHP specialty, institutional, and ancillary providers.
- **Online Care Gap Notifications (OCGN):** these web based alerts notify providers of preventive care gaps or health alerts and are systematically produced by our Centelligence™ Foresight predictive modeling system. OCGN's will be presented to all of our network providers via an eligibility inquiry search; and to our PCP's via online Member Panel Roster.

- **Member Panel Roster (Roster):** this function will allow our entire network PCPs to view, print, or export to Microsoft Excel all members under the PCP's care, with summary and detail information on each member. The Roster will also include information on whether the member has special healthcare needs, and information on those needs. Finally, our Roster will also include information on chronic or acute disease conditions the member may have.
- Our evidence-based Clinical Practice Guidelines (CPG), in line with a number of NCQA PCMH accreditation elements, further helping and encouraging any of our providers interested in moving to accredited PCMH status.
- **TruCare Service Plan:** an electronic copy of the member's care management service plan displaying the member's identified health problems, treatment goals and objectives, milestone dates and progress, in an engaging, well organized online format.
- Summary **Member Health Record (MHR):** offers an overview of the member's most current claim activity including most recent inpatient visits, most recent emergency room visits, and most recent provider office visits. The MHR also includes applicable OCGN's for the member and can be viewed online or printed for filing in the member's medical record.

In addition, we will supply our Provider Overview Reports, which will be updated regularly, and presents HEDIS based utilization measures across the care spectrum (outpatient, specialist, inpatient, and emergency room) and preventive care information concisely to our network providers, offering our providers cues to clinical focus areas for ongoing care quality enhancement.

Coordination with the State and other Stakeholders

The goals of the PCMH program are to provide better health care quality, improved self-management by members of their own care and reduced avoidable costs over time. We will submit an annual report to DHHS to reflect the progress we have made in partnership with our providers, specifying the network primary care practices that have achieved NCQA PCMH recognition, including the level of recognition.

GSHP will work with our Provider Advisory Committee to identify additional performance and outcome measures that should be shared with the Department and with consumers. As the performance measures evolve, GSHP will make them publicly available on our Web site along with HEDIS outcome measures.

The Centene Foundation for Quality Healthcare

The **Foundation for Quality Healthcare** was established to improve the quality, access, effectiveness, and value of healthcare for low-income families and individuals, focused on activities that identify and address core causes of unequal access and treatment in healthcare. Building on Centene's long-standing commitment to deliver healthcare at the local level, the Foundation develops partnerships to implement innovative approaches to promote healthy communities. In 2009, The Foundation funded a $50,000 grant to the Louisiana Primary Care Association (LPCA) to help support their initiative for member FQHCs to become NCQA recognized as Patient-Centered Medical Homes. This initiative built

on the FQHCs' strength as community-oriented providers of comprehensive care to go the next step to achieve and be recognized for fully coordinated, patient-centered care, and accountable for improving the health status of their patient population.

Health Homes

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

Granite State Health Plan's (GSHP) parent company, Centene Corporation (Centene), strives to stay on the cutting edge of health care delivery by constantly keeping informed of health care industry and government initiatives. GSHP has dedicated resources to support and aid in the development and implement state and federal government initiatives surrounding Health Homes (HH). GSHP is committed to supporting our contracted primary care providers (PCP) in delivering care with the "whole person approach" that is comprehensive, evidence-based, and culturally sensitive for their patients in coordination with specialists, facilities, ancillary providers, Centene health plan affiliates and the families or caregivers of patients.

Supporting the Health Home Model

Centene affiliate health plans have had experience with Health Home models at different stages of development. They have supported each of them by providing required resources and services that complement those provided by the Health Homes. For example, they may provide all care coordination services, or wrap around and coordinate with those coordination services provided by the Health Home itself. Smaller offices are more likely to require all care coordination services while larger ones already developing Health Home skills may only require supplemental services. In each state, we begin by assessing provider readiness and the state's willingness to partner with us.

Centene views Health Homes as an expansion of the Patient-Centered Medical Home (PCMH) model with increased emphasis on linkages to community and social supports, and the coordination of medical and behavioral health care, in keeping with the needs of members with co-morbid chronic conditions. Centene's health plans encourage network PCPs to become NCQA-recognized PCMHs and/or Designated Health Home providers through contracts with both preferred networks and individual Providers.

Provider Qualification Standards. In order for the HH program to be successful, each participating HH Provider must meet certain standards of care. The criteria listed below depict the minimum qualification requirements for each provider:

- Provider must be a credentialed, participating (contracted) health plan provider
- Provider must have extended access that may include evenings, weekends, same-day and urgent care

- Provider must have provisions for patients to receive 24 hour service beyond office visits (i.e., phone, email, online)
- Provider must have services specifically designed for patients with chronic conditions (outreach/educational programs, extended care staff)
- Provider must have an established system of communication across medical neighborhoods, hospital and emergent care
- Timely communication of patient use of ER
- Discharge planning and notification at the time of discharge
- Method of transition of care for referrals and transfer of care to a specialist including Mental Health/Substance Abuse (MH/SA) specialists
- Provider must be willing to work in a team oriented care delivery system
- Provider must be willing to provide/or have provided to patients education programs for his/her patients
- Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process

For its HH Program in New Hampshire, GSHP would also require providers to comply with any requirements not listed above but unique to New Hampshire for participation in its HH program.

Facilitation of Data Interchange. GSHP can assist HH providers and the development of HH through technology solutions to help them with workflow and operations. Our work plan templates will help providers with HH standards, and they will offer other resources such as a reminder postcard system, and documentation templates. In addition to having resources to help providers with these operational needs, GSHP has solutions to help with the exchange of health information. GSHP will be offering several HIT applications for their network providers.

Centene's secure **Provider Portals** offer tools that support PCMH and HH providers:

- **Online Care Gap Notifications:** web based alerts that notify providers of preventive care gaps
- **Member Panel Roster (Roster):** Displays all members under the PCP's or FQHC's care, with summary and detail information, including information on chronic or acute conditions on each member.
- **TruCare Service Plan:** an electronic copy of the member's care management service plan.
- **Summary Member Health Record (MHR):** a high level overview of the member most current claim activity including inpatient visits, emergency room visits, and provider office visits.
- **CenTraCare Clinical Portal (Clinical Portal),** which offers several functions necessary for effective HH operation (see Question 57 for more information).

In addition to above, we will supply our providers with a quarterly report that presents HEDIS based utilization measures (outpatient, specialist, inpatient, and emergency room) and preventive care information.

Centene's Service Support for Providers. GSHP wants providers to succeed in their quest to improve health care access and outcomes for their patients. Therefore, we augment the HH Provider's ability to deliver enhanced services for members by coordinating care through a number of our tools, services and personnel resources. We support their transition from traditional practice to HH by "wrapping around" their capabilities with services provided by our ICTs and with our CenTraCare package of information technology solutions. Our CenTraCare package includes decision-support; disease registry; performance tracking; risk assessment, prediction, and care gap identification; and care coordination functionality. Recognizing the impact of mental health and substance use on other chronic conditions and vice versa, Centene health plans educate PCPs on how to screen for, identify, and refer members with behavioral health conditions for services. We require PCPs serving as a Designated Provider to further integrate behavioral health treatment into their medical practices to include initial diagnostic assessment, development of a treatment plan, and monitoring and follow-up care. We also recruit and pay for PCPs to schedule regular onsite appointments at CMHCs serving as Designated Providers to provide coordinated care for members with severe mental illness (SMI), since these members are likely to be non-compliant with care for co-morbid medical conditions.

Integrated Care Teams. To complement and augment the capabilities within our provider network, Centene health plans employ integrated care teams (ICTs); a multi-disciplinary team comprised of registered nurses (RNs), behavioral health (BH) clinicians, social workers, Disease Management Health Coaches, and non-clinical Program Coordinators. ICTs ensure that members, often with multiple co-morbidities and changing needs, receive fully coordinated care.

Provider-based Support for Care Coordination. For FQHCs, CMHCs and other Health Homes with many assigned members, many of Centene's health plans embed Care Coordinators onsite to maximize cooperation with and support of the Health Homes' comprehensive care coordination.

Provider Performance Measures

Satisfaction Survey Results. GSHP plans to work with HH providers to develop performance measures using NCQA benchmarks, HEDIS scoring techniques and other outcome measures. Below are samples of the items we have deployed in other states for assessment and scoring. Metrics are dependent on provider specialty and area of focus. For example, adult metrics will not be used for Pediatrician.

Key Performance Metrics
Compliance with Clinical Practice Guidelines
Compliance with Medical Record Documentation and Advanced Directives Requirements
Key HEDIS Measures: Preventive Health; Adult Weight Screening and Follow-up, Respiratory Conditions; Diabetes Care; Cardiac Conditions; Mental Health Conditions; Musculoskeletal Conditions; Maternity Care; Use of Services
Member Grievances and Satisfaction Surveys
Key Non-HEDIS Measures: Flu Vaccine, Generic Prescription Fill Rates; Medication Possession Ratios; Post-partum Depression Screening; Semi-Annual Chronic Disease Maintenance Visits, Notification of Pregnancy (Centene

proprietary tool with demonstrated ROI)
Patient Safety and Quality of Care Events
Access and Appointment Availability

The HH Provider's performance score will also include results obtained from satisfaction surveys of members and/or their caregivers regarding their satisfaction with the level of service they received from their HH provider, their level of satisfaction with the quality of care they are receiving, and their level of satisfaction with their ability to access health care services.

Targeted Outcomes. Additional items to be measured to determine the HH Provider's performance score include perhaps the most critical areas where cost savings and patient utilization patterns can be measured against base year levels. Targeted outcomes will be measured for a variety of mutually agreed upon pre-established items, but would likely fall into 3 key categories:

- Emergency Room (ER) utilization and associated costs
- Hospital admissions/readmissions and associated costs
- Overall Health Benefit Ratios (HBR) and HEDIS measures

Monitoring Effectiveness of Health Homes

GSHP Quality Improvement (QI) and senior leadership staff will review performance measures monthly as described below. QA staff will report measures to our Quality Improvement Committee (QIC) quarterly for determination of needed modifications to any strategy. Our cross-functional Performance Improvement Team (PIT) also will analyze performance measures monthly, perform root cause analyses for measures that fall below desired performance, and make recommendations regarding interventions. In addition, the PIT will identify one area each quarter upon which all GSHP staff will focus interventions. The PIT will report recommended interventions to the QAPC. Annually, the QAPC with support from the QA Department and senior leadership staff, will conduct a comprehensive analysis of the effectiveness of our strategies as part of our annual QA work plan evaluation. Any modifications will be incorporated into the revised work plan.

EPSDT	• CMS 416 Screening Ratio • Well-Child Visits in the first 15 mos of Life (HEDIS) • Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life (HEDIS) • Adolescent Well-Care Visits (HEDIS)
Lead	• Lead Screening in Children (HEDIS)
Immunizations	• Childhood Immunization Status (HEDIS)
Children with Special Health Care Needs	• Children and Adolescent Access to Primary Care (HEDIS) • Appropriate Referrals to Specialty Care (evaluated through claims data and medical record review) • CAHPS Member Satisfaction Survey

Asthma	• Use of Appropriate Medications for People with Asthma (HEDIS)
Prenatal Care	• Prenatal and Postpartum Care (HEDIS) • Frequency of Ongoing Prenatal Care (HEDIS)
Dental Services	• Annual Dental Visit (HEDIS)
Behavioral Health	• Antidepressant Medication Management (HEDIS) • Follow-Up Care for Children Prescribed ADHD Medications (HEDIS) • Follow-Up After Hospitalization for Mental Illness (HEDIS)
Reduction of Inappropriate ER	• Non-emergent ER utilization per 1000
Reduction of Racial and Ethnic Health Care Disparities	• Evaluation of above noted HEDIS measures by race/ethnicity breakdown • Evaluation of member to PCP ratio for each racial or ethnic group encompassing at least 2% of our overall membership

PCP Utilization Monitoring. Since members with chronic conditions should see their provider at least every six months, GSHP will generate semi-annual reports to identify those who have not seen their provider in the past five months. GSHP will mail identified members a letter reminding them to schedule an appointment with their doctor. The letter will include the provider's name, address and phone number, with instructions for making the appointment. In some Centene health plans, members were incented through our CentAccount rewards program for engaging in these healthy behaviors.

Keeping Appointments. Providers may contact GSHP via the Provider Portal, e-mail or phone to inform us about members who do not keep appointments. A MemberConnections Representative will contact the member to reinforce the importance of attending appointments; assess and help address barriers such as transportation; and assist in rescheduling if needed. We will track the frequency of reported missed appointments over time. In addition, care coordination staff will routinely follow up with Members who do not keep scheduled appointments.

Care Management Strategy. GSHP will evaluate quality of care for those members with identified chronic conditions by collecting and analyzing clinical quality performance measures, utilization and medical audit scores. QA staff will work with providers who demonstrate consistent deficits on action plans to improve outcomes.

Non Emergency Transportation

Q59. Describe your process and procedures for coordinating and facilitating nonemergency transportation for your members.

GSHP's Provision of Non-Emergency Medical Transportation (NEMT)

For decades, NEMT management companies across the nation have demonstrated their important role in the overall delivery of health care services to the most vulnerable, needy and underserved Medicaid and Medicare beneficiaries in our nation. Managing this unique benefit along with developing and

managing a network of non traditional, non medical providers is challenging for every Medicaid program. The unique non medical aspects of NEMT programs also lend themselves to fraud, waste and abuse in the absence of diligent oversight and the resources needed to effectively manage such transportation programs. Historically, neither states nor health plans have been able to draw upon their internal expertise and resources to effectively administer its NEMT programs. For the New Hampshire DHHS program, GSHP has made the decision to subcontract the provision of NEMT services to Access2Care (A2C). A2C is a leading manager of medical transportation services and serves over four million beneficiaries of commercial insurers and various state governments. A2C is experienced in serving states with a high proportion of rural residents. A2C manages the fee-for-service Medicaid transportation programs for Idaho and Nebraska. In New Mexico and Alabama, A2C manages transportation for several Medicaid managed care organizations. A2C understands the unique challenges of rural communities and coordinating travel over long distances which makes them especially qualified to serve New Hampshire citizens. GSHP's parent company, Centene, utilizes A2C in its Florida and Texas markets. By subcontracting with an experienced transportation management company that is recognized as an industry leader, we expect to improve the quality of service to members, decrease complaints, and reduce any existing NEMT fraud and abuse in the State.

Collaboration with the State Coordinating Council for Community Transportation. In recent months A2C has met with members of the State Coordinating Council for Community Transportation (SCCCT) to explore potential areas of collaboration and partnership. It is the intention of GSHP and A2C to collaborate with the SCCCT and develop working relationships that not only enhance transportation for New Hampshire Medicaid beneficiaries but also for the community at large. We support the SCCCT's effort to streamline the delivery of transportation, increase the availability of resources and promote the delivery of needed services to at-risk populations.

NEMT Administrative Functions to be Subcontracted. With oversight from our Quality Assessment and Performance Improvement Committee (QAPI), GSHP is planning to subcontract the full array of administrative functions related to the provision of NEMT services to A2C. Below is the list of administrative functions and services to be delivered by A2C along with a brief description of each function:

- Call Center Operations
  - Establishment of toll free NEMT call intake number exclusively for GSHP Health Plan
  - Dedicated NEMT call center
  - Eligibility, Benefit, and Provider Verification
  - Scheduling of one-way and round-trip transportation
  - Selection of most appropriate, cost-effective transportation
  - Dispatch of trip assignments to NEMT providers
- Development of NEMT Provider Network
  - Lead verification through local and telephonic recruitment activities
  - Transportation Provider credentialing and re-credentialing
  - Contract execution
- Management of NEMT Provider Network
  - On-site vehicle inspections

  - NEMT Provider Training Programs
- NEMT Claims Management
  - Claims Processing and Reconciliation
  - NEMT payment and remittance advice to transportation providers
  - Submission of Encounter Data to Payor
- Quality Management Services
  - Development of transportation protocols exclusively for GSHP
  - Complaints Reporting and Management
  - Provider Report Cards
  - Member satisfaction surveys

Determining Appropriate Mode of Transportation. GSHP is committed to delivering the most appropriate and cost efficient mode of transportation for every member needing NEMT services. The process for determining the appropriate transportation resource for our members begins at the time the transportation request is made. Using a customized call script, the A2C Customer Service Representative (CSR) begins gathering information from the caller. After information has been obtained to verify the member's eligibility with GSHP, the CSR will ask a standard series of questions to ascertain whether the member has exhausted all other avenues for transport to their medical services prior to obtaining transportation through GSHP. Questions asked include:

- How has the member been getting to their medical appointments?
- How does the member get to other services (such as going to the bank, grocery store, church)?
- Does the member have a friend, relative or neighbor who can transport them?
- Does the member live near a bus route or similar public transit system?
- Does the member need any special assistance during the transport?

While asking these questions may seem redundant or unnecessary, doing so helps us to gain a clear picture of the member's access to care needs. A2C takes many precautions to ensure members are using these services only for the accepted and approved reasons. This is an important step to ensure all trips are for compensable services and is a part of the fraud and abuse detection process. Once benefit eligibility has been verified, answers to additional questions will guide the CSR to select the most appropriate mode of transportation. Below is a list of the types of questions asked to determine the most appropriate mode of transportation and level of service:

- Is the member ambulatory (unless otherwise known)?
- Does the member use a wheelchair (W/C), walker or cane? If yes, what is the extent of use (i.e. if W/C, does member use it all the time)?
- What type of medical service or treatment is the member receiving?
- Are there steps/stairs at the pick up or drop off locations?
- Is the member able to transfer into a sedan type vehicle?
- What type of wheelchair does the member have (i.e. extra-wide, electric, Geri-chair, scooter)?
- Does the member need to be accompanied to their medical appointment?
- Will the member need a vehicle that has additional safety equipment (i.e. safety restraints, safety locks for members prone to jumping out of the vehicle)?

During the entire telephone call, the CSR documents questions asked and answers given in the member's electronic file. All calls are digitally recorded and can be pulled for review as needed. Once complete information regarding the member's ambulatory abilities and their medical care needs is obtained, the CSR is then able to make arrangements for the most appropriate level of transportation while the member is on the telephone. If the member is receiving treatments for an extended time period (i.e. chemotherapy, dialysis) every effort is made to select the same transportation provider for the member's prescheduled trips.

Recurring, Complex and Long Distance Transportation. GSHP will require "Notice of Transportation" for trip requests in excess of 50 miles one-way, for rides to recurring services (such as dialysis, chemotherapy), and when higher modes of transportation is needed (i.e. wheelchair van, stretcher van, bariatric transport). The Notice of Transportation requirement serves as a safety net to ensure that our care management teams are fully aware of the transportation needs of members undergoing frequent or ongoing treatment, who are traveling long distances for care, or who have (previously unidentified) mobility issues. The Notice of Transportation requirement functions as a timely notice to the Care Coordination team that engages them in further assisting the member and ensuring their access to health care services is unimpeded.

How GSHP Will Encourage Public Transportation. GSHP and A2C will make every effort to encourage use of available public transit in New Hampshire for GSHP members. As a matter of course, A2C participates in local and regional transportation organizations whose missions are to provide a community of education, communication, and advocacy in which their members can improve public transportation services. Through participation with these organizations, A2C has continued to build a firm understanding of non-emergency medical public transportation needs and services in the numerous areas they serve. A2C also has established liaison relationships with transit agencies to ensure they receive updated information on available routes and timely trip-planning advice for member's trips. Using current fixed-route maps and data from these public transit systems and preprogrammed business logic enables the A2C scheduling platform to determine the most efficient and cost-effective trip options.

Determining Member Eligibility for Public Transit. Using customized transportation protocols, A2C will have built-in thresholds that help to identify members who are eligible for public transit services. In addition to asking the series of questions listed herein, the CSR will confirm the member's address and his/her status as an ambulatory individual by asking an additional series of questions designed to further determine whether public transit is appropriate for the member. Once all public transit eligibility check points have been verified, the CSR will then advise the member that they are eligible for the public transit program in their area and will receive public transit passes to use for their NEMT needs. If the member meets all of these requirements public transportation will be scheduled and the member will receive the appropriate passes or tickets. If the member states that they believe public transportation is not appropriate based on their physical condition, A2C will fax a physician confirmation form to the member's physician so that they may determine the appropriateness of mass transit considering the member's specific needs and medical condition. The physician will complete and return the signed form to A2C. This will relieve both members and case managers from the responsibility of obtaining that information. If the physician advises that the member can use public

transit, then A2C will assist the member with using public transit. Otherwise, A2C will assign an ambulatory/livery provider for the member.

Advance Notice and Reports. Members are asked to provide at least 5 days notice prior to their appointment in order to ensure that the passes arrive prior to their trip. In some cases A2C will use express mail options to assure timely delivery of passes. A2C will report these trips to GSHP via monthly reports and encounter data.

GSHP Pick Up and Delivery Standards. GSHP will require A2C to incorporate DHHS pick up and delivery standards in its NEMT program and will include these standards in its NEMT policies and procedures. GSHP will also include DHHS pick up and delivery standards within its contract requirements for A2C and will require pick up and delivery standards to be incorporated into A2C's agreements with transportation providers. Drivers are required to pick up members within one hour of their scheduled appointment. This time may be increased for long distance trips as needed. Delivery to the appointment site should be no more than one hour prior to the scheduled appointment. Upon completion of the appointment, the member should be picked up within one hour of placing the call for their ride home.

Transportation Provider Training. GSHP will require A2C to train all transportation providers and drivers regarding pick up and drop off standards. Training will occur during initial orientation sessions held on site for new drivers and transportation providers. NEMT Operation Manuals will be distributed to all contracted transportation providers and will contain the written pick up and delivery standards. Additionally, pick up and delivery standards will be posted on GSHP's provider portal, not only for NEMT providers, but for members and health care providers as well. A2C will train all drivers on the proper procedures to follow when picking up and dropping off a member, which includes calling the member within 24 hours of the trip's occurrence to reconfirm the pick up time and address and to remind the member to be ready at least one hour prior to their appointment time. When the member is delivered, drivers are required to give the member a card that has the NEMT provider's telephone number on it and to instruct the member to call that number once their appointment is completed for their ride home. To aid in ensuring a satisfactory transportation experience for all, members will also receive training and reminders regarding their role in timely pick up and delivery. At the time of trip set up, the CSR will advise the member to be ready for their ride at least one hour prior to their appointment (or sooner if it is a long distance trip). The CSR will also advise the member that the assigned NEMT provider will call to confirm pick up time and address within 24 hours of the trip's occurrence. The CSR will also advise the member what to do if they need to cancel or reschedule their ride or if the driver is late. By including members in the overall education of the NEMT program standards regarding pick up and delivery timeframes, we promote a satisfactory experience for the members, their health care providers and assist the NEMT providers in delivering timely, safe and excellent customer service to our members.

Transportation Provider Performance Monitoring. A2C monitors pick up and delivery practices and measures performance in several ways. Real time monitoring is facilitated through its call center. If a "Where's my ride" call is received, the CSR immediately documents the call in the A2C scheduling platform. The CSR will further assist the caller by contacting the transportation provider to inquire about the trip in question and to communicate the trip status to the member (for example, driver stuck in traffic but will be there within 10 minutes). If warranted, the CSR will schedule another

transportation provider for immediate pick up of the member. A2C also monitors pick up and delivery practices by individual NEMT providers through *Member Satisfaction Surveys*. Within the surveys, several questions pertain to the member's experience regarding a past trip, including whether the driver was on time for both parts of the trip. NEMT providers must report actual pick up and delivery times via electronic claims submission process. These reported times are then aggressively audited prior to payment of a claim. *Provider Report Cards* are prepared and distributed to NEMT providers each month. The Provider Report Cards are formatted to give meaningful and actionable feedback to the NEMT provider on all areas of services including on-time performance,member satisfaction, complaints as a ratio of trips completed, and provider no-shows. Using URAC (Utilization Review Accreditation Commission) performance metrics as a guide, NEMT providers must score 95% or better to be considered within compliance. The Provider Report Card is an effective tool for improving driver behaviors for all areas of performance. These reports demonstrate to the transportation providers the sincerity of our expectations and our commitment to assisting the transportation providers to succeed in their efforts to provide the utmost in quality transportation services to members.

Transportation Provider Compliance. In the event a *NEMT provider* falls below established performance thresholds, A2C will develop a Corrective Action Plan (CAP) in order to give the provider the opportunity to improve performance prior to removing them from the network. The CAP may include limitations to the number or types of trips assigned to the transportation provider. It may include specific requirements regarding driver training or vehicle maintenance expectations along with other items to address specific performance inadequacies. The CAP may be developed by GSHP's Quality Assessment and Performance Improvement Committee (QAPI) or A2C. If information or a complaint involving possible criminal activity or serious unsafe driving (i.e. drunk driver, accident) is received, A2C will immediately cease to assign trips to the NEMT driver in question and reassign existing trips while the complaint or situation is under investigation. If *A2C's* oversight performance falls below GSHP's established performance thresholds, we will develop a CAP. GSHP will comply and will require A2C to comply with applicable DHHS provider performance standards. Failure to meet certain NEMT performance standards may lead to sanctions until performance levels are within compliance, or termination of the transportation agreement, and will be specified in the agreement between GSHP and A2C.

How GSHP Will Ensure Vehicle Safety. Regularly scheduled, annual inspection of every vehicle in every NEMT provider's fleet is required for initial and ongoing participation in the GSHP NEMT provider network. Vehicle inspections are conducted by qualified A2C staff. Initial vehicle inspections are conducted during the credentialing phase of the provider contracting process. All vehicles must pass inspection in order for the provider to be credentialed.

Comprehensive Safety Inspections. To ensure safe, well-maintained vehicles are used to transport members, A2C requires documentation of a "passing" score after conducting a comprehensive inspection of each sedan, van and wheelchair vehicle used to transport members. Additional certification and safety equipment required in every vehicle includes, but is not limited to:

- an active vehicle registration for the vehicle
- a valid vehicle insurance card for the vehicle
- a supply of accident/incident report forms
- a First Aid kit

- a Spill kit (liquid spill absorbent, latex gloves, disposal bags, etc.)
- Child safety seat, including booster seat, where appropriate

All wheelchair vehicles must meet the Americans with Disabilities Act (ADA) regulations. Such added regulations require wheelchair equipped vehicles to have:

- access doors with greater width to accommodate a wheelchair and attendant
- higher floor-to-ceiling headroom
- hydraulic lift mechanisms that require the driver to engage the engine-wheelchair lift interlock system (an important safety feature)
- a metal mesh/non-skid plate and reflector tape at the end of the lift ramp
- a sturdy lift
- a sturdy safety rail, manual ramps or walk-on board
- operational lift controls that are accessible from inside and outside the vehicle
- four forward facing functional floor straps

Upon completion of the inspection, the vehicles receive a pass, provisional or fail score. Any vehicles receiving a fail score must be removed from service until repairs are made and the vehicle passes re-inspection. Inspection forms are kept on file and are available for review by GSHP or DHHS.

Additional Monitoring of Vehicles. Another tool A2C uses for gathering information regarding vehicle safety is the *Member Satisfaction Survey*. The Member Satisfaction Survey contains a Vehicle Assessment section with a series of questions to capture the member's impression of the vehicle's condition. Examples of questions regarding vehicle condition include:

1. Was the heating or air conditioning working properly in the vehicle?
2. Was the vehicle clean on the inside?
3. Did the vehicle have working seat belts?
4. Were the vehicle windows intact and in good condition?
5. Was the company name visible on the outside of vehicle?

From time to time, a *complaint* may be filed by a member regarding the vehicle's condition. If the GSHP call center receives this or any NEMT-related complaint, the issue is tracked and immediately reported to A2C for follow up and resolution. If the complaint presents a safety issue (e.g. seatbelt not working), A2C personnel will conduct an on site inspection of the vehicle in question and proceed with the implementation of corrective actions as warranted by the results of the inspection. Such action may include immediate removal of the vehicle from service and the development of a corrective action plan. Additionally, A2C's Field Monitor, who is assigned to serve a particular "territory" of NEMT providers, may conduct surprise inspections at any time if he/she suspects a vehicle safety or maintenance issue or is notified that a problem may exist. Regardless of the technique used to uncover vehicle safety practices, each complaint, inquiry and action is documented in the provider's file and reported to the QIC at least once per year.

How GSHP Will Ensure Driver Quality. A2C's credentialing process for NEMT providers ensures driver quality by applying the same credentialing criteria and standards for each NEMT provider, their drivers and their vehicles. For acceptance in the GSHP NEMT provider network, each driver must meet or exceed the following standards:

1. GSHP reserves the right to disallow any driver from performing services under the Transportation Agreement between GSHP and its subcontracted transportation manager.
2. Each driver must be legally licensed by the State of New Hampshire
3. Each driver must be at least 21 years of age.
4. Each driver shall receive training within 30 days of assignment to perform services under the Transportation Agreement with GSHP or its subcontracted transportation manager, for defensive driving, first aid, CPR, "spill kit" use, biohazard removal, passenger assistance, safety and cultural competency training. Each driver shall also attend additional training sessions for ongoing safety and cultural competency.
5. Each attendant shall receive training within 30 days of assignment to perform services under the Transportation Agreement with GSHP's subcontracted transportation manager, for first aid, CPR, passenger assistance, safety and sensitivity training.
6. Each driver must be competent in his or her driving habits.
7. Each driver must be courteous, patient and helpful to all passengers.
8. Each driver must be neat and clean in appearance.
9. Each driver has had less than two (2) chargeable accidents or moving violations in the last year.
10. Each driver has no prior convictions for a substance abuse, sexual crime or a crime of violence.
11. Drivers who are known abusers of alcohol or drugs that would endanger the safety of members are not permitted. If the NEMT provider suspects a driver to be driving under the influence of alcohol drugs that would endanger the safety of members, the NEMT provider shall immediately remove the driver from providing service.
12. Any individual who has had within the past three (3) years or currently has a suspended or revoked driver's license (commercial or other) is prohibited from driving for any purpose.

The list above will be extended or augmented to include DHHS requirements and other requirements deemed appropriate as part of its NEMT provider credentialing program. Driver quality is also ensured through ongoing monitoring of driver performance using data collected from complaint reports, provider report cards, corrective action plans and information collected from Provider Relations, Member Services, and QM staff.

Driver Training Programs. GSHP and A2C require each driver to attend a driver training session conducted by the contracted and credentialed NEMT provider. A2C's driver training program helps drivers to understand how their role is integral to the delivery of health care services for our members. Topics covered during the *initial driver training session* may include company and DHHS overview, explanation of NEMT benefits, trip assignment and scheduling procedures, dispatch requirements, driver service standards and communication requirements, quality assurance, monitoring and dispute resolution programs, basic first aid, and defensive driving techniques. Materials distributed to drivers during the training session include handouts of the driver training program topics, defensive driver informational materials and handbooks, previous NEMT provider newsletters, and the Provider Operations Manual. A2C provides additional driver training via its web portal that covers topics related to the unique transportation needs of persons with disabilities. These helpful training programs describe tips and techniques for helping a person from a bed or chair into a wheelchair and from a wheelchair into and out of a vehicle. The online driver training programs also express the importance of treating each passenger with dignity and respect and teaches drivers how to effectively communicate with individuals who have special needs or are cognitively impaired. Because there are

sometimes frequent changes in drivers, we conduct *driver training programs on an ongoing basis.* **Call Center Requirements for NEMT Program.** Our goal is seamless access to transportation services for our members through the GSHP Member Services call center, which enables quick connection to the A2C call center. Adding a transportation prompt to the existing toll free Member Services telephone line will be an easy and efficient way for members to navigate through the customer service menu and will facilitate quicker scheduling of their transportation by A2C. A2C can examine, aggregate, and report vital telephony data such as talk time, call volumes, speed to answer and call abandonment rates. Standard and ad hoc call center performance reports are prepared and delivered to clients in accordance with contractual requirements. For New Hampshire, GSHP will require A2C to adopt the DHHS call center performance standards, which are described below:

Call Center Activity	DHHS Performance Threshold
Calls answered by a live person	≥ 90% of calls answered within 30 seconds
Average Speed of Answer	≤ 30 seconds
Average Calls Abandoned	≤ 5 %

GSHP will require the same call center performance standards of its NEMT program as is required for any other type of call made to our Member Services center.

NEMT Quality Improvement Program. GSHP's Quality Improvement (QI) Program was developed using NCQA guidelines. However, NCQA does not extend accreditation for NEMT programs, providers or program managers. Due to the unique, non-medical nature of the benefit and the providers, the development of a sound accreditation process for NEMT has been slow, but appears to be gaining speed. Our Quality Improvement Program for NEMT services will incorporate specific DHHS requirements for performance, oversight and outcomes and will be developed in collaboration with A2C. Key components of the NEMT Quality Improvement Program are outlined below.

A. Tracking and Reporting Key Performance Metrics

- Call Center Performance – metrics measured include call volumes, call duration, speed to answer, abandonment rates
- NEMT Provider Performance – metrics measured include, but not limited to, on time performance, complaint rates, passenger satisfaction (via Member Satisfaction Surveys), vehicle maintenance
- Driver Performance – metrics measured include on time performance, complaint rates, training and certifications
- Complaint Management and Reporting – metrics measured include complaint rates by provider and call center, complaint type, complaint severity, resolution rates, CAPs

B. Report Preparation and Distribution

- Call Center Statistics – reports prepared and delivered monthly or more frequently per client requirements
- Trip Volume Report – delivered monthly or per client requirements
- Complaints Resolution Report – delivered monthly or per client requirements

- NEMT Provider Report Cards – delivered monthly

C. Conducting Surveys

- Members – conducted at least annually or per client requirements
- NEMT Providers – conducted annually or per client requirements
- Health Care Providers - conducted annually or per client requirements
- Clients - conducted annually or per client requirements

D. Training and Ongoing Service Support

- Call Center staff – training conducted for new staff and ongoing training for existing staff
- Drivers – for new drivers and ongoing training for established drivers
- NEMT Providers - for new NEMT providers and ongoing training for established providers
- Operations Manuals – updated at least annually and distributed to all contracted NEMT providers

E. Credentialing and Recredentialing

- Drivers - must have/pass necessary licensure, certification, and background checks
- NEMT Providers - must properly maintain vehicles and conduct appropriate business practices
- NEMT Providers and Drivers - must implement mechanisms to protect PHI (Protected Health Information)
- A2C – must demonstrate commitment to quality through URAC accreditation

F. Information Security

- HIPAA Compliance – required in all operational areas and for all system functions for A2C, NEMT providers and drivers and applicable employees, business associates and subcontractors
- Protecting Member PHI – required in all operational areas and for all system functions for A2C, NEMT providers and drivers and applicable employees, business associates and subcontractors

G. Risk Management

- Field Inspections – all vehicles and driver records undergo on site inspection
- Trip Audits – conducted routinely and compared against claims and reservation records to uncover fraud and abuse
- Accident and Incident Disclosure – all drivers must report accidents or incidents and are trained on procedures to follow

The Quality Improvement program for NEMT services is extensive and addresses every operational area within the GSHP and A2C organizations. Policies and procedures will be customized and implemented in accordance with DHHS requirements for NEMT standards and performance measures. With this partnership, we will have a quality NEMT program that will ensure access to care for our members throughout the state of New Hampshire.

Substance Abuse Benefits

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

Overview of Experience

GSHP through its behavioral health subcontractor, Cenpatico brings a wealth of experience managing substance abuse benefits through Medicaid as well as other state funded programs, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol endorsed by SAMHSA. Cenpatico is responsible for managing and coordinating mental health and substance abuse treatment services for Medicaid programs in 10 states and for state funded programs in Massachusetts. Our experience also includes managing services offered through state funds such as Substance Abuse Prevention and Treatment (SAPT) grants. We endorse the 12 principles addressed by SAMHSA for treating co-occurring disorders and recognize that all behavioral health settings should be prepared to address both substance use and mental health. Centene and Cenpatico's provider networks across the country offer **multiple access points for seeking, engaging and maintaining treatment, ensuring "no wrong door" for members** whether that is through the PCP, a behavioral health provider or through a substance use disorder specialty provider. In our experience, it is most effective for services to be provided in an integrated fashion that respects the individual and their recovery needs.

Engagement is the key to recovery from substance use disorders (SUD). Our approach includes a range of easily accessible services, engaging and retaining members in treatment, and evidence-based practices and innovations. In most areas where we do business, we offer a continuum of services to address changing needs, including medical detox, residential treatment, Methadone and Suboxone treatment, intensive outpatient and outpatient treatment, and peer and employment services.

In our Arizona market, for example, Cenpatico has presented SBIRT tools to emergency department (ED) personnel regarding using the SBIRT protocol, billing for SBIRT services, cost savings, reasons for using the SBIRT protocol and offering assistance on developing policies and procedures related to SBIRT implementation at 5 area hospitals. Additionally, Cenpatico's membership across the country includes recipients who are homeless, involved in the criminal justice system, with co-occurring MH disorders, and at-risk populations. In some areas these individuals also have access to SUD care through Substance Abuse and Prevention Treatment Block Grant (SAPT) funds, which Cenpatico is responsible for allocating based on priority populations, historical expenditure analyses and regional needs. SAPT services include social detox, treatment, community outreach and HIV education and testing. We tailor our approaches to special populations including: evidence-based gender-responsive treatment, such as treatment for women in the criminal justice system that focuses on stabilizing them in the community; our programs targeted for adolescents that provide outreach to juvenile detention centers, parole and probation departments and remote regions; social detox facilities to offer adolescents community-based aftercare and intensive outpatient treatment; and our Community Re-entry Program that evaluates inmates and those on probation/parole for SUD, housing, employment and other needs to develop a plan to maintain them in the community.

We bring more than coordination experience for substance abuse services. We bring wealth of experience managing and providing it. Cenpatico's success in helping members to engage and maintain adherence to substance abuse treatment plans. In 2009 the Arizona Auditor General report found that our Geographic Service Area 2 had the **highest treatment completion rate** and lowest non-completion rate of all non-Tribe Regional Behavioral Health Authorities.

From our experience, we have developed policies and **procedures that are readily adaptable for the expansion of substance abuse providers in New Hampshire which will enable more individuals to get access to services.** It is our practice to inform members, providers and communities about services available in their community and our 'no wrong door' approach. These communications happen through care management and coordination, member/provider materials, our website, and collaboration with providers and community stakeholders. In other areas, we have worked with providers and peer support staff to develop protocols for outreach to meet members wherever they may be, and engage them in treatment.

Cenpatico's programs across the country bring to New Hampshire experience with best practices for substance abuse treatment. In other markets, our affiliate's staff have **trained and delivered technical assistance to provider clinical staff on evidence-based practices** such as SBIRT, Matrix Model, ACRA model, Contingency Management and Motivational Interviewing. Through our care management and network management processes, we will ensure that our network providers engage members with substance use disorders in comprehensive treatment and service plans that include coordination with qualified addictions treatment providers.

Delivering Comprehensive Substance Use Treatment

Engagement is the key to recovery from substance use disorder (SUD). Our approach includes a range of easily accessible services, engaging and retaining members in treatment, and evidence based practices and innovations. Our goal is to engage the member in the most appropriate and least restrictive level of care and to improve outcomes. As part of our commitment to improving outcomes for members our regional Integrated Care Teams will outreach and seek to engage all members with substance use disorder to ensure care planning and service needs are being met. We will work with SUD providers to ensure that members have access to care and are engaged in services, including access to appropriate step-down services such as intensive outpatient services and Peer Support services which can be included in the individualized treatment plan to facilitate recovery in the least restrictive environment.

Easily Accessible Services. For individuals with substance use disorder (SUD), making the right services available at the moment they are ready to make a change is critical. Research points to a high prevalence of substance abuse presenting in Emergency departments (ED).14 As we have done in other programs, Cenpatico UM and Integrated Care Team (ICT) staff will work with the EDs and other providers to implement SBIRT protocols for early identification and referral strategies when members

[14] Smothers, B. A., Yahr, H. T., & Ruhl, C. E. (2004). Detection of Alcohol Use Disorders in General Hospital Admissions in the United States. Arch Intern Med, 164, 749-756.

present with either a primary or secondary diagnosis of SUD. The sooner our ICT staff can engage the member in active care planning, the better likelihood of continuation with treatment. In 2010, we implemented the best practice, Contingency Management strategy, through our CentAccount ™ Healthy Rewards debit card program. This program offers financial incentives to members who continue care and maintain sobriety. Programs like this and our 'no wrong door'approach to accessing services will be outlined in our member/provider materials, our website, and community outreach campaigns in collaboration with community and agency stakeholders.

Our Integrated Care Coordinators work in tandem with other ICT team members to ensure the environmental supports, such as housing, vocational training, child care and support groups that a member needs to maintain their sobriety are in place.

Best Practices and Accountability. GSHP and Cenpatico will continue to support and enhance SUD programs that are based on best practices and evidence-based practices such as SBIRT, Matrix Model, ACRA model, and Motivational Interviewing. When deficiencies are noted within the network, as we have done in other programs we will offer training to providers on SBIRT or other appropriate evidence based practices. Our Quality team monitors access for all services including SUD, through appointment availability call audits to ensure that all persons requesting SUD services receive a screening. We collaborate with stakeholders to address the unique prevention and cultural needs and resources of each community and tailor our approaches accordingly. In other areas we use evidence-based gender-responsive treatment, such as treatment for women in the criminal justice system that focuses on stabilizing them in the community while our REACH program for adolescents outreaches to juvenile detention centers, parole and probation departments and remote regions. Social detox facilities offer adolescents community-based aftercare and intensive outpatient treatment and our Community Re-entry Program evaluates inmates and those on probation/parole for SUD, housing, employment and other needs to develop a plan to maintain them in the community.

Integration with Primary Care. GSHP recognizes that creating an integrated service delivery system is not a one step process and will involve planned activities a monitoring to shape the system. To build on New Hampshires's current initiatives towards integration and high quality substance use disorder services, we will offer trainings to PCPs, ED's and other providers on how to use the SBIRT protocol and screen for potential BH/SUD conditions. We collect data from providers to determine the level and extent of need for training and concrete resources such as tools, educational materials, referral assistance, etc.

Risk of Co-Occurring Diagnoses. Achieving an integrated system of care requires screening for cooccurring diagnoses at every opportunity. A recent study by the Center for Health Care Strategies, Inc.15 identified 13 medical diagnoses that have a high risk for co-occurring mental health and/or substance use diagnoses. GSHP's Ingenix ImpactPro predictive modeling program will utilize combined PH, BH and pharmacy data to identify patients who should be screened for BH/SUD services because of primary diagnosis, co-morbidities or complex, chronic diseases with a high incidence of BH and substance use issues.

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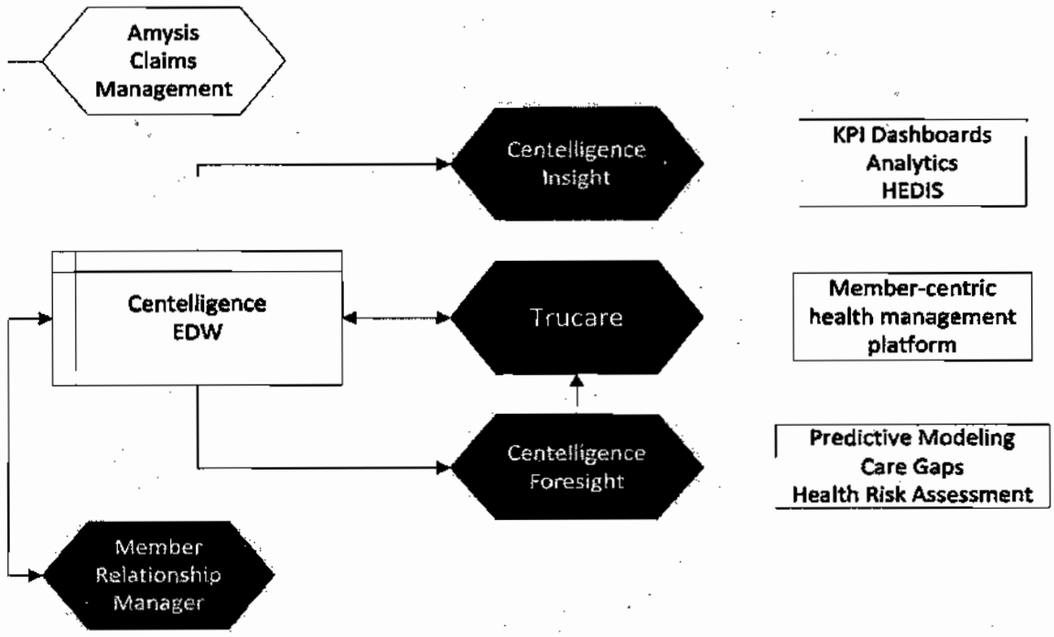
[15] Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations; Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin, and Lorie Martin December 2010

Cenpatico's behavioral health clinicians on the ICT will collaborate with the PH providers, as appropriate, and include them in the development and implementation of interdisciplinary care plans whenever possible to ensure holistic care for members. GSHP will work with BH/SUD providers and PCP's to ensure HIPAA compliance for release of member protected health information, and as applicable provide discharge summaries from BH/SUD acute care events to both primary care and BH/SUD outpatient providers to ensure a consistent approach and support positive outcomes.

Data Sharing and Integration to Promote Care Coordination for Members with Special Needs

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).

GSHP ensures integrated and GSHP for special needs members through a Care Management Program that provides access to preventive, primary, specialty, and acute services, as well as coordination with behavioral health (BH) services and community resources. However, our Program goes well beyond standard case management in two important ways. *First,* we use a multidisciplinary Integrated Care Team (ICT) model that maximizes integration of covered and non-covered services by co-locating physical and BH Case managers, support staff and Nurtur's Health Coaches in the same office space. *Second,* Our technology solutions support integration between the ITC and Providers by making all information about each member's needs and services available to all clinical staff interacting with the member. For members with special needs, this high degree of comprehensive data sharing allows for truly comprehensive integrated care.



TruCare. Both GSHP and Nurtur care coordination staff use the TruCare Clinical Management System. TruCare is integrated with McKesson's InterQual evidence based clinical decision support criteria and standard assessments and customized care plans for the member, with stratification of risk for tracking and reporting information. ICTs are able to holistically manage each Member's unique needs. With each interaction, such as a request for services, or need to update the system on progress in obtaining services or care plan status, GSHP staff will be able to update the TruCare system to reflect any new information or updates to the Member clinical profile. The ability to house the most up-to-date information available will allow the ICT and the Providers accessing the Portal to address the Member's needs in the most effective way possible.

Member Relationship Management (MRM) System. Our MRM supports our member interactions and case management activities. A Case manager can use MRM to alert Member Services staff to their need to speak with a Member we have been unable to reach by phone to discuss an identified care gap. When the Member calls our Member Call Center, our Member Service Representative (MSR) can see that the Case manager needs to talk with the Member when they pull up the Member record, and will provide a warm transfer to the Member to the Case manager.

Provider Portal. From a clinical perspective, our secure Provider Portal offers features and clinical care information to support a truly integrated care model that promotes care coordination for members with special needs. Clinical information for our Provider and Member Portals is provided through our Centelligence™ platform. Centelligence™ is our award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions. We will make our Provider Portal available to our GSHP Providers *including behavioral health and other specialty care providers.*

Our secure Provider Portal supports Network Providers in performance of office administrative functions such as transaction services online via the internet, check Member eligibility, submit

authorization requests, submit batch HIPAA claims and/or supporting attachments and documentation, enter claims online, view explanations of payment (EOP), register for electronic payment (EFT), and a variety of other functions. Incorporation of these administrative features creates added value for providers that promotes provider usage of the portal and thereby increases the richness of the data and the ability of providers and ICT staff to have complete, accurate and timely member information with which to make care and support decisions. *We will require written authorization from the member prior to releasing this data to any provider to ensure compliance with all HIPAA mandates.*

Emergency Care Record. Any provider with Provider Portal or Clinical Portal access will be able to view our Emergency Care Record (ECR) that contains a subset of information from the Member Health Record (see below). This record will enable emergency rooms, urgi-care centers and on-call providers to have access to content specifically focused on the most vital information for a provider who is otherwise unfamiliar with the member allowing for accurate assessment and treatment and eliminating the need to duplicate testing and provide uncessary services.

Clinical Portal and Member Health Records. In addition to Provider Portal access, ***all authorized*** network Providers will also have access to our Clinical Portal. The Clinical Portal builds on the administrative functionality of the Provider Portal to deliver a set of clinically-oriented informational tools to the Provider.

- When a Provider checks member eligibility through the Provider Portal, the Provider is notified of important member medical considerations via our ***Online Care Gap Notification*** (OCGN). Our Centelligence™ Foresight predictive modeling system identifies preventive care gaps by analyzing medical, behavioral, and pharmacy claims data, health risk assessment information, lab test results, and other information housed in our Enterprise Data Warehouse (EDW). Our OCGN feature automatically presents these care gaps whenever the Provider views Member eligibility.
- The Clinical Portal allows Providers to view a Member's TruCare Service Plan. The TruCare Service Plan displays the Member's identified health problems, treatment goals and objectives, milestone dates, and progress in an engaging, well-organized online format. The TruCare Service Plan also serves as a Discharge Plan in cases where this is needed.
- Member Health Record (MHR). This online summary Member Health Record (MHR) offers a well organized view of a member's care gaps as well as a cursory clinical "face sheet", along with other clinical detail information, for each member for whom we have supporting data. Our MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in our Enterprise Data Warehouse (EDW).
- Our Clinical Portal also houses evidence-based Clinical Practice Guidelines, customized for the health considerations of our DHHS Plan Member and designed to support clinical best practices.
- Our overarching objective with our clinical portal is to give the Provider a *holistic view* of the Member's health care experience and support the concept of care accountability that is central to an integrated care delivery model.

Our portal complements provider electronic medical record systems and we will seek opportunities to integrate and exchange relevant data with Health Information Exchanges, such as those recognized through New Hampshire's Health Information Exchange Planning and Implementation Project.

Appointment Scheduling. For special needs population, getting provider appoints can be difficult, expecially when there is a sudden need or change in condition. When a member contacts GSHP via phone, or secure messaging from our Member Portal, the GSHP Member Services Representative (MSR) can use our HL-7 SIU equipped Member Relationship Management (MRM) system application to determine provider availability and book an appointment for the member directly into the provider's HL-7 SIU compliant appointment scheduling software. For network providers: if the provider uses an appointment scheduling system as part of their practice management software and that appointment scheduling system supports the HL7 Scheduling Information Unsolicited (SIU) data exchange standard, we will support systematic appointment scheduling from GSHP's. Further, after the appointment is scheduled on the provider system, the appointment data will be captured in MRM, allowing MRM to notify the member that the appointment has been booked and the date and time of the appointment.

Experience Managing Listed Disease States

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.

Centene health plans and our affiliate, Nurtur Health Inc (Nurtur) partner to provide comprehensive disease management programs to positively impact the lives of our members with chronic conditions, including asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and Chronic Obstructive Pulmonary Disease (COPD). In addition to those listed above, we have disease management programs that address hypertension and hyperlipidemia, chronic kidney disease, back pain, depression, and tobacco dependency.

Nurtur has been a leading innovator in disease management since the mid-1990s, offering best-in-class programs for chronic conditions such as asthma, diabetes, and cardiovascular diseases. Since its inception, Nurtur has implemented disease management programs in over 60 markets, both urban and rural. Nurtur currently serves approximately 1.8 million Medicaid health plan members in twelve states as well as commercial employer, union and health plan clients covering over 2.5 million eligible lives. Nurtur has experience working with diverse Medicaid populations including SSI members who are facing multiple co-morbid conditions, including both medical and behavioral health diagnoses. Nurtur has significant experience in applying respiratory, diabetes, and cardiovascular disease management principles to improve care and support to Medicaid, CHIP, and other low income populations. All of Nurtur's programs are NCQA and URAC accredited. In addition, Nurtur has the distinction of being the first health management organization to receive H-TAP (Healthcare Transparency Accreditation Program) Accreditation from the Population Health Impact Institute for the five chronic disease management programs listed above, demonstrating its commitment to quality and transparency in its

outcomes reporting. Nurtur's philosophy is built around alignment, innovation, integration, implementation and reinforcement – components common to all successful organizations – and they have been recognized by a series of awards including:

- C. Everett Koop award for Nurtur's heart disease management program
- Top 10 Disease Management companies by Health Industry Research 2000-2006
- National Health Information Awards from the Health Information Resource Center, including Gold Recipient in the E-Health Care Category in 2006, and most recently, in September 2011, Nurtur received two bronze awards for its *TransFormations* newsletter and Living Color communications campaign and a merit award in the Logo Design.
- 2011 Silver Award in the Portal/Gateway Site category from the 13th Annual Web Health Awards(SM)
- 2011 National Environmental Leadership Award in asthma management by the United States Environmental Protection Agency

We identify eligible members with chronic conditions by data-mining all available member information, using predictive modeling, and persistently pursuing newly enrolled members for health risk screening to achieve early identification of members with or at risk for chronic conditions or co-morbidities. A key focus for us is to ignite in each member the behavior changes needed to improve health status and we do this through Health Coaches. Each member participating in the program works with an assigned Health Coach to establish both short and long-term goals that include modifying unhealthy behaviors. Each targeted condition has condition-specific measurable goals that allow us to measure the effectiveness of the program. One or more evidence-based guideline supports each targeted condition.

Health Coaches function as part of our multidisciplinary Integrated Care Teams that use a person-centered approach and frequent, ongoing collaboration to ensure that the member's medical, behavioral and socials needs are addressed. All identified members receive an introductory mailing of program and condition-specific information, and an Initial Health Assessment. Those at moderate or high risk then receive a comprehensive Baseline Assessment including an assessment of their readiness for increased self-management. Based on this information, Health Coaches stratify members to appropriate levels of intensity of intervention and develop self-management plans with the members.

Asthma

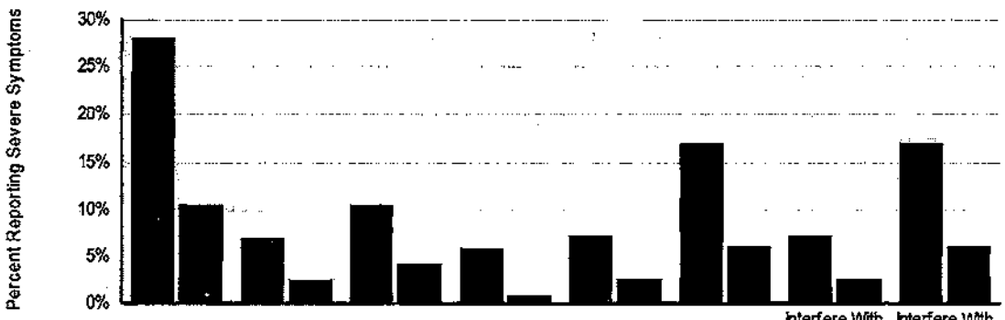
The goals for Centene's Asthma Management Program are:

- Reduce the need for rescue inhalers
- Reduce asthma-related emergency room visits and inpatient admissions
- Increase use of long-term controller medications
- Achieve improvement in control and understanding of disease
- Improve quality of life

- Promote member adherence to treatment guidelines and improve self-management skills to control asthma and optimize quality of life.

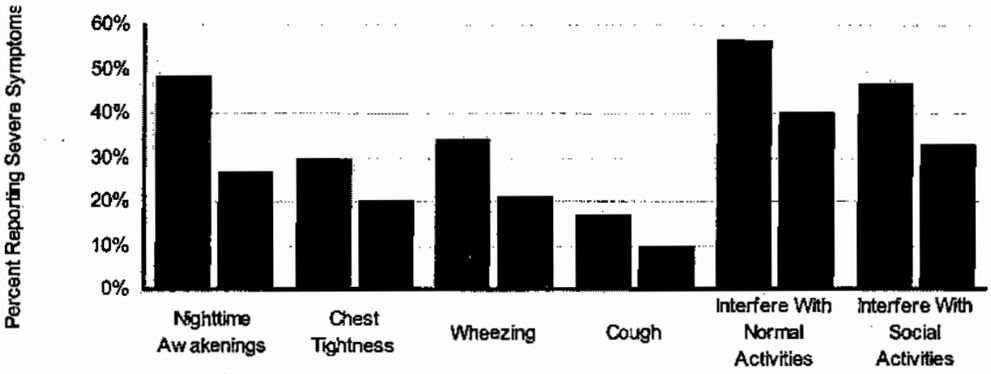
In CY2010, child and adult asthma program participants across all Centene plans significantly improved in *all* monitored symptom and functional measures. All improvements were between baseline and most recent reassessment (>= 90 days post baseline) and were statistically significant ($p < 0.05$). For example, 28% of child program participants at baseline responded that they awaken at nighttime, "more than once a week," "five or more times per week," or "one to four nights per week." At outcome, this value had decreased to 10%.

Figure 2: Child Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



	Nighttime Awakenings	Chest Tightness	Wheezing	Cough	SOB Yelling and Shouting	SOB Running and Playing	Interfere With Normal Activities	Interfere With Social Activities
Baseline	28%	7%	11%	6%	7%	17%	7%	17%
Outcome	10%	3%	4%	1%	3%	6%	3%	6%
n	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085
p	0.001	0.001	0.001	0.001	0.001	0.001	0.001	0.001

Figure 3: Adult Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



	Nighttime Awakenings	Chest Tightness	Wheezing	Cough	Interfere With Normal Activities	Interfere With Social Activities
Baseline	49%	30%	34%	17%	57%	47%
Outcome	27%	21%	21%	10%	40%	33%
n	889	889	889	889	889	889
p	0.001	0.001	0.001	0.001	0.001	0.001

Asthma Emergency Room and Inpatient. Utilization for the period from CY2008 through CY2010 for all Centene plans, shows our asthma programs significantly improved rates of emergency room use and inpatient admission. In the analysis of these claims-related measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Table 6: Emergency Room and Inpatient Utilization Related to Asthma – All Centene Plans CY2008-CY2010

Utilization Measures (# participants)	*Rate per 1,000 Participants*	*Rate per 1,000 Matched Non Participant*	*Participant Difference*	*p – value*
Asthma-Related ER Children *(49,761)*	108.7	144.1	-24.6%	**0.001**
Asthma-related ER Adults *(7,473)*	581.4	664.7	-12.5%	**0.001**
Asthma-Related Admissions Children *(49,761)*	339.9	390.3	-12.9%	**0.001**

Diabetes

The goals for Centene's Diabetes Management Program include:

- Increase the percentage of members who receive at least one HbA1c, LDL cholesterol, and retinal eye exam to the 75th percentile of the national Medicaid NCQA Quality Compass
- Promote member adherence to treatment guidelines

- Improve self- management skills in order to minimize the development and/or progression of diabetic complications and optimize quality of life.

In CY2010 for all Centene plans, our diabetes program significantly improved physiologic outcomes. For example in the diabetes program there was a nine percentage point increase in the number of participants reporting LDL levels <100 mg/dl, a five percentage point increase in participants with controlled systolic blood pressure (< 130 mm Hg) and an increase in exercise of 150 minutes per week for 57% of members who started outside of the target goal, all between baseline and most recent reassessment.

Table 7: Diabetes Physiologic Outcomes – All Centene Plans CY2010

Physiologic Measures (# participants)	*Baseline*	*Outcome*	*Difference*	*p –value*
Diabetes *(412)* LDL <100mg/DL	59%	68%	9	**0.011**
Diabetes *(889)* *Systolic BP<130mm Hg*	58%	63%	5	**0.033**

Diabetes Inpatient Utilization. For the period from CY2008 through CY2010 for all Centene plans, our diabetes program significantly improved the rate of inpatient admission. In the analysis of these measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Table 8: Diabetes Inpatient Utilization - All Centene Plans CY2008 – CY2010

Utilization Measure (# participants)	*Rate per 1,000 Participants*	*Rate per 1,000 Matched Non Participant*	*Participant Difference*	*p –value*
Diabetes-Related Admissions Adults *(12,472)*	291.7	394.4	-26.0%	**0.001**

Cardiovascular Diseases

The goal of Centene's Cardiovascular Disease Management Program is to promote Member adherence to treatment guidelines and improve self -management skills in order to prevent subsequent cardiac events and optimize quality of life.

For the period from CY2008 through CY2010 for all Centene plans, our cardiovascular programs meaningfully impacted the health status of our members, in some cases with statistical significance or near significance. In the analysis of these measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Table 9: Cardiovascular Disease Outcomes – All Centene Plans CY2008 - CY2010

Measures (# participants)	*Rate per 1,000 Participants*	*Rate per 1,000 Matched Non Participant*	*Participant Difference*	*p –value*
Congestive Heart Failure				
Heart Failure-Related Admissions (1,217)	1,102.4	1,343.6	-18.0%	0.211
All Heart-Related Admissions (1,217)	1,826.1	2,481.5	-26.4%	**0.046**
Influenza Vaccination Rate (1,217)	226.1	185.7	21.8%	0.055
Coronary Artery Disease				
CAD-Related Admissions (1,671)	480.3	549.9	-12.7%	**0.002**
All-Cause Admissions (1,671)	1,982.3	2,396.2	-17.3%	**0.001**
Influenza Vaccination Rate (1,671)	206.5	163.5	26.3%	**0.001**
Lipid Screening (1,671)	3,214.2	2,654.6	21.1%	**0.008**
ACE/ARB Prescriptions (1,671)	2,747.1	1,689.8	62.6%	**0.001**
Anti-Lipid Prescriptions (1,671)	1,847.1	1,572.2	17.5%	**0.001**

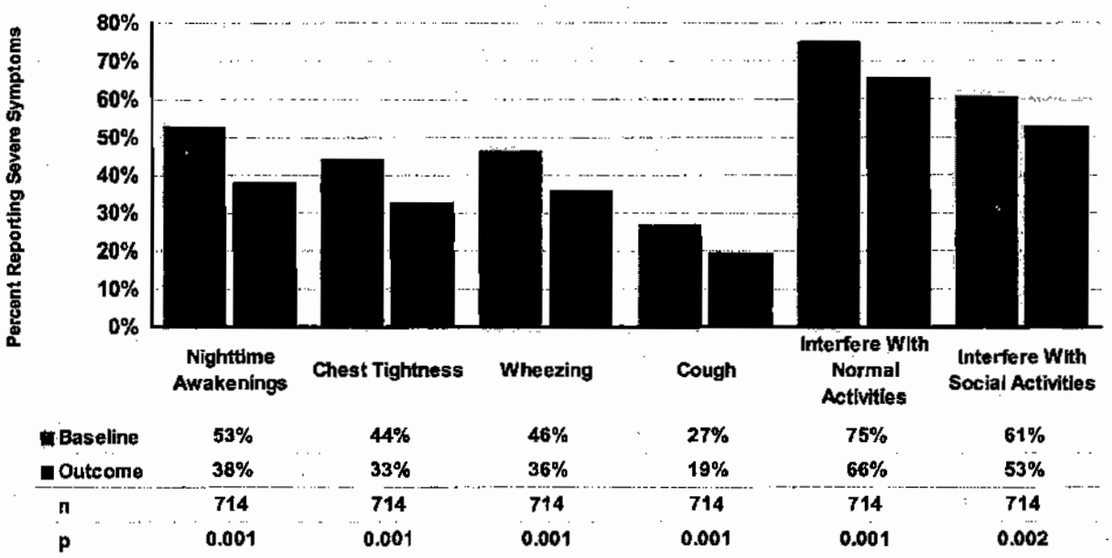
COPD

Goals for the COPD program include:

- Promote Member adherence to treatment guidelines and improve self management skills to delay disease progression and optimize quality of life.
- Reduce healthcare utilizations related to COPD.
- Improve functional status through reduced symptom severity and frequency.
- Promote therapeutic regimen recommendations of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines

Between baseline and outcome, COPD program participants that had severe symptoms reported at baseline made significant improvements in **all** program measures:

Figure 4: COPD Program Physiologic Measures



In CY2010 for all Centene plans, our COPD program significantly improved physiologic outcomes and demonstrated a 4.3% reduction in COPD-related Emergency Room utilization. Highlights include a 44.4% increase in the number of participants reporting respiratory medications prescriptions filled and increases in both influenza and pneumonia vaccinations. Of note, there was a 94.6% increase in the use of home oxygen for COPD program participants which has been shown to prolong life in the later stages of the disease and have a beneficial impact on exercise capacity.

Table 10: Chronic Obstructive Pulmonary Disease Outcomes – All Centene Plans CY2008 - CY2010

Measures (# participants)	*Rate per 1,000 Participants*	*Rate per 1,000 Matched Non Participant*	*Participant Difference*	*p –value*
Chronic Obstructive Pulmonary Disease				
COPD-Related Emergency Room Visits (4,222)	1519.4	1587.2	-4.3%	0.348
Respiratory Medication Prescriptions (4,222)	5,733.5	3,971.7	44.4%	0.001
Influenza Vaccination Rate (4,222)	208.2	167.2	24.5%	0.001
Pneumonica Vaccination Rate (4,222)	53.3	40.6	31.3%	0.007
Spirometry Rate (4,222)	356.7	314.3	13.5%	0.013
Home Oxygen Use Rate (4,222)	2,626.7	1,349.5	94.6%	0.001

Centene demonstrated notable savings in CY2010 from its disease management programs. Savings were calculated by estimating the change in medical expenses for participants from a baseline period to the participation period in the program, compared to matched non-participants over the same interval. Total CY2010 estimated savings were $16,173,860.

Table 11: Estimated Savings from Disease Management Programs – All Centene Plans CY2010

Participant Category	Participants				Matched Non-Participants			Difference in the Difference	Estimated Savings
	n	Pre	Post	Difference	Pre	Post	Difference		
Pediatric Asthma	16,529	$2,562	$2,469	-$93	$2,263	$2,277	$14	$107	$1,768,603
Adult Asthma	4583	$5,118	$3,581	-$1,537	$3,803	$4,167	$364	$1,901	$8,712,283
Back Pain	504	$6,422	$6,713	$291	$3,902	$5,931	$2,029	$1,738	$875,952
COPD	2,321	$12,102	$11,999	-$103	$9,586	$10,075	$489	$592	$1,374,032
Adult Diabetes	6,256	$9,666	$10,039	$373	$6,418	$7,174	$756	$383	$2,396,048
Coronary Artery Disease	1,058	$10,124	$11,637	$1,513	$8,238	$9,802	$1,564	$51	$53,958
Heart Failure	830	$15,208	$15,785	$577	$11,804	$12,947	$1,143	$566	$469,780
Hyper-tension	2,068	$7,470	$9,194	$1,724	$4,850	$6,827	$1,977	$253	$523,204
Total Estimated Savings					$16,173,860				

Providing Care Management for Children in Foster Care

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.

Our Texas affiliate, Superior Health Plan, has been managing the state's Foster Care population since early 2008, when Texas was one of the first states to transition its foster care population into mandatory managed care. Since the time that Superior was awarded the exclusive statewide contract for this unique population, other states have begun moving their foster care populations into managed care. Centene affiliates currently manage about 35,000 foster care members in Texas and 460 in Mississippi. Our Kentucky affiliate began managing approximately 3,800 foster care members in November 2011, and Centene will add additional foster care members with the launch of its Louisiana health plan in February 2012.

Because these children are repeatedly relocated, physicians are frequently unaware of a child's health history, status of preventive exams and services, and medication regimens. This can often result in the physician ordering duplicative services and additional medications on top of existing therapy. We have developed solutions that address this issue by facilitating communication across the continuum of care. As part of Superior's contract in Texas, the plan was tasked with providing a patient-centered, Internet-based, community health record, called Health Passport, to make member information available to authorized physicians and other health care system stakeholders such as medical consenters; individuals designated by the Texas Department of Family and Protective Services; caregivers; and case workers. Superior also worked with Cenpatico to implement a Psychotropic Medication Utilization Review (PMUR) program. Since implementing the PMUR program, the percentages of foster children receiving psychotropic medication for 60+ days, two or more medications from the same class, and five or more concurrent prescriptions have all decreased.

Chronic Care Management Program

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 you 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***

Proposed Disease Management Programs

In partnership with Nurtur, GSHP will administer chronic case management programs (CCMP) for diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, and coronary artery

disease. In addition to the disease management program areas noted above, GSHP will also provide a smoking cessation program as described above in our response to Q49. We will evaluate the addition of other disease management programs such as chronic pain management, depression, low back pain, and weight management following contract award and after we have had the opportunity to evaluate need within our membership.

Chronic Care Management Program Goals. The overarching goal of GSHP's CCMP will be to help members achieve the highest possible levels of wellness, functioning, and quality of life. Each member participating in the program will work with an assigned Health Coach to establish both short and long-term goals that include modifying unhealthy behaviors. In addition, each CCMP-targeted condition has condition-specific, measurable goals that will allow us to measure the effectiveness of the program and make any necessary program changes to maximize our impact on health outcomes. In general, program goals incorporate one or more of the following characteristics:

- Measurable indicators of some aspect of performance, either clinical or service delivery
- Relate to an area that is of importance to GSHP and DHH
- Involve clinical quality improvement initiatives consistent with the scope of services relevant to the population served.

Risk Stratification Methodology

GSHP will use the same technology for identifying and stratifying members for disease as described in our response to case management program above in Q52. Impact Pro™, a part of our Centelligence™ Foresight platform, is a state-of-the-art multi-dimensional, episode-based predictive modeling and case management analytics tool that will allow the ICT to use clinical, risk, and administrative profile information obtained from historical data to identify members who may be **at risk for high future utilization.**

Centelligence™ Foresight: Impact Pro. Impact Pro leverages outputs from the two Ingenix-Symmetry products – Episode Treatment Groups® (ETG®) and Evidence Based Medicine (EBM Connect). ETG provide a clinical context for healthcare analytics by creating unique episodes of care for each recipient. Within Impact Pro, ETG episodes describe each clinical condition for an individual and the services involved in diagnosing, managing and treating the condition. ETG episodes also serve as a key determinant of a patient's markers of risk in Impact Pro. The outputs from the EBM Connect solution support the assessment of the care delivered for an individual against evidence-based medicine, care guidelines, the identification of care opportunities and gaps in care. In addition to the Symmetry tools, Impact Pro includes a series of rigorous proprietary algorithms, including predictive risk models, each utilizing diagnostic, procedural, and pharmaceutical information available from claims data and lab results. Identifying members and measuring their risk using Impact Pro involves the following key steps:

- Identification of the clinical risk markers observed for a patient. Clinical risk markers describe a patient's array of clinical conditions (based on Symmetry Episode Treatment Groups established from claims data) and their use of health care services in the context of those conditions. Impact Pro risk markers are important in defining a member's clinical profile and how that clinical profile can be used in differentiating their risk versus the risk of other members.

- Assignment of risk weights to each clinical risk marker. The risk weights describe the incremental contribution to risk of having a clinical marker. Different risk outcomes in Impact Pro use different risk weights. A risk weight is assigned to each marker of risk for the member.
- Calculation of patient risk – a patient's risk score for an outcome is the sum of the risk weights for all their markers of risk observed.

Our stratification methodology includes specific risk factors for each diagnosis being managed. For example, left ventricular dysfunction based on ejection fraction, evidence of dysrythmia, and recent hospitalizations will impact stratification for members with congestive heart failure.

Levels of Stratification. GSHP's integrated care approach is structured to maximize the impact of case management resources for the population as a whole, while providing the most appropriate level of services for individual members, ranging from those with poorly controlled or multiple co-morbid chronic conditions to those with the best health status or no chronic condition. For example:

High risk: Members with high predicted risk for hospitalization, higher than expected utilization, poor outcomes, multiple co-morbidities (medical or behavioral health), or special health care needs will receive case management services from the ICT. An RN or BH clinician (depending on primary diagnosis) will be responsible for overall direction and coordination of the member's case and disease management services, to ensure appropriate clinical oversight of ICT staff activities. This will include coordination with the Health Coach for needed disease management services.

Moderate risk: Members with a single chronic condition (asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and coronary artery disease) will be referred to a disease management Health Coach for motivational interviewing, health education, training in self-management skills, and coordination of care and services. Health Coaches will coordinate with other ICT staff to ensure that these members receive the most appropriate mix of services to support their adherence to their treatment plan and optimize health status.

Low risk: Members with no chronic condition or with a well managed condition will receive general education through our health education programs and assistance as needed through our MCRs or MSRs through our local Member Services Call Center.

While this framework may be helpful in determining the appropriate level of intervention, GSHP's integrated care approach is flexible in providing the most appropriate mix of services for each member. Members receiving one level of management may be moved to a more or less intense level of management based on changes in the acuity of their condition. ICT staff will re-assess members at each contact to determine appropriate contact intervals based on clinical acuity, risk factors and readiness to change. MemberConnections and Member Services staff may refer members to the ICT for assessment or re-assessment at any time. GSHP may also re-stratify members following our bi-weekly Centelligence™ Foresight predictive modeling analysis of member risk. For example, a member currently categorized as low risk may be moved to case management if condition-related utilization of acute care services suddenly increases or a new co-morbid condition is identified. Our approach also offers flexibility for members to choose to receive assistance in a way that best meets their preferences. For example, a member whose condition is well controlled may still prefer frequent contact from the Health Coach to maintain that control.

Member Outreach Strategies

Once eligible members are identified, effective outreach and engagement of members and providers will be a key success factor for the CCMP. GSHP's relationship with our LPC&A owner-partner FQHCs, known and trusted organizations and Medicaid/CHIP providers throughout Louisiana, will provide immediate credibility for and confidence in our CCMP. There is a high likelihood that members eligible for the CCMP may already be in treatment, have previously sought care from, or be familiar with one of the Bi-State partner providers. Since these FQHCs are woven into the fabric of the communities they serve, GSHP's efforts to identify, outreach to, and engage members with chronic conditions will benefit from their established relationships with social service and community-based organizations that may have existing relationships with these members.

Introductory Mailing. All potentially eligible members identified with a CCMP condition will receive an introductory mailing with information about the program. Unlike many other disease management programs, an GSHP Health Coach will contact the member by phone following the introductory mailing to complete an Initial Health Assessment (IHA). The Health Coach will attempt to contact the member three or more times to complete the IHA, calling on different days of the week, including weekends, and at different times of day to maximize the likelihood of successful contact.

Motiviational Interviewing. All Health Coaches will be trained to employ Motivational Interviewing and other advanced engagement and behavior modification techniques to establish rapport, set goals, and achieve success. On a case-by-case basis for members that have difficulty communicating by phone, initial outreach to complete the IHA may occur in person by a Health Coach, either in a member's home or at a provider's office. All members with asthma considered to be high-risk based on claims and pharmacy data will be offered an in-home Baseline Assessment to allow assessment of environmental risk factors. If the member cannot be reached by phone, the Health Coach will mail a postcard asking them to call a toll-free number to discuss their health care. In 2010, almost 94% of Medicaid members contacted by a Nurtur Health Coach agreed to participate in disease management.

During initial conversations with members, we will determine which methods and style of communication the member prefers. Because different people prefer different methods of communication, GSHP' program employs multiple communication strategies, including written materials, telephonic outreach, web-based information, in person outreach through our MemberConnections™ Program and Integrated Care Team (ICT) staff, and participation in community events.

Baseline Call Assessment. For members scored to be at moderate or high risk based on the initial risk stratification, the Health Coach does a Baseline Call Assessment (BCA), which is condition-specific and includes questions about symptom severity, medications, hospital and ER use, activities of daily living, pain, medical or behavioral health co-morbidities, use of medical equipment or supplies, health literacy, unmet social needs (such as housing or food supply), family and other support, medical home, and willingness to participate. This holistic assessment features open-ended questions that foster an understanding of both the individual's clinical co-morbidities, including behavioral health conditions, and general psychosocial status. We also assess the member's current readiness for self-management in the following areas of health care:

- Daily monitoring of health indicators for the member's chronic health condition for self-triage
- Consistent self-management of acute clinical symptoms in the home/community setting
- Correct use of all prescribed medications and medication adherence over time
- Appropriate lifestyle decisions based on the member's chronic health condition and physician recommendations
- Management of depression and other mental health correlates of chronic disease
- Access to support for self-management (such as family, friends, and community services).

The assessments will be used to further stratify members to determine frequency and intensity of contact, and to establish a baseline for clinical outcome measurement. In addition to the baseline assessment, Health Coaches will complete conditions specific health assessments (CHA). If a member has more than one condition, multiple condition specific assessments may be completed. Completion of the CHA will allow the health coach to gather information about diagnoses and co-morbidity risks, comprehension of medication regimen, hospital and emergency room use, activities of daily living, pain levels, confidence level in ability to manage primary condition, presence of behavioral health conditions and disorders, psycho-social barriers to treatment compliance, and cultural and religious beliefs that affect health status.

The information is then documented in TruCare so that it is available to all GSHP staff for future interactions. Each subsequent contact with the member will involve re-assessment and re-stratification, and evaluation of improvement in risk and health status. Between contacts, all members have access to NurseWise, our 24/7 nurse advice line, as well as their assigned Health Coach and supporting ICT staff via a toll free number.

Program Interventions

The goals of GSHP's disease management program are to:

- Reduce complications related to unmanaged illness or condition;
- Coordinate health care services to optimize outcomes; and
- Coordinate and facilitate follow-up services to prevent complications.

When members who have been unmanaged receive support to make informed health care decisions and the tools to take responsibility for managing their own decisions, they show an average 51% improvement in healthy behavior.[16] Health Coaches are highly skilled in identification and discussion of barriers to compliance, and adept in facilitating a readiness for change, obtaining true buy-in for behavioral modification, and encouraging solution-oriented problem solving.

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[16] Burke BI, Arkowitz H, Menchola M., The Efficacy Of Motivational Interviewing: A Meta-Analysis Of Controlled Clinical Trials, J Consult Clin Psychol. 2003 Oct;71(5):843-61

Telephonic Interventions. Members will be assigned a personal Health Coach with expertise in their primary condition, such as an RN with cardiac experience for those with CHF. The personal Health Coach will coordinate with Health Coaches having other specialties, or with other members of the ICT, for medical or behavioral health co-morbidities, or special needs such as nutrition, exercise, or social services. Coaching will consist of an initial series of pre-scheduled outbound phone and/or in-home coaching sessions upon enrollment in the CCMP, followed by periodic continuing contact as often as necessary to respond to member questions and changes in health and functional status. The sessions may include health and medication education, motivational interviewing, psychosocial evaluation and support, tobacco cessation, nutrition, stress management and similar services. The Health Coach will educate members about their specific primary and co-morbid conditions based on their BCA and stated health goals. For example, a Health Coach could educate a member with diabetes about the disease and its possible progression, and the importance of annual physical, podiatry, and nephrology exams.

High Risk: Unstable members. The Health Coach initiates contact with the member within three business days of identification, with assessment completed as quickly as the member's health condition requires but no later than seven days after identification. Characteristics of high risk members include, but are not limited to: unstable and/or has a chronic or complex condition with ongoing physical or behavioral health needs; currently hospitalized; symptomatic and at risk for immediate emergency department visit, admission or readmission. Moderate Risk: Complex but stable members. The Health Coach contacts the member within 14 days of identification, with assessment completed as quickly as the member's health condition requires but no later than 30 days of identification. Characteristics of moderate risk members include, but are not limited to: current need for routine ongoing physical or behavioral health care, which may include but is not limited to PCP visits, specialist visits, home care provider, lab work, medications, or referral and intervention by community organizations.

Low Risk: Stable members with multiple or co-morbid conditions. The Health Coach contacts the member within 30 days of identification and completes the assessment as quickly as the member's health condition requires, but no later than 45 days of admission to case management. Characteristics of low risk members include, but are not limited to: possible risk for a potential problem or complication; history of illness or injury but currently requires little or no medical, behavioral, or social support services or, if they do, the member/family is managing the care well.

Following the initial introductory call and completion of the BCA, the health coach will contact the member/caregiver no less than every 90 days and more frequently as indicated by the member's needs. Each contact will address, at a minimum, the following issues:

- Transportation
- Compliance with condition specific care guidelines such as testing and physician appointments
- Effects of illness on member and family
- Economic needs that are barriers to addressing needed interventions
- Modifiable risk factors, such as diet, exercise or smoking

- Ability to understand educational materials
- Measure of goals achievement
- Family or other support system
- Updating the CHA as changes to the member's needs or health status are identified

Face-to-Face Outreach. In addition, staff from MemberConnections®, our intensive, grassroots education and outreach program, will assist with non-clinical coaching and support as well as connecting members to needed community resources. We will hire our MCRs from within the communities we serve so they understand our members, their needs, and the local barriers they face. MCRs will provide members with a trusted face and a personal connection to GSHP, and often visit with members in their homes or encounter members at community events and health education workshops. During these events, they may identify members who need chronic care/disease management and, at that time, provide basic education about the member's condition. MCRs will maintain a stock of education materials which allows them to, for example, provide basic asthma education and refer the member to our Asthma Disease Management Program.

Our co-location of ICT staff within our Bi-State partner high volume primary care offices affords additional opportunity to perform face-to-face outreach and education with our members.

Self-Management Plan. The Health Coach will work with the member, ICT staff and appropriate providers to develop a self-management plan that reflects the member's preferences and goals and serves as the focal point for directing future communications. A copy of the plan will be sent to both the member and the provider to ensure shared expectations. Because all member information, including assessment results and the self-management plan, will be housed within TruCare, Health Coaches and other ICT staff will be able to 'refresh the memories' of our members, reminding them of past responses or agreements to pursue behavior modifications such as quitting smoking or making dietary changes.

Coordinating Services and Information with the PCP

Provider engagement is an integral part of a successful CCMP. GSHP has developed a comprehensive and ongoing provider outreach and education plan for the CCMP. We have already begun soliciting input from Bi-State Primary Care Association regarding program design, including educational materials and preferred methods for receiving materials, and ongoing collaboration regarding service plans.

Incorporating Provider Input. Providers often have valuable insights into member behavior and suggestions for encouraging members to access care appropriately, take responsibility for their own health, and self-manage chronic conditions. Health Coaches will communicate with providers to obtain input on the service plan. This will include informing the PCP and treating providers not only about assessment results but also member goals and identified barriers to appropriate access to care and healthy behaviors. The Health Coach also will ask for provider input into development of the action plans for each member goal, strategies for addressing identified barriers, and incorporate the provider's suggested strategies into the service plan.

Since the member and provider/office staff often has established relationships, the provider may have a better understanding of a member's barriers and preferences. For example, provider staff may know that a member does not feel comfortable sharing personal information with females, but a member may not inform ICT staff of this fact. GSHP would use this information to assign the member a male Care Manager. Provider staff may also be aware that while a member can speak English, they feel more comfortable and are more fluent using Spanish. GSHP would ensure that such members are assigned Case Managers who are fluent in Spanish. Particularly during the transition from FFS to the New Hampshire Medicaid Care Management Program, these sorts of insights will be important in gaining member trust so that Case Management, Health Coaches and MemberConnections staff can provide suggestions and support for positive behaviors that the member will accept.

Centene affiliate plans and Bi-State partners know that members trust their doctor and often take health-related direction from them more seriously than they do from other sources. GSHP will work with Bi-State to explore such strategies as sending reminder postcards signed by the PCP rather than GSHP. We will also support the Patient Centered Medical Home (PCMH) in conducting outreach and encouraging for positive behaviors.

Care Manager/ICT Interaction with Providers. The Care Manager, Health Coach and other ICT staff, as needed, will communicate via phone, fax and email with the PCP to provide assessment results, member goals and preferences, service plan recommendations, and to obtain input on the service plan. The final service plan will be available to the PCP via the Provider Portal and available in hard copy on request. The Care Manager, Health Coach or other ICT staff will also communicate monitoring results to the provider via phone, fax and email, such as alerting the PCP when a member is hospitalized, has a gap in recommended care, experiences an exacerbation of a chronic condition, reports a medication side effect, or is non-compliant with treatment or medication regimen. We may invite the PCP to participate in case rounds for members with complex conditions, and we will reimburse PCPs to encourage their participation in case rounds.

For members receiving disease management, the following are key components of communications that the Health Coach will use to interact with member's treating physicians:

- *Respiratory Program Action Paths* will be sent to PCPs upon completion of the baseline assessment and include current self-reported symptoms and medications. Providers can then confirm or make changes to the treatment plans which are then reinforced by the case management staff.
- *Medical Information Forms* will be sent to providers upon completion of non-respiratory baseline assessments to request current biometrics, confirm presence of complications/co morbidities and request physician input and recommendations to the coaching process.
- *Lab Update Forms* will be provided annually and more often as needed to inform providers of changes in any relevant lab data for their members.
- *Medical Alert Fax* will be sent anytime a member is in a potentially urgent situation.
- *Quarterly Provider Newsletters* that provide refresher information about the disease management program, program enhancements, any updates to CPGs or relevant new technologies, updates on measures of the program's success, success stories that highlight a

member's success or a provider's success in improving patient health outcomes, and the names of providers who have been presented awards by GSHP.

Supporting Provider Efforts To Influence Member Behavior. GSHP will provide multifaceted support to assist our providers in influencing member behavior. This will include support to promote member responsibility for their own care and health, including appropriate utilization, compliance with treatment and medication regimens and other healthy behaviors.

Provider Education and Training. GSHP will educate our providers on our medical home policies, Case and Disease Management services, and availability of NurseWise during provider orientations, in the Provider Manual and on our Provider Portal. GSHP training will engage providers new to coordinated care and help them understand their role in educating our members on appropriate use of services. In addition, we will provide information about these policies in our quarterly provider newsletter and during Provider Relations follow up visits. For example, our Provider Relations staff will follow up with PCPs that have a disproportionate number of members with high ED use to explore potential access issues, such as appointment availability, office hours, and well-translated answering machine messages.

Educational Materials. We will offer providers brochures, posters and tool kits on various health promotion or disease-related topics that they can use with members to reinforce appropriate use of services and taking responsibility for self care. For example, for smoking cessation, we will educate our providers about the New Hampshire Tobacco Helpline and how to access important tobacco cessation resources for their practice.

Case Management Support. Our ICT staff will support provider-based member education and motivation by contacting PCPs within five business days of members' Case Management assessment, informing PCPs of the service plan, including any gaps in care, and requesting PCP input on and support for the service plan. We also will work with providers to help meet the need for after-hours or urgent care services. For example, our Texas affiliate worked with a large physician group to develop a code-based per-visit financial incentive for evening and weekend office visits, which supports members going to their PCP rather than the ED. Our affiliate also worked with a large El Paso group practice that wanted to expand its urgent care services. Our affiliate helped finance the group's establishment of an urgent care center in Austin to meet growing demand for urgent care services there.

Provider Portal. As illustrated in detail above, our Provider Portal will help network providers influence members' healthy behaviors and appropriate use of services. The Online Care Gaps will allow network providers to see when checking member eligibility whether the member is due for a test, check-up or other health screen. Our monthly performance reports will give them feedback about their performance against an appropriate peer group, which will help show them opportunities for improvement in their medical home operations, including when members are over-utilizing or under-utilizing services (and could be better educated or treated in a different manner). The Member Health Record will also include clinical profiles for each patient summarizing recent utilization of services including office visits, emergency room visits and inpatient admissions, which will help give context to providers not only in treating our members, but also in educating and influencing them about self care and appropriate use of services.

Managing Members with Multiple Co-Morbidities

As described above, recognizing that multiple co-morbidities will be common among our membership GSHP will deliver disease management services as a component of our multidisciplinary Integrated Care Team (ICT) approach to case management who are staffed together in the same office to ensure maximum coordination. Each member enrolled in case management is assigned a primary case manager, who is part of our ICT. The choice for primary case manager is made based on the member's primary health condition. For example, if the member's primary condition is diabetes, the primary case manager would be a Health Coach with support from a team nurse; if the member's primary condition is depression, a behavioral health clinician would serve as the primary case manager. If the primary case manager determines, through the detailed condition specific health assessment or through interactions with the member that the member would benefit from the support of another member of the ICT, a referral is made through TruCare and that case manager will outreach to the member within 10 business days of receiving the referral. This may include referral to a behavioral health or medical case manager, or referral to a social worker to address unmet socioeconomic needs.

All member interactions and educational material mailings will be documented in TruCare, GSHP's medical management software (described above in our response to Q62), ensuring that each member of the ICT has a holistic picture of the member's needs and the interventions provided.

Innovative Approaches to Managing High-Cost/High Risk Members

Integrated Care Teams. Our unique approach to disease and case management integrates GSHP physical and behavioral health Care Coordinators and Nurtur disease management Health Coaches co-located in GSHP's office to facilitate true collaboration for members with multiple, complex co-morbid conditions.

MemberConnections. GSHP's MemberConnections program promotes preventive health practices and connects members to community resources. Our MemberConnections Representatives (MCRs) are hired from within the communities we serve, which helps to facilitate a cultural understanding of our members and the languages they speak. MCRs support our disease management program by going into the community to work with members one-on-one in their homes and at other community locations (such as Provider offices and health fairs) to educate them and address barriers to appropriate care.

Connections Plus. GSHP will implement the Centene Connections Plus® Program, which provides pre-programmed cell phones to our high-risk members who lack reliable phone access. This innovative program provides 24-hour instant access for our members, allowing them to make calls to and receive calls from their Providers, case managers, GSHP personnel, NurseWise, and 911.

Home Tele-monitoring. GSHP will provide telemonitoring services to the highest-risk members (with multiple co-morbidities). These home wireless biometric monitoring devices will allow case managers and treating Providers to monitor key health indicators and provide opportunities for real-time, "teachable moment" interventions. Telemonitoring devices may include scales, pulse oximeters, medication dispensers, blood pressure monitors, glucometers, and EKGs. Using a proprietary web-based integration platform, multiple devices can be used with a single member, allowing us to

customize monitoring to each member's unique needs. For example, we will set alert levels customized to each member. Real-time information gathered from the devices will be accessible online to the Health Coach and CM Team, who will use monitoring information to detect and prevent acute episodes and exacerbations. A baseline will be established for each factor monitored, thus allowing our clinical staff to observe for variance from baseline. Biometric and medication compliance trends can also be analyzed after a regimen change or intervention in order to assess effectiveness and avoid situations from becoming acute. Health Coaches and CMs will work with the PCP and other treating providers to determine the appropriate devices and alarm levels for each member. In addition, the provider will also be able to have real-time access to monitoring information via the secure online site. In-home telemonitoring will enhance access and quality for members in rural areas who live far from their treating provider and those whose conditions make it difficult for them to make frequent trips to the doctor for such monitoring as blood pressure checks. The following are some claims-based outcomes measures from out telemonitoring program pre and post comparison for period ending May 31, 2011:

Measure	Historical Control Period [1]	Study Period [2]	Percent Difference	Objective
Coronary Artery Disease (CAD)				
CAD-Related Admissions per 1,000 claimant-years for those with CAD	1,730.7	962.0	-44.4%	↓
CAD-Related ER visits per 1,000 claimant-years for those with CAD	307.7	183.5	-40.4%	↓
ACE/ARB Prescriptions per 1,000 claimant-years	2,538.4	3,348.1	31.9%	↑
Heart Failure				
Heart Failure-Related Admissions per 1,000 claimant-years for those with heart failure	3,097.1	2,338.7	-24.5%	↓
Heart Failure-Related ER visits per 1,000 claimant-years for those with heart failure	144.1	92.3	-35.9%	↓
Beta Blocker Prescriptions per 1,000 claimant-years for those with heart failure	3,769.9	4,532.2	20.2%	↑
Hypertension				
Hypertension-Related Admissions per 1,000 claimant-years for those with hypertension	840.9	551.0	-34.5%	↓
Hypertension-Related Prescriptions per 1,000 claimant-years for those with CAD	1,625.0	1,930.6	18.8%	↑
Diabetes				
Diabetes-Related Admissions per 1,000 claimant-years for those with diabetes	1,130.6	665.0	-41.2%	↓

Diabetes-Related Emergency Room Visits per 1,000 claimant-years for those with diabetes	453.1	369.4	-18.5%	↓
Dilated Eye Exams per 1,000 claimant-years among those with diabetes	443.4	497.9	12.3%	↑
Lipid Screening per 1,000 claimant-years among those with diabetes	3,307.6	4,542.8	37.3%	↑
Foot Screening per 1,000 claimant-years among those with diabetes	316.7	620.4	95.9%	↑

(1) - Participants in each of the conditions are not mutually exclusive, therefore savings cannot be combined
(2) - Historical Control Period = JUN 2008 - MAY 2010 (No minimum days of participation)
(3) - Study Period = JUN 2010 - MAY 2011 (No minimum days of participation)

Integrating Programs with Medical Home CM Responsibility

Health centers provide medical homes to individuals by offering enhanced access to care, care coordination and management, as well as supportive and enabling services in a "one-stop" service approach. Enabling services such as transportation assistance to the visit, child care during the health center visit, health education, and assistance with enrollment in state public programs help patients remove barriers to care. CHCs have multilingual staff and/or interpreters available to ensure high-quality and culturally-competent service to minority populations. Since the medical home is the framework of the health center model of care, Bi-State and the health centers are participating in the New Hampshire Multi-Payer Medical Home Project that will commence on January 1, 2009 for a period of 24 months. In collaboration with our partner, Bi-State Primary Care Association, GSHP will imbed Case Managers in their locations. The onsite Case Managers will work with provider staff to complete assessments on members we have been unable to reach by phone; collaborate on service plan development; provide member education; and participate in case conferences with provider staff. These field-based staff will carry laptop computers, enabling them to stay connected to other ICT members and to document their activities in TruCare. While these Case Managers will still be assigned to an ICT to ensure multidisciplinary input and oversight of the service plan, GSHP recognizes the value of maintaining the existing relationships between provider case management staff and members. Our Case Managers will support and supplement provider staff, building on and enhancing the existing service infrastructure within the service area. A recent review recognized this embedded Case Manager approach for people with serious mental illness, citing evidence for increased receipt of evidence-based services and increased likelihood of having a usual source for primary care services.[17]

[17] Alakeson V, Frank RG, Katz RE, Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders, Health Affairs 29(5) 2010; 867-873

Coordinating Community Resources

As described in our response to Q53, GSHP understands that success in delivering high quality coordinated care means engaging with traditional Medicaid/CHIP providers, locating in communities where members live and work, and collaborating with community-based organizations to serve the whole individual in the context of family and informal supports. GSHP will provide Chronic Care and Disease Management Programs (Disease Management) for members with asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease and coronary artery disease. Using information from historical claims, health assessments and our Centelligence Foresight predictive modeling runs, we will identify members who can benefit from Case and Disease Management.

We will engage with organizations and advocates such as Child and Family Services and NH Children's Lobby, and the Dartmouth-Hitchcock Child Advocacy Center to ensure we take a holistic approach to creating a Service Plan that meets the needs of the member as comprehensively as possible, including every resource available. We also value as resources the Boys and Girls Clubs, YMCA/YWCS, food banks, clothing banks, housing program and faith based organizations to assist in providing necessary community resources to Members and Medical Consenters.

GSHP understands that primary care providers, particularly those recognized as PCHM, will most often be the member's case manager and have established processes in place to provide additional services as well as coordinate services through local community agencies that may provide services that the managed care program does not cover, but which support the member's overall healthcare needs and goals. For example, a number of our BI-State partners, in preparing to become a PCMH, evaluated their data to identify their top diagnoses. The providers then implemented education and health management support programs. GSHP's strategic partner Bi-State Primary Care Association's members Ammonoosuc Community Health Services, Coos County Family Health Services, Concord Hospital Family Health Centers, Families First Health and Support Center, Lamprey Health Care, Mid-State Health Center all have achieved NCQA Level 3 accreditation. All the other FQHCs are in the process of reaching Level 1 NCQA accreditation. These staff will serve as our grassroots community liaisons; among other things, the they will work with community-based organizations that provide non-covered services to members to establish streamlined processes for member referrals. Our intent to to actively support existing patterns of care and referrals through co-location of our case management staff within FQHCs, CMHCs and other high volume provider locations.

Transitioning Members Receiving DHHS Support Services

We will use the expertise of our Nurtur Health Coaches, who will be co-located in our New Hampshire office within our Integrated Care Team (ICT), to ensure a smooth transition from the current DHHS DM program to GSHP's DM program. Using the integrated model, our care coordination teams will be able to facilitate regular, in-person communication about members' care to streamline the care transition process. ICT staff will work collaboratively with other DHHS to establish a process, preferably electronic, for transmitting a list of transferring members who are eligible for or already receiving case management support from DHHS. ICT staff will the DHHS designated contact to obtain contact information, recent clinical data, and information from the existing service plan such as treating

providers, goals, assessed needs, and support systems. The Health Coach will notify the new PCP and send the member a letter and materials explaining our CCMP and the transition process.

The Health Coach will also reach out to the member and their caregiver/family as appropriate to conduct a comprehensive assessment of needs that focuses on the member's clinical risk, educational needs, readiness to change, cultural factors and health literacy and consider risk factors for each diagnosis being managed. The Health Coach will use information from existing care plans, initial and comprehensive assessments, and input from the member, their caregiver/family as appropriate, PCP and applicable Providers to develop an GSHP plan of care. The care plan will include not just disease management, but goals and interventions for covered services and non-covered services to address each identified need, such as non-covered Medicaid services, Food Stamps, housing services, or services provided through local social services organizations such as assistance with utility bills. The Health Coach will obtain input from his or her counterparts on the team to facilitate interventions for co-morbid physical/behavioral health conditions or social service. The Health Coach will enter care plan information in TruCare and provide a copy to the member and, with member consent, to the PCP and other relevant Providers. All ICT staff use the same integrated care plan template that is loaded into TruCare, allowing all team members *a single integrated care plan for each member.*

Organizational Alignment To Promote Care Coordination

We have learned through our 27 years of experience serving Medicaid members in 26 states that total alignment and integration, internally and externally, is the best way to provide the holistic approach that successfully engages members to improve their health status. All management policies and procedures are aligned in this effort. All contracts and provider relations are aligned in this effort, all utilization review, medical management and service coordination are aligned in this effort and every interaction with a member supports this effort. Furthermore, we are constantly using feedback, advisory groups, data and outcomes measures to reevaluate and make adjustment for greater improvements.

Aligning Case Management with Other Programs. Our Medical Management, Quality Improvement (QI), Credentialing, and the Waste, Abuse and Fraud Programs are closely linked in function and process. The CM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI department. As case managers perform the functions of UM, quality indicators, prescribed by the Plan as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, case management and the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the CM/UM staff and the practitioner or facility staff is also vital to the recredentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, precertification of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by the Plan for review and resolution as needed. The CMD or Medical Director determines if the information warrants additional review by the Plan Practitioner Affairs or Credentialing Committee. If committee

review is not warranted, the information is filed in the practitioner's folder and is reviewed at time of the practitioner's recredentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to Waste, Abuse and Fraud among practitioners and members. The Medical Management Department will work closely with the Compliance Officer and Centene's Special Investigations Unit to resolve any potential issues that may be identified. In addition, the Plan coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- EPSDT Health Check
- Services provided by local public health departments

Coordination of Members With Special Needs Open lines of communication, clear information and real time documentation, data and tracking are the keys to success as we partner with DHHS, members, families, care givers, providers and community organizations to successfully transition New Hampshire to a Care Management Services program. By including all our services in-house within Centene's family of companies, we bring unparalleled coordination and speed to action to create positive impacts. Care Management, specially of members with special needs is how we make the greatest impact in preventing duplicate services, uneccessary admissions and negative outcomes; therefore we wrap care coordination into everything we do from inclusion in provider contracting with pay-for-performance programs, enhanced credentialing to identify languages and practice capabilities, provider training and interactions on TruCare, Provider Portal, Clinical Portal, appointment scheduling and reminder services. We identify gaps in care through our software systems and communicate those to member services and providers so that the very next contact with a member can close those gaps. This becomes especially critical with specials needs populations, including substance abuse and HIV.

Integrated Data Systems and Information. We use a highly integrated data system and approach to information sharing that encompasses all aspects of a member's medical, behavioral, dental, vision and other needs and services. All clinical staff have access to TruCare that houses data related to the members, including (but not limited to) RN or BH Case manager assignment, health risk assessments, Service Plans, case notes, referrals, authorizations and quality information. TruCare will also include DHHS caseworker assignments. The Provider Portals and Clinical Portals allow any authorized provider to access up to date clinical information and the member's individual ITC service plan. The advantages of having all physical, BH and other data in a single repository cannot be overstated in managing members in these programs and settings.

Children and Youth in Foster Home/Group Home/Residential Placements

Our case/disease management programs utilize Integrated Care Teams (ICTs) and TruCare to support, coordinate and document all aspects of care and services for these members. Our experiences has shown that a single point of contact is essential to coordinating and effectively managing special needs

children and youth. Our Foster Care Coordinator (FCC) is a dedicated position assigned to facilitate communication and ensure continuity of care between the member, care takers, DHHS case manager and providers. Because these children are repeatedly relocated, providers are frequently unaware of a child's health history, status of preventive exams and services and medication regimens often ordering duplicative services and adding medications on top of existing therapy. With this knowledge, we understand the importance of developing early relationships with the DHHS Division for Child, Youth and Families and the Division for Juvenile Justice Services and the individual case workers assigned to these members. Our MemberConnections Program and ConnectionsPlus are adjunct services that support our coordination of services.

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).

As per Q&A this question has been deleted.

Approach to Providing Care Management for Foster Care

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.***

GSHP's goal is to help members involved in child protection/juvenile justice system, foster care, group homes or residential placements achieve the highest possible levels of functioning and wellness by ensuring consistent, timely access to medically necessary and integrated physical and behavioral health (BH) services. Our GSHP management program utilizes Integrated Care Teams (ICTs) and TruCare to support, coordinate and document all aspects of care and services for these members including the permanency planning process, cooperating across agencies and organizations with the member's entire range of needs and circumstances in order to improve each member's overall quality of life and achieve permanency. Our Foster Care Coordinator (FCC) is a dedicated position assigned to facilitate communication and ensures continuity of care between the member, caretakers, DHHS case manager and providers.

Identifying Children in Child Welfare or Child Protection System

In our experience, members in the child protection and/or juvenile justice systems as well as members in foster home/group home/residential placement are identified on the eligibility file we will receive from the State. This information is loaded into our Centelligence™ suite of systems (described in detail in Q46) so that all GSHP staff working with the member is able to identify the placement of the child. Within our Member Relationship Management (MRM) system we are able to capture demographic information as provided on the enrollment file as well as alternate contact information including addresses, phone numbers and email. We are also able to document names of those authorized to access HIPAA information related to the child. Additionally, we may identify these members during our Welcome Call or when the child's case worker, caretaker or provider calls in to our Member Call Center with a question about benefits or requesting authorization for services.

Comprehensive Assessment and Service Initiation

Within 30 days of enrollment we will reach out to new members to conduct a Welcome Call which includes education about rights, responsibilities, how to access services and assistance and a brief health risk screening. If the GSHP staff identify immediate needs or complex conditions, the call is 'warm transferred' to a case manager. In the case of children in child welfare or child protection, the call will be transferred to the FCC who will complete a comprehensive assessment of needs and ensure the member is linked to a medical home provider for preventive services and routine care. The FCC will work with the Member, Medical Consenter and Caregiver to complete specialized assessment instruments as applicable to the Member. Assessment instruments may include the Pediatric Special Needs Assessment; Emergency Department (high utilization) assessment; PHQ9 (nine question depression tool for non-geriatric populations); the Child and Adolescent Needs and Strengths Assessment (CANS), Mini-Mental Status Exam; and numerous condition-specific instruments. Other members of our Integrated Care Team (ICT) such as the RN case manager or behavioral health case manager are available to consult with the FCC as needed to answer medical questions and facilitate linkage to appropriate providers. In-home screenings may be conducted in extraordinary circumstances, such as follow-up to emergent service when a comprehensive assessment could not be completed prior to service delivery, inability to reach a high needs member quickly by phone.

Develop and Monitor the Care Plan

The FCC with support from the RN and BH CM will coordinate with the PCP/PCMH Team and DHHS Case Managers to obtain any needed psychological, diagnostic or other assessments and develop the Service Plan. Coordination will include, but is not limited to, sharing assessment information, providing clinical information and options for medically necessary services (including recommendations for specialty care and applicable evidence-based practice guidelines for recommended or potential services), facilitating needed or desired discussion among the PCP Team, educating the Member, Medical Consenter and Caregiver about treatment or services recommended by the PCP or other Providers, and informing the PCP/Provider about the member's DHHS Case Plan.

Working with the PCP. During the service planning process, the FCC will share information with, coordinate among and confer with the PCP. This will usually occur via phone, fax and email sharing of information, although in some cases it may be necessary for ICT staff and the PCP to meet in-person to ensure understanding of information and recommendations and finalize Service Plan development. The ICT will schedule needed meetings and facilitate as needed. Once the Service Plan is implemented, the will share all monitoring and reassessment information with the PCP at least every six months or more frequently when the Member's condition dictates or to address issues identified by the Member, the PCP, the CareManager or others. When DHHS or the court system requires health information about a Member, the FCC will coordinate with the PCP to ensure transmission of the requested information within the required timeframe.

The final Service Plan details and authorizations are entered into TruCare, our integrated utilization and case management system. To streamline the prior authorization process, the FCC is empowered to authorize out of network services. The FCC will work with the RN and/or BH case managers to ensure provision of applicable health education and help the Member, Medical Consenter and Caregiver identify and address barriers to accessing care.

Working with DHHS and the Courts. GSHP will have policies and procedures in place to ensure maximum support to DHHS in the Concurrent Permanency Planning process and the child welfare system. This will include, but not be limited to, making clinical and non-clinical staff and documentation available when requested by the assigned DHHS investigator, caseworker, Intensive Permanency Specialist, Intensive Family Preservation Specialist or child welfare legal staff. GSHP will ensure timely submission of all clinical and non-clinical information required to evaluate a member's progress toward resolving any physical or mental health issues that may be a barrier to reunification or other permanency goal. The FCC will handle non-clinical information, requests and needs of DHHS and the courts, including participation in DHHS family conferences, Permanency Plan development and revisions, and hearings. Case Managers will handle all clinical information, requests and needs (such as testifying in court about a Member's Service Plan). Case Managers will request and review DHHS case plans, safety plans and permanency plans during the Service Plan development and monitoring/modification processes.

Monitoring Service Plans

To regularly monitor clinical progress, adherence to the Service Plan and the quality and continued appropriateness of services, the Foster Care Liaison will periodically contact the member, Medical Consenter and Caregiver to review member health and functional status; satisfaction with Providers/services; the extent to which Providers/services are meeting the member's needs; and the Service Plan. This will occur at least every six months or more frequently as dictated by the member's condition or change in placement. At each monitoring contact, the Foster Care Liaison will:

- Discuss with the member, Medical Consenter and Caregiver the types, amounts and providers of authorized services
- Assess the member's current functional, medical, behavioral and other needs
- Discuss and document in TruCare these stakeholders' perceptions of progress toward and barriers to achieving goals

- Develop new goals or modify action plans as desired
- Analyze the member's treatments and services for under-utilization, appropriateness of treatment plans, medication compliance, and environmental or social factors (including any safety plans developed by DHHS) that could affect the member's care

For Members taking psychotropic medications, the BH Case manager will review these medications at the initial assessment and reassessments and will document each medication in TruCare, to include purpose, effectiveness and any adverse side effects that may have occurred. If the BH Case manager identifies concerns such as ineffectiveness, adverse effects, lack of refill or a medication that may not be consistent, the BH Case manager will discuss these with the Medical Director or Network Pharmacy Director. If warranted, the Medical Director or Pharmacy Director will contact the prescribing practitioner(s) to discuss the concerns. The Medical Director or Pharmacy Director will document these concerns in TruCare and this will be discussed with the Member, Medical Consenter and Caregiver during reassessment.

Care Plans. The IC Team will conduct assessments and facilitate development of care plans, using the process described above but also incorporating the foster parent, medical consenter, if applicable, and the FWB CCU and Children's Administration case worker. The FC Coordinator will incorporate the Care Coordination Summary into TruCare to facilitate coordination and prevent duplication of services.

The ICT, with support from the FC Coordinator, will coordinate all health and health care related service needs with the FWB Program Manager and RN Clinical Consultant staff upon enrollment, and at least quarterly, or sooner if the health-related care needs of the child require more frequent care coordination. Care plan monitoring and revisions will occur as described above for all members, but may occur more frequently as children change placements. IC Team staff and the FC Coordinator will work with new foster parents and caregivers as needed to educate them on the child's needs and care plan, assist in locating providers when a child's placement moves them away from existing providers, and ensure that the transition to a new placement occurs with no disruptions in care. The IC Team and FC Coordinator will also work with any new providers when placement changes to share assessment results, existing care plan, utilization information and other information to ensure the child continues to receive appropriate, individualized care.

Foster children may not always reside in the service area in which their case is assigned and therefore may frequently require care from out of participating providers. The FC Coordinator will review requests for services from non-participating providers and facilitate authorization and access to such providers as indicated. We may also attempt to contract with the provider or negotiate a single case agreement to facilitate direct access to needed services.

The care plan will include non-Covered Services such as non-covered Medicaid services, Individuals with Disabilities Education Act services, WIC, Head Start, school health services, Title V Maternal and Child Health Programs. It will also incorporate referrals to community resources such as WithinReach and the Foster Parent Association of Washington State.

Transitioning Out of Foster Care

GSHP will ensure continuity of care and a smooth transition to a new provider(s) of medically necessary medical and behavioral services when we identify or are notified of an member who is leaving the Foster Care program. Upon notification, the FC Coordinator will provide all required health information for the youth's transition support team during the shared planning staffing. The FC Coordinator will work with the youth transition support team to provide information to the member, medical consenter, or new caregiver regarding the traditional Medicaid application process. The member will be encouraged to enroll in traditional Medicaid or other insurance coverage available to the member as soon as possible for a smooth transition of benefits coverage and prevent interruptions of current services. The FC Coordinator may attend case conference meetings as requested by FWB CCU staff to answer questions regarding resource availability and span of coverage prior to the member's transition out of Foster Care. The FC Coordinator will also:

- Notify all existing providers of the effective date of transition and verify if current providers will be able to continue services for the member. If a current provider is unable to service member after the transition out of Foster Care, the FC Coordinator will assist in locating new providers and providing authorizations as applicable.
- Identify and coordinate any health care training needs of the member and/or familyor new caregiver once the member leaves Foster Care. The FC Coordinator will assist in coordinating and setting up training sessions upon request from FWB CCU, CA caseworker, provider or member/family/caregiver.
- Provide information and assist member/foster parent in accessing community resources.
- Assist with transitioning prescriptions, if needed.

Managing Care for members in the child protection and/or juvenile justice systems requires establishing close relationships with the DHHS's Divisions for Children, Youth and Families, Juvenile Justice Services, and Family Assistance, members, care givers, families, support services and providers. We will coordinate care and facilitate communication across providers for members in out-of-home placement to ensure access to effective and comprehensive health care including but not limited to interrelated medical, dental, vision, mental health, substance abuse, and developmental needs to achieve optimal health and wellness outcomes[18].

Assuring Coordination with Community Resources for Foster Care

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

Centene's origins as a Community Health Center and the consequent vital role community linkages have played in the company's history are always a fundamental aspect of all health plan operations. Through this experience, GSHP understands that a critical role is to translate a fragmented, confusing

array of multiple services and funding streams into a coherent and comprehensive menu of understandable choices, so that members in welfare and the child protection system and their families/responsible parties get a clear sense of the range of services available to meet their needs. To be effective, we will be more than just a payer of claims; we must partner with DHHS and be an active member of the health and social service community, engaged with the individuals and organizations that provide the wraparound services that supplement Medicaid covered services. GSHP Case managers and Program Managers will coordinate access to services, including non-covered services, and information at the request of a Member, DHHS Staff, Caregiver, Medical Consenter, PCP or ICT. This will include coordinating with DHHS Case Management Services on referrals and access to services provided by other agencies and community resources. For example, we will work with agencies such as the following:

- New Hampshire Child & Family Services
- New Hampshire Family Centered Foster Care Unit Web Site
- New Hampshire State Library - Family Resource Connection
- New Hampshire Foster and Adoptive Parent Association

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.12 Quality Management

GRANITE STATE HEALTH PLAN

3.12 Quality Management

Proposed Quality Management Program

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

Quality Management Program Overview

Granite State Health Plan (GSHP) will administer an active and effective quality management (QM) program in New Hampshire's Medicaid Care Management Program that supports and complies with DHHS's Quality Strategic Plan. GSHP will implement a Quality Assessment and Performance Improvement Program (QAPI) that meets all State and federal requirements through a well-defined structure for measuring and improving performance on clinical and non-clinical processes and outcomes.

GSHP's primary quality improvement goal is to improve members' health status

GSHP will draw on the expertise and resources of our parent company, Centene Corporation (Centene), for our QAPI program. Centene provides GSHP highly sophisticated data management, analysis, and reporting capabilities that facilitate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation based on principles of Continuous Quality Improvement/Total Quality Management.

We will also work to collaborate on existing QI initiatives of members of the Bi-State Primary Care Association (BSPCA), with whom we have developed a strategic partnership. Many of the BSPCA member FQHCs have already achieved NCQA Level III Patient Centered Medical Home Recognition, and the remainder are currently pursuing recognition, which makes them ideal partners for these types of initiatives. Partner FQHCs who have already achieved NCQA Recognition include:

- Ammonoosuc Community Health Services (FQHC)
- Coos County Family Health Services (FQHC)
- Concord Hospital Family Health Centers (Non-FQHC Hospital Based Health Center)
- Families First Health and Support Center (FQHC)
- Lamprey Health Care (FQHC)
- Mid-State Health Center (FQHC Look-Alike)

GSHP will continuously evaluate the effectiveness of our QAPI program, using the same methods that affiliated health plans have developed and enhanced over years of systematic assessments of clinical and non-clinical performance.

Program Goals and Objectives

GSHP's primary quality improvement goal is to improve members' health status and, where the member's condition is not amendable to improvement, maintain the member's current health status through a variety of meaningful quality improvement activities implemented across all care settings.

Quality Improvement goals include but are not limited to the following:

- Members will experience a high level of health status and quality of life.
- Network quality of care and service will meet industry-accepted standards of performance.
- GSHP services will meet industry-accepted standards of performance.
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across GSHP's functional areas.
- Member satisfaction will meet GSHP's established performance targets.
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and EPSDT guidelines.
- Compliance with all applicable State and federal regulatory requirements and accreditation standards will be maintained.

Program objectives in support of GSHP's QAPI goals include:

- Regularly assessing the quality and appropriateness of care provided
- Collaborating with network and community providers to improve the health of our members
- Maintaining written **QAPI policies and procedures** that specify methods, timelines, and responsible parties
- Developing and maintaining a detailed **Annual QAPI Work Plan** with specific goals, objectives, strategies, activities, timelines, and progress toward goals
- Completing projects on time and incorporating results in subsequent improvement projects
- Evaluating and reporting on the QAPI Program annually and modifying it as necessary to achieve program effectiveness
- Establishing priorities for focused audits, clinical studies, and improvement initiatives with emphasis on special needs members
- Annually reviewing current GSHP clinical practice guidelines and recommending the addition of guidelines as the needs of our member population change
- Monitoring GSHP utilization review activities to ensure that they do not have a negative impact on quality of care, through review of authorization denials, grievances, and appeals

- Monitoring member utilization to detect trends of under- or over-utilization, identifying underlying root causes and implementing strategies to address
- Identifying and investigating potential quality of care and service events and taking corrective action when appropriate
- Reviewing the credentials of providers through a peer review mechanism
- Integration of the QI Program into all areas of GSHP operations
- Conducting and reporting annual NCQA-accredited CAHPS surveys and certified HEDIS results for GSHP members
- Achieving NCQA accreditation and monitoring compliance with regulatory and NCQA requirements
- Participating in DHHS's performance improvement program activities and external quality review (EQRO) studies, surveys or other initiatives
- Complying with future CMS national reporting measures and required topics for improvement projects

Scope of the Quality Assessment and Performance Improvement Program

The scope of GSHP's QAPI Program will be comprehensive, addressing both the quality of clinical care and the quality of services provided to members and providers. GSHP's quality improvement activities will encompass all demographic groups, benefits and care settings; and address all services, including medical and behavioral health care, preventive, emergency, primary, and specialty care, acute care, short-term care, long-term care, home care, pharmacy, and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management
- Adoption and compliance with preventive health and clinical practice guidelines
- Behavioral health care management and coordination with medical practitioners
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Disparities in care
- Member grievances and appeals
- Member satisfaction
- Health education and promotion

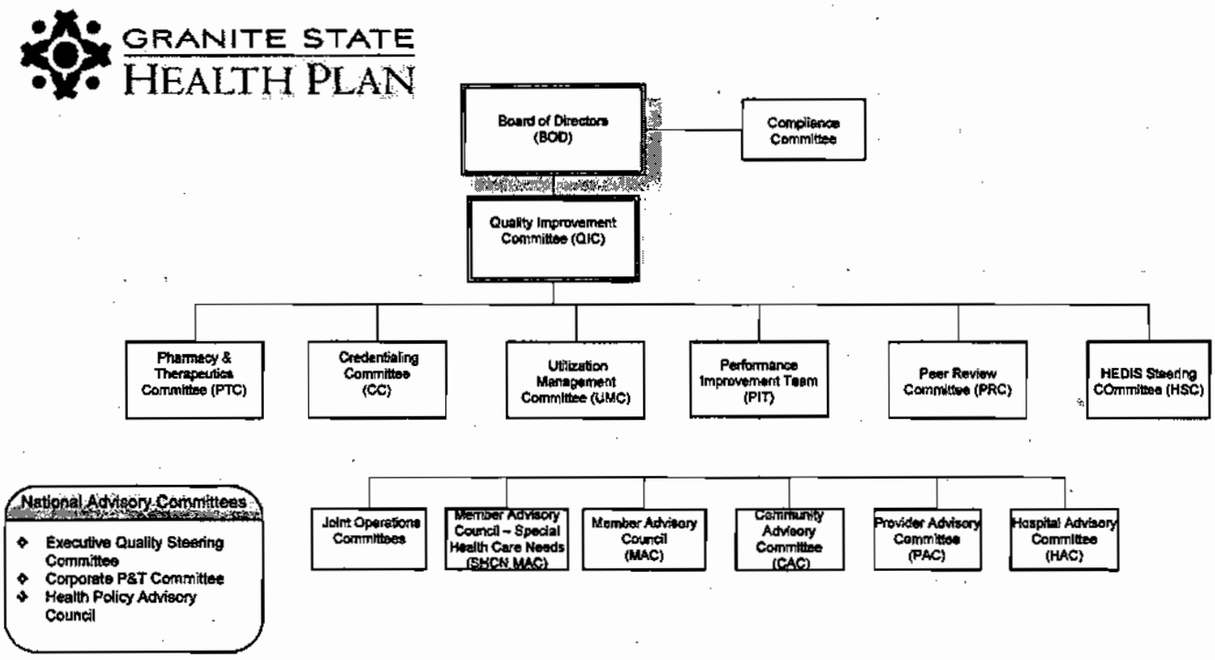
- Network accessibility and appointment availability, including specialty practitioners
- Patient safety including appropriateness and quality of health care services
- Provider satisfaction
- Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and re-credentialing)
- Utilization Management, including under and over utilization

QAPI Work Plan. To implement the comprehensive scope of the QAPI Program, the QAPI Work Plan will clearly define the activities that must be completed by each department and all supporting committees throughout the measurement year. The Work Plan will specify the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The Quality Improvement Committee (described below) will approve the QAPI Work Plan on an annual basis and review the Work Plan at least quarterly throughout the year. GSHP will submit the QIC's approved QAPI plan to DHHS to keep on file.

Quality Improvement Committee Structure

Quality is integrated throughout GSHP's business practices, and represents its strong commitment to the quality of care and services it provides to members. In order to monitor and support its QAPI Program, GSHP's committee structure will link major quality processes of the QAPI Program across functional area operations through established committees, subcommittees and ad-hoc committees, as shown in the figure below.

Figure 5. Quality Assessment and Performance Improvement Program Structure



Board of Directors (BOD). The GSHP Board of Directors oversees development, implementation and evaluation of the QAPI Program. The BOD has ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to members. The Board supports the QAPI Program by:

- Adopting the initial and annual QAPI Program and establishing mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting recommendations from the Quality Improvement Committee for proposed quality studies and other QI initiatives;
- Providing the resources, support and systems necessary for optimum performance of QI functions;
- Designating the Chief Medical Director (CMD) as GSHP's Senior Executive for Quality Improvement (SEQI); and
- Reviewing the QAPI Program, Work Plan, and QAPI Program Evaluation annually to assess whether program objectives were met, and recommending adjustments when necessary.

The Board delegates the operating authority of the QAPI Program to the Quality Improvement Committee (QIC). GSHP senior management staff, clinical staff, and network providers, who may include primary, specialty, behavioral, dental and vision health care providers are involved in the implementation, monitoring and directing of the relative aspects of the quality improvement program

through the QIC, which is directly accountable to the BOD. GSHP will have two members on the Board from Bi-State Primary Care Association: Lori Real, COO for Bi-State and Janet Atkins, Executive Director for Goodwin Community Health. In addition, Donald L. Shumway President and CEO of Crotched Mountain Rehabilitation Center will also have a seat on GSHP Board of Directors.

Quality Improvement Committee (QIC). The purpose of the QIC is to promote a system-wide approach to quality assurance, provide oversight and direction in assessing the appropriateness of care and services delivered, encourage provider participation, and to continuously enhance and improve the quality of care and services provided to members. In addition, the QIC has the responsibility for developing and implementing the QAPI program. This will be accomplished through a comprehensive, plan-wide system of:

The QIC will actively engage participating providers in its quality activities

- Ongoing, objective, and systematic monitoring
- Identification, evaluation, and resolution of process problems
- Identification of opportunities to improve member outcomes
- Education of members, providers and staff regarding the Quality Assurance, Utilization Management, and Credentialing programs.

The QIC is chaired by the CMD. Other senior management staff on the QIC will include the Vice President of Medical Management, Director of Quality Improvement, VP of Compliance & Regulatory Affairs, Director of Provider Relations & Network Development, and Director of Member Services. Subcontractor representatives may also attend the QIC as appropriate.

The QIC will actively engage in its quality activities participating network providers who represent the range of specialties across the State (e.g., Family Practice, Internal Medicine, Behavioral Health Provider, Long-Term Care Providers, Cardiologist, Neurologist, Geriatrics, dentists and other high-volume specialists as appropriate), to the extent that there is not a conflict of interest.

Current New Hampshire providers who have committed to serve on the QIC include:

- Chris Heatherton, M.D. – Lamprey Health Care
- Dr. Robert Slocum, Medical Director – Families First Health and Support Center

The QIC will act as an oversight committee and receive regular reports from all sub-committees (described below) that are accountable to and/or advise the QIC. The QIC will submit the Annual QAPI Program Evaluation to the BOD for review and approval. GSHP will submit the Board-approved annual evaluation report to the DHHS Quality Oversight Committee for review.

The following subcommittees report directly to the QIC:

- Credentialing Committee
- Pharmacy and Therapeutics Committee

- Utilization Management
- Peer Review Committee
- Performance Improvement Team
- HEDIS Steering Committee

Credentialing Committee (CC). The CC will be a standing subcommittee of the QIC, and will oversee and have operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities will be communicated to the BOD. The CC will be responsible for development and annual review of the Credentialing Program Description and associated policies and procedures. The CC will have final authority for review and appropriate approval of licensed physicians, other licensed healthcare professionals, and certain facilities that will have an independent relationship with GSHP. Credentialing activities are performed in compliance with NCQA standards as well as State and federal guidelines, as applicable. The Credentialing Committee is chaired by the CMD or Medical Director and includes representation from a range of practitioners across the contracting area to include the specialty and types of practitioners it reviews. As the Committee member leadership develops, the Committee may be chaired by a network physician at the discretion of the CMD.

Utilization Management Committee (UMC). The UMC, also a standing subcommittee of the QIC, will have oversight of and operating authority over the Utilization Management (UM) Program, including second opinions, referrals and other prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. The UMC is chaired by the CMD, who is responsible for the review and approval of medical necessity criteria; utilization management policies and procedures; after-hours nurse advice line protocols; and monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization of services, coordination of care, and member and provider satisfaction with the UM process.

To ensure that behavioral health is integrated into its QAPI program and throughout the medical management program, a behavioral health provider will be included as a standing member of this Committee. GSHP will also include the Pharmacy Director on the UMC to assist in evaluating and monitoring the appropriateness of pharmaceutical utilization and to assist in the development and implementation of various pharmacy services and programs.

Peer Review Committee (PRC). The PRC will be an ad hoc subcommittee of the QIC responsible for reviewing alleged inappropriate or aberrant service by a Provider, including quality of care concerns, adverse events, and sentinel events where initial investigation indicates that a significant or severe adverse outcome has potentially occurred, or other cases as deemed appropriate by a Medical Director. PRC members will use their clinical judgment to assess the appropriateness of clinical care and to recommend a Corrective Action Plan (CAP) that will best address each particular situation. Each PRC will include three or more network physicians who represent a range of specialties including at least one physician with the same or similar specialty as the Provider or issue under review.

Depending on the severity level assigned, CAPs proposed by the PRC may include, but are not limited to: informal verbal counseling, educational letters, formal verbal/written counseling, mandatory skill training, panel restrictions, mandatory authorization, intensive retrospective or concurrent review, suspension and termination. If the PRC assessment results in a recommendation to terminate the provider, the recommendation is presented to the Credentialing Committee for final determination. Reviews resulting in the reduction, suspension, or termination of a provider's participation due to the quality of care or services rendered will be reported to the National Provider Data Bank (NPDB) and the appropriate State licensure board in accordance with the Health Care Quality Improvement Act.

Pharmacy and Therapeutics Committee (PTC). The PTC will be a standing subcommittee of the QIC, with oversight of and operating authority over GSHP's Pharmacy Program. The P&T Committee will be multidisciplinary and include representation from a range of network physicians and pharmacist(s), clinical pharmacist(s), and a psychiatrist. GSHP executive leadership and Pharmacy/QA staff will also participate as appropriate. The PTC will be responsible for the development and annual review of the Pharmacy Program Description and associated policies, as well as activities such as reviewing pharmacy utilization; specific drug utilization review studies, particularly on the polypharmacy risks of SSI members; and drug interaction reports. Paul Friedrichs, MD of Lamprey Healthcare will be one of the providers sitting on our Pharmacy and Therapeutics Committee.

The PTC will also be responsible for evaluating and recommending drugs for inclusion on or removal from the Preferred Drug List; reviewing and recommending formulary management activities such as prior authorizations, step therapies, age restrictions, quantity limitations, mandatory generics, and other activities that affect access and patient safety; and making recommendations regarding drug utilization review activities such as targeted prescriber and/or member education initiatives. The PTC may also assist with the review of complaints and grievances regarding pharmacy issues, and have oversight of US Script, our Pharmacy Benefit Manager.

HEDIS Steering Committee (HSC). The HSC will oversee GSHP's HEDIS processes and report directly to the QIC. The HSC is responsible for reviewing monthly and final HEDIS scores and identifying areas in need of improvement. The committee will review, approve and implement Centene-led initiatives as well as direct GSHP initiatives to improve selected HEDIS measures. The HSC will direct both clinical and non-clinical, and member and provider initiatives to improve HEDIS scores. The HSC will also review or establish benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. Members of the HSC will include the VP Operations, Chief Medical Director (CMD) or Medical Director, and Directors of QI, Network Management, Member Services, Provider Services Management, Pharmacy, and other members as deemed necessary.

Performance Improvement Team (PIT). GSHP's PIT is a Centene best practice, and is a management-level, cross-functional quality improvement team that facilitates the ongoing integration of quality improvement throughout the organization. The PIT will include representation from each functional area (e.g., Care Management, Compliance, MemberConnections™, Member Services, Utilization Management, Contracting, Provider Relations/Services, Quality Improvement or others as determined by the topic under discussion), as well as employees who conduct or directly supervise the day-to-day

GSHP's PIT is a Centene best practice, and is a management-level, cross-functional quality improvement team that facilitates the ongoing integration of quality improvement throughout the organization.

activities of a department. The PIT will gather and analyze performance measures, perform barrier and root cause analysis for indicators falling below desired performance levels, and make recommendations regarding corrective actions or interventions to produce improvement. The PIT will also oversee the implementation of recommended corrective actions and interventions from the QIC and/or its supporting subcommittees, and will monitor the outcomes and report back to the designated committee.

Five subcommittees will report to the PIT, as described below.

Member Advisory Councils (MAC). The MAC is designed to represent and communicate member perspectives on the quality of care and services offered by GSHP and to offer recommendations for improvement. GSHP will conduct separate MACs for the DD/LTC population and the TANF/CHIP/Foster Care population in Step 2 due to the vast differences in the needs of these populations. MAC responsibilities may include review of: member satisfaction survey results, Member Services telephone performance levels, member education materials for relevance, understanding and ease of use, and other topics as defined by the QIC.

As described earlier in response to Question 26, the MAC will be comprised of members, family members and other caregivers who are randomly selected in accordance with the Managed Care Reform and Patient Rights Act. GSHP will inform its members about this committee through such materials as the Member Handbook, Member Newsletters, and through contacts at community events. Information about these committees will also be available on the GSHP website.

Community Advisory Committee (CAC). The CAC is an advisory committee chaired by the VP of Compliance and Regulatory Affairs with local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. The CAC responsibilities include providing GSHP with feedback regarding its performance from a community-based perspective, making recommendations related to program enhancements, helping to identify issues related to the State programs that impact community groups, and providing input on potential Plan service improvements. We have met with many different community organizations in New Hampshire including NAMI, Endowment for Health and Granite State Independent Living. Several community organizations have agreed to participate on our Community Advisory Committee including: Easter Seals and Community Support Network, Inc.

Provider Advisory Committee (PAC). GSHP will also establish a PAC. The PAC is comprised of the CMD or a Medical Director, network practitioners from across the contracting area, the Director of Contracting and Network, and Provider Relations staff as appropriate. The Medical Director chairs the PAC. The committee provides input on GSHP's provider profile, incentive programs and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance. GSHP will

align its performance incentives with DHHS's Quality Incentive Program. Granite State Health Plan has already identified two providers to participate on this committee: Dr. Jennifer Koop Families First Health and Support Center and Frederick S. Kelsey, M.D., F.A.C.P., Medical Director of Mid-State Health Center.

Hospital Advisory Committee (HAC). The HAC is an advisory group made up of key administrative hospital leaders and GSHP staff to address concerns of hospital networks with regard to prior authorization, concurrent review, discharge planning and coordination of care and payment. The Committee will meet on an ad hoc basis as determined by GSHP executive staff.

The Joint Operations Committees (JOCs). JOCs are active subcommittees of the PIT whose primary function is to provide guidance to, and oversight of the operations affecting the scope of functions of delegated vendors. Activities include reviewing periodic activity reports from delegated vendors, ensuring compliance with all NCQA standards and regulations related to the delegation relationship, and recommending actions to address any identified opportunities for improvement in delegated services. The purpose of the Committees is to provide oversight and assess the appropriateness and quality of services provided on behalf of GSHP to our members. The JOCs will include representation from each GSHP functional area as well as subcontractors.

QAPI Program Staff Resources

Chief Medical Director. The Chief Medical Director (CMD) will be the senior physician on our staff with overall accountability for GSHP's clinical activities and will have direct responsibility for our Pharmacy and Quality Improvement departments. As Senior Executive for Quality Improvement, the CMD will be responsible for the successful operation of our QAPI Program. The CMD will maintain clinical activity, practicing eight hours per week in the community.

Chief Medical Officer. To ensure a local perspective from the provider community, Granite State Health Plan will hire a part time, approximately eight hours per week, Chief Medical Officer who is a practicing physician in New Hampshire. This person will report to the CEO and have an indirect reporting relationship with the full time Medical Director/Chief Medical Director. The CMO will review performance data one-on-one with network physicians, participate on the QIC and Credentialing Committee, and in the development of practice guidelines and other clinical policies. We have included the resume of Dr. Paul Friedrichs of Lamprey Health Care who will be the Chief Medical Officer for Granite State Health Plan, in Section 6.10 of the proposal as well as the job description of the Chief Medical Director whom we will hire upon contract award.

Medical Director. Medical Directors will report to the CMD and participate in GSHP's clinical activities, ensuring consistent application of utilization criteria and reviewing potential quality of care concerns.

Director, Quality Improvement. The QI Director will report to the CMD and be responsible for and participate in the clinical functions of the QAPI Program, facilitate the development and direction of

non-clinical performance improvement, and direct the collection and analysis of clinical performance, utilization data, and grievance data.

QI Coordinator. The QI Coordinators will report to the QI Director and will conduct medical record audits, collect data for various quality improvement studies and activities, and respond to complaints with follow up review of risk management and potential preventive health/adverse event issues.

HEDIS Coordinator. The HEDIS Coordinator will report to the QI Director and be responsible for ensuring HEDIS data accuracy and timely reporting, tracking compliance with HEDIS measures, and participating in related quality improvement initiatives. The HEDIS Coordinator also will maintain an overall action plan for improving performance on HEDIS measures.

Grievance Coordinator. The Grievance Coordinator (GC) will report to the QI Director, logging member grievances and referring those pertaining to potential quality of care issues to a QI Coordinator for investigation and resolution. The GC will evaluate complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention. The GC also will track and resolve all administrative member grievances and provider complaints.

Provider Participation in Quality Improvement

Planning and Design. GSHP believes strongly in active involvement of providers in designing and implementing a clinical and quality program that has value to providers, members and our health plan. In order to build this collaborative foundation, GSHP will build on Centene's experience implementing new health plans in other states by eliciting provider participation early in the planning, design, and implementation process, as well as on a long term basis. As stated previously, GSHP has already begun developing relationships with FQHCs in New Hampshire and other providers, and is actively engaging them in the planning and design of our clinical and quality model.

Implementation and Review. GSHP will actively involve participating network providers, often times unfamiliar with managed care, at various levels throughout its QAPI Committee structure. We will include practitioners who represent the range of specialties in New Hampshire's Medicaid Care Management Program on committees such as the QIC, CC and PAC, as described above. Through these Committees, providers will be involved in analyzing data, will have an active voice in prioritizing quality studies and developing interventions for improvement, and will participate in the annual review of the QAPI program. Practitioners will have the opportunity to give input on the clinical practice guidelines to be adopted by GSHP and in the development of a provider profiling and pay-for-performance program.

For example, Superior HealthPlan, Inc. (Superior), our affiliated Texas health plan, presented changes to provider profiling metrics to their Quality Committee and received invaluable insight to a proposed measure regarding follow-up after an emergency room visit. Practitioners expressed their difficulty in knowing when one of their patients had been to the emergency room. Superior was able to partner with some of its high-volume hospitals to obtain daily listings of members who had been to the emergency room on the previous day and developed a process to share this information with their

provider network. This facilitated continuity of care and follow-up with the medical home after an emergency room visit.

Provider Education and Training. GSHP will use a variety of communications mechanisms, coupled with carefully developed, well-tested content to ensure that providers receive the information needed regarding GSHP's QAPI program, Performance Improvement initiatives, Clinical Practice Guidelines, as well as information regarding coordination and integration of care, empowerment of members, principles of the importance of a medical home, and various QI methods for use in practice. We will give providers a complete guide that includes a description of GSHP's QAPI Program as well as newsletters depicting ongoing performance and soliciting feedback. GSHP will also share important information with practitioners to enable them to work with us successfully, maintain high performance standards, and achieve optimal outcomes for our members. To reinforce our training, we will provide written manuals and guides for providers and their staff to use as reference materials, and we will use peer support, web-based communication, standing committees, new Provider orientation, onsite visits, Provider summits, peer support, online continuing education, and a provider call center.

Member Communication on Quality Improvement

On an annual basis, GSHP will make information about its QAPI program available to its members. Member information will include a description of the QAPI program, Performance Improvement Projects (PIPs), the importance of a medical home, and will be written in easily understood language, at a sixth grade reading level or less and will be available in English and other languages or alternative formats upon request. The information will include a report on GSHP's progress in meeting its QAPI goals. HEDIS and CAHPS results will be discussed, as will outcomes of PIPs. This information may be included in member newsletters or in a separate mailing or on GSHP's website and Member Portal.

Data and Analytical Resources and Reporting

GSHP's QAPI Program will be supported by the expertise and resources of our parent company, Centene. Centene has a strong commitment to quality and to providing appropriate resources to support GSHP's QAPI Program. For example, Centene will provide project planning and production of member education materials for national QI interventions, such as diabetes care initiatives. GSHP will also benefit from the exchange of ideas and sharing of national best practices in regular teleconferences with QI leadership and staff from Centene's 13 other affiliate health plans.

Data and Analytical Support. GSHP QI staff will analyze encounter and other data to identify potential areas for improvement in clinical outcomes or service delivery. Such data may include, but is not limited to, demographic information relevant to health risks or indicative of health care disparities; performance on standardized clinical measures, such as HEDIS and other quality measures outlined in the Contract; utilization trends and other medical management data; external data related to conditions or risks for similar populations; member and provider grievance, complaint, and appeal trends; quality of care complaint data; access and availability audits; claims payment statistics; and

member and provider satisfaction survey results. Additional data sources will include issues identified during care management and referrals from any source indicating potential problems or suspected fraud or abuse, including those identified by affiliated hospitals and contracted providers. QI staff will review this array of data using control charts and Pareto Analysis to identify the most prevalent or persistent issues or those that affect multiple departments.

Management Information System. Centene's management information system (MIS) is designed exclusively for modern managed Medicaid programs and state, public sector integrated medical, behavioral, and pharmacy health plan administration and care management. Our MIS is a potent combination of best of breed applications, integrated through a carefully engineered Service Oriented Architecture (SOA), and supported by over 250 IT professionals dedicated to Medicaid processing.

Our MIS and supporting IT organization have been recognized with several significant awards: most recently we ranked 22nd in *Information Week's* **2011 500 Most Innovative Business Technology Organizations** – and we were the *top* managed care company on that list.

Our QI staff's ability to access relevant data quickly from multiple sources will be a direct result of Centene's ongoing investment in this innovative use of technology. Centene's enterprise-wide MIS supports the QI Programs in all of their health plans, and will include GSHP, by providing integrated, large-scale, secure data management and communication capabilities for efficient and accurate data collection, health indicator measurement, analysis, reporting and improvement activities.

Our MIS interfaces with Medicaid across 13 states—as well as Fiscal Agents and Intermediaries across those states; over 60 electronic claims clearinghouses; our pharmacy benefits manager (PBM) US Script (a subsidiary of Centene and GSHP affiliate); our vision benefits manager OptiCare (also wholly owned by Centene); our disease management subsidiary and GSHP affiliate, Nurtur; and over 100,000 individual, group, and institutional providers—to securely exchange clinical and administrative data in full compliance with HIPAA and state transaction, security and privacy regulations.

Our IT Department and analytical staff, supplemented by additional corporate and health plan resources (such as Provider Network Management, Claims and Encounter Processing Operations, and other departments), will provide standard and ad-hoc reporting, analysis, and decision support to GSHP staff. Through our MIS, GSHP will capture and analyze data from our integrated, internal applications—including Centelligence™, Centene's integrated decision support and health care informatics solutions, and Centelligence Foresight™, Centene's proprietary predictive modeling and care gap/health risk identification application—as well as external sources, such as clinical laboratory, provider network, New Hampshire State registries, for administration, management, and other reporting requirements.

Centene's Enterprise Data Warehouse (EDW), powered by Teradata Extreme Data Appliance high performance technology, is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and vision); financial information; medical management information (referrals, authorizations, disease

management); member information (current and historical eligibility and eligibility group, demographics, PCP assignment, member outreach); and provider information (participation status, specialty, demographics) as required by the QAPI Program.

Performance Monitoring and Evaluation

GSHP will access multiple data sources using data mining tools to generate performance measures, both for standard and ad-hoc reporting, to support ongoing monitoring of the quality, safety and appropriateness of care and services. We will closely monitor the quality of both physical and behavioral health care, employing HEDIS, CAHPS, internally defined measures and key performance indicators for operations functions such as Member and Provider call centers, and claims adjudication.

GSHP's QI staff will trend performance over time and evaluate for statistically significant or meaningful trends, movement toward established goals, or differences among member subgroups.

- GSHP will act on adverse trends or when our performance falls short of established goals by using tools such as root cause analysis or cause-and-effect diagrams for more in-depth evaluation and development of, or revision to, improvement strategies or corrective action plans.
- We will evaluate even single instances of quality of care events, when appropriate, with case review and possible corrective action. After subcommittee review and discussion in most cases, the QIC will review annual summary reports and make recommendations for improvement actions.
- GSHP will regularly evaluate progress toward goals, using the QAPI Work Plan, and the QIC will make adjustments or add new interventions when indicated.

In addition to function-specific reports and reviews, we will provide both GSHP and Centene management with Executive Dashboards of trends on frequently updated, key clinical and operational measures. Dashboard indicators range from monthly medical and pharmacy utilization to claims turn-around-time, to national influenza trends.

We will routinely and continuously monitor our performance in the following areas: patient safety, adherence to evidence-based physical and behavioral health practice guidelines, utilization patterns, children with special health care needs, provider performance, provider access and availability, operational performance, member and provider satisfaction, and complaints, grievances and appeals.

Performance Improvement Activities

The QI department will implement quality improvement activities (QIAs) as required by DHHS. Focus studies and health care initiatives will include behavioral health care issues and strategies. GSHP will utilize traditional quality/risk/utilization management approaches to identify activities that are relevant to GSHP programs or a specific member population and that describe an observable,

measurable and manageable issue. Most often, initiatives are identified through analysis of key indicators of care and service based on reliable data that indicates the need for improvement in a particular clinical or non-clinical area. Other initiatives may be selected to test an innovative strategy or as required by DHHS. Projects and focus studies reflect the population served in terms of age groups, disease categories, and special risk status.

The QIC will assist in prioritizing identified initiatives based on those with the greatest need or expected impact on health outcomes and member satisfaction. Performance improvement projects, focused studies and other QI initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QIC will help to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measurable and able to show sustained improvement over time. Evidence-based guidelines, industry standards and DHHS requirements will be used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist physicians and members in managing their health.

The QIC or other subcommittee may assist in barrier analysis and development of interventions for improvement. Data will be re-measured at predefined intervals to monitor progress. We will conduct interim checks and assessments following full measurement periods. In either case, we will employ rapid cycle PDSA methodology to test changes or additions to the intervention if there is no evidence of improvement. With that methodology we:

- Plan the change, needed data and the goal
- Do a trial of the changed intervention, documenting any barriers
- Study the results, comparing them to the goal
- Act to further refine the intervention based on the results.

We will then repeat the cycle with incremental changes to the interventions until improvement is achieved and sustained.

We consider improvement to be sustained if the level of performance is maintained or further improvement occurs one year after significant improvement has been achieved, and if the improvement likely was a result of the project interventions. We will maintain successful interventions and communicate them as best practices to other Centene plans.

Oversight of Delegated Activities

The QIC may authorize subcontracting entities, such as independent practice associations, hospitals, health homes, or managed behavioral health organizations to perform QAPI or other activities on our behalf. In such cases, we will apply NCQA guidelines and DHHS requirements to determine whether subcontractor functions constitute delegated functions or not. With QIC oversight, QI staff together

with staff from other departments relevant to the delegated activities will evaluate each delegated entity's capacity to perform the proposed delegated activities prior to the executing of a delegation agreement. We will retain accountability for any functions and services delegated, and may reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

For each subcontractor, including Cenpatico Behavioral Health (GSHP's behavioral health vendor), a Joint Operations Committee will provide guidance to, and oversee the operations affecting the scope of functions provided by the delegated vendor; review periodic activity reports from the vendor and reports of member and provider complaints; ensure compliance with all NCQA standards and DHHS or other regulations related to the delegation relationship; and recommend actions to address any identified opportunities for improvement in delegated services.

Clinical Practice Guidelines and Standards

Clinical Practice Guidelines (CPGs) assist providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. GSHP will adopt CPGs in consultation with network providers (including behavioral health, as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program; valid and reliable clinical evidence or a consensus of health care professionals in the particular field; and, needs of the members. (See Section 3.11 for more detail on specific Clinical Practice Guidelines.) GSHP's decisions regarding utilization management, member education, coverage of services, and other areas included in our practice guidelines will be consistent with GSHP's clinical practice guidelines.

GSHP will adopt clinical practice guidelines for at least two non-preventive acute or chronic medical conditions and at least two behavioral health conditions (preventive or non-preventive) relevant to the target population. At least two of the adopted CPGs will directly correspond with two of the care management programs we offer.

GSHP will update clinical and preventive health guidelines upon significant new scientific evidence or change in national standards, or at least every two years. We will distribute guidelines to affected providers and, upon request, to members, potential members, medical consenters, and caregivers. Additionally, we will maintain a listing of adopted clinical practice and preventive health guidelines on the GSHP web site with links and/or full guidelines available to print, noting that hard copies are available upon request.

Practitioner adherence to GSHP's adopted preventive and clinical practice guidelines is encouraged in the following ways: new provider orientations will include the practice guidelines section of the Provider Manual with discussion of GSHP expectations; measures of compliance will be shared in provider newsletter articles and on the provider web site; targeted mailings that include guidelines relevant to specific provider types will underscore the importance of compliance; and GSHP's Physician Profiling program. We will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance.

External Quality Review Organization

GSHP will cooperate with DHHS's EQRO validation of our quality outcomes, timeliness of, and access to, the services covered in our contract. We will collaborate with the EQRO to develop studies, surveys and other analytic activities to assess the quality of care and services provided to member, and to identify opportunities for improvement.

QAPI Program Evaluation

The QAPI Program evaluation includes a summary of all QI activities, the impact the program has had on members' care, an analysis of the achievement of stated goals and objectives and the need for program revisions and modifications. Program evaluation findings are used in developing an annual QAPI Program Description for the subsequent year. GSHP will submit the GSHP BOD and QIC approved annual QAPI Program evaluation report in the DHHS-specified format to the DHHS Quality Oversight Committee for review.

The evaluation will include the following:

- An evaluation of the overall effectiveness of the QAPI Program, including progress toward influencing network-wide safe clinical practices and effectiveness of care management
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service provided to members with special health care needs
- Evaluation of the appropriateness of behavioral health services to members and outcomes related to improving the physical health of members as a result of integrating behavioral health into the members' overall care.
- Trending of measures collected over time to assess outcomes, effectiveness and ongoing performance
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies, and recommendations for new quality improvement activities
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services
- Identification of health care disparities and limitations or barriers to achieving program goals
- Recommendations for the upcoming year's QAPI Work Plan
- An evaluation of the scope and content of the QAPI Program Description to ensure that it covers all types of services in all settings, and reflects demographic and health characteristics of GSHP's membership
- An evaluation of resources and training related to the QI Program

- The communication of necessary information to other committees when problems or opportunities to improve patient care involved more than one committee's intervention.

Selecting Measures to Include in the QIP

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.

As described above, GSHP will utilize traditional quality management, risk management and utilization management approaches to identify quality improvement activities that describe an observable, measurable and manageable issue and to identify the measures we would include in the QIP that are relevant to New Hampshire's Medicaid Care Management Program populations. Our QI Department will collect and analyze data to identify potential areas for improvement using the sources and tools described in response to Question 68. We will ensure that projects and focus studies reflect the population served in terms of age groups, disease categories, and special risk status. QI staff will also obtain input from relevant quality committees or workgroups, especially those with member or provider representation, to ensure wide stakeholder input on local or regional practice patterns or cultural characteristics.

QI staff will recommend activities to the Quality Improvement Committee (QIC). The recommendations will include supporting data about the prevalence of a condition among our members, or the need for a specific service by GSHP members; the relevant demographic characteristics and health risks of the population; how improvement will be measured; the interests of members, providers and DHHS in the aspect of care or service to be addressed; and member and provider input in developing the improvement activity and goals.

The QIC will prioritize initiatives based on the expected impact on health outcomes, member satisfaction, and DHHS priorities. The QIC will assist in further defining the objectives of an initiative, the quantifiable indicators to measure improvement, and the specific intervention to be implemented. In developing its Quality Incentive Program, GSHP recommends DHHS consider the following criteria to select measures.

The QIC will prioritize initiatives based on the expected impact on health outcomes, member satisfaction, and DHHS priorities.

- Is the measure relevant for the Medicaid Care Management Program population or a subpopulation?
- Is the measure related to one of DHHS's clinical priorities?
- Is there an opportunity to improve outcomes on this measure?
- Will the population included in the denominator of the measure be large enough to make statistically valid comparisons?

- Is the measure a reliable and valid indicator with standard data collection and reporting across MCOs?

In consideration of the last criterion, we recommend that DHHS select HEDIS measures in designing a Quality Incentive Program (QIP). In reviewing the State's 2008, 2009 and 2010 Annual Medicaid Reports[19], for example, we noted that DHHS currently tracks a limited number of HEDIS measures for the Medicaid program, with performance generally exceeding national Medicaid NCQA results for most of the last three years. Nevertheless, results were relatively low on some indicators for both New Hampshire Medicaid and nationally, such as adolescent well care visits; breast cancer and cervical cancer screenings; and eye exams for people with diabetes.

With a new Medicaid managed care program, we would recommend picking measures that MCOs have significant experience with and which will include a significant portion of the population, for which there is evidence of a need for improvement, and which we would expect managed care to have an impact over fee-for-service. Wellness and preventive care measures including the first three indicators just mentioned, for which New Hampshire has baseline data for its Medicaid program, should be considered.

Other measures for consideration are those that MCOs can influence through their care management programs in serving members with chronic conditions. Measures related to asthma and diabetes care, which DHHS currently reports of for Medicaid, for example, are indicators that MCOs have extensive experience measuring, and for which improvement can result in lower rates of emergency visits and hospitalizations.

Improvement Goals

Q70. Describe how you recommend DHHS establish improvement goals.

Performance Improvement Goals for the QIP

Centene and GSHP believe that a program such as DHHS' Medicaid Care Management Services Program can only be successful when health plans and the State work in partnership. To that end, following contract award we recommend working with DHHS to develop a plan for operating the program and establishing goals for improvement to evaluate the program's success. GSHP's primary goal is to serve as a responsible, transparent partner with DHHS. Therefore, during the Program Initiation and Pre Implementation Period, we will identify key personnel representing GSHP and will ideally pair them with staff members with the respective expertise from DHHS. Selection of GSHP key contacts will ensure alignment with those identified by DHHS. We have found our most successful

[19] New Hampshire Medicaid Annual Report, Fiscal Year 2008; 2009; 2010.

implementations and idea exchanges have occurred when we hold regularly scheduled meetings between health plan representatives, state agency staff and the state's fiscal agent to discuss project status, risks, and problems, and work toward mutual resolution.

Building on the experience of our affiliated health plans, GSHP will work closely with DHHS in establishing performance improvement goals related to the Quality Incentive Program. GSHP recommends following a systematic approach that our affiliated health plans have adopted for establishing quality improvement goals. The process begins with identifying baseline data (or in the absence of a baseline, how it will be determined). We consider improvement that is maintained for one year as valid. An improvement goal can be established in several ways, including but not to the following:

- A pre-defined benchmark level of performance is achieved
- A reduction of at least 10% in the number of members who do not achieve the outcome defined by the indicator (or, the number of instances in which the desired outcome is not achieved) is achieved.

Strategy for Improving 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***

Quality Improvement Strategies for Measures included in the DHHS Quality Incentive Program

GSHP will consistently measure, track, and evaluate the quality of care that is provided to our members. This enables us to identify areas for improvement and assess the effectiveness of our intervention strategies. GSHP will adopt a performance improvement strategy for each measure included in DHHS's Quality Incentive Program in its first year.

Member Satisfaction. In order to formulate effective action plans and improve performance, based on the results received from the CAHPS 4.0H Medicaid Adult or Child Member Satisfaction Survey, plans need to understand the problems their members report and determine how these problems relate to processes the health plan can affect. Increasing member satisfaction will be achieved by creating and improving processes that impact member satisfaction. To begin with, Centene requires a call abandonment rate for health plan affiliates to not exceed 4%, a standard more stringent than the New Hampshire Care Management Program requires. Examples of call center statistics that exceed these standards are described in Section 3.5 in response to Question 22.

Patient education is also a key component in member satisfaction. Gienna Shaw, writer for *HealthLeaders Media* notes that one can improve both member and physician satisfaction by educating the patient. If one can educate the patient, this in turn can make the physician's life easier, which is good for both patient satisfaction and physician relations.[20] As described in Section 3.5, Member Services, in response to Questions 17 and 18, we will disseminate a wide variety of well-tested member education tools, customized to members' special needs, to support members in communicating with their providers and in making informed decisions about their care.

GSHP will arrange for annual CAHPS surveys to assess the quality and appropriateness of care to members. The Myers Group (TMG), an NCQA-certified CAHPS vendor for our affiliated health plans will conduct CAHPS® 4.0H Medicaid Adult and 3.0H Medicaid Child Surveys of a random sample of our population that will include:

- Health plan customer service (including call abandonment and timeliness)
- Global ratings (including overall plan)
- Getting needed care
- Getting care quickly
- How well doctors communicate

The Myers Group report will compare GSHP and all Centene health plan results against NCQA benchmark data for comparable plans and against composite benchmarks. To help plans develop responsive strategies, TMG conducts significance testing on responses and determines "Key Drivers of Satisfaction" which are the areas of service that have the greatest effect on overall member satisfaction. GSHP will use such analysis to target improvement opportunities. GSHP's Performance Improvement Team (PIT), as described in response to Question 68, will review the survey findings. We will design interventions to implement through Performance Improvement Projects (PIPs) that will be documented in the QI Work Plan. Each PIP will specify intervention components, identify baseline data (or in the absence of a baseline, how it will be determined), establish how improvement from baseline

[20] Gienna Shaw; "Educate Patients to improve both Patient and Physician Satisfaction," HealthLeaders Media April 22, 2009.

will be measured, and set time frames. Results will be measured at specified intervals and documented in the annual Quality Evaluation report.

Smoking Cessation Among Pregnant Women. Start Smart for Your Baby (Start Smart) is Centene's unique care management and education program that GSHP will provide for our pregnant members. Start Smart promotes education and communication between pregnant members and their care managers to ensure a healthy pregnancy and first year of life for their babies. Start Smart offers a range of care management techniques, including smoking cessation. GSHP's Start Smart program will encourage all pregnant members who smoke to quit and will offer incentives for them to do so. Our Start Smart program tracks program participants and ensures they are added to our Tobacco Registry for continued follow up. As described in more detail in Section 3.11 in response to Question 49, GSHP will also implement Centene's Puff Free Pregnancy program to address the increased risk of pre-term birth, low birth weight, and post-natal lung problems. Several Centene health plans have implemented the Puff Free Pregnancy program managed by Nurtur, our affiliated disease management subcontractor. Women identified as pregnant and smoking on the Notification of Pregnancy Form will be contacted for enrollment in the program.

Start Smart's educational materials impact member behavior and, combined with member incentives provided through the CentAccount program (discussed below), encourage members to engage in behaviors that will ultimately improve birth outcomes. Specifically, the program targets behaviors that will reduce the number of low birth weight deliveries, resulting in fewer neonatal ICU admissions. Since instituting the program in 2007, NICU Days per 1000 births fell 30% and the percent of births less than 1500 grams dropped as well.

Centene's enterprise approach reduces fragmentation

Coordination of Care for Children with Chronic Conditions Composite from CAHPS. GSHP will implement our Care Management Program based on Centene Corporation's Coordinated Care Model. Centene affiliates use the Coordinated Care Model to serve children with special health care needs, individuals with physical and cognitive disabilities, mental health conditions and those with chronic and/or complex conditions, including those who qualify for SSI. This model, recognized as a best practice[21], has had demonstrated success serving Medicaid members with these and other conditions. A 2010 study of high-risk members in four Centene health plans found that the plans achieved 21% higher savings for those members receiving care management compared to a control group of high-risk members not receiving care management.

GSHP will leverage the experience of our affiliated health plans to expand the boundaries of traditional Care Management and focus on self-management of chronic conditions; integration of medical,

[21] *SCHIP Innovations for Children with Special Needs in Managed Care*. Center for Health Care Strategies Resource Paper. Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus. February 2003.

behavioral health and other services; and an "outside the box" approach to developing innovative, community-based solutions. Successful strategies that we will build on and adapt for GSHP are briefly described below.

- Centene's enterprise approach reduces fragmentation. We can internally provide care management and coordination, disease management, pharmacy supports, 24/7 nurse helpline services, traditional managed care, and telemonitoring as one entity with a single, centrally-located care plan and record of services.
- Our on-the-ground, locally-based call centers, MemberConnections staff (community outreach workers), Care Managers, and hospital based discharge nurses ensure each member is supported by someone who understands the local culture and available community resources.
- We will engage members, families/caregivers and advocates in the way we provided services and in how we communicate. We will achieve member-centric care and service outcomes through advisory councils and other methods of ongoing engagement such as advocacy group participation in staff training and suggestions for network development.
- We will embrace a holistic, functional approach to care rather than a diagnosis-driven approach. Each member's caregiver will receive the education and support they need to manage chronic conditions as well as make decisions about their care plan and delivery of care.
- Our unique integrated approach to serving people with cognitive impairment, including developmental disability and mental illness, includes co-locating physical health and behavioral health Care Managers in one location. Recovery and resilience outcomes are achieved by ensuring provision of services that address behavioral and functional needs, thereby supporting physical health status improvements.
- We will support the physician community through reducing the "hassle" of managed care by asking for the lowest level of required authorizations possible, accepting out-of-network care episodes, reducing no-shows by facilitating transportation, arranging specialist appointments, offering electronic interfaces, and identifying member needs related to disabilities prior to the treatment visit.

GSHP staff will ensure that the full range of covered and non-covered services each member needs is integrated into a seamless, holistic experience of evidence-based care that improves outcomes and enhances quality of life. This approach has earned Centene plans a reputation among member populations for understanding how to meet special needs.

For example, in the service areas in which our Texas affiliate provides medical, behavioral health and long term care services to members on SSI, 81% of the voluntary SSI child population has chosen to enroll in our affiliated plan. Our Care Management Program will support members and providers through our Integrated Care Teams, as described in Section 3.11 in response to Question 63. The Program will offer sophisticated technology solutions that assist plan staff and providers in ensuring all members receive needed care that meets evidence-based standards, and innovative programs to

enhance each member's care. These resources will enable us to effectively integrate the full range of medical, behavioral health, and other services each member needs.

Shared Decision Making Composite from CAHPS. Effective member engagement in their own care and self-management contributes to optimal health outcomes and quality of life. However, many Medicaid members require intensive support and education to do so effectively and to sustain their involvement. To address these needs, GSHP will provide multiple levels of support and information to members, parents/guardians and caregivers (as applicable).

Because different people prefer different methods of communication, GSHP will use multiple communication strategies, including written materials, telephonic outreach, web-based information, and in-person interactions, as described in Section 3.5 Member Services in response to Questions 17 and 18.

GSHP will offer an expansive set of health education programs and materials that use comprehensive outreach and communication methods to effectively educate members, their families and communities about their health and self-care and how to access plan benefits and supports. Effective health education paired with incentives, assistance or information on how to access needed services provides the strongest supports for member health and functional maintenance and improvements.

Our approaches will align with evidence-based guidelines and best practices to empower members to access needed services and to have confidence in decision making, self-care and self-directed care, assist participating providers in educating their patients, and encourage the support of caregivers, family members and communities in healthy lifestyles, care plan follow-through and service access.

Adolescent Well Care Visits. As part of our multifaceted community outreach strategy, GSHP will collaborate with provider offices to ensure children are receiving preventive services, such as well care visits, immunizations and ESPDT screenings, based on clinical guidelines. GSHP will implement a Start Smart Birthday programs, similar to that of our affiliated health plans. For these events, MemberConncections Representatives (MCRs) coordinate with specific PCPs whose assigned members have a high EPSDT non-compliance rate. The providers agree to set aside scheduled time for EPSDT appointments at specified times during the week. MCRs contact each member's guardian/caregiver by phone or, if unsuccessful, send a postcard requesting a call back. During the phone call, MCRs provide education about the importance of well care visits, immunizations and screening. For example, there was a significant increase in **Adolescent Well-Care visits**, as well as Well-Child Visits in First 15 months of life, and Well-Child Visits in the 3rd – 6th years of life across our combined health plan membership in Georgia, Indiana, Ohio, and Texas CY 2008 to CY 2009.

Support for Members. To encourage members' participation in their wellness care, GSHP will offer **CentAccount**, Centene's trademark member incentive program, to reward health behaviors such as timely receipt of adolescent well-care visits. The CentAccount™ member incentive program is widely used by

Centene health plans and promotes personal healthcare responsibility and ownership by offering financial incentives that are valued and appreciated by healthcare consumers. The reward is loaded onto a health plan issued CentAccount MasterCard® debit card. Members can use this card at many merchants they already use every day, such as nationally recognized drugstores, community pharmacies, and supermarkets, to buy a wide variety of health-related items including some over-the-counter medications. Members may use the earned funds on their CentAccount cards towards healthcare goods and services not covered by Medicaid, including paying for baby products, bus passes, utilities and childcare.

We will also send reminder postcards to notify the parent/guardian that the child is in need of a well visit. Additionally, we will send new members information about well visits/EPSDT services in the new member welcome packets and mention them in welcome calls. Members will also be able to obtain such information in the Member Handbook, on our Member Portal, and in Member Newsletter.

Support for Providers. We will supply PCPs with monthly noncompliant reports that include all of their linked members due for a well-child visit or past due for services, and we will indicate care gaps on the Provider Portal to alert providers of a member's potential need for well care.

We will also facilitate adolescent well-care visits through new provider orientation and ongoing information and tools available on the Provider Portal, and in Provider Manual and Provider Newsletters.

Follow up after Hospitalization for Mental Illness (7 days and 30 days). GSHP's Integrated Care Team (ICT) for serious mental illness/developmentally disabled will provide comprehensive, systematic care coordination that begins prior to discharge from any inpatient facility. See Section 3.11 Care Management, in response to Questions 61 and 64 for more detail. Concerning follow up after hospitalization for a mental illness, Behavioral Health (BH) ICT Care Managers will assist hospital discharge planners and members with scheduling follow-up visits, and linking members to their previous outpatient behavioral health providers. Activities include conducting discharge assessments for inpatient facilities, and documenting that timely follow-up appointments are being made for the member. The ICT BH Care Manager initiates calls with a member one to two days post discharge from an inpatient facility to ask if the member has an appointment with a mental health practitioner within 7 days of his or her discharge, and will assist with appointment and/or transportation arrangements or other potential barriers to keeping an appointment. The Care Manager will call after the scheduled appointment to assure that the appointment was kept. The ICT will make call reminders to members about both 7 day and 30 day post-discharge appointments and will help members address potential barriers to keeping appointments, such as transportation.

To facilitate continuity of care, the ICT BH Care Manager will fax the discharge summary to the member's PCP and/or behavioral health provider and make post-visit confirmation calls to follow-up with member's behavioral health providers.

Cholesterol Management for Patients with Cardiovascular Conditions. Members with cardiovascular conditions will be enrolled in our Care Management program to encourage appropriate care, including cholesterol management. Nurtur, our subcontractor for disease management services, will also provide disease management services for members with congestive heart failure and coronary artery diseases, as described in Section 3.11. Care Managers will use a holistic approach by combining referral and access to community resources, transportation, follow-up care (including lab testing and results), medication review, specialty care, and education to assist members in making better health care choices. Our Model will emphasize direct member contact, such as telephonic and face-to-face education, because it more effectively engages members and allows us to provide information that addresses their specific questions and meets their needs.

GSHP will adopt and educate providers on the clinical practice guidelines (CPGs) for physical and behavioral health promulgated by the leading academic and national clinical organizations such as the American Heart Association (AHA)/American College of Cardiology (ACC) Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease, 2006. GHSP will disseminate QIC approved or revised CPGs to all providers through provider orientations and other group sessions, our Provider Portal, the Provider Manual, Provider Newsletters, and targeted mailings. We also will provide notification of guideline availability on the Provider Portal during new provider orientations, in the Provider Manual and through targeted mailings. Targeted mailings to identified providers will also include lists of members in need of services for which the guidelines are applicable. Our Medical Management Department will maintain a record of notification and distribution of guidelines. Guidelines will be made available to all members upon request.

Reduction in Child & Adult BMI. GSHP will implement a Healthy Lifestyles Program modeled on similar initiatives our affiliate health plans have adopted as one of several strategies to reduce overweight and obesity among our members.

The Healthy Lifestyles Program includes the following initiatives:

Healthy Habits. GSHP staff will visit local organizations and programs to teach members about exercise, healthy eating (including cooking demonstrations) and other healthy habits such as safety and hygiene education.

Healthy Schools. GSHP staff will visit local schools to promote our childhood obesity program, which includes a *Thumbs Up Johnnie* book about physical fitness and healthy eating and reading from its author, a visit from Thumbs Up Johnnie himself, and other information and outreach geared at reducing childhood obesity. Recognizing the importance of early intervention, this program starts as early as first grade outreaching to children to teach them the importance of healthy behaviors.

Clinical Practice Guidelines. GSHP will also adopt and educate physicians about clinical practice guidelines (CPGs) for physical and behavioral health promulgated by the leading academic and national

clinical organizations such as the National Heart, Lung, and Blood Institute's *The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* (NIH Publication Number 00-4-84 October 2000). Quality Improvement Committee members and practicing network primary care and specialty providers will provide input on current community clinical practices and how to maximize acceptance of evidence-based guidelines. GSHP will monitor compliance with CPGs and calculating and tracking BMIs for our members through medical record reviews.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.13 Early Periodic Screening, Diagnosis and Treatment

3.13 Early Periodic Screening, Diagnosis and Treatment

EPSDT

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

Overview

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program with two primary objectives: (1) assuring the availability and accessibility of required health care resources; and (2) helping young Medicaid recipients and their parents or guardians effectively use these resources. It encourages assessment of the child's health needs through initial and periodic examinations and evaluations, and promotes early diagnosis and treatment of problems, before they become high risk. Granite State Health Plan, Inc. (GSHP) is committed to providing preventive health screenings and improving the overall health of children enrolled in its health plan. Our ability to affect the incidence of EPSDT screening is vital to the overall health and well-being of our membership.

GSHP's ability to affect the incidence of EPSDT screening is vital to the overall health and well-being of our membership.

The primary goal of GSHP's EPSDT program is to facilitate age appropriate, comprehensive preventive services for GSHP Members from birth to 21 years, as outlined by the American Academy of Pediatrics. GSHPs' EPSDT programs cover preventive, diagnostic, and treatment services (including physical, behavioral, dental, hearing and vision screenings) as well as other treatment services that the provider determines to be medically necessary. We embrace the guidelines defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation. In addition, GSHP adopts Section 1905(r) of the Social Security Act (the Act) to include any medically necessary health care service listed in Section 1905(a) of the Act for members eligible for EPSDT services, including requirements found in 42CFR 441.50.

Granite State Health Plan's parent company, Centene Corporation (Centene), has shown that ensuring members choose a primary care provider (PCP) is necessary but not sufficient to guarantee members' access to preventive and primary care. The Medicaid population generally requires **intensive, ongoing education** about the benefits of primary care and appropriate access, as well as assistance removing barriers to access. As such, GSHP will link continual member education, member compliance reporting, targeted member outreach, approved member financial incentives and provider compensation to reinforce the importance of EPSDT services. This will include our "boots on the ground" approach of sending staff into the community to interact in-person with Members, and will involve family, caregivers and other key supporters. We will also recruit the assistance of providers, key community

organizations, advocacy groups and others to communicate the importance and availability of preventive care services.

Program Development and Oversight

GSHP has multiple programs to encourage the use of EPSDT services and fully shares DHHS's goal of ensuring that children receive age appropriate comprehensive, preventive services and medical necessary treatment services. GSHP knows that ensuring compliance with EPSDT requirements demands a defined, multifaceted approach. Our strategies include intensive general member and provider education as well as targeted education for members due for EPSDT services, members who are non-compliant, and providers with non-compliant members. Provider education includes assisting providers to understand all required components of EPSDT visits and how they perform compared to peers. In addition, the QI Department monitors services that should be provided during an EPSDT visit such as administration of immunizations and reinforces that a full range of EPSDT therapies are provided by GSHP to ameliorate the effects of developmental delay and health conditions such as autism.

To implement and ensure the effectiveness of our multiple compliance strategies, GSHP has designated a full-time **EPSDT Coordinator** to oversee our EPSDT efforts. This coordinator reports to our Director of Quality Improvement, who has ultimate accountability for the program. The EPSDT Coordinator has primary responsibility for coordinating all EPSDT efforts through our Performance Improvement Team (PIT), a management level sub-committee of the Quality Improvement Committee (QIC). Each month, the PIT meets to monitor components of EPSDT performance data (such as Access to Care, Immunizations, Well Child Exams and Screening) and proposes interventions to address areas needing improvement.

Member Education and Outreach

GSHP's efforts to educate our members about the importance of EPSDT services begin at the time of enrollment in our plan and continue throughout their enrollment in GSHP.

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GSHP' outreach processes include general mailings (such as the new member welcome packet, various reminders, newsletters, etc.), posted and distributed information (such as information available on the website and distributed at community events); telephonic interaction (including welcome calls and outreach calls to members due for services and non-compliant members); and face-to-face interaction which takes place at health fairs and community events, as well as during personal visits by GSHP MemberConnections Representatives (MCRs), who visit members in familiar settings such as their homes or providers' offices. GSHP's efforts to educate our members about the importance of EPSDT services begin at the time of enrollment in

our plan and continue throughout their enrollment in GSHP. Our multi-tiered appraoch starts with general member education such as the following:

- ***New Member Calls.*** Upon receipt of the eligibility file from the state, GSHP staff, in partnership with Nursewise, our 24/7 nurse advise line affiliate, will place New Member Welcome Calls to each new member. Nursewise will welcome the member to GSHP and provide information about covered services, including EPSDT services.
- ***New Member Welcome Packet.*** The New Member Packet, mailed to new members within 3 business days of notice of enrollment, will include among other things, an EPSDT brochure and an EPSDT magnet outlining the recommended periodicity schedule and information about our Start Smart for Your Baby Program and CentAccount member rewards program.
- ***Member Handbook.*** The Member Handbook serves as our members' primary reference tool for understanding GSHP and DHHS' health care delivery system and all of the benefits available under the program. The Member Handbook will include a specific section that provides information about EPSDT services.
- ***Member Website.*** GSHP will maintain a member website, which will provide general information about available services and programs; a copy of the Member Handbook and a Member Quick Reference Guide; both include information about EPSDT services. GSHP will include a page dedicated to EPSDT explaining the importance of preventive care, what to expect during the visit and the periodicity schedule.
- ***Member Newsletters.*** On a quarterly basis GSHP will send a Member Newsletter to each of our members. These newsletters cover a variety of topics, such as services available to our members, seasonal health information and reminders to receive appropriate preventive care, including EPSDT services.

GSHP's second tier member education strategies include population specific educational efforts. These activities are directed towards parents and members eligible for EPSDT services. Outreach activities include:

- ***Reminder Postcards.*** GSHP will send EPSDT reminder postcards to children and young adults during the month of their birthday.
- ***Start Smart for Your Baby.*** Start Smart is a unique perinatal program, implemented by all Centene health plans with proven health outcomes, that follows women for up to one year after delivery, and includes neonates and children up to one year of age. GSHP's postpartum mailing and follow-up calls include education and an incentive program to promote well child exams and immunizations.

Start Smart for Your Baby®

- ***In-Person Member Education.*** GSHP will implement Centene's intensive, **grassroots** outreach program called MemberConnections. Through this program, we will hire MCRs from within the communities we serve and train them as outreach and health education workers who work

with members one-on-one in their homes and other community locations to educate them and address specific EPSDT service access barriers.

- ***Baby Showers/Diaper Days.*** GSHP MCRs will host baby showers for our pregnant and recently-delivered members. We will send out an invitation to all identified new moms or moms-to-be in the area and structure the event as a typical baby shower. We will host these events as an opportunity to provide educational materials to our members, including information about infant care, lead poisoning, the importance of scheduling well visits including EPSDT visits, etc.
- ***Health Check Days.*** This program has been implemented successfully by Centene affiliate health plans to promote and facilitate preventive health well visits and EPSDT visits. At these events, GSHP will partner with provider offices across New Hampshire to identify members who are due for certain preventive care services, such as well child/EPSDT visits. MCR staff then outreach to these members to assist them to make an appointment on a certain day set aside by the practice. Similar to Health Check Days, GSHP will also work with local community resources to implement Super Shot Saturdays. In 2009, Centene's Indiana affiliate, Managed Health Services (MHS), began sponsoring Super Shot Saturdays (SSS) with key community based partners held at schools and local health departments as a means to encourage members to receive needed immunizations. SSS were organized to give parents an opportunity to bring in school-aged children on a non-business day. For example, a SSS was held at the Elkhart Health Department. The event was organized by the Community Health Nursing Staff under the Health Officer and the Elkhart Health Department. MHS provided staff and t-shirts for this event, where over 500 children were served and over 1,300 free vaccinations were administered.
- ***Back-To-School Fairs.*** GSHP will coordinate and provide support to community Back-to-School fairs that involve health promotion, EPSDT screenings and immunization administration. MCRs will play a key role in supporting these efforts by coordinating the fairs, contacting members in need of services and notifying them of the fairs, and providing staff support the day of the fair.
- ***Engaging Member Supports.*** Through our experience with members on SSI, members with severe mental illness (SMI) and members in foster care, we have learned the importance of outreaching to the caregiver and other individuals that the member looks to for assistance or guidance. For example, ensuring that members with SMI or other cognitive impairments receive needed preventive and EPSDT services often requires involvement of their 'influencer', such as a Community Mental Health Center Case Manager or a guardian.

For members who have not responded to the above interventions and are found to be out of compliance with routine EPSDT screenings, GSHP will conduct additional targeted outreach. Our quality improvement staff will generate a monthly report, identifying members who have not an EPSDT visit in accordance with the American Academy of Pediatrics periodicity schedule. The EPSDT Coordinator will send reminder post cards to identified members who are in need of recommended services. The EPSDT Coordinator, with support from MCRs, will personally call persistently non-compliant members, encouraging them to make an appointment, and offering to assist with scheduling. GSHP may also implement automated reminder messages for the remaining members identified as non-compliant.

MCRs may meet individually with members in the community and in their homes, particularly when we have been unable to contact a member by telephone.

Innovative Programs to Engage Members

- ***CentAccount program.*** GSHP's CentAccount program offers valued, financial incentives to members for achieving healthy behaviors such as receipt of EPSDT services. This card is a debit card that can be utilized at community pharmacies, CVS, Wal-Mart, supermarkets and many other stores to purchase only health care related items. Success of the program is noted when comparing the data of our Indiana affiliate, Managed Health Services, from July to December 2008 (pre-CentAccount) and July to December 2009, after the program was implemented. Member well-visits increased by 49% in one year for children between the ages of seven to eleven; twelve to twenty year olds by 43%; and an overall increase of more than 20% for all ages.

Member well-visits increased by 49% in one year for children between the ages of 7-11 in Indiana

- ***Inbound Member Services Calls.*** GSHP will implement our proprietary Member Relationship Manager (MRM) System. Upon receipt of an inbound call, the MRM will prompt the MSR with a Care Alert that notifies the MSR that the member is in need of a service, such as an EPSDT visit, so that they can notify the member and offer to assist the member with scheduling the visit and helping to arrange any necessary transportation.

Provider Education and Outreach

GSHP recognizes that collaboration with our providers is vital to the success of our EPSDT activities. To facilitate this collaboration we have implemented a comprehensive approach to provide education for and assistance to our providers. Information about EPSDT requirements and the assistance available by GSHP is offered in person during office visits, on-line via the GSHP website, included in provider newsletters, and as a part of ongoing provider training sessions.

Beginning with an initial provider orientation and continuing throughout participation, GSHP will work with our primary care providers (PCPs), FQHCs, PCCs and others who deliver prenatal or EPSDT services to offer the education and tools needed to educate members about the importance of preventive care.

- ***Online Care Gap Alerts.*** GSHP will implement Care Gaps, an innovative technology solution as part of our Provider Portal capabilities. Care Gaps alert providers of a member's potential need for interventions, diagnostic tests, and laboratory tests when the provider checks member eligibility on our website. An alert is triggered if we have not received a claim within the given time period specified by treatment guidelines for a specific condition.
- ***Monthly Reports.*** On a monthly basis GSHP will provide network PCPs a report that includes all their assigned members due an EPSDT visit the upcoming month as well as members who are past

due for services. This report is posted on GSHP's Provider Portal and gives providers a valuable tool to target their member outreach and allows them to preserve valuable office staff resources.

- ***Provider Training.*** GSHP educates all new PCPs regarding the EPSDT program. GSHP Provider Relations Specialists field staff educates all new PCPs during a mandatory comprehensive new provider orientation prior to serving GSHP members. This orientation includes an overview of all EPSDT requirements, including but not limited to the periodicity schedule and required components of each EPSDT visit. Network PCPs receive continuing education regarding these topics as well. Provider Relations Specialists follow up with on-site visits to reinforce the information offered to our providers and their office staff during multiple training activities.
- ***Provider Manual.*** Our Provider Manual is a comprehensive reference tool that addresses administrative expectations, prior authorization and utilization management processes, claims, and plan benefits. The Provider Manual includes an EPSDT section that describes services and includes references to additional information.
- ***Newsletters.*** Provider newsletters are distributed to all GSHP network providers, designed to inform providers of important clinical and quality information to assist them as they provide members quality care.

Ensuring Provider Compliance

Provider Profiling. GSHP's Provider Profiling, adopted by affiliate plans, is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and quality of care in alignment with evidence-based clinical practice guidelines and DHHS goals. Performance reporting increases provider awareness, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of clinical improvement initiatives. We include with the scorecards lists of panel members in need of recommended services and their contact information. The quarterly scorecards will use rolling 12-month data and provide national Medicaid NCQA data or GSHP goals, as appropriate, as benchmarks for each indicator. Armed with this information, primary care physicians can adjust their processes or approaches prior to the final year-end quality score, so they can positively affect their quality profile scores. As a part of the Provider contract, participating practitioners can increase their overall compensation by demonstrating improvements in EPSDT scores – part of their quality profile scores.

Medical Record Audits. On an annual basis GSHP's Quality Improvement Department will audit files from a random sample of providers to ensure that all required EPSDT visit elements are present. Each audited provider receives a letter that notifies them of the audit findings and provides information about specific opportunities for improvement. GSHP's Medical Director will meet with very high-performing providers to recognize their efforts and identify best practices that can be shared with other providers through the website, newsletters or special mailings. The Medical Director also meets with very low-performing providers to identify ways to improve outreach and provide best practices. These providers receive education regarding required elements, are targeted for other education and

collaboration efforts to increase compliance, and are re-evaluated in six months. If efforts remain unsuccessful, the provider is subject to corrective action.

Innovative Technologies

GSHP Health Plan's ability to capture and analyze data, identify baseline data and identify opportunities for improvement is essential to our success of improving provision of EPSDT services. GSHP is supported by its parent company, Centene, who has over 27 years of experience in developing and using systems to track and report on service utilization. We will use "state-of-the-art" business intelligence tools to capture data, monitor the integrity of data, and report on data specific to all aspects of our quality improvement initiatives including ensuring timely and appropriate access to EPSDT services.

Centelligence™ is our proprietary and comprehensive family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* information: everything from Care Gap and Wellness Alerts, to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, and standard and ad-hoc desktop reports. Centelligence™ continually analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations), producing "business intelligence" and delivering the right information products to the right person (e.g. Case Manager, MSR, Provider, Member) for the right task (e.g. clinical intervention, internal workload adjustments, client reporting) at the right time (e.g. on schedule, or "in real time"). The Centelligence™ family includes: our Enterprise Data Warehouse, Centelligence Insight™, and Centelligence Foresight™.

Enterprise Data Warehouse (EDW), integrates **medical, behavioral, dental, and pharmacy claims**, and member and provider demographics into a centralized repository. **Centelligence Insight™** includes our desktop reporting and management KPI Dashboards capability, as well as our implementation of Ingenix's Impact Intelligence. Both of these solutions afford GSHP and our providers the practice and peer level profiling information needed for continuous clinical quality improvement. With these tools, we can monitor our overall EPSDT participation as well as member participation by PCP panel. **Centelligence Foresight™** incorporates our Impact Pro, Catalyst HEDIS, and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications allowing us to identify and engage members before they become past due for a service.

Online Care Opportunity and Care Gap Alerts. Our Care Opportunity and Care Gap Alert features provide real-time, online alerts about the potential need for interventions, diagnostic tests and labs for certain conditions or for necessary preventive services, such as EPSDT, whenever a provider office checks eligibility via our Provider Web Portal. Providers will have access to claims information including medical, dental and pharmacy data for assigned members to identify gaps in adherence to the treatment plan. The provider will also have access to the member's ED utilization. The Care Opportunity Care Gap Alert feature provides a warning box designed to inform the user of the specific potential upcoming need or gaps. The user must close this box to continue. The Care Opportunity and

Gap functionality allows the Portal to be a one-stop shop for providers to ensure that members are appropriately accessing the care they need.

Member Relationship Management System (MRM). Centene's MRM enables GSHP to ***identify, engage,*** and ***serve*** our members in a holistic and coordinated fashion, across the breadth of their wellness, clinical, administrative, and financial matters. MRM is our integrated repository of "all things member" and has three core integrated components: member demographics system, MemberReach and MemberConnect. **MemberReach** automates, manages, tracks and reports on our workflows for *outbound and outreach* member campaigns, as well as targeted outbound interventions (such as EPSDT reminder calls and mailings). **MemberConnect** is our Customer Relationship Management (CRM) member services application which greatly expands the efficiency and extent of member and caregiver information that we can collect, transmit, display, route and use. For example, if a member or caretaker we have been trying to reach happens to call us for any reason, our Member Services Representatives (MSRs) can address the member's immediate issue. Care gap alerts as described above are visible to our Member Services staff so that when a member calls in with a question, the MSR can take the opportunity to educate the member about needed services, such as EPSDT screenings and immunizations. During the same call, the MSR can assist the member to locate a provider, schedule an appointment, or arrange transportation.

Proven Outcomes

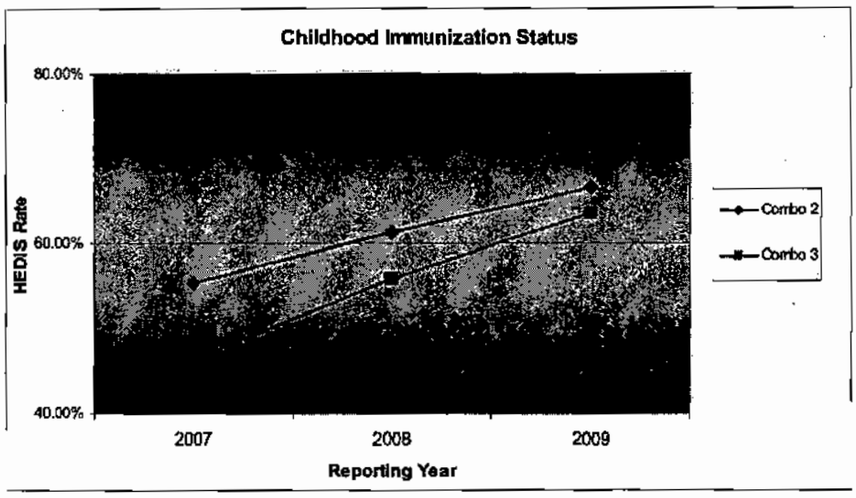
Like its affiliate health plans, GSHP, will use continuous, data-driven quality improvement to evaluate its performance and outcomes and implement process improvements. As part of our continuous quality improvement approach we monitor the outreach and the informing process and assesses how well members understand EPSDT information by regularly reviewing member grievances, provider complaints, Member Advisory Council and Physician Advisory Committee input, satisfaction surveys, and EPSDT rate trends. GSHP will track compliance monthly using Impact Pro, which integrates claims, member and provider data and use this and other reports to identify members who are non-compliant with periodicity, or are due for an EPSDT visit during the upcoming month.

Ongoing monitoring of HEDIS measures reflects the success of our multiple EPSDT strategies. Our Indiana affiliate, Managed Health Services (MHS), has been reporting HEDIS the longest of our Centene health plans. Between 2002 and 2010 MHS saw the following improvements in their well-visit HEDIS rates:

Improvements in EPSDT HEDIS Measurements for Indiana Affiliate Plan			
Well Care Measure	2002 Rate	2010 Rate	% Improvement
0 to 15 months (six or more visits)	17.7%	56.93%	221.6%
Ages three to six years	44.1%	64.53%	46.3%
Adolescent visits	23.7%	46.96%	98.1%

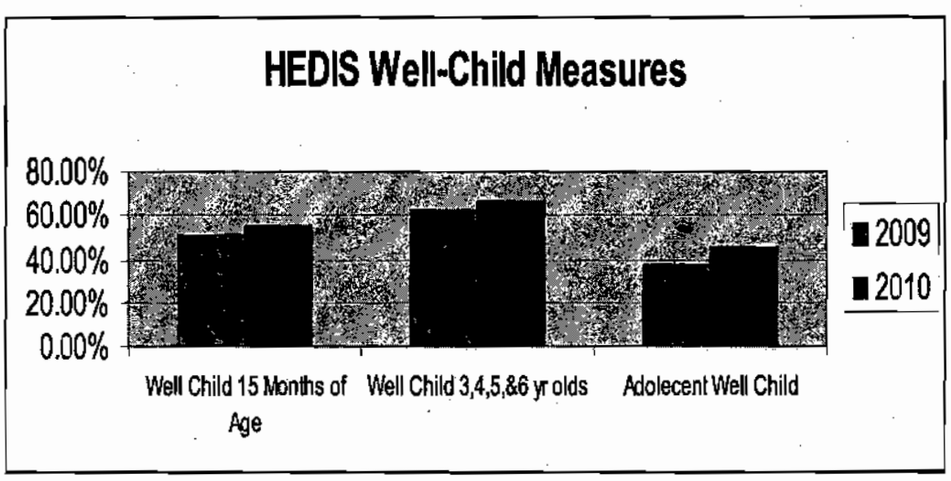
Additionally, MHS has seen immunization rates, another indicator of EPSDT performance, consistent improvement over time, as demonstrated by the following:

Figure 6: Improvement in Childhood Immunization HEDIS Rates



The graph below demonstrates Centene's continued overall improvement in provision of EPSDT related services.

Figure 7: Improvement in Centene HEDIS Well-Child Measures



GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.14 Utilization Management

GRANITE STATE HEALTH PLAN

3.14 Utilization Management

Approach to 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.***

Overview

Centene Corporation and its 13 affiliate health plans (including Louisiana effective February 2012) have garnered more than 27 years' experience maintaining effective utilization management (UM) programs across the United States for Medicaid, CHIP and Medicare populations. Our UM programs have served a broad range of members with diverse needs including:

GSHP will deliver the *right care*, at the *right time* and in the *right place*.

- Members eligible for Medicaid due to qualifying for TANF, being in Foster Care, or meeting Aged, Blind and Disabled/SSI criteria.
- Members with serious and persistent mental illness and other behavioral health conditions.
- Members with long term care services needs.
- Members who are dually eligible for Medicaid and Medicare.

Granite State Health Plan (GSHP) will build on the successful approaches of Centene affiliates to maximize health outcomes by ensuring our members receive consistent, unduplicated, high quality care according to evidence-based clinical decision criteria. Our experience has taught us that the best approach to quality medical care and cost control is to strictly adhere to our philosophy of the **right care, at the right time and in the right setting to establish a lifetime of healthy behaviors and outcomes.**

Subject to DHHS approval, GSHP will operate and maintain a UM program that promotes fair, impartial and consistent utilization decisions. Our UM Program's policies and procedures will meet or exceed all NCQA standards and federal requirements in 42 CFR 456, 42 CFR 431, 42 CFR 438, as well as all relevant state regulatory and contractual requirements. We also will require subcontractors with delegated UM authority to comply with all contractual and applicable state, federal and accreditation requirements.

Because some cases and authorizations will be open or in progress at the time a member transitions from FFS to GSHP, we will authorize existing services for a period of 30 days or until GSHP completes an initial assessment and updated care plan.

The scope of our UM Program will be comprehensive and will apply to all members across age categories and range of diagnoses, and will incorporate all care settings, including settings for preventive, primary, specialty, acute, emergency, home care and ancillary care. Our UM and Quality Improvement Committees will evaluate and update the UM Program at least annually or more frequently as needed. Our UM Program goals are to:

- Provide medically necessary services that are covered benefits.
- Emphasize evidence-based health care.
- Promote prevention, healthy choices and lifestyles.
- Actively manage cost trends in the least restrictive manner.
- Reduce administrative burden on providers.
- Provide a process for members and providers to voice concerns.

GSHP will ensure that medically necessary covered services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope. We will adopt and/or develop written evidence-based clinical review criteria and review procedures to support authorization staff. We will use recognized evidence-based national criteria reflecting accepted clinical practice to determine the medical necessity and appropriateness of covered services requiring authorization. Criteria will be selected to enable authorization personnel to determine whether services are appropriate for the member's condition, provided in an appropriate setting and meet professionally-recognized standards of care, while considering any special circumstances that may require deviation, such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization. In the case of a possible denial of coverage, in accordance with NCQA and state requirements, a Medical Director will offer to discuss the case and the medical necessity guidelines with the requesting provider prior to issuing an adverse determination.

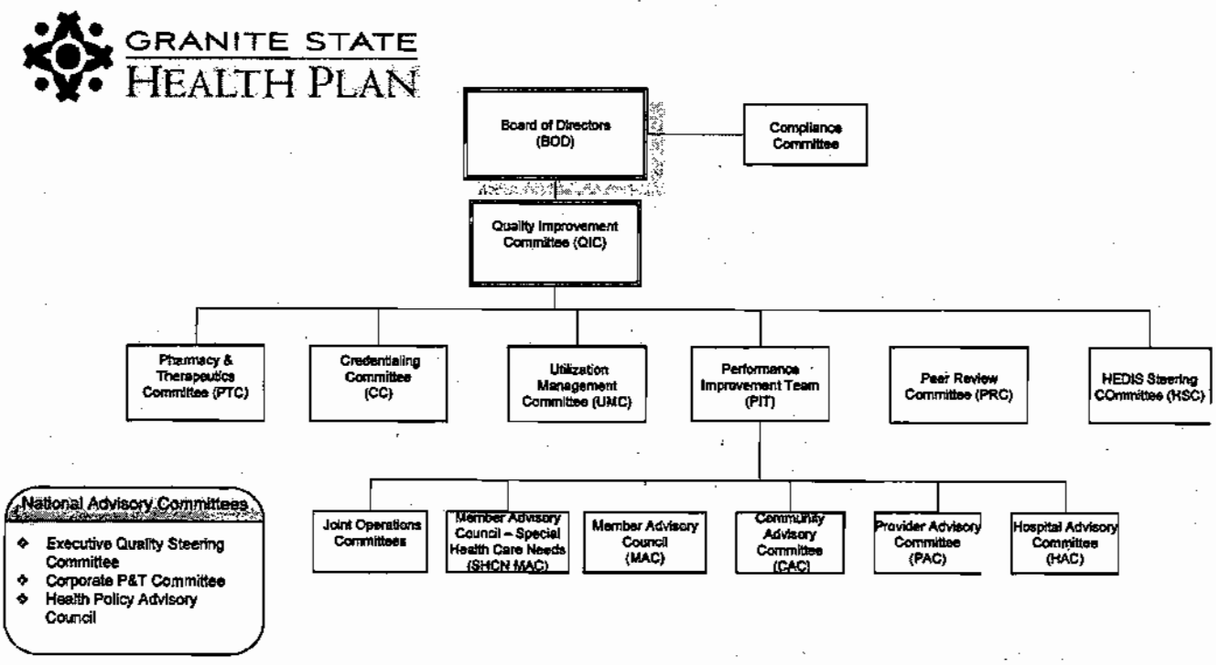
Lines of Accountability and Program Staffing

Governing Body. The GSHP Board of Directors (Board) will have legal and fiduciary responsibility for the organization and ultimate authority and accountability for all aspects of the UM Program. **The**

Board, through the Quality Improvement Committee (QIC), will oversee development, implementation and evaluation of the Quality Improvement Program, which includes the UM policies and procedures and determination of medical necessity. The Board will delegate the oversight and operating authority of UM and authorization activities to the Utilization Management Committee.

Utilization Management Committee (UMC). The UMC will ensure the effectiveness of the program and ensure that UM activities are integrated into all GSHP functional areas and departments. The UMC, which will meet no less than quarterly, will be chaired by the Medical Director. The UMC will be responsible for the review and approval of medical necessity criteria; utilization management policies and procedures; 24/7 nurse advice line protocols; and monitoring and analyzing relevant data, including providers' requests and the medical appropriateness and necessity of healthcare services provided to our members, to detect and correct patterns of potential or actual inappropriate utilization of services, coordination of care, and member and provider satisfaction with the UM process. The UMC will actively involve participating network providers in utilization review activities to the extent no conflicts of interest exist. The UMC will be comprised of network physicians representing the range of network providers throughout the state and the Vice President Medical Management (VPMM). UM, Quality Improvement and Care Management staff will also participate as appropriate.

The chart below shows the committees that will be involved in overseeing utilization management and lines of reporting and accountability to the Board of Directors.



UM Staffing Model. The authorization personnel entrusted with the responsibility of conducting Utilization Management activities for GSHP members will be medical professionals licensed in the State

of New Hampshire. Our UM staff also includes non-clinical Referral Specialists who can complete the authorization process for covered services not requiring clinical review and for in-network referral notifications. Detail on UM staffing personnel, including their credential requirements and responsibilities is provided in Question #76.

Data Sources and Processes to Determine Prior Authorization Requirements

Integrated Data Sources. Our parent company, Centene, will support GSHP's UM Program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and improvement activities. We will capture and analyze data from internal, subcontractor and external sources, including state immunization registry or clinical laboratory results. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data; financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the UM Program. This data is refreshed nightly.

Centelligence™. Centelligence™ is Centene's proprietary family of integrated decision support and health care informatics solutions. Centelligence™ integrates data from multiple sources and produces actionable information. Housing all information in the Centelligence™ Enterprise Data Warehouse allows staff to generate standard and ad hoc reports from a single data repository. Using our Centelligence™ suite of reporting systems, we can build and tabulate key performance indicators and provide drill-down capability to the individual provider or member level for investigation of suspected under- or over-utilization. Medical and behavioral health data will be integrated within the same systems facilitating effective integration of utilization management and care management activities.

Medical and behavioral health data will be integrated within the same systems facilitating effective integration of utilization management and care management activities.

Determining which Services Require Authorization. GSHP's utilization management goal is to facilitate the provision of medically-necessary covered services that are appropriate for the member's condition, provided in the appropriate setting, and meet professionally-recognized standards of care. To reduce provider administrative burden and to facilitate the timely delivery of care, **GSHP will annually review which medical services require prior authorization (PA)**, and ensure they are specific and relevant to the covered population. Our PA list includes services for which review can favorably influence care. This includes non-emergency inpatient admissions (except for normal newborn deliveries), all out-of-network services, and certain outpatient and ancillary services. Prior authorization will not be required for emergency services, urgent care services, or stabilization of emergency care.

To ensure relevance to our enrolled population, the QIC will obtain input on proposed criteria from local practicing physicians and providers familiar with the specific needs of New Hampshire Medicaid members. Once the Committee approves the criteria or guidelines, they are distributed to authorization staff, including Medical Directors, who attend mandatory training before the criteria are used in medical necessity appropriateness reviews. Staff will use the guidelines to review PA requests for inpatient hospitalizations, to conduct concurrent review, and to approve outpatient and ancillary referrals.

Nationally Recognized Criteria

GSHP will use evidence-based clinical decision support criteria, developed using or based on, recognized national criteria reflecting accepted clinical practice, along with DHHS program requirements, to determine the medical necessity and appropriateness of covered services requiring authorization. Criteria will be selected to enable authorization personnel (Prior Authorization, Concurrent Review Nurses, and Case Managers) to determine whether services are appropriate for the member's condition, provided in an appropriate setting and meet professionally-recognized standards of care, while considering any special circumstances that may require deviation, such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization. In the case of a possible denial of coverage, in accordance with NCQA and State requirements, a Medical Director will offer to discuss the case and the medical necessity guidelines with the requesting provider prior to issuing an adverse determination.

Utilization Review Criteria. Our Utilization Management (UM) criteria will ensure **timely** access to **appropriate** services that help members achieve the highest possible levels of health, wellness, functioning and quality of life. GSHP will use evidence-based clinical decision support criteria to determine medical necessity of those covered services requiring prior authorization. GSHP will use McKesson's InterQual adult and pediatric guidelines (Acute, Home Care, Procedures, Imaging, Durable Medical Equipment (DME), Subacute and SNF, Outpatient Rehabilitation and Chiropractic, and Rehabilitation) and internal guidelines to determine medical necessity for non-emergency inpatient and outpatient physical health services. We will use Interqual for inpatient and outpatient mental health services, and American Society of Addiction Medicine criteria for substance abuse services.

InterQual provides a consistent, evidence-based platform for care decisions that promotes appropriate use of services and improved health outcomes. InterQual Criteria, used by over 3000 organizations and agencies, are developed by physicians and other health professionals who review medical research and incorporate the expertise of a national panel of over 700 clinicians and medical experts, representing community and academic practice settings, as well as managed care, throughout the U.S. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and primary care physicians. They provide algorithms for inpatient hospitalizations, discharge screens to guide determinations about member readiness for a lower level of care, decision support for determining the medical appropriateness of surgical procedures, subacute or skilled nursing care, and home health services for members with catastrophic conditions or special health care

needs. **Updates to InterQual criteria are released annually and will be reviewed by the UMC as part of its annual review of medical necessity criteria, which will include updates as needed.**

Internally Develop Criteria. In most cases, GSHP will use InterQual criteria while also considering any circumstances that may require deviation, such as age, psychosocial issues, disability, co-morbidities, complications, progress of treatment, and acute or life-threatening illness when making medical necessity determinations. For services for which InterQual does not have criteria, such as new or experimental procedures, or new uses for a procedure, biopharmaceuticals, or where local practice patterns do not align with InterQual, such as therapy services, GSHP will develop criteria internally.

Centene Corporation's Clinical Policy Committee (CPC), which includes Medical Directors from each Centene health plan, develops criteria in the form of Clinical Policies for services for which there are no appropriate guidelines. The CPC reviews sources including, but not limited to, scientific literature, government agencies such as Centers for Medicare and Medicaid Services, specialty societies, and input from relevant specialists with expertise in the technology or procedure. GSHP's Chief Medical Director (CMD) will participate in the CPC, and as needed, will submit guideline development requests to Centene's Chief Medical Officer. The CPC develops guidelines based on such requests and on new technologies and procedures identified during its quarterly review.

GSHP's Medical Director will work with the CPC and DHHS to ensure guidelines address New Hampshire requirements and the needs of our members. Examples of clinical policy defined by the CPC include, but are not limited to:

Examples of Internally Developed Criteria			
Topic	Sample of References	Created	Updated
Use of unfractionated heparin (UH) and low molecular weight heparins (LMWH) in pregnancy.	• American College of Obstetricians and Gynecologists (ACOG). ACOG Practice Bulletin- Inherited Thrombophilias in Pregnancy. No.113. New Hampshire, DC: ACOG; July 2010. • Branch DW. The truth about inherited thrombophilias and pregnancy. Obstet Gynecol 2010;115:2-3. • Duhl AJ, Paidas MJ, Ural SH, et al. Antithrombotic therapy and pregnancy: consensus report and recommendations for prevention and treatment of venous thromboembolism and adverse pregnancy outcome. Am J Obstet Gynecol 2007;197:457.e1-457.e.21.	April 2011	April 2011

Treatment of macular degeneration with ophthalmic injection.	• American Academy of Ophthalmology (AAO). Age-related macular degeneration. Preferred practice pattern. Accessed February, 2010 • Facts & Comparisons®, The Formulary Monograph Service™	March 2010	April 2011
Osteochondral grafts for articular cartilage repair (autografts, allografts, and synthetic grafts).	• American Academy of Orthopaedic Surgeons. 2009 Annual Meeting Podium Presentations. Surgical efficacy of mosaicplasty for capitellar osteochontritis. • Hayes. Mosaicplasty. • National Institute for Health and Clinical Excellence. Mosaicplasty for knee cartilage defects. March 2006.	October 2008	March 2011

Clinical Practice Guidelines. Clinical practice guidelines (CPGs) serve as the basis for our prevention, education and intervention activities, including our utilization management and care management programs. While CPGs will not be used as criteria for medical necessity determinations, our Medical Director and UM staff will ensure that UM decisions are consistent with guidelines distributed to network providers. Our Utilization Management Committee (UMC), which will include contracted providers of various specialties, will review the guidelines annually and revise them as needed for consistency with local provider practice standards and compliance with DHHS requirements. The UMC will send recommended guidelines each year to the Quality Improvement Committee (QIC) for final approval.

Whenever possible, GSHP will adopt preventive and other CPGs for the provision of acute, chronic and basic behavioral health services relevant to the populations served from recognized sources such as American Academy of Pediatrics, American Diabetes Association, American Lung Association and American College of Obstetrics and Gynecology. Such guidelines will include, but not be limited to, Preventive Health (adult and child), Asthma, Bi-polar Disorder, Cardiac Disease, Depression, Diabetes, Hemophilia, HIV, Prenatal Care, Sickle Cell and Synagis. CPGs will be available on the GSHP website. Providers, members and potential members will be given a written copy upon request.

Services from Non-Participating Providers

GSHP requires prior authorization for all out-of-network services, unless the member requires emergency services, urgent care services, or stabilization of emergency care. Members are allowed direct access to family planning services regardless of the provider network participation status.

Out-of-Network Providers. During transition of care, a transition coordinator (TC) may identify new members who are in need of continued services from a non-contracted provider or facility. If the member is in an active, ongoing course of treatment, is within the second or third trimester of pregnancy or is currently receiving inpatient care, the TC will authorize out-of-network care for up to ninety (90) days or through the postpartum period, as applicable, as long as the provider agrees to:

- accept reimbursement at established rates for similar network physicians
- adhere to GSHP's quality assurance requirements and to provide necessary medical information related to such care
- otherwise adhere to GSHP policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

After immediate transition needs are arranged, our Provider Relations department may approach out-of-network providers about joining the GSHP network. If a member is receiving medical care or treatment as an inpatient on the effective date of enrollment with GSHP, we will assume responsibility for the management of such care. Our Concurrent Review Nurses will be notified of the admission and will begin concurrent medical necessity reviews and discharge planning. For hospital stays that would otherwise be reimbursed under the Medicaid Program by DRGs, GSHP understands its liability for the hospital stay is retroactive to the admission date. For hospital stays that would otherwise be reimbursed under the Medicaid Program on a per diem basis, GSHP understands its liability will begin on the effective date of enrollment to GSHP.

Requests for Expedited Prior Authorization

GSHP will implement and maintain written procedures to ensure prior authorization reviews are conducted in a timely manner in compliance with all state and federal laws as well as NCQA standards, and appropriate to the severity of the member's condition and urgency of the need for treatment as documented in the review request.

Definition of Urgent Care. Our process for expedited prior authorizations will be based on the NCQA definition of urgent care: any request for care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or jeopardize safety of the member or others due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent. GSHP does not require prior authorization or notification for access to emergency care services.

Expedited Review Process. Requests for an expedited medical necessity determination will be screened to ensure they meet the above noted definition of urgent care. GSHP considers the content of the request when determining if an expedited request meets the definition of "urgent care", and determines whether applying non-urgent time frames could lead to adverse health consequences for the member and/or cause an unnecessary disruption in care. If the request does not meet the definition, GSHP will notify the provider of the denial for an expedited review and will process the request under the standard authorization timeframes. Expedited prior authorizations determinations will be made as expeditiously as possible given the member's condition, but no later than 3 calendar days per NCQA standard or as otherwise required by DHHS. If the determination results in a denial, reduction or termination of an expedited request, the Medical Director or designee will notify the provider orally within one business day of the determination not to exceed the original determination period, and issue a written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating physician, PCP, facility, and member within three calendar days after the oral notification.

Consistent Application of Criteria

GSHP will ensure consistent and effective application of criteria by ensuring all staff understand how criteria should be applied and how to document medical necessity decisions in TruCare, our integrated health services management system. We ensure the consistent application of criteria by individual clinical reviewers through initial and on-going training as well as through monitoring activities and tools.

Utilization Management Training. Upon hire, UM staff will receive training that includes:

- Organization structure, functions ethics, compliance, professionalism
- Customer service and telephone etiquette; call routing/warm transfers to other areas such as to a case manager and member services staff
- Covered services, prior authorization requirements, reimbursement models; techniques to detect other insurance
- HIPAA and confidentiality of medical records
- Detection and reporting of fraud, abuse, and waste
- Technology appropriate to position, such as TruCare
- InterQual Guidelines including severity of illness, intensity of service, and discharge criteria
- Prior Authorization timelines, when to send authorizations to the Medical Director, adverse determinations, and medical necessity appeals
- Concurrent review and discharge planning
- Case and disease management, including referral triggers and regional issues

- Quality improvement, including quality of care concerns and current initiatives
- Grievances and appeals
- Performance standards, productivity goals, inter-rater reliability testing and quality monitoring.

Clinical review coursework is also delivered using a combination of computer-based training and traditional classroom learning. To prepare for performing medical necessity reviews, UM staff will be instructed on the correct application of InterQual criteria to determine medical necessity. During initial training, staff will acquire a working knowledge of the criteria and system documentation. After training, staff will obtain hands-on experience shadowing a preceptor in actual application of the InterQual criteria while performing UM medical necessity reviews. Once training and precepting is completed, UM staff will be tested to ensure the application of the criteria is sound. They also will be tested annually using the InterQual Inter-rater Reliability Tool (see below for more detail on these reviews and other monitoring).

In addition to training on initial hire, GSHP will conduct ongoing training on a quarterly basis, at a minimum, and as changes to UM guidelines and policies occur. Upon hire and going forward, UM clinical review staff will receive weekly updates sent to providers regarding service coverage, process changes, and medical necessity review guidance. Annual updates to GSHP clinical policies will be reviewed during UM staff meetings and during one-on-one sessions as well as being posted on our Intranet. Clinical review staff will receive information during monthly staff inservices on DHHS and GSHP policy updates through clinical education lunch-and-learn sessions and seminar opportunities. We will reinforce all training with monthly case audits and face-to-face education from supervisor to staff member.

Utilization Management Staff Monitoring. GSHP will monitor UM staff performance and consistency as follows:

- **Inter-rater Reliability Testing**. We will conduct inter-rater reliability (IRR) audits on all staff who make utilization management decisions at least semi-annually to ensure fair, impartial and consistent decision making. Our tool measures and evaluates each reviewer's comprehension, competency and consistency and is used by all Centene affiliates. Summary results for all IRR audits will be reported to the UMC and QIC.
- **Non-physician Reviewers.** We will review five percent (or at least 30 cases) per reviewer semi-annually. An initial review will occur during the three-month probationary period for each new employee. Management will discuss results with each reviewer immediately following the review, and they will consider IRR results as part of the annual employee performance review.
- **Clinical Decision Making Audit Process.** We will collect a random selection of reviewer activity via Trucare, and will blind any hard copy information. We will use the McKesson InterQual Interrater Reliability (IRR) Tool for Acute Level of Care – Adult and Pediatric as one method to score audits for inpatient authorizations. We also will use internally-developed audit tools for review of outpatient, specialty referral, durable medical equipment, care management, skilled

nursing, subacute, inpatient rehabilitation and home health authorizations. Once completed, we will evaluate audit results according to the following benchmarks:

- 90–100% - We will continue semi-annual audits. No action required.
- 80–89% - We will notify employee in writing and audit five cases monthly until accuracy reaches 90%. Corrective action will include remedial training. Employee must improve to 90% by the next quarter.
- < 80% - We will notify the employee in writing and audit cases daily until accuracy reaches 90%. Any reviewer who scores less than 80% will repeat orientation and receive intensified monitoring of all reviewer activities.

Medical Director Case Review. At least annually, the VPMM will randomly select at least three cases per Medical Director from TruCare, including approved and denied cases. The Trainer will compile copies, blind all information used to make the authorization decision, and forward the information to Centene's Corporate Chief Medical Officer (CMO). The Corporate CMO or designee will send a cover letter requesting review, IRR Forms for each case and the case information to two health plan Medical Directors not involved in the initial decision. The reviewing Medical Director will review the case, complete the IRR Form, and return the information to the CMO within 30 days of receipt. If the two Medical Director(s) disagree with the initial decision, results will be considered an error. The CMO will individually review the cases with the original Medical Director and forward the results to the GSHP Trainer to log. If opportunities for improvement are identified, the CMO will develop a corrective action plan which may include additional Medical Director training.

Interrater Reliability Program Testing. At least annually, the VPMM will assess whether our IRR Program is objectively evaluating consistency and accuracy in the application of criteria and protocols. The VPMM will evaluate the appropriateness of criteria used in making certain medical necessity determinations using data on the pre- and post- impact of prior authorization and medical necessity processes on appeals and grievance reports, trended utilization reports, and provider satisfaction with UM processes. The VPMM will also develop a report summarizing program impact on performance evaluations, retraining, orientation training and the IRR review process. The report will be shared with the UMC and QIC for review and feedback at least annually.

Monitoring Delegated UM Functions. GSHP staff will perform all UM functions locally except as noted below.

- Cenpatico: Behavioral health and substance abuse services, specialty therapy, rehabilitative services
- OptiCare: Routine and medical/surgical vision service
- US Script: Pharmacy benefit management services
- National Imaging Associates (NIA): High dollar radiology including, but not limited to, MRI, CT and PET scans.

We will contractually require these subcontractors to comply with all requirements in the DHHS contract and other state and federal requirements in their utilization management activities. Before any delegation occurs, Centene's Quality Improvement Department, in collaboration with GSHP staff, will conduct a pre-delegation audit to evaluate the delegate's ability to perform the activities to be delegated. Delegation agreements will require regular reporting, with specific format, content and timeframes.

Joint Operations Committee meetings will occur at least quarterly and any time routine monitoring identifies a compliance or performance issue. Additionally, GSHP QI staff will conduct a formal review, including medical record audit, at least annually to evaluate compliance with the GSHP delegation agreement, DHHS requirements and all applicable NCQA, state, and federal regulations.

Identifying Provider Utilization Patterns

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

Overview

The GSHP Utilization Management (UM) Program will be data-driven and closely integrated with our quality improvement and care management functions in the shared process of improving member health outcomes and controlling cost. Utilization data will be gathered, analyzed, and reported through our Quality Assessment and Performance Improvement (QAPI) Program. We will use UM data to identify under- or over-utilization of services, aberrant practice patterns, and quality of service concerns, many of which can be corrected with education, outreach or other corrective action.

We will report all utilization data to the Utilization Management Committee (UMC) quarterly unless we identify significant variances that need immediate interventions. In such cases, the Medical Director and the Vice President of Medical Management (VPMM) will assess the variance and recommend an appropriate action plan. Routine reports will include a comprehensive analysis of data, including identification of variances or trends, review of outcomes, and recommended interventions based on the findings.

To fully understand the utilization trends of our members and providers, as well as the underlying causes, GSHP will analyze a variety of "snapshots" of our utilization data. The Utilization Management Committee (UMC) will monitor and analyze data at aggregate and detail levels including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. We will use routine monthly trend reports to monitor key utilization measures such as inpatient admissions and days, ED visits, and specific preventive care services. Each report will include a drill down capability to more specific areas of interest. For example, when analyzing emergency department (ED) visits or inpatient utilization, we can look not only at total number of visits or days, but also at the utilization in relationship to

readmissions, frequent ED utilization, or presence or absence of physician office visits. We can then look for patterns of under- or over-utilization by provider, by member, or by county.

Utilization Data Management

Our parent company, Centene, will support our UM Program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and improvement activities. We will capture and analyze data from internal, subcontractor and external sources, including state immunization registry or clinical laboratory results. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data; financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the UM Program. This data is refreshed nightly.

Centene recently received the 2010 Information Week 500 award for the overall capability of our Centelligence™Insight analytics.

Centelligence™. Centelligence™ is our award-winning proprietary and comprehensive family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports. Centelligence™ continually analyzes an enormous amount of transactional data, such as claims, lab test results, health assessments, and service authorizations, to produce "business intelligence" and deliver the right information products to the right person (e.g., State Clients, Case Manager, Member Service Representative (MSR), providers, members) for the right task (e.g., clinical intervention, internal workload adjustments, client reporting) at the right time (e.g., on schedule, or "in real time").

Centelligence™ Insight - our web-based reporting and management KPI Dashboards capability. The recent integration of Centelligence™ Insight (Insight) with Impact Intelligence from Ingenix will afford GSHP and our providers the practice and peer level profiling information needed for continuous clinical quality improvement. Insight also includes our integrated MedAssurant Catalyst QSI HEDIS reporting system. Centene recently received the 2010 Information Week 500 award for the overall capability of our Centelligence™ Insight analytics.

Detecting Over Under and Inappropriate Utilization

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.

As described in detail in Question 74, GSHP will monitor and analyze data at aggregate and detail levels including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing authorized services to services received. We will use this data to identify under- or over-utilization of services, aberrant practice patterns, and quality of service concerns, many of which can be corrected with education, outreach or other corrective action.

GSHP monitors for over, under and inappropriate utilization at both a provider and member level.

Under-Utilization by Providers. GSHP Quality Improvement (QI) staff may identify a pattern of under-utilization by a specific provider by reviewing the provider's performance on profile measures for primary and secondary preventive services such as preventive health visits or diabetes care testing. Provider performance will be compared to national benchmarks, when available, and average network performance.

Process for Improvement. When provider under-utilization is identified, the Chief Medical Officer or Provider Relations staff will meet face-to-face with each provider whose combined score on all indicators falls below the 5th percentile to develop an action plan for improving identified measures to a target level of performance. QI staff will re-evaluate the provider's performance every three to six months, until an acceptable level of performance is achieved. They will also meet with select high-performing providers above the 95th percentile to identify best practices that can be shared with other participating providers. Providers will have direct access to their Performance Reports on the Provider Portal.

Over-Utilization by Providers. QI or UM staff may identify a pattern of over-utilization by a specific provider by reviewing quarterly profile reports of a provider's linked patient's utilization of inpatient, ED and other services. Concurrent Review staff may note a trend of unplanned readmissions for a specific hospital. In each case, staff will compare performance to average network performance or national benchmarks.

Process for Improvement. If performance falls below targeted benchmarks, Network Development staff or the Medical Director will meet one-on-one with the provider to discuss performance, provide education, and establish a corrective action plan for improvement. UM staff will monitor provider corrective action plans monthly, and report to both the UMC and the provider. We will continue the higher level monitoring until performance has been corrected and maintained for at least six months. In certain cases, UM staff will refer providers with patterns of over-utilization to Centene's Special Investigation Unit (SIU) for investigation of possible fraud, waste or abuse. A screening process within our claims processing operations can also generate such referrals. The SIU and GSHP staff will jointly manage any investigations resulting from these referrals. These investigations can include review of clinical records, time sheets and other original documentation.

Under-Utilization by Members. GSHP QI staff may identify a pattern of under-utilization by a specific member by reviewing routine reports from Centelligence Foresight of members in need of recommended preventive services. For example, adult/child preventive care services such as EPSDT and annual cervical cancer screening, and routine screenings for chronic conditions including hemoglobin A1c and cholesterol screenings for adults with diabetes. We may also identify members who are under-utilizing treatment services such as low use of controller medications in members with asthma. Also, members who are identified with a pattern of over-utilization of acute care services may be under-utilizing lower levels of care, preventive services or behavioral health services.

Process for Improvement. For members not enrolled in care management, our QI staff will initiate targeted reminders through postcard mailings, automated telephonic reminders, or direct outreach from one of our Member Connections Representatives, depending on the service and level of non-use. For identified members who are in care management, the assigned Care Manager will review the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, and monitor the member more frequently with personal contact, including with caregivers or guardians (for foster care members). Care Managers will continue to monitor monthly Centelligence Foresight reports to identify members persistently listed as having gaps in recommended care, and to identify those members with the highest risk for future acute care utilization, and therefore the highest priority for preventive services. We may identify members under-utilizing secondary preventive medication, such as asthma controller medications, from routine reports. The Medical Director will contact the prescribing provider with recommendations for appropriate use.

Over-Utilization by Members. GSHP staff may identify a pattern of over-utilization by a specific member by reviewing routine Centelligence Foresight reports, such as members with more than three emergency department (ED) visits in the previous 12 months, or by reviewing daily call center reports of members referred to the ED to identify members with recent previous visits. Concurrent Review staff may also identify a member with repeated unplanned inpatient readmissions.

Process for Improvement. Once staff identifies a member through any of these means, they will enroll them in care management if not already enrolled. The member's Care Manager will review the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, including behavioral health services. The Care Manager also will reconcile the member's current medications with those on the care plan, and monitor the member frequently with personal contact and include caregivers. Patterns of ED or other utilization may suggest member abuse or neglect. In such cases, Care Managers will initiate an evaluation of the member in cooperation with the DHHS Division of Children, Youth and Families to ensure the member is in a safe environment.

We may identify members with polypharmacy involving therapeutic duplication, or members with high use of controlled drugs from routine pharmacy utilization reports. Our UMC will review identified members and may make recommendations such as discussion with the prescribing physician(s). For example, in 2010 our Arizona affiliate, Bridgeway Health Solutions (Bridgeway), identified a member who was on two antipsychotic medications (Geodon and Seroquel) and recommended that our psychiatric consultant contact the member's primary practitioner. The provider was unaware of the

polypharmacy and the consultant is worked with them to wean the member off of Seroquel. Bridgeway's Pharmacy staff continues to monitor the identified member's drug utilization monthly until the adverse pattern is resolved.

Inappropriate Utilization. Possible aberrant practice patterns may be identified by UM and QI staff review of utilization data, or during review and discussion by the UMC or QIC. In addition, UM Nurses and Physician Reviewers may identify possible aberrant patterns, for example an abrupt increase in requests for lower back imaging, through their day-to-day review of authorization requests or during clinical rounds case discussions. When such possible patterns are identified, GSHP will run ad-hoc provider-level reports from our predictive modeling software to assess trends for individual providers in comparison to other providers, taking into account the risk level of their assigned members.

Aberrant practice patterns may also be detected by suspicious billing trends identified by EDIWatch fraud and abuse software used by GSHP. EDIWatch employs hundreds of edits to identify outliers, such as diagnoses or procedures incompatible with age or gender; mutually exclusive codes billed together, upcoding, add-on codes billed without primary CPT codes and non-emergency procedures billed on Sundays or holidays.

Process for Improvement. If an aberrant practice pattern is confirmed, UM staff will refer the provider to Provider Relations staff, with the participation of the Medical Director as required, for discussion of the concerning pattern, comparison to peer performance and any evidence-based relevant guidelines. If appropriate, a corrective action plan (CAP) is developed within 30 days, for approval at the next scheduled UM Committee meeting. It is the responsibility of the Medical Director to ensure that the CAP is initiated within 30 days of UM Committee approval. Six months after implementation of the CAP, data is reanalyzed to determine the impact. If the issue is unresolved, the CAP is reassessed and revised and a date for re-evaluation is determined. Dependent on the issue and the need for meaningful improvement, the UM Committee may decide that the CAP should be extended. If at the end of a time extension the issue remains unresolved, the Medical Director will prepare a written summary for review by QIC.

Utilization Management Personnel

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.

Utilization Management Personnel

GSHP will facilitate the quality and management of our UM program, authorization of services and grievance system by ensuring program accountability; recruiting, training and retaining highly qualified managers and staff; setting high ethical and performance standards; and regularly evaluating the effectiveness of the program. The personnel entrusted with the responsibility of conducting UM activities for GSHP Members are listed below along with the required credentials for each position and description of responsibilities:

- **Medical Director/Chief Medical Director** (CMD) will be physicians with a current, unrestricted license through the New Hampshire Board of Medicine. Medical Directors must have no history of or pending disciplinary action or sanctions. The Medical Director must have at least three years of training in a medical specialty. The Medical Director will devote full time (minimum 32 hours weekly) to GSHP operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Medical Director is not available, GSHP will have physician staff to provide competent medical direction. The Medical Director will be actively involved in all major clinical and quality management components of GSHP operations and be responsible for:
    - Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the Grievance System.
    - Administration of all medical management activities.
    - Serving as director of the UMC and chairman or co-chairman of the QIC.
    - Denials of care.
- **Vice President, Medical Management** (VPMM) will be a new Hampshire-licensed registered nurse, physician or physician's assistant. The primary functions of the VPMM will be to:
    - Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria.
    - Ensure appropriate concurrent review and discharge planning of inpatient stays.
    - Develop, implement and monitor the provision of care management functions.
    - Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services.
    - Monitor prior authorization functions and assure that decisions are made in a consistent manner.
- **Manager, Utilization Management** will be a New Hampshire-licensed registered nurse, physician or physician's assistant with a minimum of three years of clinical experience. The Manager of UM, who will report to the VP of Medical Management, will oversee operations of the referral management, telephonic utilization review, prior authorization, and concurrent review functions. The UM Manager will also ensure compliance with government and contractual guidelines and the mission, philosophy and objectives of the health plan and Centene.
- **Prior Authorization Staff (PA Staff)** will be New Hampshire-licensed registered nurses with a minimum of three years of clinical experience. For behavioral health (BH) services, PA staff will be licensed BH clinicians (LCSW, LPC, Licensed PhD/PsyD or Psych RN) with a minimum of three years of clinical experience in a behavioral health or substance abuse services setting. PA staff

will be trained in the application of clinical support criteria, to ensure that services provided are a covered benefit, medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting. Prior Authorization staff will communicate closely with Care Managers on our Integrated Care Teams to ensure coordination between UM and Care Management functions. PA staff will report to the UM Manager.

- **Concurrent Review Staff (CR Staff)** will be New Hampshire-licensed nurses with at least three years recent clinical nursing experience in an acute care setting (particularly in medical/surgical). For BH services, concurrent review staff will be New Hampshire-licensed BH clinicians (LCSW, LPC, Licensed PhD/PsyD or Psych RN) with at least three years recent clinical experience in a behavioral health or substance abuse services setting. CR staff will be trained in the application of Interqual to ensure that services provided are a covered benefit, medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting. In addition, CR Staff facilitate the use of alternative settings when the above circumstances are not met, or when a quality of care question arises. These staff will work onsite in network hospitals and be available telephonically for timely concurrent review and discharge planning. CR Staff will report to the UM Manager.

Concurrent review nurses will work onsite in network hospitals and be available telephonically for timely concurrent review and discharge planning.

- **BH Peer Reviewers** will conduct PA reviews and issue denials for BH services. For inpatient BH care, Peer Reviewers will be licensed psychiatrists with five or more years of clinical experience. Peer Reviewers for outpatient BH care will be licensed doctoral-level psychologists or psychiatrists. Peer Reviewers are independent consultants who are supervised by Cenpatico Behavioral Health's (our behavioral health subcontractor) Medical Director.
- **Referral Specialists** will have three or more years experience working in a medical-related setting and will support the operations of the UM Department. These staff will report to the UM Manager.
- The **Clinical Appeals Coordinator** (CA Coordinator) will collect clinical documentation to facilitate case review by a Medical Director. The CA Coordinator will also arrange for a consulting physician specialist to review appeals when specific medical expertise is needed outside the expertise of our Medical Directors, and/or is applicable to the case. This position will report to the UM Manager.
- The **Grievance Coordinator** (GC) will document, coordinate, oversee, and track analysis and resolution of member grievances. The GC will facilitate interdepartmental action to resolve grievances, coordinate the Grievance and Appeals Committee meetings, and document Committee minutes. This position will report to the Director, Quality Improvement.

In accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 43 CFR §422.210, UM staff receive no incentives to deny, limit, or discontinue medically necessary covered services to any member. UM

employee compensation includes hourly fees and salaried positions. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is *prohibited*. GSHP and its delegated Utilization Review agents will not permit or provide compensation or anything of value to its employees, agents, or contractors based on: the percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination. All UM staff will be required to sign an Affirmative Statement regarding confidentiality and compensation annually. This statement represents staff understanding that GSHP does not:

- employ incentives to encourage barriers to care and services; UM decisions are based only on appropriateness of care and service and existence of coverage;
- specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care;
- provide incentives for UM decision makers that result in under-utilization.

Prior Authorization Process

Utilization management decisions will be made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. GSHP will establish timelines for providers to make service requests as well as timelines for our UM decisions and subsequent notifications to the member and practitioner. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service via the toll-free provider call center, the Provider Portal, or through RightFax. GSHP will make a determination for urgent concurrent, expedited continued stay, or post-stabilization review within 24 hours of the request. Any authorization requests that occur while a member is in the process of receiving care will be considered an urgent concurrent request if the care meets the definition of urgent, even if the earlier care was not previously approved by GSHP. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 days from receipt of request. NurseWise, our 24/7 nurse advise line, will be available to take after hours calls and contact on-call clinical staff for emergent authorization requests.

Prospective Review of Outpatient and Inpatient Services. Providers will submit authorization requests for new or continuing services by phone, fax or through our Provider Portal. GSHP's non-clinical Referral Specialists can complete the authorization process for requests for covered services not requiring clinical review and for in-network referral notifications. Otherwise, the Referral Specialist will forward requests electronically through TruCare, our integrated medical management, disease management and authorization system, to a UM Nurse within one day of receiving the request. Within that same day, the nurse conducts a Level I medical necessity review using the appropriate guidelines

and available information about the member's condition and circumstances. Our licensed UM Nurses use UM guidelines as a resource, considering any circumstances that may require deviation, such as age, psychosocial issues, disability, co-morbidities, complications, progress of treatment, acute or life-threatening illness or clinical practice guideline requirements. If the request meets criteria, the nurse will notify the provider and issue an authorization number. If the provider submits the request by phone, the UM Nurse will do the level I review real-time while interacting with the provider, issuing an authorization number during the call should the clinical information be complete. Care Coordinators may authorize care that meets criteria for members enrolled in Care Management.

If the request does not meet criteria, the nurse may request additional information or refer the case to a New Hampshire-licensed Physician Reviewer who may authorize, deny or pend requests awaiting additional information needed to apply criteria. The Physician Reviewer reviews the case and will be available at the Provider's request for a peer-to-peer discussion to gather additional clinical information and discuss alternatives to the requested services.

GSHP may request, or accept a request from the provider or member, to extend the prior authorization decision 14 additional calendar days to allow for clinical information gathering to verify medical necessity for the service requested. We will send written notice to the member with the reason for the extension and the member's right to file a grievance. In the absence of such an extension, GSHP will notify members of decisions within seven calendar days of receipt of the original request. GSHP's goal is to provide notification of determinations within two business days of receiving the clinical information necessary to make a medical necessity determination, or real-time if the provider submits the request by phone. If needed clinical information is not received within two business days of the request, the nurse will again outreach to the requesting provider to request sufficient information for medical necessity review. If at minimum a diagnosis, rather than general symptoms, has not been received, the UM Nurse will issue an administrative denial for lack of documentation. If a diagnosis has been received but there is insufficient accompanying information to meet criteria, the UM Nurse will refer the case through TruCare to a Physician Reviewer.

The Physician Reviewer will respond to a request by the provider to discuss the request, and may consult with a board-certified Clinical Consultant from an appropriate specialty prior to issuing a final determination. The Physician Reviewer will make a determination within one day of receiving the request from the nurse. If the Physician Reviewer denies or limits the requested service, the nurse verbally notifies the provider within one day of the decision. This notification includes the Physician Reviewer's rationale for the denial, an offer of peer-to-peer discussion and the member's right to appeal the decision. GSHP will make determinations and notify the requesting providers by phone, fax or email according to the following timelines:

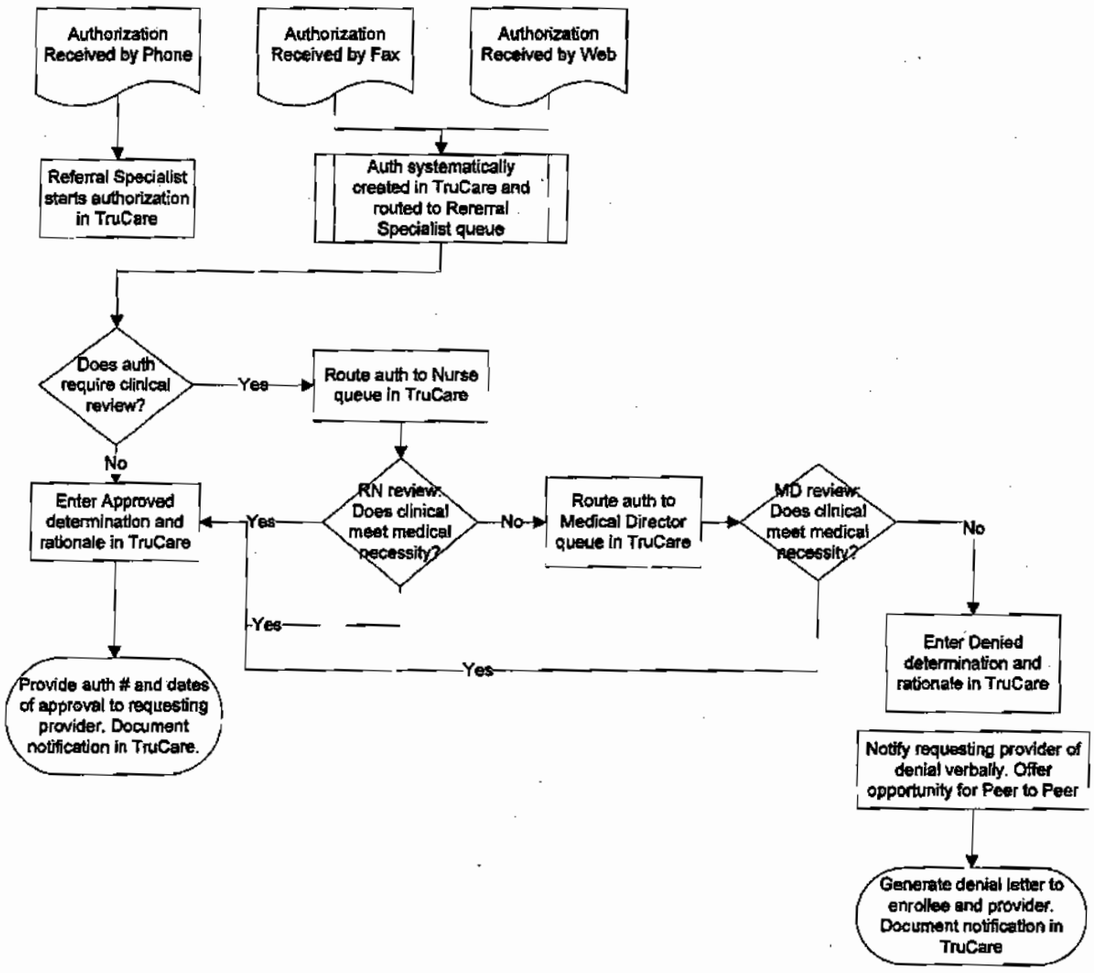
- non-urgent prior authorization requests – within seven calendar days after the request is received;
- expedited prior authorization requests - within three business days of receiving the request;

- urgent, concurrent, and expedited continued stay review – within 24 hours of receipt of the request; and
- post-stabilization or life-threatening situations - within one hour from the time of request. If GSHP has not responded within seven calendar days of receiving necessary information, the requested service will be deemed authorized.

For adverse determinations, the UM staff will send the requesting provider and member a letter explaining the decision, its rationale, appeal and expedited appeal rights and the process for doing so, the member's right to continue receiving services during an appeal and instructions for requesting a peer to peer discussion. If the letter is being sent and the member has exhausted our appeal process, it will include information about the member's rights to and the process for requesting a State Fair Hearing. An expedited appeal may be requested for a life-threatening condition or current hospitalization, and providers may appeal to a reviewer with no prior involvement in the case.

When a member is admitted to a medical facility with a behavioral health diagnosis such as attempted suicide, UM staff will coordinate with behavioral health UM staff via the shared TruCare system. UM staff will review for extenuating circumstances that prevented timely notification, such as urgent services occurring after regular business hours, before issuing an administrative denial based on late notification or lack of clinical information.

The UM Nurse will document in TruCare, our integrated medical management, disease management and authorization system, the name and title of the caller, the date and time of the request, the prior authorization number for authorizations, and, for adverse determinations, a clinical synopsis and the clinical guideline or rationale for the decision. All such documentation will be signed by the clinical staff.



Behavioral Health. GSHP will use similar policies and processes to review requests for behavioral health services. UM staff use the same TruCare integrated authorization and documentation system as physical health UM staff. For network providers, prior authorization is not required for an initial evaluation and five follow-up sessions for individual, family, or group outpatient therapy. To facilitate immediate access to care, reduce administrative burden, and lessen barriers to medication adherence, providers are not required to obtain prior authorization for medication management, with or without therapy. For outpatient therapy beyond the initial six sessions and for other outpatient services (excluding medication management and ECI services), UM Nurses will make a determination within two days of the request. If the request provides all required information and meets criteria, the UM Nurses authorize the care and notify the provider. If the request is incomplete, the UM Nurses contact the provider to obtain more information. The UM Nurses authorize care that meets criteria within two business days of receiving the complete request, and within no longer than seven calendar days of receipt of the original incomplete request. If the request does not meet criteria, the UM Nurses refer it to a Physician Reviewer within one business day of receipt. The Physician Reviewer then makes a determination, and the UM Nurse either sends the provider an approval letter and authorization

number, or notifies the provider verbally and in writing of the adverse determination within one business day. If more information is required, the Physician Reviewer contacts the provider directly and makes a determination within one day of receiving the information and within seven calendar days of the original request unless a 14 day extension has been requested. The UM Nurse then sends the provider an approval letter and authorization number or, for adverse determinations, notifies the provider verbally and in writing, within one business day, of the decision and the appeal process. If GSHP has not responded within seven calendar days of receiving necessary information, the requested service will be deemed authorized.

Medical and behavioral health UM staff both use TruCare, which facilitates coordination of services.

For prospective or concurrent review of higher levels of care, GSHP will not require prior authorization for emergency care, and we will make determinations for life threatening conditions or post stabilization care within one hour. For prospective or concurrent requests meeting criteria, UM Nurses issue an authorization within one business day and authorize a specified number of days, after which the provider must request additional authorization. At the completion of treatment, UM Nurses send the provider an approval letter and tracking number for authorized dates of service. For requests not meeting criteria, Physician Reviewer s conduct a telephonic review within one business day of the request, make a determination and notify the provider during the call. UM Nurses notify facility staff verbally and send written notice of the adverse determination within one business day of the decision. UM Nurses also monitor inpatient members to ensure appropriate care and assist with discharge planning.

GSHP will base retrospective review solely on the information available to the provider at the time of care. UM Nurses review the request for exceptional circumstances (e.g. an emergency situation prevented the provider from obtaining a preauthorization during regular business hours). If exceptional circumstances did not exist, the UM Nurse will issue an administrative denial. If they did exist, the UM Nurse will review for medical necessity and, if the care meets criteria, the UM Nurse will send the provider a letter and tracking number. If it did not, Physician Reviewers review and issue determinations within two business days of receipt of all information needed for a decision. GSHP will review behavioral health services codes billed in a primary care setting for medical necessity and, if appropriate, authorize them.

Emergency Department Utilization Review

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

GSHP will build from the experience of Centene health plans to implement a multi-dimensional program for monitoring and reducing emergency department (ED) services. Our strategy relies on best

practices and nationally recognized guidelines; expert staff; state-of-the-art technology; and an emphasis on assuring access to primary care. GSHP will incorporate successful utilization management strategies and lessons learned that resulted in overall reductions in inappropriate ED utilization for affiliate Centene health plans, including:

- ED Utilization tracking strategies and predicative modeling
- Enhanced member outreach and education
- NurseWise, our 24/7 nurse advise line
- Member service alerts and reports to providers
- Incentives for appropriate use of preventive and primary care

ED Utilization Tracking Strategies

GSHP will use data to identify, by region, members who have deviated from normal patterns of ED use. We will contact these members in writing, by home visit, or by telephone to establish the reasons for inappropriate ED utilization, identify barriers, and provide education about the importance of routine visits to their PCP, availability of NurseWise (described below) to answer questions about care and to discuss alternate levels of service such as urgent care. We will also use these reports to notify PCPs about member utilization activities.

A proven best practice is collaborating with contracted facilities to receive daily post-ED visit reports. GSHP will include language in hospital contracts to facilitate timely reporting of member ED utilization. In addition, GSHP will receive daily reports from NurseWise identifying members referred to the ED after-hours, and those with urgent calls, such as pregnant women or members with chronic care or behavioral health issues.

Contacting members shortly after their ED encounters maximizes the impact of education and facilitates appropriate and timely follow-up care with their primary care physician. Based on past experience, members under the age of 13 with one to two ED visits in 90 days for conditions not generally seen as emergency conditions responded best to non-clinical outreach. In addition, Centene studies showed newer members who presumably were less familiar with the plan or had yet to establish a relationship with their PCP showed a greater reduction in ED visits following a non-clinical outreach. Therefore, these members will receive a non-clinical outreach from the Integrated Care Team (ICT) (Level I Outreach). Members seeking care in the ED for chronic and/or co-morbid conditions, and those exhibiting drug seeking behavior responded better to clinical outreach. Therefore, members with three or more ED visits in 90 days with chronic conditions or co-morbid conditions including medical and behavioral health conditions and those with three ED visits in 90 days and evidence of more than one controlled pain prescription will receive a Case Management outreach from a member of the ICT (Level II Outreach).

Predictive Modeling

In addition to real-time tracking strategies, our ICT staff will review monthly ED Potential Misuse Reports generated from ImpactPro, our predictive modeling software, which will use medical and claims data to identify members with three or more ED visits in 90 days with chronic conditions or co-morbid conditions including medical and behavioral health conditions. These reports will be sent to the member's PCP notifying them of their patients with frequent ED utilization. Our ICT will use these reports to identify members for disease and case management programs or targeted education from the MCR. By outreaching to these members and addressing barriers to appropriate level care, we will reduce unnecessary ED utilization. For instance, an analysis of data in Centene's OH health plan revealed a high volume of members accessing the ED with a diagnosis of migraine headache. The plan developed a targeted education program about home treatment options to reduce pain and encouraged a visit to the PCP for potential medication management.

Enhanced Member Outreach and Education

The experience of Centene health plans shows that member health improves and is sustained when members, their families and informal supports are engaged in planning, directing, and evaluating their care. Our multi-faceted member education programs, will not only contribute to member health but also help reduce ER visits. Highlights of those education efforts to reduce hospitalizations and ER visits include:

- **Education upon enrollment** telephonic and written materials on the importance of selecting and establishing a relationship with the PCP prior to the onset of acute illness; how to access services; what constitutes a true emergency and alternative levels of care for urgent conditions.
- **Ongoing reminders** via messaging on our member helpline and our member newsletters, such as to remind members to call NurseWise with any health care questions and to obtain guidance in determining the most appropriate care setting.
- **Case and Disease Management support** to help members with self-care skills and thereby avoid acute exacerbation of their condition. For example, how to perform routine blood glucose and daily peak flow meter monitoring; and signs of potential problems and how to use action plans to identify next steps based on their symptoms. The information will also be available in the Member Handbook and on the GSHP's website.
- **Community Outreach and Workshops.** Our MemberConnections Representatives (MCRs), in partnership with Nurtur Health Coaches/Educators, who are hired locally and know the areas in which they will serve, will conduct community outreach and host educational workshops on such topics as diabetes management, asthma management, prenatal care, and newborn care, when to call the doctor or NurseWise and proper use of the emergency room. The MemberConnections Program proactively connects with both community-based agencies and advocacy groups to encourage members about maintaining healthy lifestyles, routine health screenings, and the use of preventive and primary care services. MCRs help organize and staff

health promotion and education events, such as wellness clinics and health fairs. We customize our efforts to meet the needs of each community or organization. By bringing prevention education and screening to communities and groups where they are, we reinforce the importance of appropriately accessing primary care and empower members to manage their conditions effectively in order to decrease unnecessary emergency department usage.

- **Website health information.** We will provide members with information through our website. All materials given to members in hard copy will also be posted to the website. Information will include overviews of our clinical management and incentive programs, links to health education resources, briefs on health news and local activities that they may print out or read online.

Indiana Medicaid: a 48% decrease in ED visits

In 2009 MHS, our Indiana affiliate, initiated outreach by MemberConnections staff to members with a recent ED visit who used the ED three or more times in six months. The staff identified 91 members for outreach in the first quarter of the initiative. The results showed that direct contact immediately after an ED visit was beneficial: the ED visit rate for these members dropped 48 percent (from 2.84 visits/month to 1.47 visits/month).

Georgia Medicaid: a 31% decrease in ED visits

Our Georgia affiliate implemented similar targeted outreach initiatives and achieved positive results. From 2009 to 2010, Peach State Health Plan realized a 31% decrease in total ED visits.

- **NurseWise.** Granite State Health Plan's 24/7 nurse advice line is administered by NurseWise and provides assistance to members in determining the potential need for ER services. NurseWise responds to callers in a culturally responsive manner, using bilingual staff, Language Services Associates, or Telecommunications Device for the Deaf for translation services. Nursewise staff will obtain information from the member using direct questions and using nationally recognized and annually reviewed algorithms determine the best level of care for the member based on presenting symptoms. If a member's condition appears emergent, the Nursewise nurse will warm transfer the member to 911. Alternately, when the medical condition does not warrant ER care per the protocols, the nurse will advise the member to seek urgent care, immediately contact the PCP or to schedule an appointment with the PCP the next business day. Additionally, the nurse will provide self-care alternatives to manage the symptoms at home such as increased fluids, fever reducing medicine or ice compress as applicable. During the 12 months prior to the end of Q3 2010, over 81% of all members whose conditions did not indicate the need for ER care heeded NurseWise advice and sought other care alternatives.

GRANITE STATE HEALTH PLAN

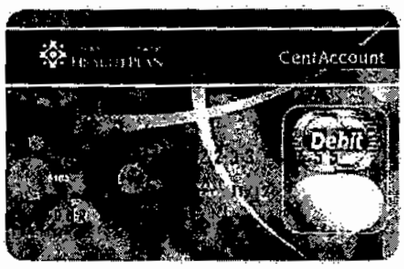
ED Redirection by NurseWise Advice Line Q4 2009 – Q3 2010

Total Number of Dispositions	11,773	11,331	11,159	10,278
Patient Original Inclination was to go to ER	4,731	4,542	4,449	3,731
NW RN Advised Other than ER visit	3,200	3,140	3,113	2,614
Patient Followed RN advice	2,573	2,627	2,478	2,167
% Compliant with RN Advice	80%	84%	80%	83%

- **Member Service Alerts and Reports to Providers.** GSHP will reduce unnecessary or inappropriate ED and inpatient admissions related to conditions that have grown more serious or complex due to inadequate monitoring or control, by providing timely online information to providers. Through our secure Provider Portal, practitioners will have access to a Member Encounter Report that will summarize recent payer-based service claims and encounter data in a way that will help them identify high service use and will allow the exchange of information between physical and mental health providers, pharmacy, emergency rooms. The encounter summary will give a snapshot of a member's physical/behavioral outpatient, inpatient and pharmacy services and will be updated frequently to support timely sharing of information (mental health data will be updated as provided by the MBHO). The report will available 24/7 and will be accessible by physical or mental health providers, including non-network providers, who have registered with Granite State Health Plan to access the Portal. This report will help motivate and support providers to reach out to members who have had recent emergency room visits, pharmacy prescriptions and inpatient admissions. Providers can use this Encounter Report to supplement their understanding of member past and future care needs in conjunction with our **online care gap notification system**. When GSHP has a sufficient history of member claims data, we will notify providers of members with gaps in recommended care when they are viewing their patient roster or checking member eligibility. For example, the notice may inform the provider that the member is due for a check-up, screening, or immunization.

Incentives for Appropriate Use of Preventive and Primary Care

CentAccount Program. GSHP will implement a member incentive program that encourages use of preventive and primary care services by rewarding members with a credit on a CentAccount card upon completion of specified visits or screenings. For example, new members who visit their PCP



within the first 90 days of plan enrollment; mothers for taking their children to appropriate well-child check-ups; and for other members who complete certain annual screenings, such as hemoglobin A1c for diabetics. Members may use their CentAccount Card to pay for medical co-pays or to purchase approved health care goods and services at more than 150 retailers, such as Wal-Mart, Walgreens, Costco, and CVS/Pharmacy. Rewarding members for healthy behaviors will reduce the incidence of complications which can necessitate emergency services.

Assuring Appropriateness of Inpatient Care

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.

Overview

GSHP will use evidence-based clinical decision support criteria, along with DHHS requirements to make individualized determinations of medical necessity and appropriate level of care for inpatient admissions.

We will use McKesson's InterQual Adult Acute, Pediatric Acute, and Subacute/Skilled Nursing guidelines. Additionally, we will utilize Cenpatico Behavioral Health's (BH's) internally-developed criteria that focus on the symptoms appropriate for treatment and the intensity of services expected/required to conduct BH concurrent review.

Any internally developed guidelines are developed based on nationally recognized evidence based clinical information and are approved by GSHP's Utilization Management Committee prior to their use. Clinical staff will utilize the above criteria as a guide, while considering the special circumstances of each member that may require deviation, such as co-morbid medical and behavioral health diagnoses. Concurrent Review is routinely conducted throughout an inpatient stay, evaluating each hospital day for medical necessity and approval based on the member's condition.

Prospective Review of Non-Emergent Admissions and Same Day Surgery Procedures

GSHP uses the same prospective review process for all services, including non-emergent admissions and same day surgery procedures. Providers will submit authorization requests for new or continuing services by phone, fax or through our Provider Portal. GSHP's non-clinical Referral Specialists will complete the authorization process for requests for covered services not requiring clinical review and for in-network referral notifications. Otherwise, the Referral Specialist will forward requests electronically through TruCare, our integrated medical management, disease management and authorization system, to a UM Nurse within one day of receiving the request. Within that same day,

the nurse conducts a Level I medical necessity review using the appropriate guidelines and available information about the member's condition and circumstances. **Our licensed UM Nurses use UM guidelines as a resource, considering any individual circumstances that may require deviation, such as age, psychosocial issues, disability, co-morbidities, complications, progress of treatment, acute or life-threatening illness or clinical practice guideline requirements.** If the request meets criteria, the nurse will notify the provider and issue an authorization number. If the provider submits the request by phone, the UM Nurse will do the level I review real-time while interacting with the provider, issuing an authorization number during the call should the clinical information be complete. Care Coordinators may authorize care that meets criteria for members enrolled in Case Management.

If the request does not meet criteria, the nurse may request additional information or refer the case to a new Hampshire-licensed Physician Reviewer who may authorize, deny or pend requests awaiting additional information needed to apply criteria. The Physician Reviewer reviews the case and will be available at the Provider's request for a peer-to-peer discussion to gather additional clinical information and discuss alternatives to the requested services.

GSHP may request, or accept a request from the provider or member, to extend the prior authorization decision 14 additional calendar days to allow for clinical information gathering to verify medical necessity for the service requested. We will send written notice to the member with the reason for the extension and the member's right to file a grievance. In the absence of such an extension, GSHP will notify members of decisions within seven calendar days of receipt of the original request. **GSHP's goal is to provide notification of determinations within two business days of receiving the clinical information necessary to make a medical necessity determination, or real-time if the Provider submits the request by phone.** If needed clinical information is not received within two business days of the request, the nurse will again outreach to the requesting provider to request sufficient information for medical necessity review. If at minimum a diagnosis, rather than general symptoms, has not been received, the UM Nurse will issue an administrative denial for lack of documentation. If a diagnosis has been received but there is insufficient accompanying information to meet criteria, the UM Nurse will refer the case through TruCare to a Physician Reviewer.

The Physician Reviewer may consult with a board-certified Clinical Consultant from an appropriate specialty prior to issuing a final determination. The Physician Reviewer will make a determination within one day of receiving the request from the nurse. If the Physician Reviewer denies or limits the requested service, the nurse verbally notifies the provider within one day of the decision. This notification includes the Physician Reviewer's rationale for the denial, an offer of peer-to-peer discussion and the member's right to appeal the decision. GSHP will make determinations and notify the requesting providers by phone, fax or email according to the following timelines:

- non-urgent prior authorization requests – within seven calendar days after the request is received;
- expedited prior authorization requests - within three business days of receiving the request;
- urgent, concurrent, and expedited continued stay review – within 24 hours of receipt of the request; and

- post-stabilization or life-threatening situations - within one hour from the time of request. If GSHP has not responded within seven calendar days of receiving necessary information, the requested service will be deemed authorized.

For adverse determinations, the UM staff will send the requesting provider and member a letter explaining the decision, its rationale, appeal and expedited appeal rights and the process for doing so, the member's right to continue receiving services during an appeal and instructions for requesting a peer to peer discussion. If the letter is being sent and the member has exhausted our appeal process, it will include information about the member's rights to and the process for requesting a State Fair Hearing. An expedited appeal may be requested for a life-threatening condition or current hospitalization, and providers may appeal to a reviewer with no prior involvement in the case.

The UM nurse will document in TruCare, the name and title of the caller, the date and time of the request, the prior authorization number for authorizations, and, for adverse determinations, a clinical synopsis and the clinical guideline or rationale for the decision. All such documentation will be signed by the clinical staff.

Concurrent Review of Inpatient Hospitalizations and Urgent/Emergent Admissions

Upon notification of acute admissions, GSHP Concurrent Review Nurses will begin discharge planning. We will provide on-site concurrent review with all hospital admissions. The concurrent review process includes:

- Obtaining necessary clinical information from facility staff, practitioners and providers;
- Notifying facility staff, practitioners and providers of coverage determinations in a timely manner;
- Identifying continuing care needs at the beginning of the inpatient stay, with reassessment throughout the stay, to facilitate discharge planning activities;
- Identifying members for referral to covered specialty programs;
- Screening for potential quality/risk/utilization management concerns and make referrals; and
- Identifying placement needs, for example skilled facilities or alternative settings.

Discharge planning begins as soon as GSHP is notified of an admission.

Concurrent review may be conducted by phone, fax or on-site at the facility where care is delivered. GSHP's process for concurrent review of hospital stays includes two levels of review.

Level I Review. Concurrent Review Nurses (CRN) or Care Coordinators (CC) conduct Level I reviews by assessing all relevant clinical information about the member's condition, including admitting diagnosis, co-morbidities, and severity of symptoms, diagnostic test results, complications, progress of treatment, age, psychosocial issues, home environment, support structure, and any other factors that may require

special consideration. The CRN or CC applies InterQual or other applicable guidelines and tools, such as for BH (Cenpatico criteria), to determine if the requested inpatient stay is medically necessary and if the member is receiving the appropriate level of care. If the request meets criteria, the CRN or CC notifies the facility of the approval, advises them of the next review date, and provides an authorization number. CRNs or CCs apply InterQual, BH or other applicable guidelines during each subsequent review to ensure that an inpatient stay is still required and that the level and location of care is appropriate to meet the member's needs. During each continued stay review, the CRN or CC consults with the facility's case management department to discuss discharge planning needs and advises the facility of the next review date. All information regarding concurrent review including the date the review was conducted, the date of next review, the level of care requested, level of care approved, information about the member's condition relevant to the concurrent review decision making process, and the criteria utilized to complete the review is documented in the TruCare system. If the member's stay ceases to meet inpatient criteria, or if appropriate alternative care options exist, the Concurrent review staff contacts the attending physician to obtain additional information. Since all Concurrent Review staff have access to TruCare, inpatient authorizations can be forwarded to the member's lead Care Coordinator, so he/she can coordinate discharge planning with the case manager/discharge planner of facility. In addition to evaluating the appropriateness of the inpatient admission and service setting, GSHP's concurrent review staff will review inpatient admissions for service delays, provide oversight of inpatient treatment protocols, monitor and evaluate sentinel events, and provide timely and intense discharge planning assistance.

Level II Review. Requests not meeting guidelines for continued inpatient stay or that meet criteria for a lower level of care than that being requested are referred to GSHP's Medical Director (MD) for Level II review. The MD will review all documentation pertaining to the request, including information related to the current admission and the member's health history, including all co-morbid conditions, and any other factors that may require special consideration. The MD may also contact the member's treating provider to obtain any additional information needed. Providers are always offered the opportunity to discuss concurrent review requests and plan of treatment with the MD prior to the issuance of a final determination. The MD may also consult with a board-certified participating provider from the appropriate specialty area, or an alternative long-term care provider, prior to issuing a final determination. If the MD approves the authorization, he/she returns the case via TruCare to the CRN to complete the authorization. The CRN then establishes a new review date in TruCare. If a Level of Care change is pending, the CRN will immediately contact the facility's discharge planner and set-up a discharge planning review that will include the member or member's representation/guardian, as appropriate, and the member's lead Care Coordinator. If after review of all required information, the MD decides to reduce or deny the request, the Notice of Action letter will be sent from the authorization system which includes a detailed paragraph explaining the reason(s) for the denial and the process for an appeal. The MD and/or CRN enters all information and rationale related to the determination in TruCare, including any consultants contacted by the MD, the rationale for decision, the date and time of oral notification to requesting provider, and the date and time of written notification to requesting provider. When requested services do not meet medical necessity or appropriate setting guidelines, the CRN will afford the requesting provider a reasonable opportunity to

discuss the plan of treatment and the clinical basis for the decision before issuing a denial notification. In the event of a life-threatening condition or current hospitalization, an expedited appeal may be requested. If denied, the MD will verbally notify the provider within 24 hours, and will send a denial letter to the member.

GSHP's timeframes for review will be conducted on all initial reviews of inpatient admissions within one business of day of notification by the facility of the admission. At the time of the initial review, the CRN will notify the facility's case manager of the date of next review. The number of days between reviews is based on the severity of the member's condition, anticipated length of stay, potential for change in member's condition or level of care required, and extent of discharge planning needs. In no instance may the review date for any admission be longer than one week without the MD's approval.

On-Site Concurrent Review. GSHP believes conducting on-site concurrent review where possible, is instrumental in achieving high quality and cost-effective health care services, and rendering the most effective outcomes. In our efforts to further this approach, we are committed to forming partnerships with facilities in the development of processes that comply with the provider's utilization review procedures and protocols (such as sign-in, sign-out, proper identification, dress code, State/Federal rules and regulations, etc). The GSHP Concurrent Review staff will also afford providers the courtesy of conducting on-site review during facility designated hours, such as standard business hours, and provide availability for concurrent review after regular business hours or on weekends.

GSHP's Concurrent Review staff will also work with the facilities to coordinate protocols, ensuring accessibility to patient's concurrent and relevant chart history, allocating adequate staff to conduct the on-site process, and availability of a daily census if applicable.

When possible, and as agreed upon by the facility through established rapport during on-site visits, our Concurrent Review staff may directly interact with members and their families to discuss discharge planning and/or enrollment in Disease Management programs where applicable.

Discharge Planning. Discharge planning is an integral part of inpatient concurrent review that begins at the time of notification and continues throughout the hospital stay ensuring an improved coordination of services following hospital discharge. Discharge planning is conducted on-site and telephonically with our contracted facilities in order to closely monitor inpatient utilization, assist with discharge planning activities, and provide education to hospital and physician staff. Concurrent review nurses will initiate discharge planning early in coordination with hospital discharge planners, and promptly communicate with the PCP regarding long-term needs. A structured discharge plan tailored to the individual GSHP member brings about potential reductions in hospital length of stay and readmission rates.

GSHP discharge planning is a process in which we work with the member's medical home to develop a plan for a smooth move from one level of care to another. Discharge placements to a safe environment, where members are not in immediate danger to their health and well being is our priority. The following appropriate care steps are made:

- Contacting members within 3 days of discharge
- Contact by Integrated Care Team Program Coordinator verifying services, medications, DME are in place
- Verifying member follow up appointment(s) are made, with transportation needs met.
- Provide all important contact numbers, names of agencies, and any medical information.
- Connections Plus cell phone provided if appropriate
- Timeliness of services are initiated
- Inform member of any additional community agencies

Retrospective Review. GSHP will conduct retrospective review for inpatient hospital stays that GSHP was not notified of either prior to admission or within two days of an urgent or emergent admission. GSHP will base retrospective reviews requiring authorization solely on the information available to the provider at the time of care. The UM Nurse will review the request for exceptional circumstances (for example, inaccurate benefit information given to the provider), and if exceptional circumstances did not exist, and non-inpatient care was provided, will issue an administrative denial. If exceptional circumstances existed or inpatient care was provided, the nurse will review for medical necessity. If the care meets criteria, the nurse sends the provider an approval letter and tracking number. If the care does not meet criteria, the case is referred to a Physician Reviewer to make the final determination. Determinations are issued within 30 days of receipt of all necessary information.

Controlling Avoidable Hospitalization and Hospital Readmissions

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.

Granite State Health Plan (GSHP) will implement strategies used successfully by other Centene health plans to identify, assess and ensure needed care for members at risk for avoidable hospitalizations and readmission. We will control avoidable hospitalizations by identifying members at risk for hospitalization and enroll them in case management to ensure care and monitoring necessary to avoid acute episodes and exacerbations. We will also analyze plan-wide data to identify areas for improvement initiatives aimed at reducing avoidable emergency department use and hospitalization.

Identification

GSHP will identify members at-risk for hospitalization through review of information received from member contacts as well as ongoing analysis of data. We will work with high-volume providers, such as

FQHCs, to co-locate case management (CM) staff who will help identify members who may require immediate intervention to avoid emergency department use or hospitalization.

GSHP will use new member contacts (such as the New Member Welcome Call) to identify at-risk members. Our CentAccount™ Program provides an incentive for members who complete our Health Risk Screening (HRS), which identifies chronic disease or special needs as well as risk factors such as non-compliance with medications or follow up care, lack of understanding of the disease process and treatment, or lack of financial or social resources for transportation, nutrition or emotional support. GSHP will mail new members a New Member Welcome Packet, which will contain the HRS and a stamped return envelope. NurseWise, our 24/7 nurse advice line affiliate company, will place New Member Welcome Calls to all members within 30 days of enrollment, during which the nurse will ask the member to complete the HRS if we have not yet received it. For members who cannot be reached by phone, GSHP will use Televox to deliver audio-postcards asking the member to call our Member Services hotline for information about their health care. MemberConnections Repesentatives (MCRs), our grassroots community and health outreach workers, will also attempt to contact members at home.

GSHP will also identify members who may be in need of interventions through predictive modeling risk analysis, and ongoing analysis of data such as enrollment, utilization and claims data, monthly Trigger Diagnosis reports, monthly ED Utilization Reports, and the monthly NurseWise Case Management Reports that identify members whose calls indicate risk for hospitalization. Our PBM, US Script, will provide drug utilization review reports allowing the Medical Director and Plan Pharmacist to identify members with multiple or conflicting drug regimes that could result in hospitalization. We will also identify members through referrals from providers, families, caregivers, community organizations and GSHP staff.

- **Case Management.** Criteria for our case management (CM) and Disease Management (DM) Programs will include, but are not limited to, certain diagnoses as well as predictive modeling to identify the highest risk members, such as those for whom pulmonary, gastrointestinal or central nervous system disease is co-morbid with cardiovascular disease. Once enrolled, GSHP Case Managers will complete a comprehensive assessment of the member's medical, behavioral health, social and other needs, and work with the member, family or caregiver, PCP and relevant providers to develop a care plan that includes services to address each identified need. By ensuring the care plan addresses the full range of the member's needs, GSHP can prevent or reduce acute episodes and exacerbations that may lead to hospitalization. Care plans for members on SSI, or who have complex conditions and special health care needs, will include needed specialty care to ensure monitoring and treatment to prevent, reduce or delay

Centene has achieved a 30% reduction in preterm deliveries (at-risk for NICU admission) through case management efforts to identify high risk pregnant members with a history of pre-term labor that would benefit from 17 Alpha Hydroxyprogesterone (17P) regimen.

exacerbations. Care plans for all members will include the preventive and primary care that all individuals need to monitor and improve health.

Care Managers will also assess and monitor member compliance with treatment, and address barriers to compliance as well as self-management. For example, a member may need help developing self-reminders to take medications at directed times. A member on asthma may need education about identifying triggers and use of spacers to avoid acute episodes. Care plans will also include community resources and non-covered services.

- **Health status** is dependent on a wide range of factors that includes but is in no way limited to medical care. For example, a member who cannot pay the utility bill loses use of their refrigerator, which may be required to store certain medications. Our CM Team would attempt to locate a local social service agency for utility assistance, or identify alternative storage locations for the medicines. We will also offer innovative solutions to high-risk members. For example, through our ConnectionsPlus Program, we provide cell phones to high risk members who lack reliable phone service. These phones are pre-programmed with numbers for the CM, PCP, other treating providers and 911. This allows the member to receive reminders and monitoring calls, and to contact the CM or provider with concerns and questions, rather than visiting the emergency department (ED).
- **Improvement Initiatives.** GSHP will identify potential inappropriate ED use and avoidable hospitalization and develop clinical improvement initiatives to address the root causes. For example, we will implement an initiative used successfully by other Centene plans to reduce inappropriate ED use. Centene's Health Economics Department will generate a monthly report of members with frequent ED visits (three or more visits in the previous month). We will outreach to these members to review needed health services, identify obstacles to PCP access, educate about appropriate ED and medical home use, and screen for enrollment in case management. We will also provide these lists to PCPs and encourage them to outreach to the members to increase medical home use. In addition, the QI Department will annually review admission rates for Ambulatory Care Sensitive Conditions, and evaluate high or upward trends as possible triggers for focus studies or clinical initiatives, or for corrective action plans for providers or facilities with high rates.
- **Hospital Readmissions.** GSHP's approach to controlling hospital readmission includes concurrent review, discharge planning, and post-discharge follow-up. Our on-site Concurrent Review Nurse (CRN) will establish personal contact with the member and family/caregiver while the member is inpatient. The CRN will collect data on the member's condition and needs to begin discharge planning as early as possible during the inpatient stay. This will include assessing medical and non-medical needs and working with the member, family/caregiver, attending physician, and PCP and treating providers to develop a transition of care plan to lower the risk of unplanned readmission. Key elements of this plan will include facilitating communication between the member's inpatient, transition, and outpatient providers, including the use of GSHP electronic health record; assessing barriers to outpatient follow-up care, such as lack of transportation in rural areas or lack of phone access; and arranging solutions such as community transportation and meal services, or as appropriate, enrolling the member in ConnectionsPlus. Discharge planning will include member

education about needed follow-up care and how to contact GSHP for questions or assistance. It will also include assignment to a CM Team for appropriate post-discharge follow-up monitoring, and the development and implementation of an ongoing care plan if needed. For example, a Start Smart for Your Baby® Case Manager will review information about NICU admissions and initiate case management services to continue until the infant is medically stable and the caregiver can demonstrate appropriate caregiving skills. The CM Team will contact the caregiver within three days of discharge to assess the member's condition and ensure follow-up services are accessed.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.15 Data Reporting Requirements

GRANITE STATE HEALTH PLAN

3.15 Data Reporting Requirements

Encounters Reports

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

A History of Success - Submitting Reporting and Encounter Data

Granite State Health Plan's (GSHP) parent company, Centene Corporation (Centene), has over 27 years of experience submitting encounters for public sector health care programs on behalf of our 13 affiliated health plans. We will leverage this organizational structure, expertise, technology, and lessons learned to ensure the integrity, validity, and completeness of all data, including encounters we exchange with DHHS.

Local and Nationwide Experience Ensures Success. Centene will provide GSHP with technology support, financial reconciliation services, and error review and resolution services, to support our encounter submission quality and error management processes. Our national experience will complement GSHP's local experience with *best practice disciplines* to provide DHHS with accurate, timely, and complete encounter submissions and an effective error management process. Centene health plans meet regularly to review encounter submission processes and discuss best practices. This allows us to leverage experiences learned from other states for use in our continuous improvement efforts. We will organize our Encounters Team at GSHP and Centene to leverage the expertise of Centene to ensure that we consistently provide excellent service to DHHS.

Accuracy. Centene currently processes and submits over 2.2 million encounters per month from over 100,000 medical and behavioral health providers across the 13 health plans for which we provide services. For mature health plans, our average first time ***success rate is over 98%***. We have provided below a quarterly summary of our accuracy acceptance rates for two of our largest health plans for the period September 2010 through September 2011.

Centene will work collaboratively with GSHP and DHHS leveraging our 25 years of experience and best practices to establish the appropriate encounter standards while ensuring DHHS obtains needed encounter data. *Please refer to Table 3.15.A.1 Accuracy and Timely Submission Factors.*

Completeness. GSHP's encounter submissions will include *all* paid claims and encounters adjudicated for our members, including those submitted by non-participating providers and our subcontractors, *and* will include both fee-for-service payments and capitated services. Using our Centelligence™ Insight reporting platform, we will compare total claims payment amounts to the total payment amounts processed on a monthly basis. These totals are then compared to the total paid amounts contained in that month's encounter submission. Using this process, we account for every paid dollar and we verify that all finalized claims have been processed as encounters and are inclusive of all payment adjustments, settlements, pends, and denials.

Timeliness. GSHP and our Encounter Business Operations (EBO) team (described below) will create and submit encounter files to DHHS based on DHHS specifications for file format, data, method and schedule. Today, we submit encounters to our state clients using HIPAA 837 format or proprietary formats according to the state specifications, on fixed weekly or monthly schedules; but can easily adjust our submission schedule based on self-monitored metrics (e.g., volume) or at the special request of DHHS.

Our EBO team and GSHP will jointly manage timely encounter submission, response processing and error resolution. Where necessary, errors are rectified by *on call* programming staff or through our change control process.

Table 3.15.A.1 Accuracy and Timely Submission Factors

State	3rd Quarter 2011 Accuracy	3rd Quarter 2011 Timely Submissions*	Last 6 Months Accuracy	Last 6 Months Timely Submissions*	Year to Date 2011 Accuracy	Year to Date 2011 Timely Submissions*
Indiana	**99.3%**	**96.4%**	**99.1%**	**96.2%**	**99.2%**	**94.57%**
Texas	**99.0%**	**99.2%**	**99.5%**	**99.1%**	**99.4%**	**99.19%**

*We define timely submissions factor as the cumulative dollar amounts accepted within a 30 day period.

People, Systems and Process Supporting Encounter Submissions

Centene's Encounter Business Operations Unit. Centene's Encounter Business Operations (EBO) unit will serve GSHP as a centralized resource supporting encounter submissions. The EBO fosters strong relationships with key functional areas such as Finance, Claims, and Information Technology to achieve our goal of accurate, timely, and complete encounter submissions. Through daily meetings between EBO and IT, we are able to quickly and confidently adjust to required changes, while mitigating secondary and tertiary operational risk, share best practices and discuss continuous improvement opportunities for GSHP.

GSHP will have an EBO Encounter Specialist who will work with GSHP encounter resources, DHHS and, where necessary, leverage the nationwide expertise of other EBO resources to address any new DHHS requirements. The EBO and GSHP team will represent a service team focused *solely* on encounter reporting needs, and provides dedicated resources with the experience and expertise to ensure accurate and timely encounter reporting.

Local Partnership with DHHS. Under the supervision of health plan leadership, GSHP will provide an encounter analyst who will acquire the specific knowledge about DHHS's encounter processing rules, and who will be responsible for the overall submission and correction of encounter data for GSHP. They will provide critical feedback into the claims adjudication and encounter reporting processes, as they best understand DHHS's requirements and expectations. GSHP will provide DHHS timely

notification of any significant changes to our systems that could impact the integrity of our claims or encounter data, including new software and strategic partnerships. GSHP and Centene view DHHS as a *partner* in our encounter reporting process and we will work openly and collaboratively to resolve technical issues and to meet any additional requirements that enhance DHHS's administrative oversight processes. GSHP's CEO or CFO will provide attestation to the truthfulness, accuracy, and completeness of all encounter data submitted to DHHS.

Automating the Encounter Submission Process. Once claims are adjudicated to a finalized status, our Encounter workflow system will extract, prepare, and submit the data as encounters to DHHS. We will configure our Encounter system to submit encounter data that complies with all DHHS standards for electronic file submission file size, submission frequency, and submission method as required by DHHS. Our encounters will capture the same line item detail regardless of the claim type, disposition (e.g., paid or denied), third party liability indicators, or capitation arrangements. We will include all rendered services, original and adjusted claims, application of retroactive fee or member changes, etc., in our encounter files as appropriate for the claim type, for submission to DHHS. We will also submit encounter files for services provided through our contracted vendors adhering to NCQA, AMA coding, UB-04 editor, NCCI, *and DHHS standards* regarding the definition and treatment of certain data elements captured on claims, use of standard codes (including CPT Category I and II, HCPCS Level II and ICD-9-CM), counting methods, units, etc. As described below, we will conform to all current and future standard code sets in compliance with federal guidelines. Centene will retain all data elements in our claims history necessary for creating encounters in compliance with DHHS requirements.

Specific functionality provided by our Encounter system includes, but is not limited to:

- Support of DHHS-specific business rules
- Automation of GSHP defined actions, in conformance with DHHS guidelines, to correct repairable encounters
- Linkage to base claim database, outbound encounters, and inbound acceptance reports to facilitate comprehensive encounter reconciliation efforts
- Automated prioritization of encounter correction activities
- Extensive operational and executive reporting to identify encounter trends, monitor acceptance rates, and proactively correct issues
- Automated extract and delivery mechanisms to minimize bottlenecks and the need for manual intervention

Root Cause Analysis and Resolution to Improve Encounter Submissions. Centene and GSHP's Continuous Quality Improvement (CQI) approach will focus on the entire life cycle of a claim from inbound claim submission through encounter acceptance to identify and resolve underlying causes of encounter submission errors versus correcting errors. Below is an example of regular CQI activities related to identifying and resolving potential provider claim issues that affect encounters.

- Conduct a review of weekly check audit results to identify potential areas of concern

- Attend DHHS encounter meetings to assist us in identifying additional areas of concern and opportunities to continuously improve our processes
- Utilize DHHS provider billing manuals and incorporate them into our own manuals to guide provider claim and GSHP encounter submission

When we identify a provider claim issue that impacts encounter submissions, GSHP staff will review electronic claim images, claim system configuration, and encounter system edits to determine the specific reason behind the issue. Once we have reviewed all of this information, our staff will develop the appropriate corrective action(s) necessary to resolve the issue. For example, based on our highest reject reasons, we might identify specific edits that need to be moved to the front end of our claim processing system to reject or deny inaccurate claims submissions as early as possible in the process.

These activities allow the claim to be corrected and submitted accurately by the provider. We will then, in turn, submit an accurate, timely, and complete encounter to DHHS.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.16 Grievance and Appeals

GRANITE STATE HEALTH PLAN

3.16 Grievance and Appeals

Complaint and Grievance Process

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***

Granite State Health Plan (GSHP) will establish, implement, and maintain a fully developed, member-centric grievance process that meets all DHHS requirements. Our processes for identification, receipt, tracking, response, review, reporting, and resolution of Medicaid member inquiries, grievances and appeals comply with all State, federal and NCQA requirements. GSHP will promote and maintain an internal function dedicated to the identification and prompt resolution of oral and written grievances, and member appeals. Our policies and procedures govern the resolution of inquiries, grievances and appeals, and encompass expedited review, external review, and access to the State's Fair Hearing system. GSHP will maintain written policies and procedures clearly describing the grievance and appeals process and will provide the Member Grievance Policy and additional information to providers and subcontractors at the time of contracting, in the Provider Manual, Provider Newsletters and on the Provider Portal. We will educate members about the Member Grievance Policy through our Member Handbook, Member Newsletters, and Member Portal and during telephonic and face–to-face interactions with members. The timeframes noted below are in accordance with NCQA standards; GSHP will alter these accordingly to comply with those defined in the MCO Contract.

Grievance System

Authority and Staffing. The Board of Directors (BOD) will have final authority and responsibility for the process, and will delegate operational oversight and implementation to GSHP's Grievance and Appeal Committee (GAC). The GAC will review all appeal, complaint, and grievance data, including any handled by subcontractors under a delegated agreement, to identify trends or issues requiring follow up or improvement. The Grievance Coordinator (GC) and Clinical Appeals Coordinator (CAC) will be responsible for ensuring all aspects of the process are documented, routed, processed, tracked, resolved, and reported per DHHS requirements. In addition, all GSHP staff will be trained about the grievance process and its importance, member and provider rights, and how to assist members and providers in filing complaints, grievances and appeals.

Reasonable Assistance to Members. GSHP believes that members should have their concerns and issues heard and addressed as soon as possible. We educate our members about how to contact GSHP's Member Services Department if they have an inquiry or concern, and about the grievance

process, in the Member Handbook, on the GSHP website, Member Portal, and at least annually in our Member Newsletters. All materials are written in easy-to-understand language equivalent to a 6th grade or lower reading level. A member or member's authorized representative may contact GSHP at any time with an inquiry on behalf of a member. They may contact GSHP orally, in writing, by mail, facsimile, electronic mail, through the GSHP Member Portal, by dialing GSHP' toll-free Member Services Helpline, or in person. We take pride in our responsive customer service, and attempt to resolve the issue or inquiry for the caller at the time of the call. All GSHP staff is trained to identify, document, and route verbal or written issues, inquiries, grievances or appeals to the GC or CAC, although most individuals and members call the Member Services Helpline with their initial inquiry. When responding to inquiries, Member Service Representatives utilize help screens and other system documentation to assist them in addressing issues or provide information to the member's satisfaction. GSHP ensures that communication with designated representatives on behalf of members is HIPAA compliant. Our GC will confirm the member has provided written consent for any representative contacting the plan on behalf of the member. When appropriate, the GC will supply a consent form for the member to complete and return. In all cases the member has access to GSHP assistance in filing member inquiries, grievances, appeals, or requests for State Fair Hearings. GSHP will provide personal assistance to any member needing support in any stage of the grievance process; including communication assistance such as translation, TTY/TTD availability, interpreter services, or alternative formats for materials. We will make forms available to members, providers, and other authorized representatives to submit grievances or appeals on behalf of members. GSHP will provide appeal forms with all written adverse action notices, on the Member and Provider Portals, and upon request.

Appropriate Expertise. Member Service Representatives (MSRs) and Care Management (CM) staff are typically the member's first point of contact regarding the filing of a grievance or appeal. All MSR and CM staff is trained to document and resolve the member's concern during this first contact when possible. This procedural training will also be extended to all GSHP staff who works directly or indirectly with members. All staff will be trained to recognize any expression of dissatisfaction, and follow procedures to ensure the member's issue is appropriately captured and addressed, which includes emphasis on the importance of the grievance and appeals process and procedures, and the rights of both the member and provider. GSHP's written policies will ensure that no punitive action will be taken against a provider who supports a member's complaint, grievance or appeal, or files a complaint, grievance or appeal on a member's behalf. The appropriate GSHP staff or Medical Director involved in the resolution of grievances or appeals will not have been involved in any prior level of review or decision-making, and will have authority to require corrective action as appropriate. Physicians involved in reviewing medically related grievances and appeals will have appropriate experience treating the member's condition or disease, and will not have been involved in any prior level of review or decision making. Members and providers will be allowed to submit supporting documentation for consideration by the Medical Director or other designee.

Member Grievance Process

A member grievance is any member expression of dissatisfaction about any matter other than an Action (described below). Possible concerns identified as grievances may include, but are not limited to, the quality of care or services provided to a member, any aspects of interpersonal relationships such as the rudeness of a provider or GSHP employee, or failure to respect the member's rights. The term 'complaint' generally refers to an informal grievance, i.e. a grievance that is resolved immediately by a MSR to the member's satisfaction and not requiring additional investigation. However, any 'expression of dissatisfaction' about a matter other than an Action is handled per the processes described within.

Receipt and Documentation. Members, authorized representatives acting on a member's behalf, and providers (with the members' written consent) may file a grievance orally by using our toll-free or TTY/TDD number, in person, via the Member Portal, or in writing. Grievances will be logged and maintained within our Member Relationship Manager (MRM) system which provides a central location for documenting, tracking and reporting of member grievances by category, and facilitate monitoring of the grievance resolution process and timeframes. Upon receipt of an oral or written grievance, the MSR or GC will complete a case within the MRM and assign it to the Grievance queue for processing. The case contains all the necessary data fields for the reported incident to be investigated, such as the receipt date of the grievance`, identification of the member and the individual recording the grievance, the nature and disposition of the grievance; and the date of resolution and corrective action completed to resolve the issue. The GC will scan any additional supporting documentation received with the grievance, using the Centene Document Management System (CDMS), and attach to the member's grievance case in MRM. Please see the following attachments for the member grievance process:

Acknowledgement. Staff receiving grievances orally will acknowledge the grievance and attempt to resolve it immediately. This often occurs through member interaction in the call center. MSRs will make every effort to assist the member with options to resolve the issue. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. For example, if a member expressed dissatisfaction regarding a particular provider, the MSR would explain the grievance rights and offer to find a new provider for the member. The issue is still acknowledged and reported as a grievance however, the resolution of a new provider assignment would be in place, if this resolution is to the member's satisfaction. All oral or written grievances will be forwarded to the GC for tracking, written acknowledgment, and resolution. If resolved upon intake, the acknowledgement letter will include appropriate language advising of the resolution agreed upon. If not resolved at the time of intake, the GC will send a written acknowledgment letter within five business days of receipt. The GC will include a description of the grievance procedure including timeframe for resolution.

Investigation. The GC will conduct an initial review, which may include contacting the member for additional information or clarification of the issue and gathering applicable documentation from other GSHP departments. For example, the investigation may include the assistance or input of the member's Case Manager, or the Provider Services Department if the matter involves a GSHP provider,

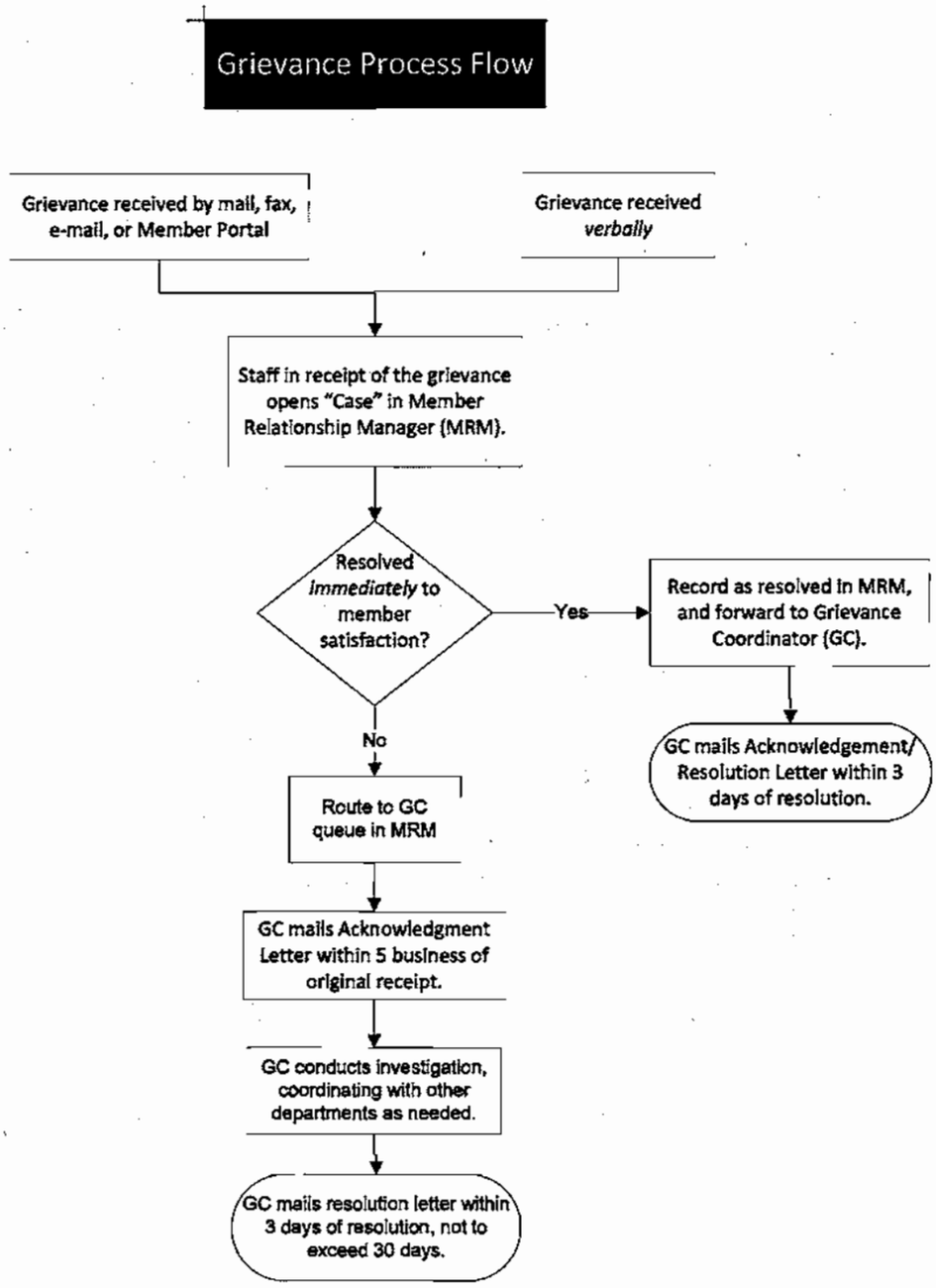
or review of the log of prior contacts with GSHP as recorded in MRM. Clinical issues, including grievances filed as a result of a service denial or a decision to deny a request for an expedited appeal resolution, are forwarded to the Medical Management Department for investigation or review by a physician or other appropriate clinician. If the grievance involves a quality of care issue, it is escalated to the Director, Quality Improvement for review, resolution and inclusion in the quality of care investigation process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the GSHP Compliance Officer for resolution. The Compliance Officer will also determine whether the issue should be forwarded to DHHS, and accordingly will report credible cases of fraud, waste, and abuse to DHHS within 15 days.

Notice of Resolution. GSHP will consider a member grievance resolved when the member is satisfied with the resolution. The GS will resolve the grievance as expeditiously as possible, not to exceed 30 days of receipt. Our internal goal is to resolve grievances within 10 business days. The GC will send written notice of resolution within three calendar days, not to exceed 30 days from initial receipt of the grievance. Regardless of the outcome, GSHP will not discriminate or retaliate against a member for filing a grievance or appeal or requesting a State fair hearing.

Tracking Grievances. Grievances will be categorized within MRM under standard categories outlined in GSHP's contract or DHHS's reporting guide. Some examples of effective and efficient categories for detailed reporting is demonstrated by our affiliates at Bridgeway Health Solutions (Bridgeway) in Arizona. Bridgeway utilizes a tiered grievance classification process consisting of broad categories including: Transportation, Medical Service Provision, Contractor Service Level, and Access to Care. These categories are further defined by sub- categories to delineate and trend issues while monitoring and tracking resolution timeframes. On at least a monthly basis, all GSHP grievance data will be compiled into one Member Grievance Report, which the GC will review for identification of trends. Any trends that are discovered which are specific to a department or service, are submitted to the appropriate department for review and corrective action. This data is also submitted monthly to DHHS as required, and a report is presented at the quarterly Grievance and Appeal Committee for further review and recommendations as needed. GSHP recognizes that trending of member expressions of dissatisfaction provides valuable information about what may be problematic for a member and what changes need to occur to provide optimal service to members.

GRANITE STATE HEALTH PLAN

The following chart depicts our grievance process.



Appeal of Adverse Action

An appeal is defined as a request for the review of an Action taken by a health plan. The definition of an Action includes: the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner including failure of GSHP to act within the required timeframes. GSHP's parent company, Centene, and its affiliate health plans maintain an excellent record of meeting grievance and appeal resolution timeframes. Members will have 30 calendar days from the date of the receipt of the *Notice of Action* to request an appeal. Members, the legal representative of a deceased member's estate, or a member's authorized representative (with written consent from the member) acting on behalf of the member, may file an appeal orally or in writing. Providers filing an appeal on behalf of a member will require the member's written consent, other than in the case of an expedited appeal request. Oral inquiries regarding an appeal of an Action will be treated as an appeal. An oral appeal request must be followed by a written, signed appeal; however, if the appeal request is received orally, the oral receipt date will be considered the initial receipt date of the appeal. Expedited requests do not require written follow up.

Acknowledgement. The CAC will document written or oral appeals requests within one business day of receipt. The content of the appeal, including all clinical aspects involved and any actions taken, will be documented. The CAC will send the member or authorized representative an acknowledgement letter within 5 working days of receiving the request that will include the subject of the appeal, explanation of the appeal process, and the member's rights, including the right to submit comments, documents, or other evidence relevant to the appeal in person or in writing.

Resolution Time Frame. GSHP will resolve appeals as quickly as the member's health condition requires, but in the case of standard appeals, appeals will be resolved and the member and provider notified within 30 calendar days of receipt, and for expedited appeals within 72 hours of receipt. The resolution time frame will be extended for up to 14 calendar days if the member requests the extension, or if the delay is in the best interest of the member and the member agrees to the extension. We also will provide the member with written notification of the reason for the delay for extensions not requested by the member.

Expedited Appeal Process. GSHP will follow DHHS's timeframes and processes for handling expedited and standard appeals, including extending time periods within guidelines, if the extension is in the best interest of the member. A member or provider may request an expedited appeal of an Action, while pursuing the appeals process if it could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The CAC will immediately gather supporting documentation for expedited appeal requests and forward all information to a Medical Director (MD with the same or similar specialty, who was not involved in any previous level of review. Prior to issuing a final adverse determination, the MD will also contact the requesting provider to obtain any additional information the provider or member would like the MD to consider. Requests related to an ongoing admissions, continued hospitalization, or other health care services for a member who has received emergency services but has not been discharged will be processed as an expedited appeal

request. For expedited appeal requests, the MD will render a decision within 72 hours of receiving the request, or sooner, as the member's condition requires. An oral expedited appeal request does not need to be followed by a written request for the expedited appeal. The MD or CAC will provide prompt verbal notice of all decisions to the provider and member within the 72 hour timeframe that will include the decision outcome along with information on the DHHS appeal process in the event of an adverse outcome. The CAC will send written notification within three calendar days of the expedited decision. If a request for an expedited appeal resolution is denied, the appeal is transferred to the standard resolution process and reasonable efforts are made to provide the member and provider with prompt oral notice of the denial of the expedited request and written notice within three calendar days.

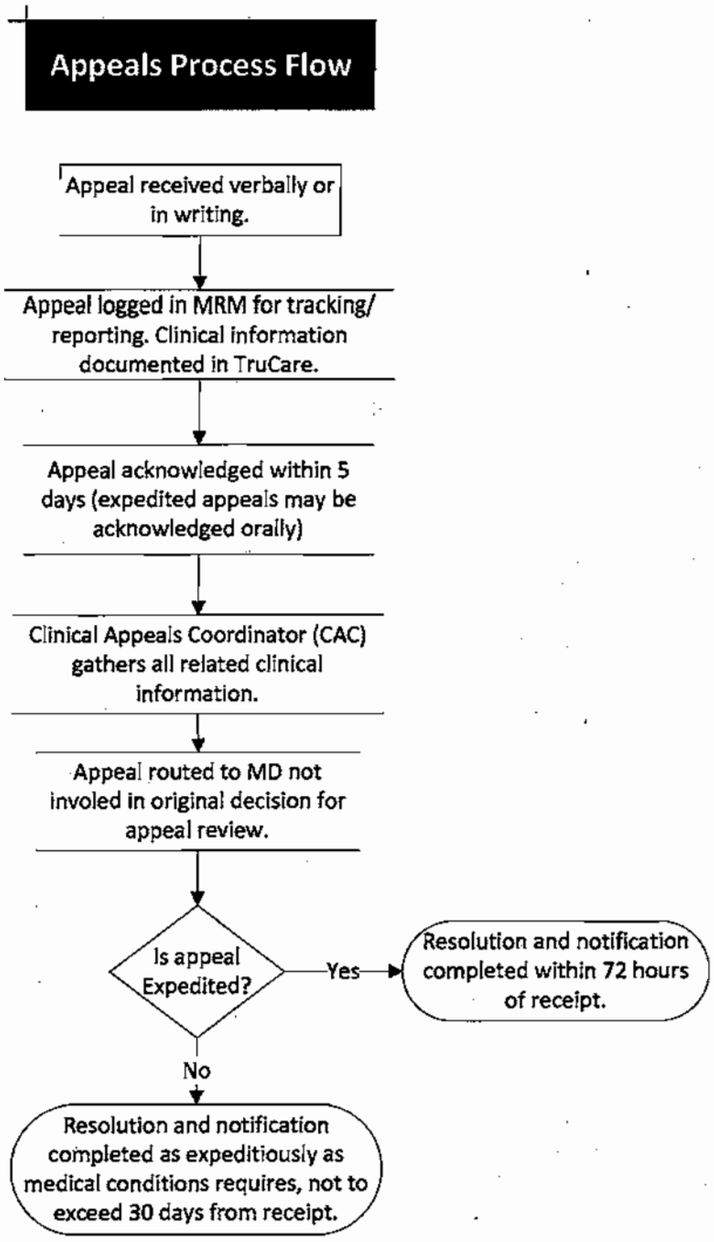
Levels of Review. A physician with appropriate clinical expertise will review appeals involving clinical issues or any medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination and who was not involved in the initial determination or any prior decision-making. Members are encouraged to submit additional documentation, in person or in writing, to support their case and are reminded of the limited time available for expedited appeals. When received, any additional documentation related to the appeal is date-stamped and included in the file for review.

Timing of the Notice of Resolution. The CAC will provide written notice of the appeal resolution to the member and the provider within two business days of the decision, not to exceed 30 calendar days following receipt of the appeal. Adverse appeal resolution notices will include, but are not limited to, the appeal decision and reasons for the decision in easily understood language, reference to the protocol or criterion on which the decision was based, notification of the member's rights, including the right to receive a copy of the actual protocol or criterion on which the decision was based, a list of titles and qualifications of individuals participating in the appeal review, and the right to request a State fair hearing and the procedure for doing so. This letter also includes instructions on how to request a hearing, that the member may ask for the continuance of previously authorized benefits until the matter is resolved and how to make a service continuance request. If the member (or his/her designated representative) requests a State fair hearing, GSHP ensures all supporting documentation is forwarded to New Hampshire's fair hearing board, within seven calendar days from the date GSHP receives the written hearing request.

Continuation of Benefits. We will continue a member's benefits through the appeal resolution process (until the final decision by GSHP or the State fair hearing decision is issued) if the appeal was filed within 10 days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired and the member request an extension of benefits. If these conditions are met, benefits are continued throughout the appeal process. The services will remain in place until at least one of the following occurs: the member withdraws the appeal, the appeal decision is rendered and the member does not request a continuance within the designated timeframe pending a hearing, filed hearing results in an adverse decision for the member, or the original authorization time period expires or authorization service limits are met.

GRANITE STATE HEALTH PLAN

The following chart depicts our appeals process.



Using Data to Improve Processes and Performance

Complaint, grievance and appeals data will be reviewed by appropriate staff and committees for action as needed. The Grievance and Appeal Committee will review quarterly reports of complaints, grievances and appeals to identify trends and areas of concern, including whether GSHP and DHHS standards for timeliness and other processing issues are being met; to identify patterns related to specific issues, providers or GSHP departments; and to target any needed corrective actions. The Utilization Management Committee (UMC) will review appeals data to identify trends that indicate that specific utilization guidelines should be updated, developed or clarified; or that there is a provider education need. Complaint, grievance and appeal data as well as data relating to processing standards (such as timeliness) will also be submitted and quarterly to the Quality Improvement Committee for trending and analysis. GSHP will incorporate aggregate data in member and provider satisfaction analysis for the annual QI Program Evaluation.

The table below summarizes how Grievance and Appeal data will be used to identify performance issues and develop performance improvement initiatives and which department will be involved in developing and implementing the initiatives.

Performance Issue	How Data Will Be Used	Department
Access/Availability Deficiencies	Identifying Network Gaps; Provider Wait Times, Compliance, and Training	Provider Relations
Quality of Care, Member Safety, Abuse of Member –Adult and Child	Training/Re-credentialing/Peer Review	Medical Director, QI
Benefit Questions	Improvements to Written Materials	Member and Provider Services, QI
Service Levels	Staffing Adjustments/Training Technology Enhancements	Member/Provider Services
Customer Service Deficiencies	Business Process Improvement	Applicable Functional Area
Inappropriate Billing Practices	Fraud and Abuse	Compliance/Special Investigations Unit

GSHP Affiliate Experience

The summary below depicts examples of how our Arizona affiliate, Bridgeway Health Solutions, serving approximately 4,700 members within the Arizona Long Term Care population (ALTCS), utilized the process reflected above for analysis of Grievances throughout the course of the contract cycle, continuing to capture appropriate data for prompt identification of trends as well as document interventions and outcomes. Examples of identified issues, interventions and outcomes include the following:

Transportation: In 2007, Bridgeway noted a spike in issues related to transportation including but not limited to late or early pick-ups, with primarily involved the same transportation provider. Through coordination with our Provider Relations Department, and Quality Management Department, Bridgeway increased the oversight and monitoring of this transportation provider to ensure improved customer service and adherence to policies and procedures. A comparison in the review of 2008 grievance data shows a significant reduction in the number of received grievances related to transportation, which is attributed to Bridgeway's interventions following the identified issues from the previous year. Reporting of grievances in this category remains low through the 2011 reporting cycle.

Provider's Billing Members: In 2008, review of grievance data revealed that in a majority of these instances, the issues was not generally related to dissatisfaction or frustration, but rather a need for assistance with ensuring the provider's records were updated with the member's current eligibility/enrollment information. Bridgeway responded to this trend by utilizing the Member Services Department to develop a tracking database, and work closely with the Provider Relations and Case Management Departments to either (a) ensure the provider has the appropriate member eligibility/enrollment information, and/or (b) utilize the database as a recruitment tool, identifying non-contracted providers already seeing our members, and contact for potential contracting with Bridgeway. Following this effort, reporting of grievances in this category remains low through the 2011 reporting cycle.

Network Gaps: Bridgeway maintains a reporting category for identification of issues related to access to care, or network gaps. Identified concerns in these areas remains low, with only three received grievances in 2008 where members were experiencing difficulty in securing attendant care services in ne of our rural counties. In these cases, we were able to promptly address the needs of the member through assistance of our locally-based Case Manager and Provider Relations Representative and resolve the issue by securing attendant care services for the members. The matters collectively were resolved within five days to the satisfaction of the members, and there were no additional reported grievances in this category through the remainder of the plan year.

The summary below depicts examples of how our Texas affiliate, Superior Health Plan (SHP), serving approximately 115,000 current enrollees within the CHIP population, addressed captured member grievances. Over a 24 month period (Jan. 2009-Dec. 2010), Superior, captured a total of 1384 CHIP member complaints. The majority of these complaints are categorized into the three groups below which represent approximately 96% of the total number of complaints.

Provider's Billing Members/Balance Billing: This category describe any occurrence in which a member receives a bill from a provider. The vast majority of these complaints originate from miscommunication between the member and provider upon the date of service. It has been determined that members receive bills most often as a result of not presenting their Superior CHIP ID card when the service is rendered. Superior's investigation of these concerns usually results in the billing provider agreeing to either submit the claim to Superior or adjust the member's account to a zero balance. Actions taken to address these identified complaints included the following: 1) Provider outreach, I in which SHP reminded billing providers of their contractual obligation to hold CHIP

members harmless for covered benefits; 2) Member outreach in which Superior advised members of their responsibility to present their Superior CHIP ID card at the time of service. Members were also educated on the importance of notifying Superior immediately upon receipt of a billing statement. Members had previously been disregarding statements and only notifying Superior once their account had been placed with a collection agency. By notifying Superior of statements timely, the billing concerns can be addressed quickly and easily. Outcomes from these interventions reflected that as a result of provider and member education, SHP has seen a decrease in the number of balance billing complaints received from CHIP members.

Health Plan Administrative ID Cards: This category identified instances where the SHP considered the members' non-receipt of Health Plan ID cards to be a complaint in certain circumstances. Further research identified two issues related to this matter, (1) involving a system eligibility load error, which SHP was able to promptly resolve and (2) involving the US Postal Service delivery process, which was address in coordination with adjustments to the SHP labeling system to revise the order in which delivery addresses were printed in coordination with use a cross reference and validations of addressed by way of the national code of addresses. These practices contributed to a significant decrease in SHP's receipt of calls and complaints related to Member ID cards not received during this reporting period.

Quality of Care / Quality of Service: Of the Quality of Care/Quality of Service complaints, 38% reference the attitude/customer service received from the practitioner's office staff. Of the documented complaints, 37% were about the general care received from the provider. The members are typically dissatisfied with either the level of care or the length of time the provider spent examining the patient. 5% are complaints about providers declining requests for referrals. Other issues relate to appointment availability, copayments, dirty office sites, etc.

Superior has implemented a new process of monitoring complaints and quality issues between re-credentialing cycles in order to maintain a network of direct and delegated participating practitioners who meet or exceed Superior Health Plan's (SHP) standards for delivery of high-quality and safe care to members. Quarterly, a collaborative report is generated by the QI Department and Provider Complaint Unit to monitor potential practitioner concerns. Superior reviews complaints on an ongoing basis during the intervals between formal re-verification of credentials. The credentialing staff will refer any incidences of potentially poor quality of care or recent sanction to the Quality Improvement Department (QI) so that important quality or safety issues may be identified and, when appropriate, acted on in a timely manner. If the result of the review indicates that any practitioner has exceeded the thresholds defined by the Provider Complaint Unit and QI, they are referred to the (Quality Improvement Committee) QIC. The QIC may determine additional action regarding practitioners who have met the threshold of complaints as follows: 1) continued monitoring, 2) corrective action plans or 3) referral to SHP's Peer Review Committee.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.17 Fraud and Abuse

GRANITE STATE HEALTH PLAN

3.17 Fraud and Abuse

Front-End Claims Editing/Auditing

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

Centene Corporation and its affiliate health plans have over 27 years experience delivering accurate and efficient claims processing, payment, reporting, and encounters for Medicaid, CHIP and Medicare claims. We use comprehensive clinical and data related edits to assess the accuracy and validity of all provider claims. These edits may be triggered at varying stages of the claims adjudication process. Each of these stages is supported by various technologies that offer flexible, adaptable, and dynamic configuration rules, allowing us to incorporate state specific billing policies regarding claims submission, adjudication and payment. These technologies integrate DHHS and Centene policies and procedures, and will be kept current with nationally recognized and state specific claim coding guidelines. Below is a description of our front-end claims editing and auditing functionality.

HIPAA Electronic Data Interchange (EDI) Edits

In the best interests of our providers, state clients, and our own internal operations, our preferred mechanism for claim submission will be through EDI. Therefore, GSHP will *actively* provide multiple options for electronic claim submission, outreach and education to encourage providers to *submit claims electronically*. Centene has found through our historical data, that when providers prepare claims electronically, the time from patient service to Centene receipt is less than half the time compared to claims submitted on paper. In addition EDI Claims data is more complete because technology validates much of the data submitted in the earliest possible stage in the adjudication process.

EDI claims are verified real-time for HIPAA format adherence which improves our claim auto-adjudication rate and the quality of the downstream encounter data we prepare and submit to our state clients. Our system will validate claims data against data structure rules and syntax; test to ensure conditional rules requiring secondary fields are accurate and complete; and will ensure all data is in compliance with our HIPAA Transaction Companion Guides. These upfront edits not only ensure that transactions are compliant with federal mandates and DHHS rules, but they improve processing efficiency by recognizing and rejecting problematic transactions in the earliest stage of the process and notify to our trading partners and providers through an audit file. This rapid turnaround allows providers to correct and resubmit non-compliant claims as quickly as possible for adjudication and payment.

Pre-adjudication Edits. Our system will map, translate, and validate claims data, ensuring that common edits are consistently applied for EDI and paper claims. We configure our system to validate certain

claim data elements, including member identification; billing and rendering provider; and other data elements against data we currently have in AMISYS Advance, our core claims processing system. If a transaction is rejected for any of the specific reasons during this process, notification is systematically sent to the EDI trading partner or submitting provider, conveying the specific DHHS-approved edit that did not pass our upfront validation processing. Examples of pre-adjudication edits include:

- ***Member Validation*** – confirms presence of member record in our systems
- ***Dates of Service Validation*** *– confirms that the dates of service on the claim are valid and do not contain a future date or a date outside of the member's eligibility span*
- ***Diagnosis Code Validation/ICD9*** **Tables** – confirms the presence and accuracy of ICD9 and procedure codes, and all HIPAA code sets.

Once the claim passes the above pre-adjudication edits, it is automatically loaded into AMISYS Advance. There are relatively few situations where an "unclean claim" is loaded into AMISYS Advance, such as specific scenarios where it is impossible to determine whether a claim is totally "clean" without applying adjudication logic. These situations include claims where supplementary documentation is needed, such as signed consent forms, or where we need third party payer documentation for member's with known "other insurance" (OI). We will configure the system to prioritize all pend types related to "supplementary documentation needed" situations so that these pends are immediately routed to a claims analyst specialized to handle these cases. If the analyst determines that we do not have the requisite supporting claim documents, we will immediately deny the claim, and the provider is notified within five business days via detailed information, including the reason for the denial in the HIPAA 835 Remittance Advice, online Explanation of Payment (EOP), and/or paper EOP (depending on the provider's preference).

Six Steps of Adjudication

All claims that successfully pass the pre-processing edits are loaded for adjudication into AMISYS Advance. The system accepts the Julian time stamps, for both paper and electronic claims, indicating when the claim was received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track our adherence to claims processing timeliness standards. AMISYS Advance's audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, operator ID stamping, and accommodates the setting of different audit parameters.

AMISYS Advance performs *six primary steps of adjudication* that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. The steps are listed below along with a brief description of each and specific examples of edits that will be configured within each step for DHHS claims.

- Step 1: Field and General Edits. The system assesses the presence and validity of required claim data such as CPT/ICD9 codes and whether the fields are consistent with the business rules

outlined by DHHS and federal regulations, as well as age, gender, duplicate, and timely filing edits. Example edits include:

- Procedure Code/ICD9 (ICD 10 when implemented): code inconsistent with member gender
- Procedure diagnosis code deleted, incomplete, or invalid
- Invalid type of bill.

Step 2: Member Eligibility. The system verifies eligibility of the member, member service dates, coverage type and existence of other insurance. Example edits include:

- Verifies that a member is eligible during the dates of service indicated on the claim.
- Validates member eligibility based on the date of birth of the member associated with the submitted member ID.

Step 3: Provider Eligibility and Status. The system checks the submitting provider's eligibility to participate in GSHP network and receive payment, as well as the provider's network participation status for the dates of service. For example:

- Participating or nonparticipating status is verified
- Pend edits will apply if the provider TIN or NPI is not on file

Note: In the event a pend occurs for the above reasons, Centene has an established process to quickly review and resolve the pend. We have specialists that work specific pend types which are routed automatically by our claim workflow system, integrated with AMISYS Advance, to the appropriate pend specialist queue.

Step 4: Prior-authorization. AMISYS Advance is integrated with **TruCare**, GSHP's integrated, member centric health services management platform where primary authorization data is held. The system is configured to determine if an authorization is required for a specific service, then if applicable, verifies the presence of a prior authorization, and confirms that the dates of service are within authorization date spans and service limits. Examples of prior authorization edits include:

- Authorization is or is not on file
- Procedure does or does not match authorization
- Service has or has not exceeded the authorized limit.

Step 5: Covered Services. To define exactly which services are covered and at what levels, the system determines covered services by applying configured eligibility, provider, and benefit management rules, along with tables of valid procedure codes and ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations. This step determines if a member is eligible for the services rendered, if the service date falls within the effective date of the benefit and meets all the criteria established for payment. Examples of edits related to covered services include:

- Denial edit will apply if a service is not covered or exceeds the benefit limit
- Pend edits will apply if a service has exceeded a benefit amount.

Step 6: Pricing. AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. Pricing edits may include:

- If the provider is out-of-network, the appropriate fee schedule is applied
- When appropriate, pend queues are set up so that claims are reviewed by senior claims staff to determine appropriate pricing. For example, first time claim submission from non-participating providers or claims that exceed high dollar billing thresholds.

Coding Review

Once claims have been adjudicated but prior to payment, they are further analyzed to determine **clinical appropriateness and correct coding.** We use ClaimsXten (CXT), McKesson LLC claims prepayment auditing software which contains a comprehensive set of rules based on nationally recognized coding guidelines. CXT addresses coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edit rules are based on generally accepted principles of coding medical services for reimbursement and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions. Instead, CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. CXT's flexible configuration tools will allow GSHP to customize these edits by incorporating state specific provider coding/reimbursement policies and DHHS benefit criteria into the applicability of these edits. Examples of the edits that are performed by CXT include:

- ***Unbundling:*** submission of a global CPT/HCPCS code along with other CPT/HCPCS codes that are considered included in the global code billed
- ***Global Surgical Period:*** addresses the payment/nonpayment of evaluation and management services billed during the global surgical period of another procedure.

Fraud, Waste, and Abuse Clinical Review

Centene has entered into a strategic partnership with Verisk's HealthCare Insight (HCI) subsidiary to further evaluate claims to detect clinical coding errors, inaccuracies, and potentially fraudulent billing patterns. Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, GSHP will be able to provide DHHS with an additional level of screening for clinical billing discrepancies and proactive fraud, waste, and abuse detection/prevention services, without disrupting claims turnaround time. HCI's clinical edits are based on national coding standards and customized to accommodate state specific rules and regulations. Once a claim passes through all edits described above and reaches a status of paid, we provide HCI with a paid claims file along with a historical provider claims file (if

provided by DHHS). By providing the claim history files, HCI can assess claims based on patterns of submission from a provider such as analyzing utilization patterns, hospitalization frequency, and billing habits. HCI then evaluates these files utilizing their proprietary code validation and profiling software. HCI conducts an initial sweep of the paid claims file (typically within two to four hours) and returns notification of claims requiring further review and evaluation by HCI's licensed registered nurses and certified coders. We are then able to release all claims successfully passing the HCI edits and suspend only those requiring additional review as identified by HCI. Upon completion of HCI's review, typically within 12 to 24 hours, HCI makes a pay/deny recommendation based on a review of the immediate claim and the patient's claim history. Prior to finalizing the claim, our Payment Integrity Team reviews and approves or denies all HCI recommendations.

Communicating Fraud to DHHS

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

Timely communication between GSHP and DHHS is vital to the success of combating program fraud and abuse. We will report all credible allegations of Medicaid fraud or abuse to DHHS, for referral to the Attorney General's Office and the Medicaid Fraud Control Unit within 15 days. We will make an expedited referral to DHHS if a delay in reporting the referral could result in harm or death to a patient; the loss, destruction, alteration of evidence; a potential unrecoverable monetary loss, and/or hindrance of an investigation or criminal prosecution of the alleged offense. We will also require subcontractors to report credible cases of fraud or abuse immediately to the GSHP Compliance Officer for reporting to DHHS. The Compliance Officer will ensure that subcontractor reporting follows the same processes described herein.

GSHP and our subcontractors will cooperate fully with State and federal agencies in any investigations and subsequent legal actions. Once we report a case of suspected fraud to the State, we will suspend all plan efforts to investigate, resolve, or take further action, unless so directed by the State or the State approves actions recommended by GSHP. The purpose of this process is to ensure we will not interfere with any ongoing State investigation or enforcement process. It is our policy to obtain DHHS approval of our recommended next steps. For example, we will only put a reported provider on pre-payment review after obtaining approval from the State. We understand that DHHS retains the right to determine case disposition and retain settlements on cases investigated by Medicaid Fraud Control Unit.

GSHP and Centene will not disclose the existence of any investigation conducted by State or federal law enforcement officials. If and when the State gives us approval to complete our own investigation, the GSHP Compliance Officer will immediately notify Centene's Special Investigation Unit (SIU) to proceed with the investigation.

We will meet monthly with DHHS, or more frequently as needed, to discuss areas of interest in past, current and future investigations and to improve the effectiveness of fraud, waste and abuse oversight activities. We will also provide a quarterly report to DHHS on the number of complaints that warrant preliminary investigation. The report will include: the source of the complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case. We will also report quarterly to DHHS all claims review audits in process or completed during the quarter in a format and mode mutually agreed upon with DHHS but that meets the minimum requirements specified in Section 3.17 of the RFP. We will provide select, authorized DHHS staff, or individuals authorized by DHHS, direct ***online, secure, inquiry-only access*** to our claims data for the purpose of data mining and review. In addition, we will provide training on the tools, system documentation, and best practices for these select DHHS individuals, to ensure effective ad-hoc use of our online reporting and decision support environment.

Fraud and Abuse Program

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

- ***Fraud detection methods that will be used***
- ***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***

GSHP will cooperate and assist DHHS and any other State or federal agency in identifying fraud, waste and abuse (FWA). Our FWA Compliance Plan provides detailed guidance for the prevention, detection, investigation and reporting of billing conduct and other activities related to FWA that do not conform to State and federal laws and regulations. Our staff, providers, members, and subcontractors play key roles in our strategy, and Centene's Payment Integrity Unit (PIU) provides dedicated resources for the investigation and technical support needed to operate an effective FWA Compliance Plan. Our Plan incorporates best practices based on the experience of Centene's affiliate health plans and as identified by the National Health Care Anti-Fraud Association (NHCAA), of which Centene is a member.

We will establish internal controls and written policies, procedures and standards of conduct that articulate our commitment to comply with all State regulatory and contractual requirements and with federal requirements in accordance with 42 CFR 455, 42 CFR 456 and 42 CFR 438. Our FWA Compliance Plan will direct a wide range of activities and involve a coordinated effort across departments within GSHP and the Centene corporate offices. All Centene and GSHP employees will have the responsibility to identify and report fraud, waste and abuse.

We will also comply with the Exclusion Program of the U.S. Department of Health and Human Services. The GSHP Credentialing Specialist will query the Federal Office of the Inspector General's List of Excluded Individuals and Entities Database and DHHS' excluded provider listings (if provided) for each provider applicant during the initial credentialing process, and monthly thereafter. If an applicant is found in either database, they will be immediately denied network participation. If a contracted

provider is found in either database during the monthly review process, the Credentialing Specialist will notify the Vice President of Medical Affairs and the Compliance Officer for GSHP. The Compliance Officer will notify DHHS and the provider will be immediately suspended from the network. In addition, we will recoup any claims paid to the provider during the exclusion period.

Fraud, Waste and Abuse Compliance Plan - Administrative Organization.

The GSHP Compliance Officer and Compliance Committee will oversee internal and external FWA monitoring activities and are accountable to the GSHP Board of Directors.

Compliance Officer. GSHP will designate its Compliance Officer as the organization's FWA authority with the ultimate oversight responsibility for carrying out the provisions of the Compliance Plan and communicating with regulatory authorities and DHHS staff. The GSHP Compliance Officer routinely communicates with GSHP's Compliance Committee, the Centene Corporation Senior Director of Payment Integrity, as well as colleagues at affiliate health plans on common issues, best practices, and training initiatives. **Compliance Committee.** The GSHP Compliance Officer will serve as the Chair of the GSHP Compliance Committee, which will meet at least quarterly and includes managers from every GSHP department. This committee reviews and determines the need for further action regarding any compliance issues.

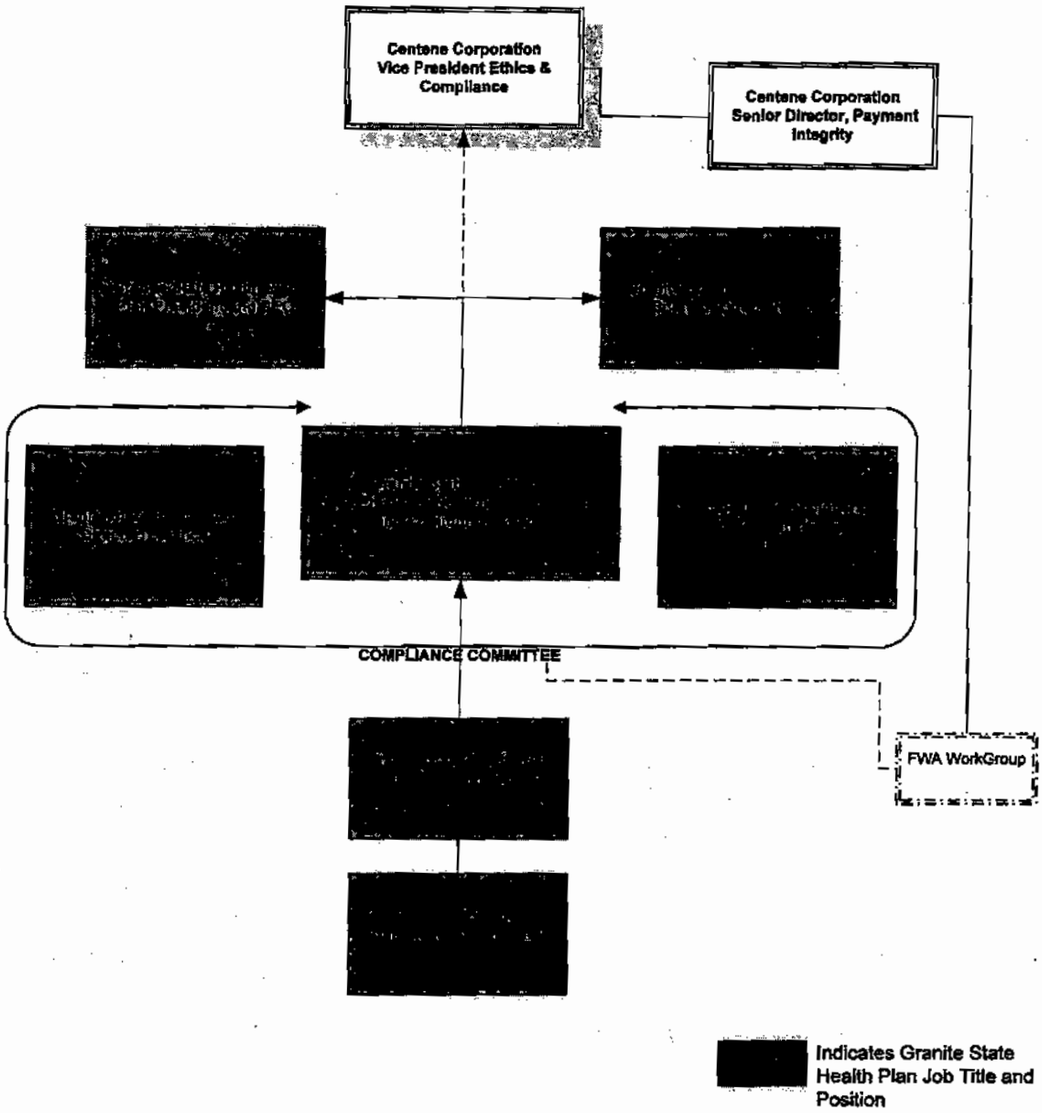
Corporate Support. The Centene Senior Director of Payment Integrity (PIU) reports to Centene's Vice President, Ethics and Compliance, and is a member of the National Health Care Anti-Fraud Association's (NHCAA) Board of Governors and regularly attends trainings and conferences. The PIU is comprised of the Prepay Compliance, Coding Compliance and Special Investigations Unit (SIU).The PIU interacts with Centene's Chief Medical Officer, Medical Management, Contracting and Claim Services Units as needed and shares all information and best practices with affiliate health plan staff, including the GSHP Compliance Officer.

FWA Work Group. The GSHP Compliance Officer will meet every other month with GSHP's Medical Director, as well as SIU to review active FWA cases, discuss any outstanding issues and present information on new potential cases. These meetings, when coupled with regular calls and ad hoc meetings, allow GSHP's Compliance Officer and other GSHP work group participants to interface with our SIU and keep informed on current fraud schemes, detection best practices or other new alerts from OIG. The SIU provides this work group with reports, analysis, and research on any potential issues identified.

State Meetings. The GSHP Compliance Officer, a representative from the SIU and other designated GSHP representatives will attend all meetings set by DHHS to collaborate on FWA policies and operations, including procedural updates or training sessions. The GSHP Compliance Officer will be the point person for communication with DHHS officials and will be available to meet periodically with DHHS and the Attorney General's Medicaid Fraud Control Unit (MFCU) to discuss any identified issues of fraud, abuse, neglect or overpayment.

GRANITE STATE HEALTH PLAN

Compliance Staff Organizational Chart



Fraud, Waste and Abuse Compliance Plan and Processes

Our Compliance Plan will focus on prevention, detection, investigation and reporting of fraud, waste and abuse while preventing potential health risks to members. We will review and update our

Compliance Plan, at least annually, to ensure that the results of previous year's activities and "lessons learned" are incorporated into our program.

Prevention GSHP will establish internal controls to prevent fraud, waste and abuse that include, but are not limited to:

- GSHP employee pre-hire background check and screening
- Provider and subcontractor profiling, credentialing and screening
- Contractual agreements that contain program integrity requirements and terms obligating compliance
- Education and training for Board members, employees, providers, and subcontractors
- Utilization Management and Lock-In Programs
- Front-end claims editing and audit processes

For detail on the GSHP's prevention strategy refer to Question #87. Refer to Question #82 for detail on front-end claims editing and audit processes.

Detection. We will regularly run algorithms to detect fraud, waste and abuse. Based on previous experience and emerging fraud trends, GSHP, in collaboration with the PIU and Corporate Internal Audit, will develop state specific provider and member claims audit tools based on our experience in other markets and DHHS guidance. Audits may be focused on a group of providers or provider types with concerning billing patterns. In addition, Centene provides its affiliate health plans, including GSHP, with a variety of tools, resources and programs aimed at uncovering and eradicating fraud, waste and abuse. These tools and programs include:

- ***ClaimsXten® (CXT).*** This McKesson LLC claims prepayment auditing software is used to review outpatient facility and physician claims after adjudication but prior to payment. CXT ensures the claims are in compliance with national coding guidelines published by the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and various specialty organizations (i.e., CMS' Correct Coding Initiative). This tool is able to identify billing errors without delaying payment to the provider.
- ***HealthCare Insight (HCI).*** Centene Centene's strategic partnership with HCI helps to ensure payment is made for the services rendered and to reduce payments made for FWA. HCI uses predictive modeling to identify aberrant claims and uses clinicians to review the claims prior to payment. For example, providers commonly misuse modifiers which make procedures payable when reviewed by the code audit software (CXT). However, by using clinicians to review claims we are able to create a clinical picture, using the patient's history, to determine if the procedure was appropriately billed. In another example, HCI's clinical validation process recently flagged a provider as an outlier for billing an after-hours code on approximately 75% of the members seen at the office. The provider's claims are currently being denied for medical records to validate the services rendered. Denial recommendations are sent to Prepay

Compliance, who reviews the edits and accepts/rejects HCI's recommendation based on state guidelines, contracts, and historical claim information.

- ***Claims Payment Audits***. The corporate Claims Audit Department will perform a comprehensive audit of a statistically valid sample, utilizing a confidence level of 99%, of all GSHP processed claims including paid, denied, appealed, and adjusted claims. The steps of this statistically valid claim audit include ensuring the following criteria are met:
    - Claimant was eligible for benefits at the time the services were provided.
    - Claims were processed in accordance with utilization review and case management decisions.
    - Claims data was complete and accurately entered into the system.
    - Authorizations were on file for all claims, where appropriate.
    - Contracted providers were paid in accordance with contractual rates.
    - Nonparticipating providers were paid in accordance with New Hampshire Medicaid rates.
    - Other insurance was investigated for coordination of benefits, and when appropriate, GSHP liability was reduced.
    - Duplicate claim submissions were identified and denied.
    - Reimbursement was made to the correct party.
    - Non-covered services were appropriately identified and denied.
    - The processed claim was supported by adequate documentation.
    - Verification that services for which reimbursement was made was provided to member.
- ***EDIWatch***. Centene will utilize EDIWatch to perform retrospective reviews on GSHP claims. EDIWatch is a fraud and abuse software that identifies suspicious billing trends and is used to train claims investigators. EDIWatch employs hundreds of edits to identify outliers, such as high cost claims, upcoding, usually high number of units, excessive new patient visits, diagnoses or procedures incompatible with age/sex, mutually exclusive codes billed together, add-on codes billed without primary CPT codes and non-emergency procedures billed on Sundays or holidays. In addition to known fraud schemes, EDIWatch utilizes both CMS and AMA guidelines for these edits. Recently, Centene identified an OB/GYN provider serving our affiliated Texas health plan billing for infertility services, which were not covered benefits. Record review confirmed the billing of infertility treatment, unnecessary ultrasounds and services not documented. The provider has been referred to the Texas Health and Human Services Commission OIG and a prepayment review has been initiated, which is expected to result in a savings of approximately $125,000.

- ***Business Objects***. Business Objects is a claims data extraction tool that Centene will utilize to review GSHP claims. We periodically review the number of doctor and emergency department (ED) visits per GSHP member. Member queries are written using Business Objects to help identify potential doctor shoppers, ED abusers, and individuals who share their Medicaid ID card. These reports will be forwarded to GSHP for further investigation and to develop appropriate corrective actions.
- ***Quality Control Audits***. GSHP and Centene's Medical Management units will conduct regular joint quality control audits by reviewing various reports including those related to providers with a high number of referrals, providers administering outdated treatment, and member ED utilization.
- ***Subcontractor Oversight.*** As part of GSHP's oversight of all subcontractors, we will require subcontractors to report any suspected fraud or abuse to GSHP's Compliance Officer. The GSHP Compliance Officer will ensure that any subcontractor reporting follows the same processes described herein.

The SIU will review audit findings, usually as part of the regular FWA Work Group meetings, and determine if it is a billing error correctable with education or if it appears to be an fraud or abuse issue, which requires further investigation. The SIU will evaluate and provide the FWA Work Group attendees with analyses of the relevant claim history, comparable provider billing practices, comparable member utilization patterns, State regulations, an evaluation of the claims causing potential concern, and a review of member or provider addresses. GSHP will work with DHHS to review our current processes and will comply with any requested process enhancements or changes.

Investigating and Reporting

If the SIU identifies a situation with evidence to demonstrate a credible case of fraud or abuse, GSHP's Compliance Officer will be notified immediately. The GSHP Compliance Officer will notify the appropriate State offices, depending if the case is member or provider related, within 15 days of detection or sooner if a delay in reporting could result in harm to the patient, loss of evidence or hindrance to the investigation.

When GSHP believes that a provider billing error (waste) exists, GSHPs Medical Director and Provider Relations Manager will work together with the SIU to investigate and educate the provider. If necessary, a provider may be placed on prepayment review until the billing error is corrected. When this occurs, the GSHP Compliance Officer and the SIU will work together to ensure that medical records are reviewed to prevent overpayments for future claims submitted by the provider. Once a provider is educated, the SIU will re-review the provider's billing practices within six months of the education to validate that the erroneous billing pattern has been corrected. If the billing pattern has been corrected, the case will be closed and the final resolution reported to DHHS. If the billing practice has continued, the GSHP Compliance Officer will be notified. The GSHP Compliance Officer will work closely with DHHS to determine the next steps of the investigation.

Investigation Conducted by State. Once a credible case of suspected fraud or abuse is reported to the State, GSHP will suspend all plan efforts to investigate, resolve, or take further action, unless otherwise directed by the DHHS, so as not to interfere with any ongoing State investigation or enforcement process. GSHP, or any Centene affiliate, will not disclose the existence of any investigation conducted by DHHS or a federal law enforcement agency.

Investigation Conducted by GSHP. When Centene's SIU is notified of potential fraud or abuse, the staff will assign a case number and conduct a preliminary investigation, within 30 working days of receipt, to determine if the case is credible. The investigation includes a description of other investigated provider issues, when the provider or member last received education, a review of billing patterns for suspicious indicators, and a discussion of which State regulations or program guidelines have been violated. The results will also be reviewed with Centene's Chief Medical Officer. If no irregularity is detected, the case is closed, filed for future reference and the FWA Workgroup and GSHP's Compliance Officer will be informed of the results.

If it is determined the initial evidence suggests a billing irregularity, GSHP's Compliance Officer will report the case to DHHS as a credible case of suspected fraud or abuse. Once GSHP has received approval to proceed, the SIU will select a sample of claims for medical record review and send the request to the FWA Work Group and the GSHP Compliance Officer for review and approval. Upon approval, the SIU will send a certified letter to the provider requesting the identified medical records. Once the medical records are received, within 60 working days, the SIU will review the medical records and discuss the results with Centene's Chief Medical Officer. GSHP's Compliance Officer will review the results with the FWA Work Group and the GSHP Chief Medical Director. If fraud or abuse is identified by the reviews conducted, Centene's SIU will work closely with the FWA Work Group and the GSHP Compliance Officer to ensure that DHHS receives all relevant information pertaining to the case in a timely manner.

If it is determined that there is a billing error, but not fraud, the FWA Work Group and the GSHP Compliance Officer will request that the SIU prepare and send an education letter to the provider. This letter may contain a notice to recoup overpayments. Providers have the right to appeal any planned recoupment. The Provider Relations Specialist will coordinate a meeting with the Provider to review the results of the investigation, facilitate education/training of staff related to correct billing guidelines and work out the details for repayment of any funds owed.

Reporting Concerns to the State. A crucial part of our Compliance Plan is to report any provider (individual, group, clinic, hospital, pharmacy, agency) whose billing activity appears to be more than erroneous or wasteful. GSHP will provide any assistance including written materials, onsite visits, or resources to help educate providers and their billing staff about errors. However, we will report any provider to DHHS if we suspect a provider is submitting claims that are wrongly coded or not supported by documentation in the medical record, if we receive a credible report of abuse or fraud, or if we have requested recoupment that is not received. Our GSHP Compliance Officer, or designee, will forward the following information to the appropriate State agencies:

- Provider name and ID number
- Source of the potential compliance issue (if known)
- Type of provider
- Nature of the potential compliance issue
- Approximate dollars involved
- Legal and administrative disposition of the case

While member fraud often occurs on a smaller scale than provider fraud, it is critical to monitor as part of our program. Monitoring includes case management data, member calls, and claims data to deter, detect, and resolve any issue. Some of the indicators we will train our staff to be aware of include:

- Similar treatments or medications prescribed by more than one doctor
- Excessive doctor visits to providers other than the member's PCP
- High volume of ER visits

These indicators are not absolute proof of member fraud, waste or abuse, but simply caution that a member's chronic condition is not under control or the member has a condition that has not been properly diagnosed and requires plan intervention. If GSHP has credible suspicions or knowledge of member fraud, waste or abuse, we will report it to DHHS within 15 days of detection.

If during the course of a review or member interaction, our Member Services, Connections and Medical Management staff identify physical, sexual or emotional abuse of members by providers, we have corporate policy and processes in place to report the problem immediately to the appropriate State agency. Our corporate policies are adopted by our affiliate health plans and are modified to align with state specific laws and requirements regarding reporting.

Quarterly and Annual Reporting to the State. GSHP will report quarterly and annually to DHHS on the progress of our compliance activities, including meeting our goals and objectives. We will also report provider educational initiatives related to billing and medical records. We will keep DHHS informed of the important findings of our investigations, such as if we were to identify what appeared to be a trend in a certain type of billing error in one part of the State or an identifiable health system, or a group of providers that appeared to be billing members inappropriately. GSHP will also include a list of recoupments from providers in its quarterly report. All instances of suspected fraud, abuse, waste, and overpayment will be reported to DHHS immediately upon discovery. Refer to Question #83 for more detail.

GRANITE STATE HEALTH PLAN

Fraud Recovery Collection

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

Centene's established experience as an administrator of health care programs since 1984 has demonstrated to us that the most effective approach to overpayment collection is through front-end identification that prevents claims from even entering our payment system, thereby reducing the risk of erroneous payments. However, we also have in place multiple systems for identifying, reviewing, tracking and recovering provider overpayments.

Projected total savings for CY 2011 Centene Program Integrity Unit efforts are at least $25 million.

Cost Avoidance

Centene partners with HealthCare Insight (HCI) to proactively identify billing errors, abuse and fraud. HCI uses predictive modeling, coding analysis and skilled clinical review to identify aberrant claims. HCI's value in identifying aberrant claims is based upon its nationwide and multi-payer database of claims data, which offers them a holistic view of provider billing patterns. HCI uses specially trained registered nurses to review system-detected reimbursement issues in conjunction with claims history, allowing them to evaluate the claim from a clinician's perspective and makes a recommendation to pay or deny the claim. This additional evaluation prevents unnecessary resubmissions of claims and provides consistent and logical claims processing.

Examples of some of the issues HCI identifies include: keying errors, unbundled/fragmented services and inappropriate use of modifiers. For example, providers commonly misuse modifiers, which make procedures payable when reviewed by ClamsXten (CXT). However, clinicians reviewing the claim will be able to create a clinical picture using the patient's history to determine if the procedure code was appropriately billed.

Once a claim has been through Centene's pre-payment edit process and undergone coding review by CXT, GSHP will automatically and securely transmit all submitted and adjudicated claims data to HCI for immediate analysis. Within two to four hours of receipt, HCI will identify claims that warrant a clinical review, and Centene will process the remaining claims for payment. Within 12 to 24 hours of receiving the claims data from Centene, HCI will notify the SIU of claims suspected of FWA. Prepay Compliance staff will review the flagged claims against state guidelines, contract provisions, historical information, and other factors and will either accept HCI's denial recommendation or release the claim for payment.

Overpayment Recovery Process

We partner with Health Management Systems (HMS) for recoupment of provider overpayments for all our affiliate health plans and in accordance with our recoupment policy and procedures. HMS will review provider payments based on criteria developed in partnership with GSHP. The Centene SIU will be responsible for providing any information requested by GSHP to assist with the overpayment identification process. Once HMS identifies overpayments they first notify GSHP to review and validate the findings and upon approval issue a letter to the provider stating they have been overpaid. Providers will have the right to appeal any planned recoupment within 30 days of notification. If the provider does not respond to the overpayment notice either through an appeal or by making payment, then the amount owed will be automatically recouped from future provider payments. In cases where the recoupment amount is substantial, HMS will negotiate a payment plan with the provider. Unless otherwise stated in the HMS notice of overpayment, the recoupment figure will represent the extrapolated overpayment made during the prior eighteen months. The figure will be based on the dollar value error rate identified during the clinical review. HMS will manage the recovery process, including tracking and interaction with the provider. However, the provider has the right to contact GSHP with any issues or concerns.

Pharmacy Lock-In Programs

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

The GSHP Lock-In Program will build on the lessons learned and successful practices of other Centene health plans and our pharmacy benefits manager affiliate US Script. US Script serves over 1.2 million low-income members and their families who span a wide range of age and program categories, including: the aged, blind, and disabled (ABD), Temporary Aid to Needy Families (TANF) children and adults, children in Foster Care, residents of nursing and other long-term care facilities, and individuals enrolled in the Children's Health Insurance Plan (CHIP) or other state-sponsored programs.

Centene has over 27 years of experience in full-risk Medicaid managed care and Provider/Pharmacy Lock-Ins are Routine Offerings Within these State Contracts

General Policies and Procedures for the Lock-In Program

GSHP will have capabilities to customize our Lock-In Program to comply with the State's criteria, described in *Appendix D DHHS Office of Improvement and Integrity Pharmacy Lock-In Program* of the RFP, and other criteria specified by DHHS and the *State of New Hampshire DUR Board*. We are

prepared to present our Lock-In policies and procedures and to report the status of all members enrolled in the Lock-In Program, as requested by DHHS.

Potential candidates for the member Lock-In Program may be **identified from member patterns of overutilization through data analytics in our Centelligence™ enterprise management system (including analysis of emergency room utilization), through review of pharmacy/prescriber data by our pharmacy benefits manager (PBM), and through referrals from providers.** Our pharmacist or Medical Director must review a member's drug utilization, taking into consideration existing diagnoses such as cancer, before a member is considered for the Lock-In Program. If we identify a pattern of overutilization or drug seeking behavior, the member **may be restricted to using a single pharmacy, prescriber, or both.** Once a notification process occurs (complying with DHHS timelines and appeal opportunities) and a member's lock-in becomes effective, any claims or authorization requests received other than from the assigned pharmacy will be denied. Exceptions are allowed for an emergency 72-hour supply of medications from other pharmacies in the following circumstances: emergency room prescriptions filled when the assigned pharmacy is closed; antibiotic prescriptions filled when the assigned pharmacy is closed; and, the prescription is needed while out of town when the assigned pharmacy is inaccessible. Members assigned to the Lock-In Program also will be enrolled into our Care Management Program, so they can be educated on the appropriate use of prescription medications. A Care Manager will contact both the member and the member's PCP to inform them of the pharmacy assignment and the rationale for the decision. ***Additional details on our Lock-In Program are available under Question 6 from Section 3.3 of our response.***

In some cases, members will use emergency Department (ED) services as a way of getting around the pharmacy lock-in. We will use data to identify members who have deviated from normal patterns of ED use and, if appropriate, lock-in the member to a specific emergency department.

Centene Lock-In Program Effectiveness

Following are two innovative approaches that we will use to detect inappropriate member use of prescription medications.

Pain Medication Management Program. We will implement Centene's Pain Medication Management program to ensure evidence-based prescribing of opioids and reduce the risk of overdose, addiction and drug interactions. We will educate providers about appropriate evidence-based prescribing and monitoring for signs of opioid abuse through orientation, the Provider Manual and Provider Portal, and when we identify one of the provider's members for the Pain Management program. Monthly our Pharmacist and Pharmacy Coordinator will monitor drug utilization to identify members with a diagnosis of chronic, non-cancer pain who are taking opioids at a combined daily dose of greater than 120 units of medication per day. Our Pharmacist will outreach to the prescriber(s) to inform them about the member's identification in the Pain Medication Management Program. The Pharmacist will discuss requesting a second opinion from a pain management specialist, request preauthorization of all opioid medication, and negotiate a taper plan that will result in safer dosing levels. The Pharmacy

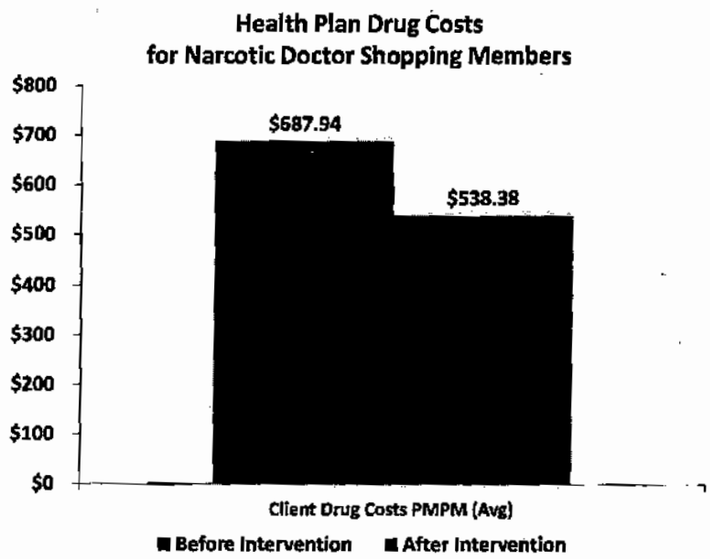
Coordinator will also refer the member for care management. The Care Manager will contact the member to provide education about the risk of using high dose opioid medications, and will work with the Pharmacist to review the member's utilization against the utilization guidelines for our patient review and coordination program. The Care Manager will assist the member in selecting providers as needed if the patient review and coordination program staff opts to limit (lock-in) the member's choice of providers. The Care Manager will also provide needed referrals to behavioral health services and substance use disorder programs for assessment. The Care Manager and Pharmacist will coordinate with the PCP to monitor member progress and review their utilization prior to the end of the program placement period to determine if an additional placement period is necessary.

[redacted]

Narcotic Doctor Shopping (NDS). Doctor shopping is the act of visiting several different doctors to obtain prescriptions for the same (or similar) medications. Abuse of prescription medications often begins with legitimate use; however, certain medications such narcotics, have high risk for dependence and members can become addicted. According to the Drug Enforcement Administration (DEA), doctor shopping is one of the primary ways addicts obtain prescription drugs for non-medical use. To identify probable doctor shopping, US Script reviews pharmacy claims for: (1) members using three or more different prescribers to fill narcotic medications during a 30-day period and the top prescribers of these doctor shopping members; and, (2) the top prescribers of all members receiving narcotics during a 30-day period. As substantiated by review findings, US Script sends intervention letters to the identified prescribers.

This process has proven very successful in reducing narcotic doctor shopping. One Medicaid plan working with US Script reduced its baseline of nearly 180 members exceeding the Narcotic Doctor Shopping criteria of three or more different prescribers by 98%. Another Medicaid plan found 81% of the prescribing stopped for the members identified through the Narcotic Doctor Shopping intervention – saving the plan 22% in the identified members' drug costs. (**Figure 8**).

Figure 8: Narcotic Doctor Shopping Intervention Results



Other Fraud and Abuse Prevention Programs

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

Fraud and Abuse Prevention

GSHP's Fraud, Waste, and Abuse (FWA) Program will establish internal controls to prevent fraud, waste and abuse, including (but not limited to) the following:

Provider Profiling and Credentialing. The GSHP Credentialing Department will assist in the prevention of FWA by ensuring that participating providers are appropriately credentialed and eligible to provide services. As part of the credentialing process, they will complete primary source verification of each provider's training, expertise and legal authority to provide quality care, and any sanctions, restrictions and limitations imposed by regulatory agencies, state medical boards or other managed care organizations. Credentialing staff will also request and require detailed disclosure of all individuals and entities with an ownership or control interest in the course of provider application, credentialing, re-credentialing and contracting. At the same time, they will screen providers against OIG's List of Excluded Individuals and Entities (RFP Section 3.17), and on a monthly basis thereafter. We will immediately terminate any employment, contractual and control relationships with excluded

individuals and entities. Our policies and procedures also will include provisions regarding provider credentialing requirements, exclusions and appeals consistent with 42 CFR 455.101.

Identified provider issues will be presented to GSHP's Credentialing Committee for review and action recommendations. The Committee will review each case and render a determination to accept the provider in the network with or without limitations, or deny participation in its entirety. Credentialing staff will periodically monitor sanctions, complaints, and quality of care issues between recredentialing cycles to assure that no actions have been brought against participating providers. Credentialing staff also will work with SIU staff to make investigation referrals as needed. For example, when Credentialing staff uncover a sanctioned provider, they will inform the GSHP Compliance Officer and SIU, so that GSHP can begin reviewing the provider's billing patterns and recoup funds paid during the exclusion period. In addition, the Compliance Officer will notify DHHS of any provider identified with sanctions, or other issues, resulting in exclusion from participation in federal programs or termination from network (if provider was previously credentialed).

Subcontractor Screening and Education. Prior to contracting with any subcontractor, GSHP's Compliance and Quality staff will conduct a background check. The Compliance Officer will request and require detailed disclosure of all individuals and entities identified with an ownership or control interest in the course of subcontractor application and contracting. GSHP will not contract with any entity that has been debarred or excluded by any federal or state agency. We will screen subcontractors with an ownership control or interest against lists of excluded individuals/entities during the application process and prior to contracting and on a monthly basis thereafter. We will immediately terminate any employment, contractual and control relationships, with excluded individuals and entities per federal Exclusion Program requirements. GSHP's Compliance officer will educate subcontractors on their responsibilities to prevent, detect and immediately report suspected cases of fraud, waste and abuse.

Provider and Subcontractor Agreements. Our provider and subcontractor agreements will contain our program integrity requirements and terms obligating providers to comply with all relevant laws, regulations, program requirements, and incorporate, by reference, our Provider Manual. All terms and conditions of our contract with DHHS will be binding upon our network providers and subcontractors.

Provider Education and Training. We will educate and train providers and subcontractors prior to contracting and periodically thereafter. During the contracting process, Network Development staff will educate providers concerning appropriate billing and on their responsibilities to prevent, detect and report suspected cases of fraud, waste and abuse. We will also provide them with detailed information about the False Claims Act as identified in the Social Security Act, Section 1902(a)(68). We will contractually obligate them to immediately report any concerns about non-compliance within their organization or that they may have observed of GSHP staff, by a member, or by another subcontractor or provider. We also include guidance in our Provider Manual concerning appropriate billing and how to report suspected non-compliance to GSHP.

Pre-Hire Screening. In order to maintain integrity and safety in the work place, GSHP will perform reference and background checks for all employees that will review or verify the applicant's Social Security number, national criminal history, previous employment, education, Office of Inspector General (OIG) exclusion, FDA Debarment List Status (only for Script Assist RNs and certain pharmaceutical positions). We will also screen for ownership or controlling interest relationships and exclusions, as described in section 3.17, paragraph three, of the RFP.

GSHP Staff Training. The GSHP Compliance Officer, in conjunction with department heads, conducts plan specific training sessions to ensure our employees understand the contract requirements that pertain to their job responsibilities. The Compliance Officer also trains all GSHP employees on how to identify and report suspected fraud, waste and abuse. This training includes the federal False Claims Act provisions, administrative remedies for false claims and statements, State laws relating to civil or criminal penalties for false claims and statements and the whistleblower protections under such laws. We will establish written policies and procedures that are included in these training sessions. Such training will occur within the first 30 days of employment and on an annual basis thereafter. Documentation of attendance and participation is required and maintained by the GSHP Compliance Officer. To supplement this training, Centene also conducts mandatory computer based training regarding Corporate Compliance for all employees. Compliance training topics change from year to year. Overall training themes include such topics as speaking up and raising concerns, receiving concerns from employees for managers, careful email communications and insider trading. Additionally, each department director will be required to conduct training sessions on GSHP's policies and processes specific to their functional areas. Where cross-functional processes are in place, directors coordinate and conduct interdepartmental training sessions, as appropriate. Refer to Question 88 for more detail on GSHP internal training programs.

Utilization Management. The Medical Director and UM staff will be responsible for reviewing prior authorization requests to determine whether services are medically necessary. They also will annually review prior authorization requirements to protect against over- or under-utilization of services. GSHP will also implement a program focused on reducing member over utilization of the Emergency Room. We will provide case management, and next-day notification from participating ERs for members identified by clinical records, drug and ER-utilization information of members who have been identified by the state, providers, and GSHP staff as having high or persistent, inappropriate use of pharmacy and ER services, or who are suspected of potential fraud and abuse. For example, our Indiana affiliate, Managed Health Services (MHS) tracks all members who had more than one ER visit within a 30-day period and whose ER use is five standard deviations above average member utilization, regardless of prescription use. Through their Right Choices Program, MHS assigns a Case Manager to each member and restricts the member to only one ER of his or her choice. MHS works to establish agreements with each member-selected hospital to notify MHS by the following day of the member's presentation in the ER. MHS also provides frequent educational contacts, such as case management phone calls, special brochures and letters that describe appropriate ER use; encourages calls to NurseWise our 24/7 nurse call line; and help members arrange for and keep primary care visits.

Lock-In Programs. The GSHP pharmacist or Medical Director will review member drug utilization, taking into consideration existing diagnoses such as cancer, in order to identify a pattern of over utilization or drug seeking behavior. If such a pattern is established the member will be locked-in or restricted to using a single pharmacy, prescriber, or both.

Internal Training Programs on Fraud and Abuse

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

GSHP Education and Training Regarding Fraud, Waste and Abuse

GSHP believes that the key to preventing, deterring, and detecting fraud, waste and abuse (FWA) lies in training employees at all levels of our organization. GSHP will include training on FWA in our Business Ethics and Conduct annual training module and during new hire orientation. The Employee Handbook, which every employee is required to read, also reinforces this information. The goals of our Fraud, Waste and Abuse Compliance Plan and extensive training initiatives are to:

- Uphold GSHP's commitment to business ethics and compliance.
- Educate our employees on identifying and preventing occurrences of FWA.
- Provide discipline or additional education, as appropriate.
- Provide reporting mechanisms and complete any necessary reporting.

Annual Staff Training. We also conduct a series of companywide mandatory training sessions each year. Every fall, the GSHP Compliance Officer will attend a Centene Compliance Officer Conference where each attendee receives an updated guide and training materials, which are in turn used to train all health plan staff. During the fourth quarter each year, all employees, subcontractors, temporary staff and any consultants must attend a Fraud, Waste and Abuse training session. The training session will be led by a trained member of the GSHP Compliance Department. These training sessions are limited to no more than 20 employees to allow the attendees to confirm their understanding, share relevant experiences, and ask and receive answers to questions. We document each session utilizing signed attendance logs. Upon completion of the training, the training materials and signed logs are scanned and stored in Compliance 360©, our comprehensive compliance program management tool.

The focus of our training is the Centene Code of Conduct, which insists that all employees, officers, and directors, have the responsibility to comply with our compliance policies and all applicable state, federal and local laws and regulations at all times and to report any concern they have regarding possible noncompliance. GSHP employees will be trained to notify the Special Investigation Unit (SIU), either directly, through the Compliance Officer or a toll-free hotline, of any identified issues. Our organizational value of integrity stipulates that failure to report a violation is considered a violation of

our code of conduct. In addition to both state and federal FWA requirements, other training modules include requirements to not inappropriately use or disclose confidential or protected health information, engage or assist with insider trading, and not provide monetary business courtesies to government employees. Staff will also be trained on the requirements of the False Claims Act and Anti-Kickback statute. This annual mandatory training also educates and reminds employees of our obligations under the federal HIPAA privacy rules (including updates like HITECH), and state laws to protect the privacy of our members' information.

We conclude training sessions with a reminder that there can be a wide range of consequences for employees who violate our policies and the applicable laws and regulations. This includes personal, civil and criminal consequences for people who engage in violations, or know about them and do not report them; as well as consequences under our disciplinary guidelines up to and including termination of employment. GSHP's goal is to maintain transparency and continue to build on our parent company's reputation as an organization that strives for the highest ethics and compliance and proactively identifies and mitigates any potential instances of noncompliance.

CENTENE

Centene Corporation

"It is the policy of Centene Corporation to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable laws, both in letter and spirit.

In this, there is no compromise."

-Michael F. Neidorff

Intranet Training for Employees. In addition to the annual training, Centene and GSHP provide computer based training modules on topics such as "Speaking Up: How and When to Speak Up with a Concern." This online course takes employees through a scenario of speaking up to a manager about a topic like potential conflict of interest, and includes instruction on the proper way to make a report, how the manager should handle the situation, our zero tolerance non-retaliation policy for a report submitted in good faith, and what to expect from an investigation and follow up. Other online sessions related to maintaining program integrity have included:

- Avoiding Insider Trading
- Centene 101 – Compliance, HIPAA and Fraud, Waste and Abuse
- Handling Employee Complaints and Concerns (training for supervisors and above)

Provider and Subcontractor Training. During orientation sessions, GSHP will educate providers about our FWA Program, which includes information about their obligations and how to report any concern directly to the health plan or via our FWA hotline. We also disseminate this information in our Provider Handbook, through the Provider Portal, through articles in GSHP's quarterly Provider Newsletter (also available on the web to both contracted and non-contracted providers), in letters, in classes, and during onsite visits to individual providers. These visits may be routine, the result of a random audit, an issue focused audit, or an inquiry generated by some reported concern.

During their initial orientation meetings, the GSHP Compliance Officer will educate our subcontractors' Compliance Officers and Operations Management teams on contract requirements, reporting requirements and their obligations to investigate and report FWA activities. Any affiliate subcontractor personnel who work on-site at GSHP's office are included in our mandatory annual trainings. GSHP's contracts with subcontractors contain terms obligating them to comply with all relevant laws, regulations, DHHS mandates, and incorporates by reference, our Provider Manual. Furthermore, we contractually obligate subcontractors to immediately report any concerns related to potential noncompliance within their organization; or issues they may have observed at GSHP, at a provider's office, by a member, or by another subcontractor. At a minimum, GSHP will conduct quarterly Joint Operating Committee meetings (JOCs) with each of its subcontractors, or more frequently based on volume of business, criticality, sensitivity of responsibilities, or historical performance. During these JOC meetings will review operational reports, compliance, and program integrity efforts.

Training on Internal Communication Processes Regarding Fraud and Abuse. Our Compliance Department, led by the GSHP Compliance Officer, uses several methods of communication to address employee concerns, questions, and reports of potential noncompliance. The combination of new hire orientation and ongoing employee training, along with the participation of Compliance Department staff in Quality Improvement Committee and workgroup meetings encourages our employees to approach our Compliance Department staff members with any questions or concerns. In addition, we provide an Ethics and Compliance toll free helpline and a FWA toll-free hotline for employees, providers, members, subcontractors, or others to anonymously report their concerns of noncompliance. These phone lines are available 24 hours a day, 365 days a year, and are operated by a third party that specializes in providing confidential assistance to corporations. Use of a hotline that is administered by a third party enhances the potential for reporting of FWA issues and allows callers to report concerns anonymously. The hotline administrator logs all suspected FWA issues and forwards them immediately to the Centene VP, Ethics and Compliance or the Senior Director, Payment Integrity for further investigation and follow-up.

GSHPs' staff training will include instruction on the variety of resources they can use to report a FWA issue or concern, including the employee's supervisor, the Compliance Department, the toll free FWA Hotline, or the internal FWA referral form. We stress during our training that the most important thing is to report any and all suspected instances of FWA or noncompliance without fear of retaliation. All reporting resources (including telephone and e-mail contact information) are listed in training materials and on CNET, an intranet site available to all employees across Centene health plans and subsidiaries. GSHP will ensure that the written policies and training materials described above emphasize the consequences of any willful violation or failure to report will result in disciplinary action, up to, and including, termination of employment.

GRANITE STATE HEALTH PLAN

Engaging Members in Preventing Fraud and Abuse

Q89. Describe how you engage members in preventing fraud and abuse.

GSHP will educate our members about fraud, waste and abuse prevention through our Member Handbook, our quarterly Member Newsletters, the GSHP website and the Member Portal. We will provide these resources to all new members, including those who lose eligibility and re-enroll with the plan. Our materials provide guidance to members concerning how to use services appropriately, the proper use of the emergency room, over-utilization issues, and how and where to report persons suspected of abusing program benefits.

Through our Explanation of Benefits (EOB) survey process we engage the member in preventing fraud and abuse by requesting the member contact us regarding whether they received the specified services. We will randomly survey a sample of members by mailing an EOB which states that the document is not a bill. In the event the member did not receive the services, the recipient is requested to contact GSHP Member Services immediately. Members over the age of 18 will also be able to access a Member Portal, which includes access to online EOBs and allows the member to report any services that were not rendered. We will not survey members using EOBs where the care was related to women's health care, family planning, and behavioral health services as this could create a violation of member confidentiality requirements.

For Foster Care members, and our members with special health care needs we will also invite the participation of Caregivers, Medical Consenters, and Case Workers in the prevention of fraud, waste and abuse.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.18 Third-Party Liability

GRANITE STATE HEALTH PLAN

3.18 Third- Party Liability

TPL Recovery Experience

Q90. Describe your TPL recovery experience. Provide empirical evidence of your collection percentage against TPL identification.

Experience with Medicaid TPL Processing

As a trusted administrator of public sector programs for 27 years, Centene Corporation (Centene), Granite State Health Plan's (GSHP) parent company, has designed Third Party Liability (TPL) claims processes and data interfaces around the requirement that Medicaid programs are the "payer of last resort". Centene has a history of *successfully managing cost avoidance* for our 13 managed Medicaid health plans. GSHP will benefit from this experience through leveraging the cost avoidance processes of Centene and our affiliated health plans, as well as utilizing the services of Centene's post recovery payment and TPL service vendor, HMS. HMS further assists us in identifying opportunities of TPL and cost avoidance as well as recovering payments made for our members subsequently found to have TPL. HMS further enhances our client's recoveries by leveraging their resources to establish TPL, which further supplements our cost avoidance efforts.

Cost Avoidance and Recovery Performance. Across all Centene health plans and 21.9 million medical and behavior health claims processed year to date, October 2011, we successfully recovered 5.5% of total claims paid for our clients. Of this total, ***91%*** was through ***cost avoidance*** by ***correctly*** identifying TPL during claims adjudication prior to payment. The remaining 9% was inadvertently paid for claims with TPL. Overall TPL combined recovery rate was 19% for subrogation, commercial and Medicare coordination of benefits (COB) claim.

Maximizing Identification and Recovery of TPL

Q91. Describe how you will maximize the identification and recovery of TPL.

Taking A Pre-Emptive Approach to Identify TPL.

Our experience has shown that the *best approach to cost avoidance* is to *minimize the need to recover costs in the first place* and we employ several methods to support our "pre-emptive" strategy. These methods use the eligibility subsystem of our Member Relationship Management (MRM) System. MRM is our enterprise based, master data management application for member data, containing our master membership indices and all things member related including history. MRM is tightly integrated with our claims processing systems to support collection and maintenance of TPL information at the

"member level". We use TPL information to automatically recognize and prompt the suspension of claims that may be submitted without required Explanation of Benefits (EOBs) or payment information from a primary payer. During the claims adjudication process, the claims system checks for TPL and will pend or deny the claim based on the information contained within the record. A dedicated team of resources within our claims operations team, who have extensive knowledge and expertise in COB and TPL administration, will process COB.

Our pre-emptive strategy to *maximize the identification* of TPL includes the following processes:

Systems/Processes for Testing, Updating and Validating Enrollment in TPL Data. Centene uses automated processes to support efficient and accurate cost avoidance by systematically identifying members with third parties responsible for payment.

- **Data Mining.** Centene's Claims Department regularly identifies COB and TPL cases by data mining through our Centelligence™ informatics platform and using diagnosis and trauma edits (see below for more information), in addition to member outreach, to confirm the presence of TPL based on these edits. We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™ Insight. A claims analyst regularly reviews standard Insight claims operations reports focused on first time claims with EOB attachments and claim adjustments. The claims analyst routes this information (member contact information, plus other insurance from EOB or adjustment request) to our Claims Department Phone Call Team (Phone Call Team) to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately. The Phone Call Team is dedicated to making calls to insurance companies and updating the member's record in MRM with accurate TPL information.
- **Health Management Services.** We augment our TPL identification processes with established national recovery vendors through our partnership with HMS. Each month, we securely send member demographic data to HMS. By matching this data to HMS' database of national insurance eligibility information, HMS can identify other available coverage. HMS verifies coverage directly with the carrier through a combination of online tools and telephone contact, and sends the resulting data back to Centene. We then load this "member level" TPL information into MRM and from there the data automatically, and electronically, feeds our claims system. We validate TPL data we receive from HMS by systematically matching member identifiers in the TPL files we receive from HMS with the corresponding identifiers we have on members in MRM. We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™ Insight. A claims analyst regularly reviews standard Centelligence™ Insight claims operations reports focused on first time claims with EOB attachments and claim adjustments. The claims analyst routes this information (member contact information, plus other insurance from EOB or adjustment request) to our Claims Department Phone Call Team (Phone Call Team) to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately. The Phone Call Team

is dedicated to making calls to insurance companies and updating the member's record in MRM with accurate TPL information.

- **Reconciling Enrollment File.** We will establish a file transfer protocol between the DHHS or DHHS's fiscal agent to receive enrollment and private insurance information. Our preferred arrangement would be to receive this in the eligibility file, but can, and do receive TPL information in proprietary formats from some of our state partners. . We receive this information, the data will be systematically loaded into our MRM. MRM houses current and historical member information and maintains our master member index to assure member data integrity. MRM systematically promulgates updated eligibility data, including COB data obtained from the eligibility file or proprietary format, to our other applications requiring that data, including the eligibility subsystem of our claims processing platform. This is the first step in our approach to ensure the eligibility subsystem contains current information necessary to identify members who might have TPL. If at any time, the TPL data we receive from DHHS differs from the information we have received from any other source, we will ensure that DHHS receives that updated information either directly or through DHHS's designee to ensure synchronization of data between GSHP and DHHS.. We will work with DHHS to determine the best way to support sending TPL data to DHHS, for example, via the HIPAA 834 transaction.
- **Educating Providers.** Through our regular provider orientations, ongoing training meetings, and our online Provider Manuals we will inform and educate providers about the importance of identifying TPL information at the time the member receives service and submitting denial notices from third parties, automobile accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where member liability exists. We will also provide them with any additional instruction needed related to including TPL payer and payment information in the COB and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions.
- **GSHP Provider Portal.** We are introducing a new capability on our secure Provider Portal:
    - We will allow GSHP network providers to submit to us requisite TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents electronically via the portal. This information will be accessible by our claims processors to expedite finalizing claims with TPL. In all circumstances, GSHP will review submitted documentation, validate the initial findings, and expedite the processing of the claim.
    - A provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility available through our secure Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, but no entry is made concerning third party payments, our claim entry application will alert the provider about this missing information at the time the provider is entering the claim.
    - We will allow authorized provider users of our Provider Portal to see any current TPL information we have collected for a member. TPL checking by the provider thus

becomes a routine part of the member eligibility verification process before the claim is created and submitted.

- **Identify and Address Billing Errors.** Centene's Claims Department continuously examines claims submissions for patterns of billing errors from providers, including those related to TPL, through the use of decision support tools within our Centelligence™ Insight reporting system. When we identify providers having problems related to billing primary payers, our Provider Relations staff will outreach to the provider to offer targeted provider education.
- **Notification from GSHP Staff.** GSHP staff may become aware of TPL during member and provider interactions, chart reviews, etc. When GSHP staff learn about TPL that is not already included in the member's eligibility record, they will submit a notification via MRM to the COB/TPL Analyst, requesting that the member record in MRM be updated. When the COB/TPL Analyst updates the MRM master member record, our claims processing platform will update automatically with the TPL information to ensure accurate handling of future claim submissions. Additional coverage information also may be discovered through the authorization, concurrent review, or case management processes. In these situations, the local Case Manager or Referral Specialist creates a claims note in TruCare, our case management and clinical documentation system. The claims note indicates the name of the insurer, the policy and group number, the name of the member, and the effective date. This information is then transferred to the COB/TPL Analyst for updating in MRM, and subsequently our claims system, our other applications, and transmitted to subcontractors dependent on this information.

Capturing Third-Party Resource and Payment

Q92. Describe your method and process for capturing third-party resource and payment information from your claims system.

TPL Information on Claims Received. Claims may contain TPL information on the claim form itself indicated in the appropriate boxes on the CMS 1500 or CMS 1450 claim forms, or on an attachment to the claim, such as an EOB from another carrier, or in the COB and other payer segments of the HIPAA 837 EDI claim submissions. In this case, our integrated claims workflow and processing system, will electronically route the claim to our COB/TPL Analyst to investigate and validate the existence of TPL. Upon confirmation of TPL the COB/TPL Analyst will update the member's TPL information in MRM, which will then electronically update AMISYS Advance for future claims payment determination and allow our claims processor to coordinate benefits for the pended claim and finish adjudication.

Retrospective Post-Payment Recoveries

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.

Pay and Chase, and Subrogation. HMS provides post payment recovery for recoupment when TPL is not known at the time we pay the claim, and for subrogation to parties with TPL. On a weekly basis, we will provide HMS with a claims detail report of claims processed the previous week. If HMS determines that a claim is related to TPL or subrogation, they will initiate steps to recover the overpaid TPL dollars. HMS will then bill the primary insurer on behalf of DHHS within 65 days after TPL information is confirmed. When HMS confirms that a member's claim has TPL and we have paid the claim as primary, they will submit a claim to the primary insurer and request reimbursement to GSHP for their amount of payment. Our recovery efforts are transparent to the provider, easing the provider's administrative and financial burden, as there is no need for GSHP to recoup previous claim payments or request the provider attempt to obtain payment from the primary carrier.

Diagnosis and Trauma Edits. Consistent with our affiliate health plans, we will load accident related ICD-9 diagnosis code edits into our claims adjudication system, creating another way GSHP will intercept claims that may be the liability of a third party. If a claim is received without documentation to support the liability or non-liability of a third party, and the claim contains an accident- or injury-related diagnosis code and/or trauma indicator of "Y," we will pay the claim and request that the provider submit accident-related documentation or payment information from the third party. Typically we would send this information to Health Management Systems, Inc. (HMS), our partner for post-payment recovery services, for further investigation. However, we will forward this information to DHHS so that DHHS can follow up for determination of an accident or trauma case as required in the RFP. Also as described in the RFP, we will create a process for mailing letters to the member directly, and on receipt of the returned correspondence from the member, send these to DHHS for further determination.

Collection Rate of TPL

Q94. Describe your collection rate of TPL when a third-party payer is identified.

Our year to date (through October, 2011) overall collection rate of TPL when a third payer was identified was 19%.

Process for Sharing TPL Information with DHHS

Q95. Describe your process for sharing TPL information with DHHS.

GSHP will report all TPL information to DHHS in the format and medium prescribed by DHHS, for all members. Additionally, we will submit, via our encounter data submissions, post payment TPL recoveries we make to DHHS after we discover any TPL. We currently submit TPL information and adjustments for retrospective findings in our encounter submissions to most of our state partners and we will also do so for DHHS, if required. We also exchange TPL information through the eligibility HIPAA 834 transaction, or other proprietary format specified by our state clients. We will also make available any supporting documentation required by DHHS.

We will provide DHHS with a monthly file of our COB collection efforts and results. This file will include all of the fields identified in Section 3.18 – Third Party Liability, subsection k. In addition, we understand that DHHS will actively pursue, collect and retain all post payment recoveries from all available resources for services to members under the contract where GSHP has determined, and as agreed upon with DHHS, that the amount of reimbursement that GSHP can reasonably expect to receive is less than the estimated cost of recovery. Currently, Centene does not pursue any claim that is less than $5 and any provider with a total claim amount for the period of less than $50, unless otherwise specified by our state partners. We will supply DHHS with a file, in the format specified by DHHS, with the necessary information to pursue these collections. In addition, we will make available to DHHS all information necessary to pursue accident and trauma settlements, administer the mail order pharmacy program and benefit determinations for Veterans Administration programs, and administration of the Health Insurance Premium Payment Program. Finally, we fully cooperate with our state partners in all oversight and audit activities and will make available to DHHS or DHHS designated party all information required for external audit of our TPL processes.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.19 Administrative Quality Assurance Standards

GRANITE STATE HEALTH PLAN

3.19 Administrative Quality Assurance Standards

Internal Claims Quality Review Program

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.

Claims Quality Review Program

Complementary Audit Methodologies from Multiple Perspectives. We view our claim audit activities not only as a compliance and monitoring exercise, but also as an *opportunity* to identify system, staff, provider, or systemic process improvements, and to act on these opportunities to enhance payment accuracy and ensure all funds are targeted for appropriate member care. Centene Corporation (Centene) and Granite State Health Plan (GSHP) will employ a number of *complementary* claim audit methodologies, conducted by our:

- Internal Audit Claims Division (IACD): focused on assessing configuration accuracy and claim quality for financial, payment and processing accuracy
- Claims Department: focused on continuous improvements in claim processor staff performance
- Additional Audit Processes: Centene has an extensive audit program, including External Auditors, our Special Investigation Unit, our Information Technology Department, Compliance and Ethics and finally, overarching all of these processes, our Internal Audit Department.

These methodologies ensure that limited New Hampshire and federal Medicaid matching funds are appropriately and accurately applied toward the health care of New Hampshire's Medicaid Program members.

Oversight and Audit Structure – Staffing and Type of Reviews.

IACD. Claims quality is monitored rigorously by Centene's IACD. The IACD was organized in 2001 in an effort to provide continuous feedback to management on processing, payment and financial accuracy of claim payment. The division is *independent* from the Claims Department and reports directly to the Chief Audit Executive, who reports directly to the Chief Executive Officer and Audit Committee of the Board of Directors (a reporting structure organizationally *independent* of the Claims Department). IACD performs detective quality audits and implementation audits and reports *audit results* to the claims processing teams and management; and provides quarterly reports directly to the CEO and Audit Committee of the Board of Directors, as well as to the Claims Management Team, and to applicable local plan and state clients – as we will for GSHP Senior Management and DHHS.

Claims Processing Department. Our Claims Processing Department located in Farmington, MO, will provide most of the claims processing functions for GSHP. Within the Claims Department, we will have a dedicated claims processing team for GSHP. Separate from this team, but within the Claims Department, we have a team of Quality Review Analysts (QRA) who conduct ***Staff Audits*** to evaluate

the performance of all staff involved in claims processing *before and after* claims are paid, and staff adherence to job specific guidelines.

In addition to these claims teams, and as a best practice, we will provide a local claims expert, our *GSHP Claims Liaison*, who will report to the GSHP XXX, and will work closely with DHHS to thoroughly understand and ensure all DHHS requirements are implemented.

The combined team of the IACD, QRA, and the GSHP Claims Liaison will conduct ***Targeted Audits*** to evaluate specific areas, such as claims paid with high financial impacts, high rates of denials for individual Claim Processors and key provider claims review.

All our audit teams use supporting information from AMISYS Advance, our core claims processing system and related, integrated systems to evaluate claims processes and produce audit reports. Our management team uses these reports to *monitor* and, in conjunction with QRAs and IACD staff, take appropriate corrective *action,* if needed.

External Auditors. Finally, Centene engages external independent auditor, KPMG LLP, to conduct financial reporting audits and compliance with the Model Audit Rule (MAR) through Sarbanes Oxley Act (SOX) audits and MAR compliance review; and of the design and operating effectiveness of controls over Claims Processing and Data Center Operations previously through the SAS-70 Type II audit and in 2012, Centene will adopt the new Service Organization Control (SOC) audit. The External, independent auditor issues an opinion on the company's effectiveness in these areas and we continue to receive unqualified opinions from these audits, annually.

Frequency of Reviews. Our IACD conducts monthly audits of a statistically valid sample of claims, as well as prepayment audit of trial check runs through 90 days post go-live and . Our Claims Department audits are higher frequency, and are conducted both before and *after* claims have been adjudicated and paid. External Audits are conducted annually.

In the paragraphs below, we will describe the IACD monthly audit in detail. *For more detail on our Claims Department audit and external audits please see our response to Q.99 Additional Quality Assurance Monitoring.*

Sampling Methodology. The IACD performs a statistically valid, random sample quality review audit of processed claims, assessing claim quality for processing, payment and financial accuracy, as well as compliance with contract obligations. The sample provides for a 99% confidence level, plus or minus 2.5% and includes paid, denied, appealed and adjusted claims. The Claim Audit division incorporates best practices outlined by industry experts such as the *Essential of Managed Care,* written by Peter Kongstvedt and *Statistical Decision Theory with Applications to Business Economics,* written by Ik-Kwon, PhD.

Definition of Errors - The following attributes are audited for all processed claim samples:

- Trace claim dollars in the audit sample to the specific underlying source documents (e.g. provider contracts, fee schedules, benefit grids, etc).

- Claims were accurately entered into the system, including: diagnosis, charges, provider, claimant, and procedure codes *(accuracy of claim data entry).*
- Benefits were paid to the correct party *(claims associated with correct provider).*
- Authorizations were on file for all claims, when appropriate *(proper authorization was obtained for service).*
- The claimant was eligible for benefits at the time the services were provided *(member eligibility accurately applied).*
- Contracted providers were paid in accordance with contractual rates *(allowed payment agrees with contracted rate).*
- Non-contracted providers were paid in accordance with Medicaid rates *(allowed payment agrees with reimbursement to non-contracted provider requirements).*
- Duplicate claim submissions were identified and denied *(duplicate payment of a unique claim is not allowed).*
- Claims were processed in accordance with utilization review/case management decisions regarding services and if the reason for payment was accurately applied *(reason for denial applied accurately).*
- Non-covered services were appropriately identified and denied, and the reason for payment was accurately applied *(reason for denial applied accurately).*
- Other insurance was investigated for coordination of benefits and when appropriate, liability was reduced *(co-payment application considered and applied).*
- The processed claim was supported by adequate documentation.
- Effect of modifier codes was correctly applied.
- Proper coding was consistent with provider credentials.

Performance Measure Calculations. Our IACD audits review each claim for processing accuracy, financial accuracy and payment accuracy. The methodology utilized for calculating each attribute is detailed below:

- **Processing Accuracy:** Total accuracy including financial and non-financial errors

  = (# of Claims Audited - # of Errors)/# of Claims Audited
- **Financial:** Total DOLLAR VALUE of errors to the total DOLLARS paid

  = 1-((Overpaid + Underpaid)/ (Paid))
- **Payment:** NUMBER of claims with financial errors to the total NUMBER of claims audited = (# of Claims Audited - # of Claims with Payment Errors)/# of Claims Audited

Performance Standards. Processed claim accuracy performance metrics are summarized in the table below. The targets reflect industry benchmarks, outlined in the *Essentials of Managed Care,* written by Peter Kongstvedt which are consistent with DHHS standards

	Benchmark - *Essentials of Managed Health Care*			
	[illegible]	[illegible]	[illegible]	[illegible]
Processing - *Accuracy including financial and non-financial errors*	90%	95%	98%	Below *Acceptable* standard
Payment - *Total dollar value of errors to the total dollars paid*	95%	97%	99%	Meets or exceeds *Acceptable* standard
Financial - *Claims with financial errors to the total claims audited*	99%	99%	99%	Meets or exceeds *Good* standard

Results of Internal Claims Quality Review

Q97. Provide the results of your internal claims quality review program for the past 12 months.

Centene continuously strives to meet and exceed industry standard processing goals as seen in the chart below depicting our financial, payment and processing accuracy for the period October 2010 through October 2011.

Results by Operational Area

	Config/Claims		
	2011		
	Financial	Payment	Processing
All Business 4th Q '10	99.6%	99.3%	98.9%
All Business 1st Q '11	99.3%	98.9%	98.5%
All Business 2nd Q '11	98.6%	97.9%	97.2%
All Business 3rd Q '11	99.1%	97.6%	95.3%
All Business YTD '11	99.1%	98.2%	97.0%

Failures to Meet Claims Accuracy Standards

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.

Currently, across Centene's 14 health plans, we do not have service level agreements with our state partners. This said, Centene consistently sets high internal standards for all operations and services across our health plans and routinely and continuously monitors our performance.

Regardless of how we come to learn of a performance issue, whether through the IACD process, or the Claims Department and External Audit processes described below, when we find issues related to claims processing we immediately investigate and put into place mitigation to improve outcomes. Related to claims processing, any of the following methods may be applied to correct performance:

Correction Methods

- **Education and Retraining.** Claims processing issues related to claims staff performance or provider billing errors are typically remediated through education and retraining. QRAs or IACD communicate all staff deficiencies to the immediate Supervisor who establishes a retraining plan. Upon completion of training, the QRA or Supervisor may implement a targeted audit to confirm that additional training or action is not warranted. QRAs will communicate all provider billing problems to GSHP's Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist.
- **Analyst Mentoring Program.** This mentoring program pairs an experienced analyst with a less experienced analyst to identify opportunities to model and improve accuracy and production.
- **Change Request (CR).** If it is determined that the error is due to configuration, our GSHP Claims Liaison and our Configuration team will review the logic causing the error to determine where the issue lies and will put in a CR to have the configuration changed accordingly. All CRs go through testing, validation that the correct outcome was achieved, User Acceptance Testing and finally, are promoted to production when these steps are completed.
- **Process Modification.** Upon identification of a potential systemic process deficiency, our QRA or IACD staff notify Centene's Process Quality Department, who will employ tools such as Lean Six Sigma to determine root cause. Through analysis and cross-functional dialogue with all affected departments, this team evaluates and recommends process improvement plans.
- **Provider Specific Monitoring and Audits.** Centene and GSHP are committed to ensuring that providers have the tools and support systems in place to ensure claim timeliness, accuracy and completeness of data submitted. We conduct a number of claim audits on submitted claims and, where necessary, root cause analyses to identify system or coding problems, and initiate outreach and education to targeted provider billing staff to provide guidance and instruction as necessary. For GSHP, this outreach will be conducted in person, via email or telephonically. Our GSHP Claims Liaison will also attend large group orientations, training sessions and workshops

to provide the claims expertise necessary to respond to specific questions raised by providers and their billing staff.

Administrative Quality Assurance Monitoring

Q99. Describe any other administrative quality assurance monitoring conducted by your organization.

New Business Implementation Claims Processing Monitoring

Due to the significant number of new business integrations, in 2007, IACD extended its oversight to new business integration risks. There are two primary goals of new business monitoring:

- Provide real-time identification of errors in contract-related configuration (e.g. benefits, fee schedules, and pricing) and accuracy of provider data claim payment fields prior to the start of operations; and
- Provide insight into new business, with early detection of emerging operational risks within the first 90-days of operations.

As a result of real-time audits and focus on quality, Mississippi and Illinois (recent new business implementations) experienced claim payment accuracy results greater than 97%, *within the first 90 days of operations.*

Pre Go-Live: Prior to the Start of Operations

Prior to the start of health plan operations, Internal Audit will participate on weekly Integration Task Force meetings, helping to identify current and emerging risk areas. As contract-related configuration is implemented by the new business configuration team (e.g. benefits, fee schedules, pricing) and provider data is set-up, Internal Audit will perform real-time audits of critical claim system inputs (source documents). In addition to testing performed by the configuration team, we also audit certain system components critical to claims payment. Exceptions are logged and reported to management regularly. Additionally, the timeliness of correction is monitored by Internal Audit and communicated throughout the integration of a new plan to executive leadership.

Post Go-Live: Within the First 90 Days of Operations

During the first 90 days of operations, Claim Audit conducts ongoing audits of trial check runs, with the intent of identifying claim payment errors *prior* to payment. Results of audits are communicated with new business implementation and configuration teams, issues are logged and status updates are provided to executive management regularly throughout the first 90 days of operations.

Significant focus on quality, supported by prompt operational assessments, speeds operational maturity as experienced in both our Mississippi and Illinois markets.

At 90 days post implementation, Internal Audit will conduct an Operational Assessment. The operational assessment includes a review of 140 key

attributes, spanning all critical processes within core functions (e.g. Medical Management, Contracting, Provider Data Management, Compliance, Quality Improvement, Finance, Credentialing, etc) for compliance with industry best practices, including:

- State contract requirements
- NCQA standards
- Policies and procedures
- Scalability and change readiness

In addition to core process reviews, Internal Audit will conduct an implementation lessons learned review. The goal is to continuously improve new business implementation procedures, embedding lessons learned and action takeaways into future implementations.

Additional Claims Department Auditing

Outlined below are several of the monitoring and audit activities that will be conducted by our Claims Department or in conjunction with GSHP Claims Liaison. These are best practices gleaned from our experience with our affiliate Medicaid managed health plans:

Claims Staff Audits. Although frequency, function and methods of individual staff audits differ along each step in the claims life cycle, our approach to staff audits will focus on determining if staff have successfully completed applicable training; know the performance benchmarks for their position and the role audit plays in performance achievements; understand their job function; and know how their job as Claims Processor impacts the entire claim life cycle. QRAs are Claims Subject Matter Experts (SME's) with extensive claims administration experience, and many have held operational positions in the functional areas they now audit. The QRA staff audit each processor with a frequency and sample size appropriate to that processor's experience level and recent quality performance, with no less than 25 claims audited per processor, per month. QRAs randomly select claims for audit using AMISYS Advance and a Data Analysis Tool, configured with processor specific thresholds. QRAs review all processor adjudication actions to confirm whether they adhere to Centene policies and procedures, and whether the processor is correctly using and maximizing the use of workflow tools. When the QRA completes the audit report, they and/or the processor's supervisor meet with the processor to discuss audit results and review each error in depth to determine if additional training is required. If necessary, the QRA or supervisor may implement a follow up, targeted audit to confirm whether the processor has a clear understanding of the proper handling of the erred claim situation.

Targeted Audits. The combined team of the QRA, the IACD staff and the GSHP Claims Liaison will conduct *Targeted Audits* to evaluate specific areas, such as claims paid with high financial impacts, high rates of denials for individual Claim Processors and key provider claims review.

Quarterly Key Provider Claim Reviews. The local GSHP Claims Liaison will review the top twenty claim submitting providers or *key provider group* claims quarterly and provide scoreboard results to GSHP's Contracting and Network staff for HEDIS scoring and Pay for Performance results. GSHP's Provider Relations staff will also evaluate top denials and intervene with providers if billing patterns reveal potential errors.

EDI Claims Submission Analysis. In conjunction with Centene's Electronic Data Interchange (EDI) Help Desk, the local GSHP Claims Liaison will collaborate to identify and educate providers who submit paper claims and attempt to encourage electronic submissions via our Provider Portal or EDI clearinghouses.

Claims Xten® Reviews. The GSHP Claims Liaison will review the results of the Claims Xten® edits to determine if a provider is consistently billing with unbundled, incidental or retired codes. If identified, the Provider Claims Educator will outreach and educate the provider's office. See our response to Q.82 for more information on Claims Xten®.

External Audits

Annually, Centene engages external, independent auditors to supplement our internal reviews and controls, as described below:

SAS 70 Type II/ Service Organization Control (SOC). Annually, Centene engages external, independent auditor KPMG, LLP to conduct an audit of the design and operating effectiveness of controls over Claims Processing and Data Center Operations. Centene has engaged for this assessment since 2004, receiving unqualified opinions in all reviews (i.e. no discovery of material adverse findings).

Prior to 2011, the report on controls of a service organization provided by external, independent auditors was issued under Statement on Auditing Standard No. 70. Effective in 2011, the International Auditing and Assurance Standards Board and the Auditing Standards Board implemented changes to replace the SAS 70 Type II report with the Service Organization Control (SOC) report. The SOC report includes service organization controls relevant to the user entities' internal control over financial reporting. The report is similar to the SAS 70 II with a new standard requiring management present an assertion regarding the fairness of presentation of the controls, their suitability of design and the effectiveness of their operation as presented in the report. Centene has adopted the new auditing standards.

Sarbanes Oxley Management Report on Internal Controls over Financial Reporting. Centene's management is responsible for establishing and maintaining adequate internal controls over financial reporting and supporting MIS controls, including those related to security and confidentiality. *Each year*, management conducts evaluations of the effectiveness of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations. Our Internal Audit Department and Ernst & Young, LLP conducted our most recent audit of these controls for the period ending December 31, 2010, and concluded that Centene's internal controls over financial reporting were effective. Centene's assessment of the effectiveness of internal controls for the period ending December 31, 2010, was audited by KPMG, LLP, another public accounting firm. *No significant deficiencies or material weaknesses were identified.*

Continually Auditing Operations and Monitoring Regulations to Ensure Compliance

Throughout Centene Operations, we have a culture of continuous process improvement through monitoring and oversight. Below we describe a few of these additional controls from a broader, enterprise perspective.

Centene Internal Audit Department. In addition to the claims audit processes described above, Centene's Internal Audit Department (Internal Audit) provides assurance, insight and objectivity to stakeholders. The Vice President of Internal Audit (or Chief Audit Executive) reports directly to the CEO and Audit Committee this enables objectivity and independence. Internal Audit operations consist of the following:

- *Enterprise risk management:* Facilitates the identification, assessment, and monitoring of risks and helps enhance the risk culture throughout the organization.
- *Internal audit activity:* Evaluates the overall control environment and conducts audits of operational, regulatory, financial, information system, compliance and emerging risks.

HIPAA Assessment. Centene' Compliance Department audits and evaluates compliance with the HIPAA security standards by periodically assessing environmental or operational changes that may impact adherence to the standards. In the event the evaluation results in a determination of non-compliance, immediate steps are taken to remediate any deficiencies and reinstate compliance.

Penetration Testing. Our IT Security Department conducts penetration testing on our systems, networks, and websites on an on-going basis. During these penetration tests, we attempt to compromise our websites and email systems via such mechanisms as Denial of Service attacks, phishing, spoofing, and other tactics, as well as occasional social engineering tests, such as false emails allegedly from Centene or GSHP employees inviting the receiver to click a malicious link. We also periodically retain an outside firm to perform penetration tests. In 2010, Centene contracted third-party firms to conduct both external and internal penetration tests using Via Forensics and Ernst & Young respectively. All identified issues were prioritized by risk, remediated, and retested to ensure compliance. Additional third-party firms will be contracted to provide penetration testing services in 2011 to independently verify the security of Centene applications, systems, and networks.

Information Technology Risk Assessment. As recently as 2010, Centene engaged Ernst & Young to review Centene's IT risk profile/risk universe, to ensure that we had identified appropriate risks, their potential severity, likelihood of occurring, and impact. Ernst & Young, LLP reviewed our organization's IT risk profile and provided a few additional risks for inclusion in the risk universe. Our IT risk profile is used in Centene's Enterprise Risk Management (ERM) process, which includes an ongoing review and assessment of Centene's risk environment with senior management.

Monitoring Claims Payment Timeliness

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.

Our parent Centene Corporation (Centene) will manage the claims processing function for Granite State Health Plan (GSHP) and brings 27 years of experience processing claims for public sector health care programs to GSHP, DHHS and the New Hampshire Medicaid Program. Internally, Centene sets high standards for all health plan operations and works in a culture of continuous process improvement in service of our members, providers and state partners.

Monitoring Performance

We are able to monitor performance due to our integrated Management Information System (MIS) and award winning Centelligence™ business intelligence platform.

A key design point of our MIS is the transaction-driven, near real-time integration of our production applications with our Centelligence™ business intelligence platform, and how that platform interoperates with our key production systems. For example, when a claim is finalized in our claims processing system that "event" posts to our Centelligence™'s Enterprise Data Warehouse (EDW) in near real time. Our key production integrated behavioral and medical applications, including claims processing, our TruCare health services management application, and our Member and Provider Relationship Management systems (MRM and PRM, respectively) are all integrated with Centelligence ™.

> In 2010, Centene was recognized with the **2010 Gateway Business Innovation Award** for its web-based executive dashboards, which provide real-time intelligence and are updated daily to provide early warning of adverse trends, claims drill-down for a quick analysis of clinical, financial or operating issues, and predictive modeling.

Powering the information needs for our claims department, Centelligence ™ Insight provides operational reports and executive dashboards measuring Key Performance Indicators (KPI) to monitor inbound claims volumes, inventory status, and submission patterns, among other operational metrics. Centelligence™ supports operational monitoring and reporting needs for our entire claims department, Centene corporate staff, Centene's independent Internal Audit department, as well as local Claims Liaison & Compliance Officer at our plans such as GSHP. Below are a *few examples* of the daily claims reports used by our claims department to monitor operations:

Functional Area	Report Name	Short Description	Frequency
Claims	Claims Aging Report	Daily report used to track claims aging (excluding adjustments)	Daily
Claims	Pended Claims	Daily report used to monitor claims that are pended by reason code	Daily
Claims	COB Savings Report (COB report)	Used to measure COB savings dollars on monthly basis. Shows difference of what Centene would pay as prime vs. what we pay as secondary (after prime insurance pays).	Daily
Claims	LL Pended Claims Report - Claim Type H	Used as a review mechanism for dollar amounts. Automated during check runs.	Daily
Claims	EDI vs. Paper	Report showing volume of paper vs. EDI claims receipt by day/week or month	Daily

The Executive Dashboard: Affording GSHP Leadership a Consolidated View of Operations. In addition to the daily reports above, our executive dashboard collects daily and monthly data for all our health plans, which will include GSHP, to create a self-service executive view. The Dashboard will permit GSHP management to perform drill-down analysis, creating an environment in which summarized metrics can be broken down into detail level data. All metrics are calculated and stored for historical analysis and trending. If during the month and for any reason, internal or state mandated performance standards are at risk, we will immediately initiate root cause analysis, identify the issues and correct the technology or process to return claims processing to the expected performance.

DHHS Access to Data. We will provide access to Business Objects to DHHS for online access to New Hampshire Medicaid program information and data. Business Objects provides end users with a web-based analytical reporting tool through a user-friendly interface. Local GSHP and DHHS users will be trained to drill down and view different levels of detail to support decision making. The result is a powerful and intuitive graphical interface "experience" that identifies data in business terms, without the need to learn coding or query language. Business Objects enables end users to clearly understand and answer relevant business questions. This intuitive interface contributes to the accessibility of the information and fosters a broad user community of base users, "power users", and Centene IT professionals.

Administrative Efficiency. We continuously look for ways to improve our administrative efficiency utilizing our reporting platform. One example is the provider scorecard that GSHP will use for analyzing a provider's pattern of paper versus electronic claims and claim payments against all our most efficient

providers. The report will be available to internal staff who work directly with providers and accessible to our internal staff through our Provider Relationship Management (PRM) system. This report will also be a valuable tool for staff as they work one-on-one with providers regarding EDI claims submissions. The data in this report will demonstrate the connection between a provider's claims submission practice and the impact on their business in terms of claims accuracy and reimbursement turnaround. By pulling the data together and presenting it in this format, GSHP staff will be equipped with powerful and easy-to-understand information that will resonate with providers as we work together to improve EDI participation and reduce administrative costs. Please see Q103 below for more information on our EDI capability.

Monitoring and Addressing Aging Pends - Claims Workflow Management.

In addition to monitoring claims processes through Centelligence™ and acting on that information as necessary, our claims platform is configured to manage GSHP's pended claims in *real time* by creating an electronic work item that sends pended claims to a claims processor *skilled to address the specific pend reason* via Automated Workflow Distributer (AWD). The claim processor can then address the pend issue within our workflow tool, and the appropriate claim change is immediately made in our claims system, with a full audit trail of the change and all other financial transaction activity. By "pushing" claims in real time to trained processors who possess a particular area of expertise, such as our coordination of benefits processors, we are able to ensure more rapid pend resolution. AWD also provides processors with immediate access to claim images (including attachments), and supports the communication and routing between departments to resolve a claim pend. When the "pend issue" is addressed, we re-adjudicate the claim using the six-step process described below in Q103.

We will also configure AWD to identify and escalate any pended claim that is approaching 20 days to a claims supervisor to ensure visibility and timely resolution. This intentional awareness of aging pends will allow immediate realignment of resources to work areas of concern and will ensure we maintain claims processing timeliness standards. In addition, this awareness drives research for additional auto adjudication opportunities.

Claims Payment Timeliness Standards

Q101. Describe the current claims payment timeliness standards used within your organization.

Over all Centene health plans, our 2011 operational goal for claims Turn Around Time (TAT) is to process 98% of all claims to paid or denied within 30 days. With our enhanced capabilities, this standard has been raised to 99% starting January 1, 2012. We also target to receive 85% of all claims electronically, knowing that when claims are received electronically, we improve our TAT, our auto-adjudication rates and ultimately improve provider satisfaction.

Claims Performance

Q102. Provide your organization's actual performance for the last 12 months in relation to your claims payment timeliness standard.

We acknowledge DHHS timeliness standards of 95% clean claims to pay or deny within 30 days and the balance of those claims within 60 days. From October 2011 to October 2012, across all Centene health plans, we processed over 98% of all clean claims to a status of paid or denied within 30 days. This record and our operational commitment to move claims approaching 20 days to a claims supervisor as described above, will ensure our ability to process all claims to a paid or denied status within 60 days.

System to Process Claims

Q103. Describe the system you use to process claims.

Electronic Claims Management Functionality.

Centene's state of the art HIPAA and DHHS compliant claims adjudication process and integrated claims processing system is outlined below from provider claim submission to provider payment. See ***Figure Q.103.A: Claim Processing Workflow*** for a flowchart that illustrates this end to end process. We will configure our systems for the specific rules of DHHS and will modify our configuration as required to ensure we remain consistent with DHHS and Federal requirements.

Ready and Organized to Implement. Our integrated MIS components with open, well documented industry standard application, data, and communications interfaces allow us to implement connectivity reliably and quickly with our state clients, their intermediaries (some of which we work with in multiple states), and providers. Our MIS components all feature configuration utilities that are *table driven* and *parameter based*, with very little need for custom software development and thus minimal implementation risk. As a result, our IT Implementation Team can focus our project efforts on detail analysis, precise definitions of business rules and Granite State Health Plan (GSHP) and DHHS specific data edits, thorough integrated internal and external test plans with full scenario test cases, thoroughly configured and tested data and online communication links with DHHS the DHHS's Designee, and our network providers and other Trading Partners.

Change Management Processes. We also utilize IT industry recognized *best practices* in Change Management, such as the Agile Software Development Life Cycle (SDLC) discipline for rapid, iterative deployment of implementations as well as system enhancements or changes - including software configurations for our health plan start/ups or expansions; while maintaining auditable business controls. We implement system configuration changes as part of an integrated release management process. Each Centene application team (e.g. claims, reporting, care management) establishes and publishes a release calendar, with controlled releases typically every two to four weeks, a frequency which mitigates operational risk by reducing emergency changes. We will review and implement a formal change request and change management process with the Department. Centene will also

configure a DHHS Microsoft SharePoint to offer DHHS access to implementation and change documentation. Centene utilizes MicroSoft's SharePoint web application platform today to securely host Intranet services for all employees, including employees at our 13 affiliated Centene health plan operations across the United States; to collaborate securely both within a department and interdepartmentally; and to share information externally with state partners.

Flexible Claim Submission Methods. Centene has the ability to receive GSHP claims in several ways to meet the various processing capabilities and requirements of our providers:

1) HIPAA 837 Professional and Institutional EDI claims from multiple clearinghouses. Today we receive claims from over 60 trading partners across 13 states and will accept claims from any clearinghouse that meets our performance and service quality standards, and which can implement our HIPAA companion guides. GSHP providers will also be able to submit HIPAA EDI 837 batch files *directly* to us through our secure web based Provider Portal.

2) Providers can enter claims directly into our HIPAA compliant Direct Data Entry (DDE) online claim submission facility (available on our Provider Portal). This functionality is especially convenient for our smaller provider offices, yet it offers the same EDI validation as our batch claim submission processes.

3) On paper. We also accept CMS 1500 and UB04 paper claims. Paper claims are delivered from the US Postal Service on a daily basis. Within one business day, these claims will be scanned and converted to data using our new, integrated Centene Document Management System (CDMS)

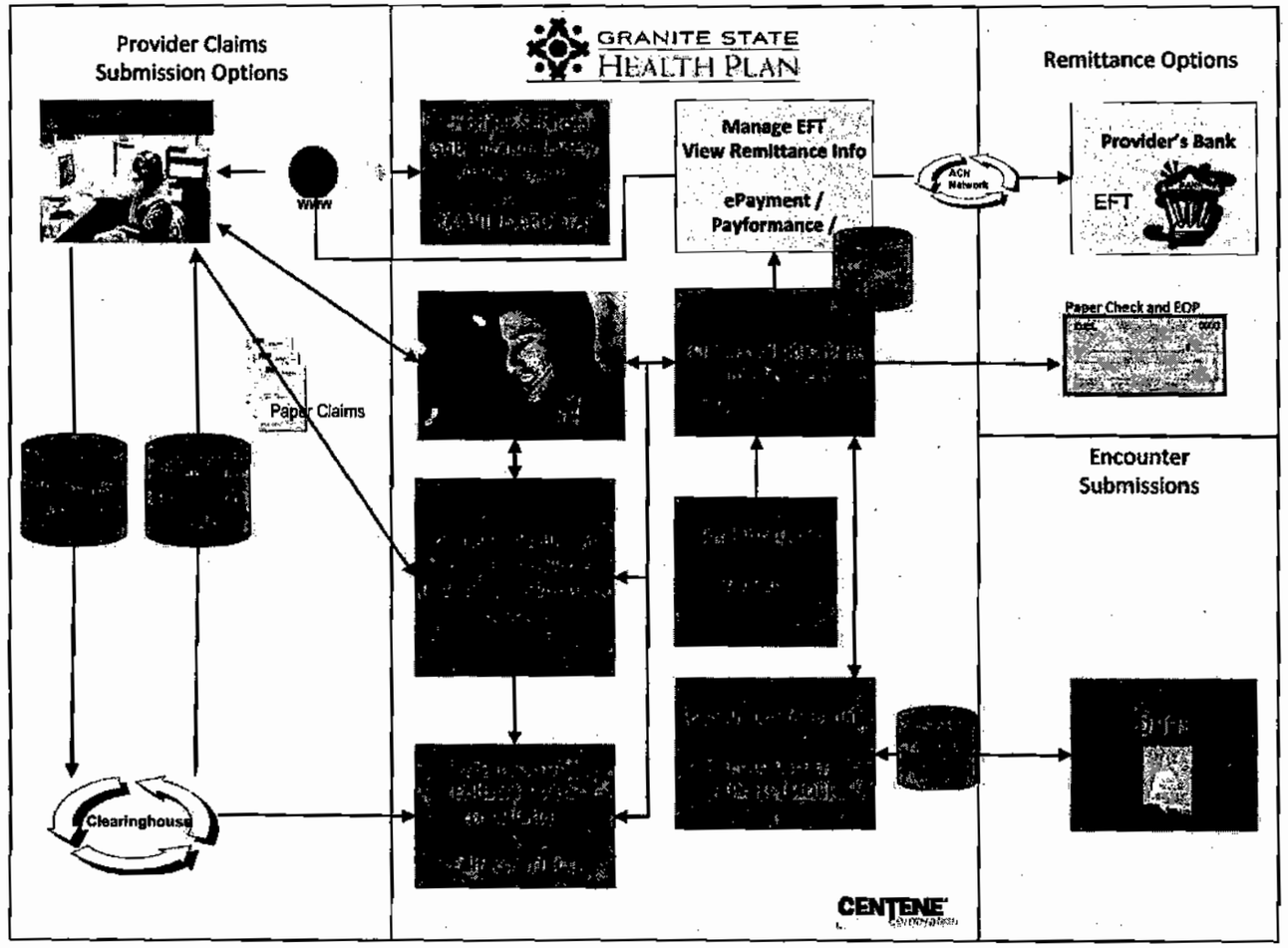
During the first quarter of 2012, Centene will significantly enhance the document administration capabilities of our integrated nationwide MIS, through deployment of the Centene Document Management System (CDMS). CDMS is Centene's automated content management system; expressly designed to efficiently and securely manage inbound and outbound paper, fax, and all other unstructured documents (e.g. image files, Word documents, PDF's) sent *to*, created *by*, or transmitted *from* our health plans (e.g. GSHP). CDMS also provides targeted online document *retrieval* directly by users, as well as through our integrated Centene production applications - including our claims system, TruCare clinical care management system, our member and provider service applications (MRM and PRM respectively), and our governance, risk management and compliance (GRC) system Compliance/360; through any number of indices (or "tags"). CDMS allows our health plans to configure specific document *retention policies* - in line with specific state requirements - by document type (e.g. claim attachments, appeals correspondence, clinical records) - providing a consistent, comprehensive approach to document management to support enrollee and provider services, contractual and regulatory compliance, informatics reporting applications, and internal and external audit discovery needs.

Enabling Claims EDI and EFT. In the best interests of our providers, state clients, and our own internal operations, our preferred mechanism for claim submission is through EDI. We have found, through our historical data, that when providers prepare claims electronically, the time from patient service to Centene receipt is less than half the time compared to claims submitted on paper. Claims data is more complete and clean because technology validates much of the data submitted at the earliest possible stage in the process. Consequently, Centene aggressively educates and supports providers on the benefits and methods of EDI claim submission with the result that, in the last 12 months, more than

86.5% percent of all medical claims were submitted electronically to Centene, and more than 88.5% of all behavioral claims were submitted electronically across Centene's subsidiaries. For this reason GSHP will *actively* provide multiple electronic claim submission options and education and encourage providers to *submit claims electronically.*

HIPAA EDI Compliance. HIPAA format adherence is verified real-time using our EDIFECS X-Engine compliance software which improves our claim auto-adjudication rate and the quality of the downstream encounter data we process and submit to our state clients, such as DHHS. X-Engine validates data against X12 syntax and rules for data structure; tests to ensure conditional rules requiring secondary fields are completed accurately and completely; and ensures all data is in compliance with our HIPAA Transaction Companion Guides. These upfront edits not only ensure that transactions are compliant with Federal mandates and DHHS rules, but they improve processing efficiency by recognizing and rejecting problematic transactions in the earliest stage of the process, and sending notification to our trading partners and providers through the ANSI TA1/997 Functional Acknowledgment (FA). This rapid turnaround allows providers to correct and resubmit non HIPAA compliant claims as quickly as possible for adjudication and payment.

Figure Q.103.A. Claims Processing Workflow



Pre-adjudication Edits. EDI and paper claims data are processed through our EDIFECS and TIBCO middleware, to map, translate, and validate the data, ensuring that common edits are consistently applied. We configure TIBCO to validate certain claim data elements, including member, billing and rendering provider and other data elements against data we currently have in our claims processing system. Refer to Q. 82 for a list of claims edits. If a transaction is rejected for any of the specific reasons configured in TIBCO, an ANSI 277 Unsolicited (277U) notification is systematically sent to the EDI trading partner or submitting provider, conveying the specific DHHS-approved edit that did not pass our upfront validation processing.

Six Steps of Adjudication. All claims that successfully pass the pre-processing edits are loaded for adjudication into our claims processing system. Our claims system accepts the Julian time stamp, for both paper and electronic claims, indicating when the claim was received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track our adherence to claims processing timeliness standards. Audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, operator ID stamping, and accommodates the setting of different audit parameters. Our claims system performs six primary steps of adjudication that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. These steps are listed below along with a brief description of each and specific examples of edits that will be configured within each step for DHHS claims.

Step 1: Field and General Edits. AMISYS Advance determines the presence and validity of required claim data such as CPT/ICD9 codes and whether the fields are consistent with the business rules outlined by DHHS and federal regulations; as well as age, gender, duplicate, and timely filing edits.

Step 2: Member Eligibility. The system verifies eligibility for service dates and coverage type, and existence of Other Insurance (OI).

Step 3: Provider Eligibility and Status. The system checks the submitting provider's eligibility to see members and receive payment from us as well as the provider's network participation status for the dates of service.

Step 4: Prior-authorization. Our claims platform is integrated with TruCare, GSHP's integrated, member centric health services management platform where primary authorization data is held. The claim system is configured to determine if an authorization is required for a specific service, then if applicable, verifies the presence of a prior-authorization, and confirms that the dates of service are within authorization date spans, limits etc.

Step 5: Covered Services. To define exactly which services are covered and at what levels, the system determines covered services by applying configured eligibility, provider, and benefit management rules, along with tables of valid procedure codes and ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations. This step determines if a member is eligible for the services rendered,

if the service date falls within the effective date of the benefit and meets all the criteria established by DHHS for payment.

Step 6: Pricing. AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. Reference our response to section 3.18, question Q.90 Third Party Liability for more information.

Claims Workflow Management. The workflow component of our integrated claims management platform will manage GSHP's workflow of any pended claim in *real time*. If a claim pends the workflow engine will immediately route an electronic work item to a claims processor skilled to address that type of claim pend. The claim processor can then address the pend issue, and the appropriate claim change is immediately made, with a full audit trail of the change and all other financial transaction activity. By "pushing" claims in real time to trained processors who possess a particular area of expertise, such as our licensed medical review clinicians, we are able to ensure more rapid pend resolution. Our claims platform also provides processors with immediate access to claim images (including attachments) and supports the communication and routing between departments to resolve a claim pend. When the "pend issue" is addressed, we re-adjudicate the claim using the six-step process described above.

Coding Review. Once claims pass adjudication above, they are further analyzed by CXT to determine clinical appropriateness of claim coding. CXT contains a comprehensive set of rules based on nationally recognized coding guidelines (cited below), which address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edit rules are based on generally accepted principles of coding medical services for reimbursement and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions. Instead, CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. Standard edits provided by CXT are based on nationally recognized guidelines, including but not limited to:

- *American Medical Association (AMA):* CXT utilizes the CPT Manuals, CPT Assistant, the AMA website, and other sources.
- *Centers for Medicare & Medicaid Services' (CMS):* In addition to using the AMA's CPT manual. CMS offers a variety of edits including the National Correct Coding Initiative (NCCI) for professional and outpatient services.
- *American Board of Anesthesiology:* CXT offers edits based on this and other specialty boards.

Fraud, Waste and Abuse. Centene has also entered into a strategic partnership with Verisk's HealthCare Insight (HCI) subsidiary to further evaluate claims to detect clinical coding errors, inaccuracies and potentially fraudulent behaviors in billing. Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, GSHP will be able to provide DHHS with an additional screening of clinical billing discrepancies and proactive fraud, waste and abuse detection/prevention services, without disrupting claims turnaround time.

Claims Payment. Once claims pass through all the above edits, all claims are processed with a status of paid or denied on the next claims payable cycle. The date of payment and the check or transaction

number are captured with the claim. The payable cycle determines claims timeliness penalties (if applicable) and applies interest payments in accordance with DHHS rules (again, if applicable). At the provider's option, a check will be mailed along with an Explanation of Payment (EOP) or they will receive an Electronic Funds Transfer (EFT) in the provider's designated bank and remittance advice. EOP's will also be available on our secure GSHP Provider Portal and we will offer providers the option of receiving the HIPAA 835 Electronic Remittance Advice (ERA) in lieu of paper EOP's. Our EOPs and ERA's are customizable by health plan and we will review the design of the EOP with DHHS prior to go-live implementation.

If a claim is denied for any reason, the provider will still receive an EOP (or ERA) with an explanation of denial and resubmission address, if applicable. The EOP or ERA clearly outlines for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable.

Record Keeping. Member, provider, and claim information is available for each claim, as well as real-time history of the actions taken on the claim. Whether the claim is pended, paid or denied, our claims system assigns a transaction date and a code indicating the reason for any action taken. All of this information can be viewed online by Centene and appropriate GSHP personnel. All claims loaded into our claims system are maintained at the claim and line detail level. Once adjudicated, the claim record is translated into a HIPAA compliant 837 format for encounter processing by our Encounter system and submission as a clean encounter to our State clients.

Subcontractor Claims Processing Functions. GSHP delegates claims payment operations for vision claims to OptiCare Managed Vision® (OptiCare), GSHP's affiliated vision benefits subsidiary and subcontractor; pharmacy claims to US Script, GSHP's affiliated pharmacy benefits subsidiary and subcontractor. Opticare and US Script receive claims directly from providers and process them through their own internal proprietary systems in adherence to all DHHS requirements, and according to the appropriate fee schedule or contractual rate. Opticare and US Script provide GSHP with claim encounter files and monthly operational claim reports, which are reviewed as part of the GSHP delegation oversight function.

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

3.20 Delegation and Subcontractors

3.20 Delegation and Subcontractors

Subcontracting Plan

Q104. Describe your subcontracting plan, in detail, if you intend to subcontract with other entities to perform portions of the Scope of Work.

Granite State Health Plan (GSHP) subcontractors are a critical extension of our organization and provide specific expertise in various areas. GSHP will maintain accountability for all subcontractor operations and performance. The majority of our key subcontractors are affiliated with GSHP as subsidiaries of our parent organization, Centene Corporation (Centene). This affiliation uniquely positions GSHP to provide truly integrated benefit delivery through both shared information and telecommunications systems and a proven track record of established best practices that result from similar collaborative relationships in other states. GSHP and its affiliated subcontractors will share comprehensive member, provider, and other information through core systems, such as our front-end clinical case management (TruCare) and claims and eligibility (AMISYS Advance), and various reporting and decision support applications. Our integrated structure simplifies and strengthens monitoring and oversight through the ready availability and transparency of information as well as effective communication among affiliated organizations.

GSHP intends to use eight subcontractors, for the Medicaid Care Management Program. Our proposed subcontractors consist of three non-affiliate vendors:

- National Imaging Associates - management of radiology services
- Teledoc – telehealth services
- Access2Care - non-emergent medical transportation

We will also subcontract with five affiliate vendors:

- Cenpatico Behavioral Health - behavioral health and outpatient therapy services
- NurseWise – 24/7 clinical information and nurse triage services
- Nurtur Health - disease management
- US Script – pharmacy benefit management; and
- OptiCare - vision services subcontractor

Additional information about our subcontractors can be found below in our responses to questions 105 and 106.

For each of our subcontractors, including both affiliate and non-affiliate vendors, GSHP will utilize a comprehensive evaluation process that begins prior to contracting and delegation of the designated activities to the vendor and continues throughout the duration of the contract. Once a vendor has completed pre-delegation evaluation, GSHP will execute a contract with the vendor that outlines the specific responsibilities of that vendor and the ongoing process for oversight and reporting. *Additional information about our subcontractor oversight process can be found below in our response to question 107.*

Names of Subcontractors to be Used

Q105. List the names and addresses of the Subcontractors to be used, as well as their location(s).

The follow table lists each of GSHP's subcontractors, their locations and the work they will be performing:

GSHP Subcontractor	Address	Work to be Performed
US Script, Inc.	2425 West Shaw Avenue Fresno, CA 93711	Pharmacy management services
Nurtur Health, Inc	20 Batterson Park Road Farmington, CT 06032	Disease management services
Cenpatico Behavioral Health, LLC	504 Lavaca Street, Suite 850 Austin, TX 78701	- Behavioral health services - delivery of outpatient Speech, Physical and Occupational Therapies
NurseWise, LP	7711 Carondelet Ave., Suite 800 St. Louis, MO 63105	Clinical information and nurse triage services
OptiCare Managed Vision	112 Zebulon Court Rocky Mount, NC 27804	Vision care services
National Imaging Associates (NIA)	6950 Columbia Gateway Drive Columbia, MD 21046	Management of high-tech radiology services
Access2Care, LLC	2500 Abbott Place St. Louis, MO 63143	Non-emergency medical transportation services
Teladoc, Inc.	One Sound Shore Drive, Ste. 304 Greenwich, CT 06830	Telehealth services

Services Subcontractors will Provide

Q106. Describe the services that the Subcontractor will provide and provide evidence of their experience providing those services.

Affiliated Subcontractors

Name, Address	Cenpatico Behavioral Health, LLC
Subcontractor Overview & Experience	Cenpatico, a GSHP affiliated subsidiary, customizes behavioral health solutions, including disease management services, by providing clinical and administrative expertise to governmental entities, health plans and employers. Cenpatico's success stems from a commitment to managing behavioral health care services that can be clinically integrated into health plan programs, while enhancing consumer access to care. Their experience includes providing behavioral health care benefits, provider services and training, customer services, and clinical services through a regional administration model, including integrating and analyzing data from diverse data sources in order to provide centralized and efficient management of behavioral health services. Quality improvement is woven through Cenpatico and has led to many successes and achievements. Their commitment to quality, innovation and teamwork is evidenced by the fact that their CEO chairs their Quality Improvement Committee. They continually monitor the efficacy and efficiency of operations through the quality lens and waste no time making swift changes to ensure optimum performance. Their committees and workgroups are peer-supported and include network providers, which is essential to ensuring that clinical and quality processes and procedures do not unnecessarily burden the provider. Cenpatico's back-to-back URAC accreditation is a tangible indicator of successful quality initiatives. In 2008, Cenpatico was once again awarded a full URAC Health Plan Accreditation through January 2011; they are also currently in preparation for their first NCQA Survey scheduled for mid 2010. ***2.b MHS, Medicaid, and Related Experience.*** Cenpatico has managed inpatient behavioral health services for MHS members since January 2003. Since 2007, Cenpatico has provided integrated behavioral health services, including disease management services, for MHS members. As an MHS affiliate, Cenpatico coordinates care, ensures follow up with behavioral health providers and communicates with PMPs after members' psychiatric hospitalizations. Cenpatico contracts and manages a network of inpatient and outpatient providers statewide. Cenpatico has been innovative in creating programs and processes

	that educate and encourage best practices in behavioral health treatment including joint clinical staffings with providers and medical case management, provider site visits, preferred provider status and online education resulting in continuing education units ("CEU"s). Cenpatico served approximately 2,000 MHS members through its intensive case management program throughout 2009. Cenpatico case/care management staff, are co-located in the Indianapolis and Fort Wayne offices with MHS case/care management staff and serve as part of the Integrated Care Team. Cenpatico has been in business since 1994 and is one of the nation's most experienced behavioral health companies in managing behavioral health benefits for individuals enrolled in Medicaid, SCHIP, and other publicly funded programs. Cenpatico currently provides risk based managed behavioral health services to 1.4 million members in ten states, including contracts with Medicaid health plans in Arizona, Florida, Georgia, Indiana, Ohio, South Carolina, Texas and Wisconsin and direct state contracts in Arizona and Kansas. Cenpatico provides managed care behavioral health services for Massachusetts CommCare and CommChoice, publicly subsidized health insurance programs through a health plan contract.

Name	NurseWise, LP NurseWise™ CARE. RIGHT. NOW.
Subcontractor Overview & Experience	GSHP affiliated subsidiary, NurseWise is a seamless, simultaneous, and efficient virtual healthcare organization offering quality telehealth and medication adherence services to Medicaid health plans and state Medicaid programs, as well as, managed care providers, academic institutions, physician groups, hospitals, the armed services and employer groups. NurseWise began operations in 1995 and has been a leader in the telehealth community for over 16 years. NurseWise operates 24 hours a day, 7 days a week and differentiates themselves from other nurse advice lines through the availability of bilingual staff (almost 70% of current NurseWise staff are fluent in both English and Spanish). For non-English and non-Spanish speaking members, NurseWise has partnered with the Language Services Association (LSA). LSA is an established language service provider and provides interpretation services in over 230 spoken languages. This is more than any other company in the industry. To accommodate the needs of hearing impaired members, NurseWise utilizes Telecommunications Device for the Deaf (TDD) services. NurseWise line staff and management team are diverse and reflective of the populations served, which demonstrates their commitment to Culturally and Linguistically

	Appropriate Services (CLAS). NurseWise has been continuously URAC accredited since 2006. Full re-accreditation was granted in June 2009. NurseWise has demonstrated conformity with NCQA standards in the areas of Utilization Management, Quality Management and Improvement, and call center operations as they apply to the Health Call Center. The sound infrastructure and exceptional customer service of NurseWise has allowed them to increase their call volume over the years as needed. For example, in 2008 NurseWise completed 995,764 calls, in 2009 1,308,746 calls, 2010 1,421,325 calls and in 2011 they anticipate completing over 1,550,000 calls. NurseWise has a proven record of accomplishment in customer service with the objective for every NurseWise interaction to result in customer satisfaction. NurseWise provides services to over 2 million Medicaid clients enrolled in Medicaid managed health plans in eleven states, plus the District of Columbia, including Arizona, California, Florida, Georgia, Indiana, Kentucky, Massachusetts, Mississippi, Ohio, South Carolina, Texas, and Wisconsin; and holds direct service contracts in Montana and Oregon. NurseWise registered nurses have an average of 10 years of experience and possess knowledge and expertise in a broad range of specialties, including behavioral health, critical care, emergency and urgent care services, pediatrics, maternal/fetal medicine, poison control, as well as crisis and triage call center experience. These skilled clinicians have the ability to respond to health needs across a caller's lifespan. NurseWise provides medical advice to members so they can receive the appropriate care, at the appropriate place, at the appropriate time.

Name, Address	Nurtur Health, Inc. nurtur
Subcontractor Overview & Experience	Nurtur, a GSHP affiliated subsidiary, is a leading innovator in disease management since the mid-1990s, offering best-in-class programs for such conditions as coronary artery disease, congestive heart failure, diabetes, asthma, chronic obstructive pulmonary disease (COPD), smoking cessation, hypertension and hyperlipidemia. Nurtur's presence in both the government and commercial sectors affords the company insights and experiences that it uses to innovate and cross-apply best practices for the benefit of all its clients. Nurtur is distinguished from its competitors in the richness and depth of its patient-centered health coaching model and its ability to integrate with care managers to provide optimal health management for each member throughout

the entire continuum of care. Nurtur has extensive experience developing highly-customized and flexible solutions that integrate its services with health plan care management, behavioral health, and other service providers to apply a seamless and well-coordinated service experience to the member.

Nurtur believes that all consumers and customers should receive quality based services. Nurtur's multitude of awards and accreditations below speak to this commitment to quality:

- NCQA and URAC accreditation for asthma, cardiovascular disease, congestive heart failure, COPD, and diabetes
- The Population Health Impact Institute's Methods Evaluation Process (MEP) accreditation, which denotes data measurement transparency and an efficient continuous quality improvement process.
- C. Everett Koop award for heart disease management program
- TOP 10 Disease Management companies by Health industry Research 2000-2006
- National Health Information Awards from the Health Information Resource Center 1999-2006

Nurtur's programs have achieved significant improvements in health status and reduction in inpatient and ER utilization in Centene health plans. For example, Nurtur's asthma management program improved utilization and achieved cost savings, demonstrated by statistically significant reduction in asthma-related inpatient admissions of 7% and ER visits of 4% across all of Centene's health plans. Nurtur's diabetes program has demonstrated statistically significant improvements in clinical outcomes, including a 38.9% increase in members with HgA1c <7, a 41% improvement in members with controlled blood pressure (< 130/80) and decreases in average LDL cholesterols for 43% of members who started outside of the target goal reaching the target goal. In addition, the programs have shown an 8.7% improvement in members with body mass index <30. Nurtur's congestive heart failure management program has also demonstrated statistically significant improvements, including a 26% improvement in members with LDL cholesterol < 100 mg/DL, a 39.7% improvement in controlled blood pressure, and an 18% increase in members receiving influenza vaccines. Nurtur currently serves approximately 1.8 million Medicaid health plan members in twelve states as well as commercial employer, union and health plan clients covering over 2.5 million eligible lives. Nurtur has experience working with diverse Medicaid populations including SSI members who are facing multiple co-morbid conditions, including both medical and behavioral health diagnoses.

Name, Address	OptiCare Managed Vision, Inc.
Subcontractor Overview & Experience	OptiCare, a GSHP affiliated subsidiary, has provided capitated vision administration services for over 30 years, and is an industry leader in medical eye care administration. They have accomplished this by implementing a medical knowledge base and then developing systems that allow them to employ this knowledge. They provide eye health benefits for contracting parties in 16 states. The typical range of benefits administered includes well eye exams, prescription optical products and medical and surgical services related to eye care. Their routine vision benefit includes an effective preventive and early detection program to assist in driving down healthcare costs. They administer these benefits with no required prior authorization or paperwork for the member. OptiCare has leveraged their leadership position in key markets to build a strong provider base of eye care professionals that includes ophthalmologists, optometrists and opticians. They have a national contracted provider panel with over 13,000 provider locations and contract directly with all participating providers. In addition, OptiCare employs an "any-willing" provider panel. If a provider meets OptiCare's quality and other contractual requirements, the provider is invited to join the panel. They contract with independent and retail chain providers nationally and educate these providers concerning covered services. Unlike their competitors, OptiCare has the ability to offer seamless integration with their health plan partners to meet their members' medical and surgical eye care needs, including participation in disease management programs. They work with health plans to ensure that the proper levels of care are provided for both routine and medical eye care, and have deployed programs to target those who may have unique vision care risk factors and needs, including those with diabetes and glaucoma. One example of this integration is the capability OptiCare offers to collect and provide data to health plans, such as diabetic members who have had an eye evaluation. OptiCare collects not only the primary diagnosis but also any other related diagnosis. This data is crucial to identifying the underlying diagnoses that led to the member's eye care needs. For example, if a member presents for a routine eye examination, but also has another disease such as diabetes, Opticare can report this information to the health plan. This information can then be used for disease management interventions and HEDIS measurement purposes. OptiCare also outreaches to members directly to encourage and schedule eye exams for identified diabetics who may not be aware of their vision benefits or

	the need for them. These programs have shown great success and have a direct impact on the quality of care members receive. In one of their most recent studies, OptiCare scheduled eye exam appointments or confirmed appointments scheduled for approximately 28% of the diabetic population. OptiCare has performed several other, larger outbound calling efforts for the Medicaid populations of heath plan partners, including one in Ohio for over 2,500 identified diabetics. For another plan, OptiCare documented increases of 22-50% of identified diabetics receiving care following an intensive three month outreach program. OptiCare has administered vision benefits for the Medicaid population for over 20 years. They currently provide these benefits to approximately 2 million Medicaid members in twelve states. OptiCare has long-term exclusive contracts with nationally recognized health plans with a solid documented track record of satisfied clients. OptiCare adheres to or exceeds NCQA guidelines.

Name, Address	US Script, Inc.
Subcontractor Overview & Experience	Founded in 1999, US Script provides progressive pharmacy benefit management services that maximize pharmacy dollars while enhancing quality of care. US Script's clients include, but are not limited to, Medicaid health plans, third party administrators, brokers, colleges, school districts, and self-funded employers. Available services include Preferred Drug List administration, clinical authorizations, pharmacy network contracting and management, rebate administration, reporting, claims adjudication, account management, pharmacy provider call center and services, pharmacy and therapeutics support, pharmacy auditing, and selected drug utilization review and quality improvement functions. Medicaid health plans represent a significant portion of US Script's client portfolio. US Script administers pharmacy services for ten Centene affiliated health plans in nine states, including Arizona, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Ohio, and South Carolina. In cooperation with their Medicaid health plan partners, US Script currently provides prescription benefit management services to health plans representing 1.2 million low-income members and their families. These members span a wide range of age and program categories, including: the aged, blind and disabled (ABD), Temporary Aid to Needy Families (TANF) children and adults, children in Foster Care,

	residents of nursing and other long-term care facilities, and individuals enrolled in the Children's Health Insurance Plan (CHIP) or other state-sponsored programs. One of US Script's strengths is their ability to create customized programs that address the specific needs of the populations they serve. For example, in Centene's Georgia subsidiary health plan, US Script implemented an edit to identify any tetragenic drug that is applied to all members who are identified as being pregnant. In addition, US Script currently provides pharmacy services for 11 of the 39 Mental Health and Mental Retardation (MHMR) clinics in Texas, which serve 87 of Texas' 254 counties and provide services for their County Indigent Health Care Programs. US Script reduced costs for these centers through innovation and tailoring services to their unique needs. For example, US Script developed and provided the MHMR clinics with a premier Prescription Assistance Program (PAP) from MedData Services. This automated program is unmatched in the industry and is currently used in many State Departments of Health and by major hospitals. This one program has lowered the costs of medications from 20% to 40% for the individual clinics, while reducing the number of employees required at these clinics to manage a Prescription Assistance Program. US Script has been URAC accredited for Pharmacy Benefits Management since 2008 and is also Mail Order accredited as a Verified Internet Pharmacy Practice Site by NABP.

Nonaffiliated Subcontractors

Subcontractor	National Imaging Associates NIA A Magellan Health Company
Overview & Experience	GSHP will utilize non-affiliate NIA to manage high-tech radiology services. National Imaging Associates, Inc. (NIA) has been in the business of radiology and specialty benefit management since 1995. NIA is an indirect, wholly owned subsidiary of Magellan Health Services, Inc. (Magellan), a leading, diversified specialty health care management organization. Through this synergistic relationship, NIA has been able to leverage an expansive set of competencies provided by Magellan—such as its national call center operations and experience in customer service, network development/contracting, claims payment, clinical management, and information technology resources. Because of the many synergies created by NIA's relationship with Magellan, its health plan partners have access to an enhanced, integrated, and innovative solution

unmatched in the industry.

They have developed a broad range of effective strategies to meet the diverse needs of their customer populations. Their extensive experience in reducing expenses, improving quality, and focusing on radiation safety serves as a strong foundation for their commitment to ongoing innovation. NIA successfully manages programs for a broad spectrum of state Medicaid contracts, multi-state Medicaid health plans, and large regional health plans with Medicaid lines of business.

An example of such effectiveness is the active reduction in the rate of excessive radiation exposure not only for the entire popuation, but especially for the under 18 population. NIA is able to prevent excessive radiation exposure by monitoring the CT request rate for the under 18 population. After a program implements, NIA is able to significantly reduce the amount of CT usage in the population that is most vulnerable to excessive radiation exposure.

Through NIA's rich Medicaid experience, they have gained an in-depth understanding of Medicaid regulations and special requirements, and have collaborated effectively with Medicaid payors to address the challenges inherent in diverse Medicaid populations such as TANF, ABD, CHIP, and dual-eligibles. NIA has translated all of their knowledge of advanced diagnostic imaging management issues and trends into a full array of solutions that offer guaranteed savings for their customers.

The NIA solution incorporates a comprehensive, end-to-end approach to addressing and managing the key drivers and critical components of high-end elective outpatient radiology studies, as well as a cost-effective approach to managing low-end radiology performed in provider offices. This solution has been paramount to their success in delivering appropriate care, leveraging network efficiency, addressing quality and patient safety, providing a differentiating experience for participating providers, and actively engaging members in their health care experience. For their health plan partners, this solution leads to improved cost, quality, and affordability.

As the first radiology benefits management (RBM) company certified by NCQA and one of the first accredited by URAC, NIA brings to its health plan partnerships more than 16 years of experience as an RBM industry leader. With customers across 41 states covering more than 4.5 million Medicaid lives, Medicaid represents approximately 25 percent of NIA's book of business.

NIA is a "thought leader" in serving Medicaid and in providing consultative and programmatic strategies that address quality outcomes, patient safety, and clinical efficiencies. By ensuring quality, and thereby reducing duplicate and unnecessary testing, NIA is able to deliver significant savings to payors. For more than a decade, NIA has collaborated effectively with health plans as well

	as state Medicaid entities to address the unique and varying imaging challenges across all Medicaid populations.

Subcontractor	Access2Care
Overview & Experience	Access2Care (A2C) is a business unit of American Medical Response, the nation's leading provider of ground ambulance service and an important community resource in New Hampshire. Access2Care manages the medical transportation benefit for over four million beneficiaries' nation-wide serving commercial insurers and various state governments. A2C is the leading manager of medical transportation services in the country. A2C is experienced in serving states with a high proportion of rural residents. Specifically, in Idaho and Nebraska where they manage the Medicaid transportation for the state governments and in New Mexico and Alabama where the manage transportation under contract with managed care organizations. Access2Care understands the unique challenges of under-resourced communities and coordinating travel over long distances which makes them especially qualified to meet the needs of New Hampshire Citizens. Centene utilizes Access2Care in other markets such as Texas and Florida. In recent months A2C has begun discussions with members of the State Coordinating Council for Community Transportation to explore potential areas of collaboration and partnership. It is the intention of Centene and Access2Care to continue that collaboration and develop working relationships that not only enhance transportation for New Hampshire Medicaid beneficiaries but also for the community at large. We support the Council's effort to streamline the delivery of transportation, increase the availability of resources and promote the delivery of needed services to at-risk populations. As a leading innovator of Medical transportation delivery programs A2C has developed systems which improve access to medical services while reducing the administrative cost of delivery the routine transportation. A2C was the first national manager to create an online interface with the transportation providers so that transport requests could be managed electronically rather than by paper. The online trip management software allows for speedy cancelation of members who have disenrolled thus preventing the waste of resources that occurs when service is attempted for someone who is no longer covered by the program. They extended the ordering functionality into electronic claims submissions. The electronic claim submission process allows the provider to receive payment for covered services within twenty-one days of

	submitting a clean claim. These are just examples of how the A2C program reduces the administrative cost of delivering service, increasing the viability of the providers participating in the network. Access2Care places a great deal of emphasis on provider credentialing, training and oversight. This results not only in timely and appropriate transportation but also helps to reduce potential fraud and abuse. At the time service is requested the business rules of their software helps to determine the appropriate level of service and thus drives services to the least-cost and most appropriate mode of transport. When public transportation is available and appropriate it will be used. Likewise, when a beneficiary needs wheelchair van transportation it will be documented and used. As a part of a multi-billion dollar health care provider company Access2Care has a special understanding of how the management of transportation can be integrated into efforts to enhance wellness and reach beneficiaries with chronic conditions. Centene and Access2Care partnered on a program in South Florida where Access2Care arranged home visits by local Paramedics who would assess and treat at risk diabetics. They were able to coordinate between primary care physicians, the health plan and laboratory services to assure that blood pressure readings and LDL A1c blood tests were completed and reported. They are currently working on a program in rural Texas to help reduce emergency room visits and hospitalizations of asthma patients by providing in-home education to parents and family members.

Subcontractor	TeleDoc Teladoc
Overview & Experience	Teladoc is the nation's first and largest provider of access to telehealth consultations. Its nationwide network of licensed, board certified primary care physicians serve more than 3 million members. The company was founded in 2002 and has now provided more than 100,000 consultations. Teladoc meets the needs of health plans, employers, states, unions, associations and consumers as an innovative complement to non-emergency primary care by providing accessible, high-quality care at an affordable cost. Teladoc connects members to U.S.-based, board-certified physicians 24/7 via telephone or secure online video. Upon requesting a consultation, patients receive a call back from a doctor within an average of 22 minutes for $38 or less per session. Each consultation includes a comprehensive review of a patient's electronic health record. Teladoc physicians treat a variety of conditions and, if medically appropriate, prescribe medication. With approval,

Teladoc can send a record of the consultation to the patient's primary care physician.

By delivering fast and convenient access to quality care without having to leave the home or office, Teladoc improves employee productivity and significantly reduces utilization of more costly alternatives, such as emergency rooms or urgent care facilities. By delivering fast and convenient access to quality care without having to leave the home or office, Teladoc improves employee productivity and significantly reduces utilization of more costly alternatives, such as emergency rooms or urgent care facilities.

Underscoring Teladoc's clear leadership in the telehealth space, Dana Mead, a partner at Kleiner Perkins Caufield & Byers (KPCB), a leading investment company serving the healthcare and new technologies industries was recently quoted saying:

"KPCB seeks to identify industry leaders in markets that address significant unmet needs and are poised for explosive growth, Teladoc and telemedicine clearly meet these criteria. We look forward to partnering with Teladoc to make a meaningful impact on the U.S. healthcare system."

Monitoring Performance of Subcontractors

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.

Vendor Oversight Program

Centene Corporation has developed an extensive Vendor Oversight Program (VOP) for the purpose of ensuring all subcontractors comply with federal and state laws, regulations and contract requirements. The GSHP Compliance Officer will be responsible for monitoring and documenting subcontractor adherence to these requirements. The VOP encompasses the following key elements: execution of contract terms and agreements, delegation audits, performance monitoring, administration of Corrective Action Plans, enforcement of contractual penalties, quarterly Joint Operating Committee Meetings and coordination of day-to-day business operations.

All GSHP subcontractors with delegated services will enter into a written agreement which includes, but is not limited to:

- responsibilities of the plan and the subcontractor;
- specific delegated activities, including business and regulatory reporting requirements;
- performance standards and reports for oversight of delegated activities; and,

- explicit statement of consequences and corrective action process if the subcontractor fails to meet the agreement terms, up to and including revocation of the delegation agreement.

Before the subcontractor agreement is executed, GSHP will conduct a pre-delegation audit to evaluate the prospective subcontractor's ability to perform the delegated activities. The audit includes a comprehensive review of the organization's policies and procedures specific to the delegated activities, staffing capabilities and the overall organizational performance record. The subcontractor's delegated programs will be compared to the GSHP, State, NCQA, HIPAA and other applicable regulatory standards. In the event delegated activities are added to an executed agreement, a pre-delegation audit will be performed on those additional programs prior to delegation.

GSHP will also provide to DHHS an annual schedule identifying subcontractors, delegated functions and responsibilities, and when the subcontractors will be reviewed. We will audit our subcontractor care systems and performance annually. This annual audit consists of a desk review, a file audit and a system audit to cover all delegated functions. The annual audit may be on-site, but off-site reviews may be performed, no more than every other year, if the subcontractor is in good standing.

Monitoring Subcontractor Performance

On an ongoing basis, GSHP's Compliance Officer in collaboration with the respective GSHP business counterparts will monitor the day-to-day operations of the delegated subcontractor. Depending on the delegated activities, the subcontractor reports and engages in routine conversations with respective GSHP business counterparts to ensure our members receive services as outlined in the subcontractor agreement. In addition, the Compliance Officer will conduct quarterly Joint Operating Committee meetings with each subcontractor and the respective GSHP business owners to review the overall performance of the subcontractor. These meetings include a focused review of performance dashboards, reports, member/provider complaints, upcoming business process changes, quality improvement initiatives or other pertinent regulatory updates. Minutes are recorded and approved at each meeting and stored in Compliance 360 (C360), our contract compliance monitoring software. The Compliance Officer subsequently reports the status of each vendor to the Quality Improvement Committee and Compliance Committee.

The ongoing monitoring and reporting of subcontractor performance is also recorded by the Compliance Officer using the C360 system. At least monthly, and as applicable to each subcontractor, the Compliance Officer will document the subcontractor's performance. In addition, the Compliance Officer will monitor each subcontractor's reporting requirements that include, but are not limited to encounter data; provider demographics; complaints, grievances and appeals; network adequacy; utilization management; and any other applicable DHHS reporting requirements.

Quality Improvement and Corrective Action Plans to Improve Performance and Ensure Positive Results. In the event a subcontractor fails to meet performance requirements and standards, the Compliance Officer will work with the subcontractor to draft a Corrective Action Plan (CAP) outlining all deficiencies or standards violated; the expected, measurable results; a detailed action plan to correct deficiencies; and, a due date for completion of the CAP. In some cases of sustained non-performance,

failure to meet performance standards will result in the assessment of financial penalties. Prior to submitting a CAP to the subcontractor, the GSHP Compliance Officer will review the CAP with the Corporate Compliance Officer. By including the Corporate Compliance Officer (CCO) in the process, the CCO can assess overall risk to the organization and collaborate with the National Contracting team regarding potential future actions with the subcontractor. ***See Attachment 3.20.107-A Sample Corrective Action Plan Report located at the end of this section.***

Risk Prevention. GSHP will conduct several activities to prevent, or detect early, potential risks as a result of subcontractor performance or activities:

- The GSHP Compliance Officer reviews vendor performance issues during Performance Improvement Team and Compliance Committee meetings. Teams will discuss performance issues, status of CAPs and any newly identified issues.
- On a monthly basis, Corporate Compliance conducts a joint meeting with all Centene affiliate health plans to discuss trends in performance with vendors and any newly identified challenges.
- Corporate Compliance audits all affiliate plans on a quarterly basis to ensure the health plans are conducting vendor oversight in accordance with the oversight program process.
- During Monthly Risk Calls between the Corporate Office and affiliate health plan compliance teams, any subcontractor on a CAP or with an open risk in C360 are discussed in detail to assess ongoing or potentially elevated risk to the organization.
- In collaboration with Corporate Quality Improvement, the GSHP Compliance Officer, the Quality Improvement Director and other GSHP business owners will conduct an on-site pre-delegation audit of delegated subcontractors. We will follow-up with an annual on-site performance audit. If the subcontractor is in good standing, then off-site reviews may be performed.
- At least annually, Centene Internal Audit conducts a review of the vendor oversight program, to include assessment of CAPs, C360 Audit for documentation evidence and interviews with key business owners regarding the program and overall vendor performance. Audit results are shared with Centene Executive Team, Board of Directors and the GSHP Board of Directors, President and Executive team.

Transferring Data to Subcontractors

Q108. Describe data you will transfer with your subcontractor(s) and how that data will be transferred.

Centene Corporation (Centene) will operate and manage the data exchange and processing requirements for Granite State Health Plan (GSHP) with our affiliated subcontractors: US Script (Pharmacy Benefit Management); OptiCare (Vision Benefit Administration), Nurtur Health Inc. (Nurtur - Disease Management); and our non-affiliated subcontractor, Access2Care, GSHP's Transportation Vendor. While NurseWise, GSHP's 24/7 Medical Triage telehealth service company, and Cenpatico Behavioral Health, LLC (Cenpatico) are also subcontracted vendors, these affiliated subcontractors use

the same unified applications and processes as GSHP, enabling a critical dimension in care coordination and eliminating external data transfer processes between Centene and these subcontractors.

As part of our normal business support capabilities, Centene successfully receives, processes acknowledges, updates, and transmits formatted data to and from our integrated Management Information System (MIS) from a wide variety of Trading Partners (state agencies, fiscal intermediaries, enrollment brokers (EB), claims clearinghouses, medical test labs, providers, as well as our subcontractors) through all industry standard methods (VPN, Secure FTP, https, etc.).

Receiving, Processing, Updating and Sending Data to GSHP Subcontractors

Centene has in place today HIPAA compliant data transfer processes and protocols with our affiliated subcontractors and, as we have done for thirteen states that we serve today, we will configure our systems via parameter driven, table based utilities (no programming necessary) to support the necessary file transfers for the Medicaid Care Management Program. Because these subcontractors are within the Centene family of companies, data is not transferred externally, and thus remains in our control and is subject to the same diligent administrative, technical and physical safeguards Centene employs to safeguard the data of our state clients. For more information on these safeguards and HIPAA compliance, please reference Attachment 2.4.3 MIS Overview. We will also work with Access2Care, GSHP's Transportation Vendor to establish the necessary file exchanges (with the same HIPAA compliant controls and safeguards that we employ internally) which include enrollment files ***to*** Access2Care; and claims / encounters and provider data ***from*** Access2Care; similar to what we do with our transportation vendors in other states. Please refer to Figure 108-A: Data Interfaces with GSHP Subcontracted Vendors, for the discussion below.

Enrollment Data. We process inbound HIPAA 834 enrollment transactions on a daily, semi-monthly, and monthly basis for our state clients in accordance with companion guide specifications per state, or state Fiscal Intermediary (FI) or Enrollment Broker (EB). We receive and transmit HIPAA 834 transaction files via our secure file exchange management system, Coviant Diplomat (Coviant). Our TIDAL job scheduling software manages the member load process, ensuring overall process integrity. Inbound 834 files are automatically processed through our EDIFECS EDI subsystem for HIPAA 4010A *and 5010* compliance validation and translation. We support a wide range of file transmission acknowledgement protocols, including ANSI standard 997, 999, TA1, 831, 824 and AHCCCS proprietary formats, which we utilize with our subcontracted vendors. EDIFECS, in conjunction with our TIBCO middleware also edits for duplicate member records, date criteria validity, field data integrity, and valid date spans. Any member records that trigger edits default into an exception report where they are systematically corrected using data correction routines prior to subsequent processing.

Once processed through EDIFECS, enrollment and eligibility data is loaded into Member Relationship Management (MRM), our member data management system, through Add, Delete, and Modify transactions, with accurate begin and end dates – all within 24 hours of receiving the HIPAA 834 from DHHS.

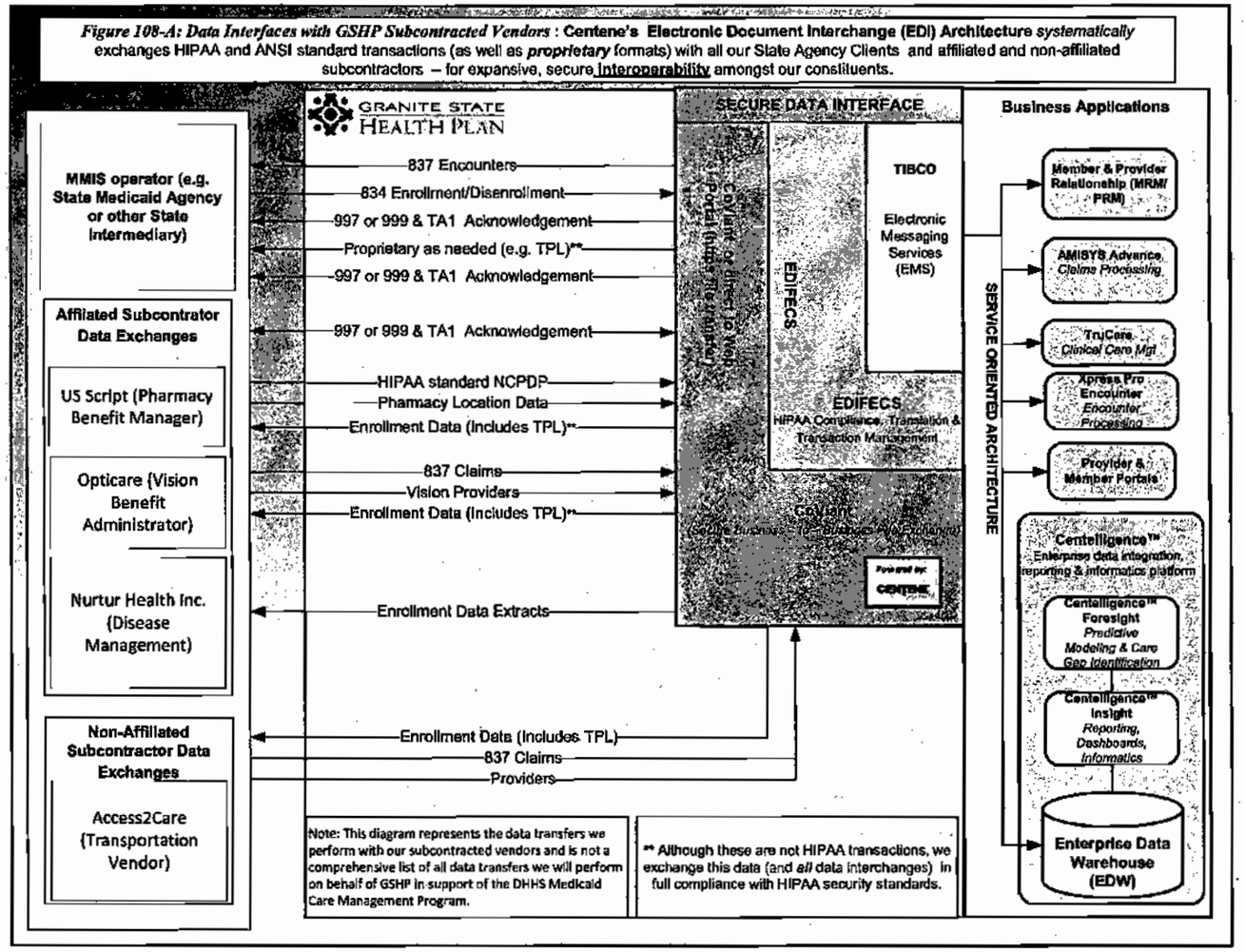
MRM is our "system of record" and master data store for "all things member" related, including history of that member data. MRM houses our master member index (MMI) – an internal global member identifier similar to a master patient index, to tie together alternate or historic member identifiers. MRM allows us to systematically link information about the member across that member's relationships with us or DHHS, or prior health coverage spans (where we have such history). Once member data populates MRM, that data is systematically promulgated in near real time to our systems including our Centelligence™ Enterprise Data Warehouse (EDW), thanks to the event-driven, transaction based capabilities of our Service Oriented Architecture (SOA).

From our eligibility subsystem and EDW, we generate enrollment files for our subcontracted vendors. We have in place today HIPAA compliant Business Associate Agreements (BAA's) with our affiliated subcontractors. We will execute this same BAA with Access2Care prior to contract execution with DHHS. In addition, we will consider DHHS a direct third party beneficiary of the HIPAA compliant business associate agreements we have with all of our subcontractors for the Medicaid Care Management Program.

We send eligibility to our subcontractors using the HIPAA 834 transaction, sending only that member data that is needed for eligibility and benefit verification and claims processing by our vendors which includes application of Third Party Liability (TPL) when available. Nurtur leverages our EDW through secure file extractions of member data, for those members in a disease management program. ***ALL*** data transfers are done in a secure HIPAA compliant environment and utilize Secure File Transfer Protocol (SFTP) and data encryption technologies using Public Key Infrastructure (PKI) implementations. We send data to our subcontractors on a daily basis, to ensure timely member service and process support.

For the Medicaid Care Management Program we will also be transmitting HIPAA compliant member eligibility to Access2Care (after execution of BAA with Access2Care), GSHP's transportation subcontractor. As we do with all of our health plan implementations, we will thoroughly review and test the eligibility data interface process with Access2Care prior to go-live.

Figure 108-A: Data Interfaces with GSHP Subcontracted Vendors



Claims and Encounter Data. Centene's Vendor Management Department manages our contracts and service level agreements with both our subsidiary subcontractors, US Script and OptiCare, as they will with our non-affiliated subcontractor, Access2Care. These contracts require timely, accurate and complete claims processing. We use the industry leading Governance, Risk Management and Compliance (GRC) application Compliance 360 for our contract management activities. Compliance 360 incorporates State contract requirements and regulations with internal compliance activities, policies, procedures and projects and helps us continuously manage and monitor our contracts with our subcontractors, helping us to remain a trusted and transparent partner of our state clients.

US Script, OptiCare and Access2Care will receive claims directly from their providers and process them through their own internal proprietary systems in adherence to all DHHS requirements, and according to the appropriate fee schedule or contractual rate. US Script, OptiCare, and Access2Care will provide GSHP with claim encounter files, and monthly operational claim reports, which are reviewed as part of the GSHP delegation oversight function. Note that our subcontractors, Nurtur and NurseWise offer services that do not include claims processing functions. Additionally, Centene processes claims on behalf of Cenpatico Behavioral Health; so again, no encounter file transfer is required.

US Script. US Script has HIPAA compliant, NCPDP data interfaces with its pharmacy network and nearly 100% of US Script claims are received electronically and adjudicated real-time. The list of drugs available within the formulary will be available on our secure, web based Provider Portal so that the prescribing physician can see what is on PDL and, therefore, what will require a Prior Authorization

In addition, through US Script's connection with SureScripts (the leading e-Prescribing interchange service), US Script is able to support physician offices and hospitals with member eligibility check, formulary / Prescription Drug List (PDL) and member claim history via the provider's standards based e-Prescribing system.

OptiCare. OptiCare uses Risk Manager software to process and adjudicate vision claims, which support the unique requirements for routine vision exams, and vision medical/surgical capitation arrangements. Risk Manager's eligibility, authorization, benefit and reimbursement modules resemble that of AMISYS Advance with an emphasis on vision related coding structures. OptiCare maintains relationships with popular clearinghouses for electronic submission of claims; utilizes OCR/imaging technologies to eliminate the need to manually enter paper claims, and supports the disbursement of claim payments through various methods such as check and EFT and paper EOP unless they "opt out" and chose to obtain EOB's via OptiCare's secure website.

Access2Care. The maximum time frame for processing claims and making payment to providers is 100 percent in 21 days. Tracking provider claims and turnaround time are fundamental factors of our reimbursement program. Claims are either electronically date stamped when submitted via the website by providers or, if submitted by paper, are date stamped upon receipt. All turnaround time is measured based upon the claim number and the received date to the payment or denial notification.

Our vendor contracts call for accurate, complete, and timely encounter submissions be submitted to our Encounter Business Operations team at Centene, where we oversee all aspects of our subcontractor's encounter operations. Our subcontractors are required to comply with the same

encounter submission requirements as GSHP. In the event a subcontractor does not comply with encounter requirements, we will activate our corrective action processes (which can include monetary penalties) for non-compliance.

File transfers for encounters are in HIPAA compliant 837P and NCPDP format and will be exchanged with Centene over Secure FTP.

Provider Data. We receive from each of our vendors US Script, OptiCare and Access2Care, provider data to support our provider search functionality on our provider portal and to provide DHHS with accurate and complete provider data. Provider data files are proprietary and are exchanged over secure FTP. Provider data is loaded into our Provider Relationship Management system (PRM) to maintain provider data and ensure the integrity of provider data through PRM's systematic controls, data entry tools and interfaces.

At the heart of PRM is the system's provider data management system which integrates provider related information across our other MIS components needing to use provider data. PRM also provides data to our on line provider directory.

Data Available for Reporting and Analysis. Claims and provider data we receive from our subcontractors is loaded into the Enterprise Data Warehouse (EDW) component of our award-winning, Centelligence™ reporting platform. Centelligence™ is a proprietary and comprehensive family of integrated decision support and health care informatics solutions. Centelligence™ continually analyzes an enormous amount of transactional data, such as claims, lab test results, health assessments, and service authorizations, to produce "business intelligence" and deliver the right information products to the right person (e.g., state clients, Case Manager, Member Service Representative (MSR), providers, members) for the right task (e.g., clinical intervention, internal workload adjustments, client reporting) at the right time (e.g., on schedule, or "in real time").

Centelligence™ is fully integrated with our core internal systems, as well as with our external interfaces and secure web portals. This allows our Centelligence™ Enterprise Data Warehouse, to integrate data in near real time and supply the most timely and accurate data possible to our integrated SAP BusinessObjects Enterprise suite of reporting tools, as well as our other Centelligence™ reporting applications.

Integrating Subcontractors with Care Management Program

Q109. Describe how subcontractors are integrated with your care management programs.

Care Management Subcontractors

GSHP will incorporate the expertise of three Centene affiliate subcontractors in the operation of our Care Management Program.

- **Cenpatico.** Cenpatico will provide behavioral health clinicians for our Care Management Program. Cenpatico services will include behavioral health and substance abuse services, specialty therapy, and rehabilitative services.
- **Nurtur.** Nurtur will provide disease management interventions to with multiple co-morbid conditions, including both medical and behavioral health diagnoses.
- **NurseWise.** NurseWise will provide our 24/7 nurse advice line, respond to afterhours calls to our enrollee call center, and conduct new enrollee welcome calls. The chart below shows Coordinated Care's organizational structure, with staff positions directly providing Care Management services shaded in dark green. Positions that provide support for care management functions are shaded in light green.

Integrated Care Teams

GSHP plan will integrate our delegated subcontractors into our care management program through our multi-disciplinary, co-located Integrated Care Teams (ICT) and through support from TruCare, our fully integrated state-of-the-art care management software. In addition, our delegated subcontractors who are Centene affiliates provide the added value of similar administrative structures, management tools, policies, and training requirements.

Subcontractor integration into GSHP is enhanced through co-location of care management staff and TruCare our fully integrated, state-of-the-art care management software.

Co-Location of Integrated Care Teams. We recognize that multiple co-morbidities often exist in chronically ill individuals and that the level of support required by these individuals is likely to change over time. The ICT will include co-located staff from GSHP; Nurtur, our affiliated disease management subcontractor; and, Cenpatico, our affiliated behavioral health subcontractor. Co-location of the ICT will facilitate regular, in-person communication about the member's care and achieve a level of coordination and integration that voicemails and emails among multiple case managers cannot. Because Centene health plans have found that locally delivered services achieve the best outcomes, we will hire staff that is from and familiar with the communities they serve and will locate our ICT members in New Hampshire.

TruCare. To further facilitate subcontractor integration into our care management program, both Nurtur and Cenpatico will have access to our case management software. TruCare provides all clinical staff, including our subcontractor affiliates, with one consolidated window into member health risks, care gaps, service and authorization history, and other clinical test, assessment, and medication information.

Integrating Subcontractors with TPL and Fraud and Abuse Programs

Q110. Describe how subcontractors are integrated with your TPL and fraud and abuse programs.

Subcontractor Integration for Third Party Liability

As a trusted administrator of public sector programs since 1984, Centene has designed third party liability claims processes and data interfaces around the requirement that Medicaid programs are the "payor of last resort." Centene has a successful history of managing cost avoidance for our managed Medicaid health plans as well as recovering payments made for our members who were subsequently found to have third party liability (TPL). **Our experience with TPL has shown that the best approach to cost avoidance is to minimize the need to recover costs in the first place.** Our Member Relationship Management (MRM) System contains our master member index and "all things member related" including history. GSHP will integrate our affiliated Pharmacy Benefit Manager subcontractor U.S. Script, and our affiliated vision services subcontractor OptiCare, into our TPL process through the MRM system. MRM systematically promulgates updated eligibility data, including coordination of benefits (COB)/TPL data to the claims processing system of U.S. Script and OptiCare. These subcontractors will be contractually required to review members for COB before adjudicating any claims. We also contractually require that these subcontractors report monthly to us their TPL findings and any instances where they have identified the existence of TPL outside of the MRM system. We will incorporate our subcontractor findings into our monthly TPL reporting to DHHS.

For the other GSHP contracted services, such as our behavioral health affiliate Cenpatico, we will process their claims directly. Therefore, it is rare that these subcontractors would have any member interaction to identify a TPL situation. Should any of these subcontractors become aware of an instance of TPL, their policies and procedures dictate that they make the GSHP aware of the situation as part of their reporting requirements.

Additionally, US Script and OptiCare subscribe through Health Management Systems (HMS),our TPL subcontractor, who will pursue COB payment recoupment when OI is not known at the time we pay the claim, and for subrogation to parties with TPL. If HMS determines that a claim is related to OI or subrogation, they will initiate steps to recover the overpaid TPL dollars. HMS will bill the primary insurer on behalf of the subcontractors within 60 days after TPL information is confirmed.

For more detail on the GSHP TPL Process refer to RFP Section 3.18.

Subcontractor Integration for Fraud and Abuse Programs

Centene Corporation oversees the vendor ethics and compliance activities of its entire organization, including its affiliate health plans and affiliated subcontractors. Established by Centene's Board of Directors in 1998, the Ethics and Compliance Program is designed to lay the foundation for the company and its affiliates in developing effective, consistent internal controls to promote adherence to

state and federal contractual and regulatory requirements as well as Centene's own ethical and business policies. Centene offers DHHS the added value of having all our affiliate health plans and affiliated subcontractors under the same compliance umbrella. All our health plans and affiliated subcontractors have similar operational structures in place, use the same tools to monitor compliance, participate in the same employee ethics and compliance training, and hold all employees and subcontractors to the same standards of conduct, transparency and performance.

In regards to our non-affiliated subcontractors, we will integrate them into our Fraud, Waste and Abuse Compliance Plan through contractual agreements that contain program integrity requirements and terms obligating compliance. We will educate and train subcontractors prior to contracting and periodically thereafter. During the contracting process, we will educate subcontractors concerning appropriate billing and on their responsibilities to prevent, detect and report suspected cases of fraud, waste and abuse.

Our Compliance 360 system (C360) is an effective tool for integrating all health plans and all subcontractors into our Ethics and Compliance Program. C360 allows us to track and monitor compliance with contract requirements, state and federal regulations, and Centene's own ethics and business policies. Using C360 will allow GSHP to perform assessments and monitor compliance by employees and subcontractors; manage State deliverables to ensure timely development, quality review, approval and submission; track incidents of non-compliance or corrective action and document progress on remediation; track State correspondence; generate multiple variations of reports to track and trend performance, and produce a contract compliance dashboard and online review/audit process for internal and external auditors.

We integrate our subcontractors into our Fraud, Waste and Abuse Compliance Plan through our initial screening process, written agreements, education and training, and vendor oversight process detailed below.

Subcontractor Screening. GSHP will conduct a thorough background check of any potential subcontractor prior to entering into a written agreement. This background review includes required disclosure of all individuals and entities with an ownership or control interest in the subcontractor. We also screen for and will not contract with any entity that has been debarred or excluded from program participation by a federal or state agency. We will immediately terminate any contractual relationships with excluded individuals or entities if discovered after the initial background screening.

Subcontractor Agreements. Our contractual agreements will contain our program integrity requirements and terms obligating subcontractors to comply with all relevant laws, regulations, and program requirements. All terms and conditions of our DHHS contract will be binding on our subcontractors. We will contractually obligate them to immediately report any concerns about non-compliance within their organization or that they may observe of GSHP staff, by a member, or by another subcontractor or provider.

Education and Training. We will educate and train subcontractors prior to contracting and periodically thereafter. During the contracting process, our Network Development staff will educate subcontractors on fraud, waste and abuse definitions and their responsibilities to prevent, detect and report suspected cases. Our training will make subcontractors aware of our confidential, toll free Compliance Helpline for reporting purposes.

Vendor Oversight. The GSHP Compliance Officer will collect and review routine and ad hoc reports from each subcontractor related to claims payment, encounters, member and provider complaints, third party recovery and financial data as required in the subcontractor agreement. We will conduct ad hoc audits of encounters, claims payment, and other operational performance elements as a normal course of their business. In addition, subcontractors will be subject to annual audits that will include a review of their fraud, waste and abuse processes and compliance. The Compliance Officer will meet with subcontractors on a regular basis during the Joint Operations Committee meeting, during which they will discuss potential and actual compliance issues.

Sanctions or Penalties if Subcontractor Fails to Perform

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.

If GSHP, through the monitoring plan or audit process, determines that the subcontractor is not performing in accordance with the standards outlined in the written agreement, the subcontractor will be placed on a corrective action plan and subsequent penalties will be applied if performance does not improve. **Each subcontractor agreement contains specific performance standard requirements and the associated penalties for failure to meet those standards.** For example, if a subcontractor fails to meet the timeliness requirements for monthly reporting in a particular month we would impose a penalty amount as specified in their contact. The ongoing monitoring and reporting of subcontractor performance and penalties is recorded by the Compliance Officer using the Compliance 360 (C360) system. All Centene affiliate health plans use C360 to track subcontractor performance. Delegated vendors' performance tracking logs are stored in the tool allowing for centralized tracking and immediate viewing of all oversight activities including any sanctions or penalties. Below is an example of C 360 screen shots for tracking specific subcontractor performance standards when a penalty is imposed. In addition, ***Attachment 3.20.111-A Sample Performance Monitoring Repor is located at the end of this section.***

GRANITE STATE HEALTH PLAN

Business Partner Information

[redacted]	Centene [redacted] CenteneTest ODV 2012
[redacted]	Active
[redacted]	9/5/2011
[redacted]	Vendor XYZ
[redacted]	123456789
[redacted]	Delegated Vendor for ABC Health Plan for Dental Services.
[redacted]	Lab Tele-health Add Remove
[redacted]	555-5555
[redacted]	
[redacted]	www.compliance360.com
[redacted]	jthomas@centene.com
[redacted]	Thomas, Jennifer
[redacted]	Keeley, Joseph L.
[redacted]	Foster Care Medicaid Add Remove All
[redacted]	Centene Business Partner Worklo
[redacted]	Partial Compliance
[redacted]	Delegated Contract for XYZ Vendo
[redacted]	

[redacted] Delegated Contract for XYZ Vendo

[redacted]

Business Partner Form D Information New

Filter Date of Latest Filing Contains Filter Adv. Filter

Date of Latest Filing	Reason for Filing	Actions
5/1/2011	Change of Name	Actions

Showing 1 - 1 of 1 Display 10, 20, 30 at a time <<First <Back 1 Next> Last>>

Contacts/Tracking Grids New

Filter First Name Contains Filter Adv. Filter

First Name	Last Name	Performance Standards Quarterly Comments	Reporting Requirements Quarterly Comments	Actions
		Tracking Grid updated 8/1/2011	Tracking Grid updated 7/1/2011	Actions
		Updated 11/14/2011	Updated 11/14/2011	Actions

Showing 1 - 2 of 2 Display 10, 20, 30 at a time <<First <Back 1 Next> Last>>

Vendor Dashboard Add

Filter Status Contains Filter Adv. Filter

Status	Name	Type	Federal Tax ID	Name	Actions

Showing 0 - 0 of 0 Display 10, 20, 30 at a time <<First <Back Next> Last>>

Meeting Minutes and CAP Documentation

[redacted]

Attachment List New

Name	Attached By	Type	Date Attached	Source	Actions
2nd Quarter Meeting Minutes	Thomas, Jennifer	File	9/5/2011	Business Partner	Actions
CAP Documentation	Thomas, Jennifer	File	11/11/2011	Business Partner	Actions

Showing 1 - 2 of 2 Display 10, 20, 30 at a time <<First <Back 1 Next> Last>>

Please Rate This Vendor on their Responsiveness to Issues Over this Past Quarter

1 - 3 Poor Responsiveness
4 - 6 Some Issues with Responsiveness
7 - 9 Appropriate Responsiveness

Vendor Penalty Information

[redacted]

[redacted] $250.00

[redacted] $500.00

[redacted] Timeliness Penalties

IF YOU ARE PERFORMING VENDOR OVERSIGHT, YOU MAY ENTER THE BAA IN THIS SECTION:

Contract Addenda New Addendum

Filter Title Contains Filter Adv. Filter

Title	File Status	Actions
2012 Contract Addendum	Checked In	Actions
Vendor BAA	Checked In	Actions

Showing 1 - 2 of 2 Display 10, 20, 30 at a time <<First <Back 1 Next> Last>>

Client Attestation and Other Contract Documentation

Attachment List New

Name	Attached By	Type	Date Attached	Source	Actions
		No records to display			

Showing 0 - 0 of 0 Display 10, 20, 30 at a time <<First <Back Next> Last>>

Tasks New Task New Multiple Tasks

Status	Name	Project	Resp. Party	Sched. Finish	Actions

Showing 0 - 0 of 0 Display 10, 20, 30 at a time <<First <Back Next> Last>>

Save | Save and New | Save and Return | Return | Spell Check

Attachment 3.20.107-A

Sample Corrective Action Plan Report

GRANITE STATE HEALTH PLAN

Meeting Minutes and CAP Documentation

[redacted] ☑

Attachment List New

Name ▲	Attached By	Type	Date Attached	Source
3rd Quarter Meeting Minutes	Thomas, Jennifer	File	9/5/2011	Business Partner
CAP Documentation	Thomas, Jennifer	File	11/21/2011	Business Partner

Showing 1 - 2 of 2 Display 10, 20, 30 at a time <<First <Back 1

Please Rate This Vendor on their Responsiveness to Issues Over this Past Quarter

1 - 3 Poor Responsiveness
4 - 6 Some Issues with Responsiveness
7 - 9 Appropriate Responsiveness
10 - No Issues Reported to Vendor

[redacted] 8 ☑

I had an issue with Timeliness of reporting in May, but the issue was resolved without any problems.

[redacted]

Tasks New Task | New Multiple Tasks | Assign All

Status	Name ▲	Project	Resp. Party	Sched. Finish
Planning	VENDOR ALERT - ISSUE NOTIFICATION		Galaste, Rhonda	

Showing 1 - 1 of 1 Display 10, 20, 30 at a time <<First <Back 1

Save | Save and New | Save and Return | Return | Spell Check

Attachment 3.20.111-A

Sample Performance Monitoring Report

HEALTH PLAN **CORRECTIVE ACTION PLAN** CAP Status: New Request Level: 1st Compliance: **Non Compliant**	Developed By: Compliance Department Functional Unit: **Subcontractor ABC**	Date: 07/01/2011

SUMMARY STATEMENT OF DEFICIENCES	REQUIRED DATE OF COMPLETION	EXPLANATION OF WHY DEFICIENCES OCCURRED	PLAN OF CORRECTION	CONTACT NAME	TARGET COMPLETION DATE
For FY2011, subcontractor's initial acceptance rate for Encounters has been 97.9%. Per State requirements, the initial Encounter pass rate should be 99%. Issues contributing to performance levels falling below the 99% requirement are: 1. Submitting previously submitted files (duplicate for Field 5) 2. Submitting files with incorrect claim numbers (Duplicate Field 11) 3. Submitting files with incorrect claim suffix (error with reissued claim) Due to ongoing issues with manual processes, Health Plan expects any future errors to be corrected both short and long term. All long term solutions should be automated and not reliant on manual corrections.	All issues corrected (either manually or automatically) by the May Encounter file submission. In addition, if any previously identified error (including those listed) occurs and results in an initial acceptance rate of less than 99% starting with the August 2011 file submission, health plan will impose financial penalties as outlined in the Agreement, Exhibit 5.	**Action Item No. 1** Duplicate files submitted due to lack of system constraints which allowed for manual duplicate file transmittals. **Action Item No. 2** Invoice numbers rolled from 6099999 to 0100000. As a result of this, some invoices were submitted without the leading zero. **Action Item No. 3** Manual controls on file archival resulted in error allowing for an incremental suffix on reissued claims	**Action Item No. 1** Add a "transmitted" flag in the billing system that will prevent users from submitting manual duplicate transmissions. Will also implement a check and balance process to validate if an original file has been merged into a previously transmitted file. **Action Item No. 2** Changes will be made to the current logic to correct the issue and the original claim number updated accordingly. **Action Item No. 3.** This issue occurred in prior month and was resolved.	Mary Jane	8/31/2011 7/31/2011 6/30/2011

SAMPLE

Name of Subcontractor Performance Standards
(Exhibit 5)

					Julian			Aug		
					Date	Report Result		Date	Report Result	
[illegible]	[illegible]	Report Measurement Tool	Report Frequency	Manager	Received		Meet Target (Yes/No)	Received		Meet Target (Yes/No)
Eligibility	Network shall load the eligibility file within two (2) business days of receipt from HMO.	Network to report to HMO in a mutually agreed upon format	Monthly	Susan Kohler	Confirmation files received daily					
Encounter data	Network shall submit encounter data to HMO by the 5th calendar day of each month in the format set forth by the State and communicated by HMO.	HMO will log and track receipt of file and errors identified (a) by HMO and (b) by State.	Monthly	Susan Kohler	Files Received	96% acceptance initial submission	No			
Encounter data	Network shall submit all corrected encounter data to HMO within twenty days after notification by HMO that data is incomplete or incorrect.	HMO will log and track receipt of file and errors identified (a) by HMO and (b) by State.	Monthly	Susan Kohler	Files Received					
Claims Processing	Timely payment standards as required by the Connector: Pay 90% of all Clean Claims for Covered Services from Providers within thirty (30) days from the date the Contractor receives the Clean Claim and pay 99% of all Clean Claims from Providers within ninety (90) days from the date the Contractor receives the Clean Claim.	Network System Report	Monthly	Susan Kohler	Reports sent to Centene					
Claims Processing	Network claims payment accuracy must be 97% or above.	Network System Support	Monthly	Susan Kohler	Reports sent to Centene					

Name of Subcontractor Performance Standards

(Exhibit 5)

					Jul 11			Aug 11		
					Date	Report Result		Date	Report Result	
Item	Target	Report Measurement Tool	Report Frequency	Manager	Received		Meets Target (Yes/No)	Received		Meets Target (Yes/No)
Member Appeals	If Member appeals are not delegated to Network, Network may be called upon to provide information on an appeal that HMO is processing. A request for information on a standard appeal shall be resopnded to within 10 business days. An expedited appeal shall be responded to within 1 business day. HMO must clearly communicate whether the appeal is standard or expedited, and give the appropriate deadline at the time of the request.	HMO Appeal Tracking Log	Per occurrence	Susan Kohler	None					
State Requirements	No sanctions or penalties will be assessed by the Connector on HMO as a result of acts or omissions of Network.	State Reporting	Per occurrence	Susan Kohler	None					
Authorization/ Precertification	100% of authoriztion/precertification decisions are made and communicated within 10 business days. In addition, the following documentation must be completed when applicable: -Notice of Action (NOA) for denials -State Hearing Form	Audit of Authorization/ Precert File	Quarterly	Susan Kohler	Reported on Dashboard					
Provider Appeals	100% of written provider appeals must be resolved within 30 calendar days. 1st level shall be the responsibility of the Network, all 2nd level appeals will be routed same day to HMO for resolution. The Network will adhere to findings of 2nd level appeals and 3rd level arbitration.	Audit of provider appeals	Quarterly	Susan Kohler	None					
Access to Services	In markets that Network is performing contracting and network development, Network must ensure that an appropriate Dental provider is identified within 2 business days of a request for services, if applicable, or non-par provider will be secured. Appointments must be made in the timeframes required by the State. If none available, time frames will be as follows: Urgent (1day); Routine sick (1week); well care (1 month)	HMO member placement spreadsheet	Monthly	Susan Kohler	No issues identified					

Name of Subcontractor Performance Standards
(Exhibit 5)

					Jun 11			Aug		
					Date	Report Result		Date	Report Result	
Method	Target	Report/ Measurement Tool	Report Frequency	Manager	Received		Meets Target Yes/No	Received		Meets Target Yes/No
Contracting and Network Development	Network must maintain network adequacy requirements of one (1) provider within 30 miles of a Covered Person's zip code (urban) and 45 miles of a Covered Person's zip code (rural), or as otherwise required by the State. Network will not be penalized in cases where it can demonstrate that a provider is unwilling to contract.	GeoAccess Reports supplied by Network.	Monthly	Susan Kohler	Yes	Per Ratio report, gap in Norther MRA. DQ addressing gap				
Medicaid Coverage Guidelines	HMO is required to cover all dental services that are covered under the Medicaid fee-for-service (FFS) program. Network must ensure that no services that would be offered under the FFS program are denied to HMO members. Also, no service should be paid, without HMO prior approval, for services considered non-covered under the Medicaid FFS program. This standard shall not prohibit Netowrk from determining the medical necessity of various services and denying non-medically necessary services when appropriate.	HMO Grievances for denials and audit of paid claims and the State encounter reviews for payment on non-covered services	Per occurrence	Susan Kohler	Yes					
Telephone answer Timeliness Member Not Delegated	Average speed of answer for Network's phone unit will be 90% of calls answered by a live person in less than 30 seconds.	This report not applicable as DQ has not been delegated Member Services	Weekly	Susan Kohler	N/A					
Telephone answer Timeliness Member Not Delegated	Call abandonment rate will be less than 5%.	This report not applicable as DQ has not been delegated Member Services	Weekly	Susan Kohler	N/A					
Telephone answer Timeliness Member Not Delegated	Blocked call rate will be less than 1%.	This report not applicable as DQ has not been delegated Member Services	Weekly	Susan Kohler	N/A					
Financial	Lag reports should be delivered by the 5th business day of the month for the previous month.	HMO will log and track receipt of lag reports.	Monthly	Susan Kohler	Reports sent directly to Finance					
HEDIS Reporting	Network shall make best efforts to ensure that HMOs HEDIS scores related to dental encounters shall be equal to or greater than NCQA 75th percentile. HMO shall communicate the NCQA percentiles to Network annually.	Receipt of reports from Network	Annually	Susan Kohler	N/A	N/A				

Subcontractor Name
Report Criteria per contract
(Exhibit 6)

	Report Spec Name	File Name	Due Date to Content	Location/ Method	Design Document	Business Owner	Last Rec'd	Next Due	Status
Encounter	Encounter Data	Monthly on the 15th	Monthly	STLSFTP1			7/15/2011	8/15/2011	
Provider Directory	Provider Directory	MA_DD.dat	Bi Weekley by * AM CST Tuesdays; if applicable change file by 10 AM Friday	STLSFTP1			7/4/11 7/11/11 7/18/11 7/25/11	8/1/11 8/8/11 8/15/11 8/22/11 8/29/11	
	Provider Supplemental file	dd_Provider_YYYYMMMDD.csv	Weekley	STLSFTP1			7/4/11 7/11/11 7/18/11 7/25/11	8/1/11 8/8/11 8/15/11 8/22/11 8/29/11	
State Reporting	COB Report -Pay and Recover, Cost Avoidance, Total Recovery, Accident/Trauma and TPL (Cover Sheet and Data)	MA_DD_COB_YYYYMMDD	Semi-Annual	STLSFTP1			7/9/2011	N/A	
	Significant Changes in Provider Network	MA_DD_Significant Change_YYYYMM	Semi-Annual	STLSFTP1			7/9/2011	N/A	
	Data Certification Report	MA_DD_Data Certification_YYYYMMDD	Semi-Annual	STLSFTP1			7/9/2011	N/A	
	Waiting Time Access Report	MA_DD_Wait Time_YYYYMMD	Annual	STLSFTP1			7/9/2011	N/A	
	Provider Manual Updates of Changes	MA_DD_Provider Manual_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Specialist to Enrollee Ratio Report	MA_DD_Specialist to Enrollee_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Specialist Geo report	MA_DD_GeoAccess_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Provider Profiling	MA_DD_Provider Profiling_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	

	Summary of Analysis of Access and Availability	MA_DD_Summary Access and Availability_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Waiting Timee Access Report - Specialist	MA_DD_Access and Availability_YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Credentialing Policy and Certification Submission	MA_DD_Credentialing Certification _YYYYMMDD	Annual	STLSFTP1			7/9/2011	N/A	
	Fraud and Abuse Report and Certification	MA_DD_Fraud and Abuse_YYYYMMD	Annual	STLSFTP1			7/9/2011	N/A	
Internal Reporting	Claim File	MA_DD_Claim_Utilization_Management _yyyymmdd.xls	Weekly	STLSFTP1			7/4/11 7/11/11 7/18/11 7/25/11	8/1/11 8/8/11 8/15/11 8/22/11 8/29/11	
	Eligibility Confirmation_	MA_DD_Eligibility _Confirmation _yyyymmdd.xls	Load file every two business days from receipt	STLSFTP1			7/1/11 7/6-7/9 7/12 - 7/16 7/19-7/23 7/27-7/30	8/2 - 8/6 8/9-8/13 8/16-8/17 8/23-8/27 8/30-8/31	
	QMC Minutes	MA_DD_QMC_Minutes_yyyymmdd.xls	At least Quarterly	STLSFTP1			Missing Q2-2011	8/13/2011	
	QM Program	MA_DD_QMC_Program_yyyymmdd.xls	Annually	STLSFTP1			N/A	N/A	
	QM Workplan	MA_DD_Workplan _yyyymmdd.xls	Annually	STLSFTP1			N/A	N/A	
	QM Program evualation	MA_DD_Program_Eval_Workplan_yyyymmdd.xls	Annually	STLSFTP1			N/A	N/A	

QI Reports	Compliants/Grievance/Appeal List (provider only)		Monthly	Define format: Include all received even if sendt to health plan for resoulution. Include dat and person at healthplan to which complaint was forwarded for			7/1/2011	8/5/2011	
	Geographic Availability Report		Semi annually	Practitioner and provider distribution in geographic area. % of Members who have a provider within a certain # of miles per the contract			7/9/2011	N/A	
	Summary of Provider Availability		Quarterly	Summary of # & Types of practitioners and providers			7/9/2011	N/A	
	Annual Provider Access Evaluation		Annually -refer to Regulatory Reports	Included in Annual QI Evaluation			7/9/2011	N/A	
	Annual Provider Availability Evaluation		Annually -refer to Regulatory Reports	Included in Annual QI Evaluation			7/9/2011	N/A	
	Adherence to Medical Record Standard		Annual	Included in Annual QI Evaluation			N/A	N/A	
	Evaluation of QI Program		Annual	Included in Annual QI Evaluation			N/A	N/A	
Credentialing Reports	Practitioner Roster		Monthly Updates; Annual	requirements are due to HMO within (10) calendar days, including all initially credentialed, derecredentialed, & denied recrededentialed practitioners with cause, in which case Network shall			7/1/2011	8/5/2011	

	Credentialing Activity Summary		Quarterly, due 15 calendar days after the end of the qtr.				7/9/2011	8/15/2011	
Claims files	Mutually agreed upon		Monthly- Refer to Claim Files noted above				N/A	N/A	
Provider Service Reports	Summary of inquiries grievances and appeals regarding delays in or nonpayment of claims including the status of each complaint		Monthly	Submitted as part of the monthly complaint, greivance & appeal			None	8/15/2011	
	Documentation (except for information deemed priveleged under STATE lay) of any inquireis qnd investigation of Network or any individual subcontracting physician or provider relateed top this agreements make by regulators agendcies and documentation of the final resolution of such investivation		Monthly				N/A	N/A	

Subcontractor Name
Corrective Action Plan Tracking Grid

Date	Issue	Action Taken	Resolution
7/1/2011	Encounters initial pass rate <99%	Subcontractor must meet standard with August 2011 submission or penalties will be imposed.	

Subcontractor		Jan	Feb	Mar	1st QTR	Apr	May	June	2nd QTR	July	Aug	Sep	3rd QTR	Oct	Nov	Dec	4th QTR	YTD
Calls Received																		
Calls Answered																		
Calls Abandoned																		
% Calls Abandoned	<5%																	
% Speed to Answer	>80% w/in 30 sec.																	
Speed to Answer (sec)																		
Average Hold Time (sec)																		
Blocked calls	<1%																	
Reports	By due date & accurate																	
Clean Claims (Paid)	97% w/in 15 Business Days																	
Reports	By due date & accurate																	
Number																		
Bundled																		
Individual																		
Timely resolution	% resolved in 30 days																	
Urban Meeting Access	1 w/in 30 miles																	
Rural Meeting Access	1 w/in 45 miles																	
Reports	By due date & accurate																	
Number of Applications Received																		
Number of Applications Pending																		
Number of Applications Denied																		
Number of Applications Approved																		
Average Number of days to Credential																		
Reports	By due date & accurate																	
Reports	By due date & accurate																	
98% acceptance rate; eff May 2010, 99%	File Accepted																	
Corrective Action Plan																		

GRANITE STATE HEALTH PLAN

Proposal Narrative, Project Approach and Technical Response

6.6 Description of Organization

GRANITE STATE HEALTH PLAN

6.6 DESCRIPTION OF ORGANIZATION

Bidders must include in their Proposal a summary of their company's organization, management and history and how the organization's experience demonstrates the ability to meet the requirements of this RFP.

- *At a minimum respond to:*
- *General Company Overview*
- *Ownership and Subsidiaries*
- *Company Background and Primary Lines of Business*
- *Number of Employees*
- *Headquarters and Satellite Locations*
- *Current Project commitments*
- *Major Government and Private Sector Clients*
- *Mission Statement*
- *This section must include information on:*
  - *The programs and activities of the organization*
  - *The number of people served*
  - *Programmatic accomplishments*
- *And also include:*
  - *Reasons why the organization is capable to effectively complete the services outlined in the RFP;*
  - *All strengths that are considered an asset to the program*
- *The Bidder should demonstrate:*
  - *The length, depth, and applicability of all prior experience in providing requested services;*
  - *The skill and experience of staff and the length, depth and applicability of all prior experience in providing the requested services*

GENERAL COMPANY OVERVIEW

Granite State Health Plan is a wholly owned subsidiary of Centene Corporation. Centene health plans operate on the core philosophy that quality health care is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive health care services to our members. Centene's Managed Care Programs operate in two segments: Medicaid Managed Care and Specialty Services. Centene's Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care, Long Term Care, and subsidized and commercial health insurance for uninsured and Medicare enrollees (the latter through Special Needs Plans). Centene Specialty Services include pharmacy benefits management, vision care, behavioral health, life and health management, a 24/7 nurse advice line, and medication treatment compliance. Through the specialty division, Centene offers the whole package for integrating health care solutions that address the often complex needs of Medicaid members.

GRANITE STATE HEALTH PLAN

Centene has **27 years of experience** in Medicaid managed care programs for low-income populations, and currently serves over **1.6 million members** in full-risk managed care programs in 12 states: Arizona, Florida, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Mississippi, Ohio, South Carolina, Texas and Wisconsin. Our Louisiana affiliate was recently awarded a contract to begin a full-risk managed care program in Louisiana in the first quarter of 2012. Centene operates Medicare Special Needs Plans in Arizona, Georgia, Ohio, Texas and Wisconsin.

Centene has experience serving many **different Medicaid populations**, including TANF/CHIP, ABD, and Foster Care populations like those in the Medicaid Care Management Program. See the table below for a list of all services and populations by State. Centene health plans excel at serving members with special healthcare needs, we believe that through our programs and support services we truly make a difference in our members' lives. **Nine of GSHP's affiliated health plans (AZ, FL, IL, KY, MS, OH, SC, TX and WI) provide services to approximately 223,000 SSI/ABD members with over 45,000 of those members part of the dually eligible population, increasing to 10 with our 2012 Louisiana implementation. We also operate managed long term care programs in Arizona, Florida and Texas.**

Providing **Medicaid Managed Care Services** and **Health Care** for the **Uninsured** and **Underinsured** is Our **Only** Focus

Our Texas affiliate has served people with disabilities in various regions since 2007 and recently was awarded a contract in the Dallas Service Area that covers an additional 17,000 ABD enrollees. Our Texas affiliate also manages care for over 34,000 children in Foster Care. Our Massachusetts affiliate became the first new Massachusetts health plan in over two decades when it was awarded a contract by the Commonwealth Care program, a publicly subsidized health insurance program serving approximately 150,000 low-income (up to 300% of FPL) working adults who are not eligible for Medicaid and lack access to employer-sponsored insurance.

Our managed care model uses integrated programs that can be delivered effectively only by a local staff, resulting in meaningful job creation within the communities we serve, and because our staff is local, Centene's health plans have a strong connection with the communities they serve. This approach to managing health plans ensures that members, providers, state agencies and community resource agencies are able to partner with trusted individuals from their communities and that our stakeholders have direct access to local, accountable health plan staff.

Our parent company, Centene, has more experience in the past five years partnering with states to transition from fee-for-service to managed care than any other managed care organization. From our approach partnering with local providers to our local operations – Centene's and GSHPs commitment to locally delivered healthcare is unparalleled. Through our 27 years of operations we have been able to take national best practices but yet locally implement to meet the specific needs of Medicaid recipients in New Hampshire.

GRANITE STATE HEALTH PLAN

Table 1: List of Centene Services and Populations by State

Government Solutions	AR	AZ	FL	GA	IL	IN	KS	KY	LA	MA	MS	MT	OH	SC	TX	WI
TANF		•	•	•		•		•	•				•	•	•	•
CHIP		•		•		•		•	•				•	•	•	•
ABD (Non-Dual)		•	•		•			•	•		•		•	•	•	•
ABD (Dually Eligible)		•	•					•							•	•
Long-Term Care		•	•												•	
Foster Care								•	•		•				•	
Medicare Special Needs Plan		•		•									•		•	•
Other Subsidized Health Insurance Programs	•					•				•					•	
Specialty Health Solutions																
Pharmacy Benefits (US Script)		•	•	•	•	•	•	•		•	•		•	•	•	
Behavioral Health Management (Cenpatico)		•	•	•	•	•	•	•		•			•		•	•
Life & Health Management (Nurtur)		•	•	•		•			•	•	•		•	•		•
Managed Vision (OptiCare)		•	•	•	•	•		•	•	•	•		•	•	•	•
Telehealth (NurseWise)		•	•	•												

[1] OH and TX are carving the pharmacy benefit into the managed care programs in October 2011 and March 2012, respectively.

Partnership with Bi-State Primary Care Association. Granite State Health Plan and Bi-State Primary Care Association have formed a unique partnership to enhance the delivery of care to Medicaid members in the State of New Hampshire. We will develop on-site care management capabilities to assist members in meeting their healthcare needs. GSHP will co-locate care managers from our Integrated Care Teams on-site at three FQHC sites: Coos County Family Health Services, Avis Goodwin Community Health Center and Lamprey Health Care. As we evaluate our membership including access needs and higher acuity populations, we also plan to expand into additional FQHCs and co-locating RN Care Mangers in certain CMHCs to facilitate access for members with physical health needs. We will provide support enabling Bi-State to increase access to care by recruiting additional providers enhancing their ability to serve additional Medicaid recipients healthcare needs including access to social services, community outreach and support services. We will work with Bi-State to target the barriers to accessing care and will collaborate with them to provide solutions; Bi-State will have two board members on the GSHP Board of Directors as well as participation on our Quality Committees ensuring feedback and opportunities to improve the quality of care and access to care for our Medicaid members. ***Bi-State currently provides primary care to approximately 20,000 New Hampshire Medicaid recipients, this partnership is intended to work toward doubling the capacity of Bi-State providers to allow increased access to care in New Hampshire. This partnership is not intended solely to address the needs of today but more importantly the needs of tomorrow.***

An **Integrated Approach** allows for a creative and flexible environment that ensures **members receive what they need, when they need it.**

Service Model. We believe that a locally based integrated care model is the most effective way to coordinate care. All Centene Health Plans, including Granite State health plan, will have locally based

Integrated Care Teams which include an RN Care Manager, Behavioral Health Clinician, Social Worker and Health Coach co-located and working together as a team to provide holistic care management services for the member including physical, behavioral and social supports. We also have MemberConnections Representatives (MCRs) at the health plans to support the integrated care teams. MCRs are health outreach workers hired from within the communities they serve – because of this they understand the barriers that can prevent people from accessing healthcare, such as geographical barriers and weather related issues that can make transportation and access to primary care and specialists extremely difficult. MCRs make home visits to members when we are unable to contact them by phone, they participate in health fairs and outreach activities and provide the "Connection" to community resources and social support services for the member. Because we understand and have the experience delivering care to members with special healthcare needs, we have also created a Special Healthcare Needs Connections Representative (SHNCR). This person will provide another level of expertise to "Connect" those members and/or their caregivers to community support services specific to members with disabilities, allowing the caregiver to spend quality time with the member rather than trying to navigate the healthcare system. The integrated care teams will co-locate care managers in several of the FQHC sites of our provider partner Bi-State Primary Care Association. These care managers will be there to deliver an additional layer of support for the FQHCs and enhance the care already being provided to patients. GSHP will facilitate coordination among the Health Home, other providers and members by encouraging use of our On-Line Clinical Portal and Member Health Record as a shared source of health visit, immunization, prescription drug and other historical member data.

> The goal of our care management program is to **Facilitate Access** to and **Coordinate Services** to assist the member/family in maximizing outcomes, and achieving goals, independence, and improved quality of life.

THE GRANITE STATE HEALTH PLAN DIFFERENCE

- Our **enterprise approach**, whereby GSHP will subcontract with other Centene subsidiaries for key Care Management functions, reduces fragmentation. We will internally provide care management and care coordination for physical and behavioral health needs, disease management, pharmacy supports, 24/7 nurse advice services, traditional managed care, and telemonitoring as one entity with a single, centrally-located care plan and record of services. Right time right place right care
- Right time right place right care Focus on compliance through Care Mgmt through proper utilization and better outcomes – proper settings to ensure better outcomes and healthier populations
- Centene takes great care in developing provider networks that are organically grown and locally nurtured. As one of the nation's largest and most experienced Medicaid managed care organization for state sponsored Medicaid managed care programs, Centene has helped all of its 13 state clients to successfully transition either all or part of their Medicaid populations from fee-for-service to managed care or from another health plan to ours. Our successful track record stems from our

commitment to supporting local providers and building on existing local programs for each of our state clients as we work together to serve our nation's poorest and most vulnerable citizens. Medicaid providers have provided more than health care services to Medicaid members – they have performed a public service for the entire community and deserve our support. Unlike commercial carriers that tend to use a "one size fits all" approach to network development, Centene recognizes that special needs populations require a customized network that is experienced and willing to provide quality care to our members. Therefore, **we first seek to build our provider networks from the ground up – at a local level - with traditional Medicaid providers as the foundation of our program.**

- Our on-the-ground, **locally-based call center, community outreach workers, Care Managers, and hospital based discharge nurses** ensure each member is supported by people who know and understand the local culture and available community resources. Centene health plans grow from the ground up, from within the communities we serve, and in **collaboration with our FQHC partners** and other community providers who already know and serve our members. Through our relationship with Bi-State Primary Care Association and our local staffing model, we will bring together the best of both worlds: national experience and local perspective.
- **Our approach to care** - holistic and functional rather than diagnosis-driven. Each member will receive the education and support they need to self-manage their special healthcare needs and chronic conditions, as well as make decisions about their care plan and delivery of care.
- Our unique **integrated model** will address physical, behavioral, functional, social and other needs, preventing the service gaps and duplication that members experience under the traditional 'silo' approach to care. Our integration approach extends beyond the structure of our Integrated Care Teams to locating Care Managers onsite at Bi-State affiliated FQHCs and other high-volume provider locations including CMHCs.
- **Supporting Providers** and reducing the "hassle" of managed care by asking for the lowest level of required authorizations possible, accepting out of network care episodes, reducing no-shows by facilitating transportation, arranging specialist appointments, offering electronic interfaces, and identifying enrollee needs prior to the treatment visit.
- **Information Technology To Power DHHS' Medicaid Managed Care Program.** Our enterprise scale, multi-functional, interoperable and integrated Management Information System (MIS) has the proven capability to serve New Hampshire's program, and is a competitive distinction in the US Managed Medicaid market, supplying the technology infrastructure necessary for collaborative, accountable, transparent and coordinated care - delivered at ever improving quality and lowered cost. Our MIS will enable GSHP to quickly move from ***information*** to ***insight*** to ***actionable impact,*** providing a seamless *flow of data* across GSHP, providers, members and DHHS - from

Ranked 22nd Across All Industries in Information Week's

2011 500 Most Innovative Business Technology Organizations – and we were the ***top*** Managed Care company on that list.

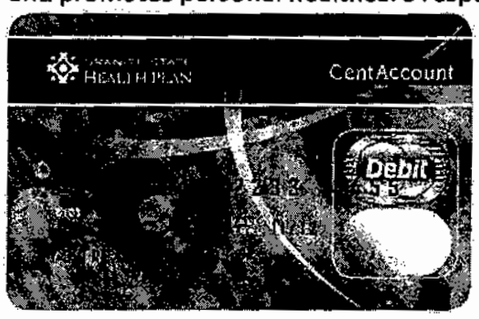
source all the way through to our award winning Centelligence™ data integration, decision support, predictive modeling and informatics platform. Reflecting the mission and 25+ years' experience of Centene our MIS is focused **solely** on state and federally funded public sector managed care programs in the service of over 1.6 million Americans today across 13 states. This necessarily means that our MIS is engineered for secure, efficient, yet flexible interoperability (in place today) with our State Medicaid clients - as well as ancillary State Agencies such as those responsible for children and families, education, and judicial oversight. Our MIS is designed to accommodate the unique *provider collaboration* and widely varying provider support needs endemic in public sector medical and behavioral health plans, with features such as multiple methods to support electronic or efficient paper claims submission and payment (electronic or paper) specifically designed for public sector providers, secure web based administrative and clinical tools for eligibility inquiry, authorization submission & inquiry, claim status inquiry, online care gap notification and clinical tools for the Medical and Health Home provider community. Through Centene's methodical approach to Service Oriented Architecture (SOA) we incorporate (and continually assess) "best of breed" software components to enable the best possible integrated medical and behavioral public sector MIS platform; with industry leading functional support for the unique needs of provider network management; claims and encounter processing; healthcare analytics, reporting, and predictive modeling; and member, caregiver, and provider service support. Underlying this "layer" of functional software is a redundant, highly available hardware, telecommunications, and system software foundation designed to deliver scalable, reliable, and responsive information support; with full adherence to HIPAA compliant transaction integrity and security , as well as management controls for Sarbanes-Oxley (SOX) and SAS-70 auditability and transparency. Perhaps most important, Centene and GSHP bring the experience of over 275 Information Technology (IT) professionals with the kind of day-to-day operational experience in public sector medical and behavioral health support invaluable to a statewide program such as DHHS'. The Information Technology industry has continually recognized Centene's investment and focus on our compelling use of IT, and (most recently), we ranked 22nd across all industries in Information Week's **2011 500 Most Innovative Business Technology Organizations** – and we were the ***top*** Managed Care company on that list.

- **Engaging Stakeholders Early and Often.** We engage members, families/caregivers in care and how we provide services by including members in treatment planning and seeking input from members and advocates in such areas as enrollee materials, staff training and network development. GSHP has met with advocacy organizations such as Community Support Network, Inc., Granite State Independent Living and Easter Seals Disability Services and provider groups such as Bi-State Primary Care Association with whom we have formed a collaborative partnership – we find it critical to obtain immediate and ongoing support from these types of organizations and engage them early and often. CSNI, Easter Seals and the Council on Community Transportation have expressed interest in participating on our Community Advisory Committee. We have already appointed three board members to the Granite State Health Plan Board of Directors: Donald L. Shumway, Crotched Mountain President & CEO, Lori Real, COO for Bi-State and Janet Atkins, Executive Director of Goodwin Community Health. Our provider partner Bi-State Primary Care Association will also actively participate on our Quality Committees; **Lori Real, COO for Bi-State and**

Janet Atkins, Executive Director of Goodwin Community Health will sit on our Board of Directors. Dr. Robert Slocum and Chris Heatherton M.D. will participate on the Quality Improvement Committee, Paul Friedrichs, M.D. will sit on the Pharmacy & Therapeutics Committee, Ed George from Manchester Community Health Center will sit on our Peer Review Committee and we will have Dr. Jennifer Koop and Frederick S. Kelsey, M.D., F.A.C.P. participating on our Provider Advisory Committee.

INNOVATIVE PROGRAMS

CentAccount. The CentAccount™ member incentive program is widely used by Centene health plans and promotes personal healthcare responsibility and ownership by offering financial incentives that



are valued and appreciated by health care consumers. Rewarding members for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement. Eligible members can earn rewards for completing annual preventive health visits; and completing other recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. The reward is loaded onto a Granite State Health Plan -issued CentAccount MasterCard® debit card. Members can use this card at many merchants they already use daily, such as Walgreens, CVS, Rite-Aid, Shaws, Hannaford, Price Chopper, Demoulas, Market Basket, Stop & Shop and Wal-Mart, and other stores throughout the State to buy a wide variety of health-related items, to buy a wide variety of health-related items including some over-the-counter medications. Members may use the funds on their CentAccount cards towards health care goods and services not covered by Medicaid as well as pay for childcare, utilities, transportation and baby items.

Fluvention Program. This annual campaign, offered at each of Centene's health plans, is available for all members and also provides targeted outreach to high-risk members. The program provides information about preventing the transmission of the influenza virus

by encouraging members to get the seasonal influenza vaccines and taking everyday precautions to prevent illness as well as information about what to do if a LHC member (or family member) becomes ill. Our integrated communications approach includes direct mail, phone calls, providing information via health plan websites, posting information in provider offices and pharmacies, and collaboration with community groups to host events where flu prevention information is provided. For example, in an effort to reach as many unique community locations as possible, our Indiana affiliate health plan created a contest where staff were rewarded for most team member participation in distribution of Fluvention materials and for delivering materials outside contiguous counties. As a result, we were able to distribute materials to 92 different sites, including laundromats and a Hispanic grocery store. Centene health plans also conduct general community awareness through public service announcements on television and radio. During 2009, we targeted education efforts related to health hygiene, preventative care and the benefits of obtaining appropriate care of their condition, for groups

that are at higher-risk for contracting the H1N1 influenza virus, including pregnant women, children from six months old up to 24-year-old adults, as well as adults with chronic health conditions. Incentives in the form of gift cards were given to members who received both flu vaccines.

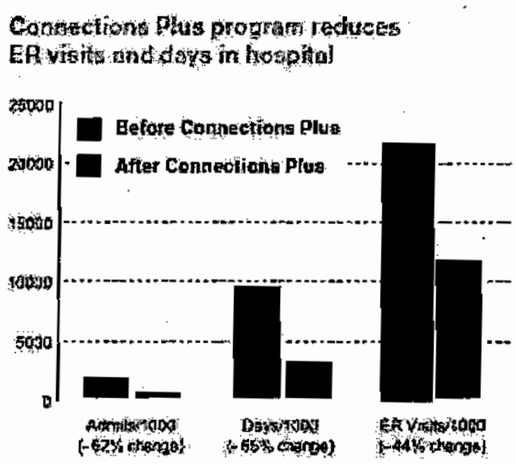
Telemedicine and Telehealth. Centene's health plans excel at delivering quality health care in rural markets. Part of what makes us successful is our willingness and ability to develop telemedicine networks in largely underserved areas. Our affiliate health plan in Texas, for example, provides covered services to members in 170 rural counties across the state where access to PCP services is limited. In Texas, Centene collaborates with Teladoc Inc. (Teladoc), the nation's first and largest telemedicine provider, to provide 24/7 telephone or video access to board certified physicians in situations where our members are unable to reach their medical home providers. Our experience in Texas has shown that telemedicine reduces overall emergency room and hospital readmission rates, and increases member compliance with care protocols. For our members living in the most remote regions of New Hampshire, where access to health care is difficult for everyone (not just Medicaid members), we will contract with Teladoc to implement telemedicine and telehealth programs in order to augment members' ability to receive timely and quality health care services. Currently, our members access telemedicine services via our 24/7 nurse response team (NurseWise) where they are triaged and screened to ensure appropriate contact and coordination with their PCP was first attempted. Where appropriate, this intervention guides the member back to their medical home for timely medical care. If the member's PCP cannot be reached, our nurse response representative will stay on the line with the member while connecting them to Teladoc. A Teladoc "visit" includes medical history and telephonic consultation conducted by a board certified physician and can include prescription of medication if necessary. The consultation is always scheduled to occur within 30 minutes from the time the member's health history information is submitted to the consulting physician contacting the member. We look forward to collaborating with DHHS and local providers in this endeavor, which we believe is an effective way to resolve access to care issues that can be challenging in rural areas. We have obtained a Letter of Commitment from Teladoc and describe their organization and services in Section 3.20 the subcontractor section of this RFP.

In-home Telemonitoring. GSHP will provide telemonitoring services to the highest-risk members (with multiple co-morbidities), for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. This patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level or a diabetic or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the member's case manger and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the case manager, trigger an Interactive Voice Response phone call to the

80% Reduction in Readmissions for Members Receiving Telemonitoring Services in 2010

member, and/or alert other members of the ICT or the member's provider. The technology is entirely web-enabled; all members are provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at anytime, as long as they have access to the Internet. The technology represents a quantum leap forward – and sets Granite State Health Plan apart as having the only device-agnostic, real-time biometric monitoring capability among its competitors. Three other Centene health plans have already implemented this program and initial data indicates that it is impacting health outcomes for members. **GSHP Arizona affiliate Bridgeway Health Solutions, realized an 80% reduction in readmissions for members receiving telemonitoring services in 2010.**

Connections Plus®. All Centene affiliates have implemented our Connections Plus® Program, which provides pre-programmed cell phones to our high-risk members who lack reliable phone access. This innovative program provides 24-hour instant access for our members, allowing them to make calls to and receive calls from their providers, case managers (including behavioral health case managers), GSHP staff, NurseWise, and 911. The overall objective of the program is a reduction in preventable adverse events such as inappropriate ER use or hospital admissions through improved access to health care information and treating providers. High-risk members receive a cell phone (at no expense to the member) that has pre-programmed direct dial to the member's PCP or other treating provider, Care Manager, NurseWise (our 24/7 nurse advice line), and 911. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The cell phones are also used so that care managers can send the member a text message with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members. As part of the program, Centene health plans also provide members MP3 players loaded with podcasts in Spanish and English, relevant to member condition.



The podcasts are also available for members to download from the website. Examples of podcast topics include diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches, healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives. This program received ***URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award*** and was awarded the ***2011 Medicaid Health Plans of America (MHPA) Technology Award***

Start Smart for Your Baby®: Start Smart for Your Baby (Start Smart) promotes education and communication between pregnant members and their care managers to ensure a healthy pregnancy and first year of life for their

Start Smart for Your Baby™

babies. Start Smart offers a range of care management techniques, including health screenings, educational literature and MP3 players with educational podcasts designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well child visits.

The **Start Smart® Baby Shower Program** is designed to educate pregnant members about prenatal and postpartum care for themselves and their newborn. The "Baby Showers" occur once per quarter. "Baby Showers" are conducted in a class environment by health plan staff. Led by a registered nurse and assisted by MemberConnections, the classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a review of the Granite State Health Plan Start Smart® and MemberConnections programs. Upon completion of the class, participants have the option to take part in a raffle. The winner of the raffle will receive a basic infant car seat. Granite State HP will provide new mothers with a diaper bag and starter supply of diapers upon completion of an educational-based Start Smart® Baby Shower class.

$14 million

Savings due to lower NICU costs in 2010

Puff-free Pregnancy. Studies show that pregnant Medicaid women are 2.5 times more likely to smoke than those not on Medicaid[22] and pregnant smokers are 1.5 to 3.5 times more likely to have a low birth weight baby.[23] Studies also show that quitting by the 1st trimester results in infant weight and body measurements comparable to infants of nonsmokers.[24] Members enrolled in this program receive written materials that provide education about the risks associated with smoking during pregnancy and information about strategies for quitting. They also receive telephonic coaching from a certified Tobacco Treatment Specialist and are able to call in to speak to one of these specialists when they feel they need additional support.

Puff Free Pregnancy

START SMART for Your Health: Start Smart for Your Health™ is a medical management program designed to help members manage a series of health conditions. The program provides members with tools to empower them to be active participants in their healthcare team including wellness programs, educational information and access to care management. The objective of the Start Smart for Your Health program is to increase the quality of life and reduce the need to access the healthcare system for complications from the condition. Drawing on our collective nursing resources, medical expertise,

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[22] *Lipscomb LE, Johnson CH, et al. PRAMS 1998 Surveillance Report. Atlanta: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion,CDC,2000.*

[23] *Pollack,H, "Sudden Infant Death Syndrome, Maternal Smoking During Pregnancy, and the Cost-Effectivesness of Smoking Cessation Intervention,: American Journal of Public Health (91(3):432-36, March 2001*

[24] *US Dept Health and Human Services. Women and Smoking: a Report of the Surgeon General.2001*

quality initiatives and experience understanding the needs of our Enrollees, the program will return value to our Enrollees, provider networks, state governments and shareholders.

Centene's Start Smart for your Health Program also identifies regional community health education needs, improves outreach and communication with the health plan and community-based organization members, and actively promotes healthy lifestyles such as disease prevention and health promotion. The Healthy Lifestyles Program includes the following:

- ***Healthy Schools/ Adopt a School Program:*** Health plan staff visit local schools to promote our childhood obesity program, which includes a Thumbs Up Johnnie book about healthy eating and reading from its author and visit from Thumbs Up Johnnie himself, and other information and outreach geared at reducing childhood obesity.
- ***Kids Club/ Childhood Obesity Program.*** Centene health plans are working to raise awareness with their members and the communities they serve concerning the dangers of childhood obesity. The Kids' Club educates child members on a variety of health topics, but focuses heavily on obesity prevention. Health plans outreach to children directly through newsletters, contests (such as healthy recipe contests) and other events. We use "Thumbs Up Johnnie", a child-friendly, nationally recognized character to help educate children about fighting obesity and preventing the spread of germs through proper hand washing. Thumbs Up Johnnie will visit schools as part of the "Adopt a School" program to read, "Super CENTEAM 5, The Adventures of Thumbs Up Johnnie". Students receive copies of the book, character-themed bracelets and take part in pre/post presentation tests about healthy eating habits and proper hand washing. Teachers who turn in their post-presentation tests receive a set of Thumbs Up Johnnie books for their classroom and bookmarks for their students. The Thumbs Up Johnnie series is a valuable tool to teach children about making healthy choices.
- ***Healthy Homes:*** This initiative assists individuals who live in low-income or public housing to identify and address health hazards in the home, such as lead and use of coal. Potential neighborhoods in New Hampshire that may benefit from this program include the Manchester area, which is known for issues with lead-contaminated homes.

Health Check Health Days. Health Check Health Days (HCHD) are preventive health check-up programs for GSHP members. At these events, GSHP will partner with provider offices and our partner Bi-State Primary Care Association sites across New Hampshire to identify members who have missed certain preventive care visits. GSHP staff then outreach to the member to encourage them to make an appointment for the needed service on a certain day set aside by the practice. GSHP outreach staff are at the providers' offices on these days to reinforce the importance of preventive care and answer questions about the member's health plan benefits. GSHP plans to focus on HCHDs for well-child/EPSDT visits, mammography screenings, immunizations, and diabetic screenings.

Video Pilot for Members with Obesity. In addition, GSHP will be a pilot site for a new Centene initiative, developed in partnership with the *Microsoft Corporation,* to address obesity. In consultation with the PCP, member, and parent/legal guardian (if applicable), we will invite select members in care management to participate in a personalized exercise program. The program location (which may be a community site such as a Bi-State FQHC partner, or in some cases, a member's home) will be equipped with a combination of Microsoft's Kinect intelligent video system, Xbox console, and Lync Server unified communications software. Each Kinect/Xbox system will include exercise program software designed to complement the enrollee's dietary and exercise regimen. Kinect measures the member's "visual vitals" to calibrate the program, and displays and tracks calories burned during the session against pre-set goals. A virtual coach will provide positive reinforcement messages based on the member's exercise activities. In addition, the member (or caregiver/parent) can initiate or receive video conferencing requests with or from the Care Manager.

We will phase in additional functions and capabilities as we prove the logistical soundness and usability of this compelling technology, such as the customized use of Microsoft's Xbox Points incentive program which provides reward points for meeting exercise goals. Xbox Points may be used to download movies, music and/or additional Kinect/Xbox games.

Transitioning Youths Programs. Recognizing that youths who "age out" of foster care lack the supports of most teens, Cenpatico, our behavioral health affiliate has developed several programs to assist in their transition: Transitioning Youth Service Management - A dedicated a service manager serves this population as the Transitioning Youth Service Manager. Cenpatico identifies youths ages 17 and older and outreachs to the foster families, and through them, the youth, to discuss their needs. Their goal is to answer any questions about medications or mental health issues - things these youths would need to know once they leave care. Through this program, Cenpatico is part of the larger initiative that works with youths as they age out; bringing the behavioral health perspective to the table.

AWARDS

Centene programs have garnered recognition for innovation, comprehensiveness and improved outcomes. Listed here are examples of the recent acknowledgement of some of our efforts.

Start Smart For Your Baby®

- 2010 URAC/GKEN International Health Promotion Award: Start Smart - Winner
- 2010 URAC Best Practice: Start Smart – Consumer Health Improvement category - Platinum Award
- 2010 National Health Information Award: Start Smart For Your Baby - Your Pregnancy Guide - Silver Medal
- 2010 Web Health Award: Start Smart For Your Baby audio book: webcast audio category - Gold Award Winner
- 2010 Web Health Award: Start Smart For Your Baby podcasts: webcast audio category - Merit Award Winner
- 2010 Case-in-Point Magazine : Start Smart For Your Baby - Honorable mention for Women and Children's Case Management; Honorable Mention for Best Overall Case Management Program

- 2009 NCQA Best Practice: Start Smart for Your Baby

Start Smart – 17P

- 2010 Case-in-Point Magazine: 17P – National Winner for Women and Children's Case Management
- 2008 Ohio Association of Health Plans Pinnacle Award for Best Practices: 17P

Asthma

- 2011 EPA National Environmental Leadership Award in Asthma Management
- 2010 National Health Information Award: "Adventures from Puffletown" (childhood asthma book) - Silver Medal

Case Management

- 2011 Case-in-Point Magazine : Peach State Health Plan's Pain Medication Management - Platinum Award

Nurse Response

- 2011 Case-in-Point Magazine: NurseWise Rapid Response Program - Platinum Award
- 2010 Case-in-Point Magazine: NurseResponse Treatment Adherence program - Platinum Award

Connections Plus

- 2011 Medicaid Health Plans of America (MHPA) Best Practice: Technology Award
- 2010 Case-in-Point Magazine: Connections Plus - Honorable Mention
- 2009 URAC Silver Award for Best Practice: Connections Plus - Health Management category
- 2008 NCQA Best Practice (via UHP health plan accreditation): Connections Plus

Synagis

- 2011 Case-in-Point Magazine: Centene Synagis® Success - Platinum Award

Information Technology

- Our MIS and supporting IT organization have been recognized with several significant awards: most recently **we ranked 22nd in Information Week's 2011 500 Most Innovative Business Technology Organizations** – and we were the top Managed Care company on that list.
- In May 2011, Nurtur was awarded a prestigious Silver Award from the 13th Annual Web Health Awards(SM) within the Category Portal/Gateway Site in recognition of their high-quality electronic health information.
- Centene's IT department earned the 2010 Business Innovation Award at the Gateway to Innovation conference for its desktop executive dashboard

Multiple Award Winner

- 2010-2011 Medicaid Health Plans of America (MHPA) Best Practices Compendium:
  - Connections Plus
  - Generic Drug Fill Rates
  - NurseResponse Treatment Adherence Support Program
  - Nurtur Asthma program
  - Physician Summit Awards
  - Start Smart 17P Program
  - Start Smart Notification of Pregnancy

- Synagis
- Texas Health Passport Impact on Foster Care Children
- Thumbs Up Johnnie Health Initiative for Children

COMMUNITY INVOLVEMENT

We have a strong track record of community involvement. Since Centene's beginnings as a Community Health Center, the company has operated according to the fundamental principle that successful health and social services organizations must be active members of the community. Further, it is not good enough to come into an area simply to arrange services. **Centene health plans hire local staff from within the communities we serve**, who know our members, speak their languages, and are able to facilitate services in a culturally sensitive manner. As we interact with community organizations we teach each other and work together to find solutions to problems, creating a multiplier effect and our joint efforts will be more beneficial to the people we serve than the efforts of any single organization on its own. Through community involvement, GSHP will be able to effectively locate resources in the community and coordinate them with covered services to deliver a seamless package of care that meets the full range of an individual's needs, thus enabling choice in the delivery of services and a voice in living independently in the community. We not only become aware of these resources, but become active partners with many organizations, through participation in community events and sponsorships of associations that provide advocacy and services for our members. Below are some examples of our Community Involvement and Sponsorship:

Georgia – Peach State Health Plan

- Peach State Health Plan employees partner with the March of Dimes to make a difference in the lives of premature babies by participating in the annual March for Babies walk in Atlanta's Centennial Olympic Park. In addition Peach State employees donate more than $10,000 to the March of Dimes for Babies Campaign.
- Peach State Health Plan sponsored the Big Brothers Big Sisters of Metro Atlanta (BBBSMA), the area's leading youth mentoring organization, 2011 Big & Little Picnic. Peach State Health Plan donated $100,000 Columbus Regional Healthcare System and The Medical Center to address the shortage of pediatric physicians in Muscogee County and surrounding areas. The funds will be used to help establish a medical practice that will increase access to primary and pediatric care, primarily for those enrolled in the Medicaid program in the Columbus area.

Indiana - Managed Health Services

- In 2008, MHS hosted members who had completed their well child or well baby visits to a Gary Southshore Railcats game. Tickets and transportation were free, young members were given school supplies in backpacks, and MHS members and the general public were treated to free health screens like hearing, blood pressure and blood sugar tests (conducted in partnership with a local FQHC).
- In 2009, when the unemployment rate in Elkhart County skyrocketed, MHS contacted the county health department, local charities, and local churches in order to provide much needed financial sponsorship and, just as important, personnel to coordinate and staff health

screenings and health education events. One of these health events attracted more than 400 participants, a clear indication of real need which MHS filled in the right place at the right time.

- MHS employees are encouraged to work as volunteers with not-for-profit community-based organizations to help them achieve their goals. Employees serve in leadership positions, on committees, and as trustees to at least 38 different organizations as diverse as Special Olympics, Prevent Blindness of Indiana, Covering Kids and Families of Indiana and Project Home Indy. Beyond this, MHS encourages staff to get involved in the community through service-based team building events such as our day-long sponsorship of a Habitat for humanity "build" held in the fall of 2009 on the Southside of Indianapolis.

Texas – Superior HealthPlan

- The Austin Provider Relations team volunteered at the Angel House Soup Kitchen in September 2012. They helped prepare everything and then took their time to serve those who are less fortunate. They served over 300 people and will volunteer on a quarterly basis.

National Community Partnerships

- **Special Olympics-** Centene's donation to the Special Olympics in 2011 will assist in the construction of the first-ever training facility in Columbia, MO.
- **March of Dimes-** Centene is a proud national supporter of the March of Dimes organization. Each year, numerous Centene employees participate in the annual walk and holds collection drives internally to send additional funds back to the organization.
- **United Way-** Centene is a proud leading donator to the United Way organization, which represent nearly 200 local agencies working in the St. Louis community and thousands more nationwide. Through the combined efforts of Centene's charitable giving efforts and the personal pledges of its employees, Centene continues to increase its annual donation back to the organization.
- **Joplin Disaster Relief-** Through the combined efforts of Centene employees, generous monetary and material donations were collected and distributed to the Joplin community after a tornado destroyed their town in May of 2011.
- **American Red Cross Blood Drive-** With blood shortages at an all-time high, Centene employees came out in full force in July of 2011 to donate when the American Red Cross came to their headquarters. The employee's blood units that were collected totaled out to 117 lives saved and because the drive was so successful, additional drives will be organized in the following year.
- **Starkloff Disability Institute** – Supported the Starkloff Disability Institute to conduct a survey among hiring managers and others with direct hiring authority for major employers in the St. Louis area to provide unique and invaluable insight into the attitudes and assumptions these professionals bring to the recruiting and hiring of people with disabilities. This study had two objectives: 1. to expand on existing research into the attitudes of people with hiring authority by exploring the attitudes of hiring managers for local companies, and 2. to identify solutions that would be effective in opening the hiring process to people with disabilities. The survey

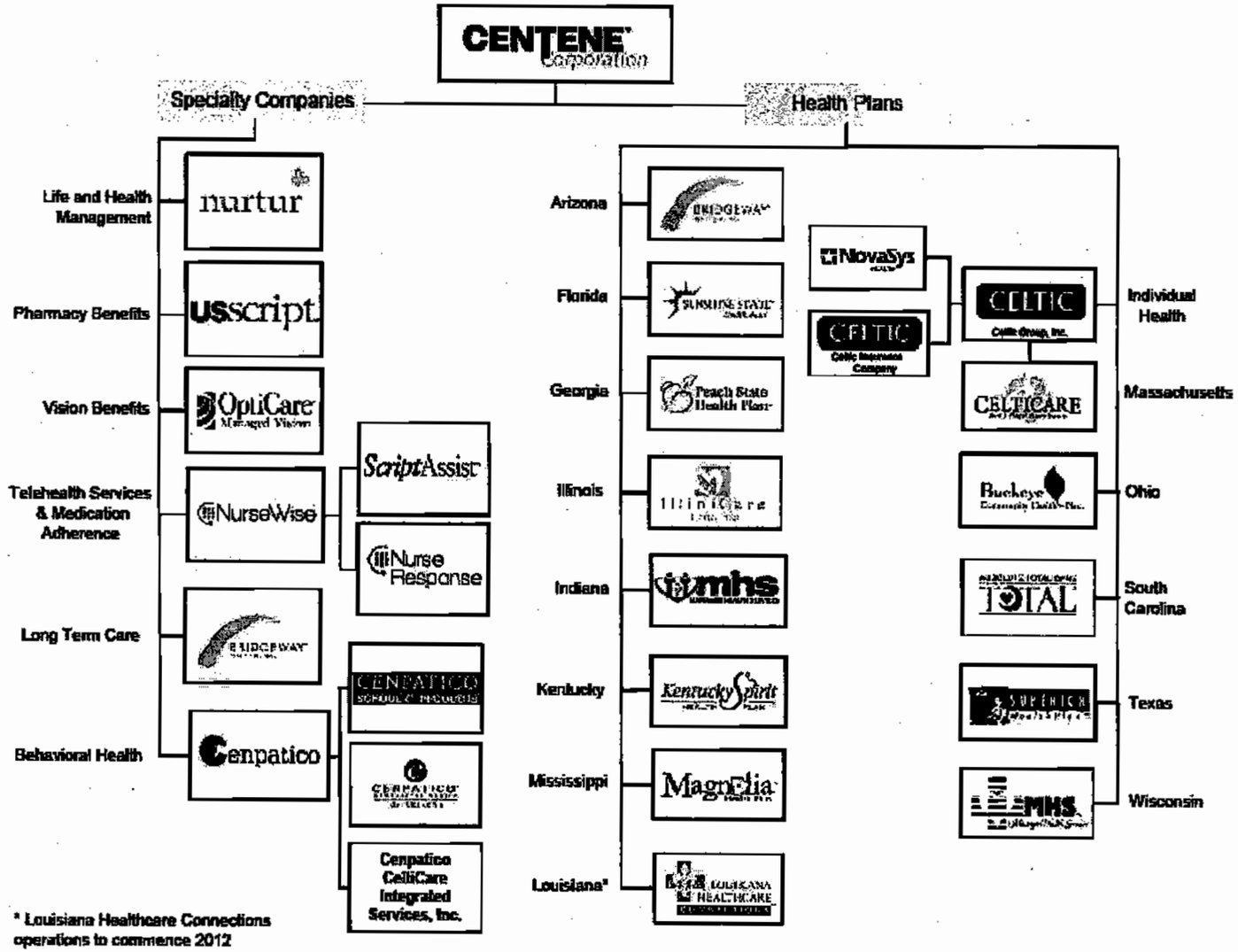
identified Issues Directly Related to Hiring Managers and Issues Beyond the Control of Hiring Managers and identified opportunities for improvement at all levels.

OWNERSHIP AND SUBSIDIARIES

Granite State Health Plan is a wholly owned subsidiary of Centene Corporation. Granite State Health Plan does not have any subsidiaries. We have included a list of Centene subsidiary health plans and specialty companies below.

6.6 DESCRIPTION OF ORGANIZATION

GRANITE STATE HEALTH PLAN



* Louisiana Healthcare Connections operations to commence 2012

COMPANY BACKGROUND AND PRIMARY LINES OF BUSINESS

Granite State Health Plan is a wholly owned subsidiary of Centene Corporation, formed for the sole purpose of providing Medicaid managed care services in the State of New Hampshire. Centene Corporation was founded as a single health plan in 1984 by Betty Brinn in Milwaukee, Wisconsin. Betty grew up poor, and spent her childhood years in and out of foster homes. Despite her humble beginnings, Betty established Centene upon the mission of "caring and service to others." Centene still operates under this philosophy today. Michael F. Neidorff, Chairman and Chief Executive Officer of Centene, joined the company in 1996 with the fundamental belief that every American is entitled to quality health care with dignity. He believed the company had the people, the experience and the approach to help states most effectively coordinate health care services for the underserved populations. Today, through a comprehensive portfolio of innovative solutions, we remain deeply committed to delivering results for our stakeholders: state governments, members, providers, uninsured individuals and families and community organizations. **More than 27 years ago we began serving Medicaid managed care recipients and we are still doing it today – it is what we know and what we do.**

Centene's primary lines of business operate in two segments – Medicaid Managed Care and Specialty Services. Centene's Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government-subsidized programs, including Temporary Assistance for Needy Families (TANF), the Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI)/Aged, Blind and Disabled (collectively ABD), Foster Care, Long Term Care, and subsidized and commercial health insurance for uninsured and Medicare enrollees (the latter through Special Needs Plans). Centene Specialty Services include pharmacy benefits management, vision care, behavioral health, life and health management, a 24/7 nurse advice line, and medication treatment compliance. Through the specialty division, Centene offers the whole package for integrating health care solutions that address the often complex needs of Medicaid members.

NUMBER OF EMPLOYEES, HEADQUARTERS AND SATELLITE LOCATIONS

As a newly formed corporation, Granite State Health Plan does not have employees. We discuss our hiring process and the activities underway more specifically in section 6.10 Staffing and Resumes. Granite State Health Plan will be headquartered in the Manchester/Concord area. Through our partnership with Bi-State Primary Care Association, we will have three satellite locations with our ICTs co-locating in the FQHC sites: Coos County Family Health Services in Berlin, Avis Goodwin Community Health Center in Somersworth and Lamprey Health Care in Nashua. Granite State Health Plan's parent company, Centene Corporation employees 1,500 employees at its headquarters and satellite offices. Please refer to the table below for a listing of satellite locations.

Centene Corporation Headquarters	7700 Forsyth Blvd.	Clayton	Missouri
Centene Corporation Satellite Office	16090 Swingley Ridge Road	Chesterfield	Missouri
Centene Corporation Data Center	6430 Weldon Springs Road	O'Fallon	Missouri
Centene Corporation Claims Facility	1 Centene Drive	Farmington	Missouri
Centene Corporation Claims Facility	2000 26th Street South	Great Falls	Montana
Centene Corporation Mail Distribution Center	1239 Hanley Industrial Court	Brentwood	Missouri

CURRENT PROJECT COMMITMENTS

Granite State Health Plan's parent company, Centene Corporation has the following implementation project commitments scheduled for 2012:

- Louisiana Healthcare Connections (Louisiana) – New Health Plan Implementation scheduled February 2012
- Superior HealthPlan (Texas) – Expansion scheduled for March 2012

MAJOR GOVERNMENT AND PRIVATE SECTOR CLIENTS

Please refer to tables below for a list of major government and private sector clients for Centene health plan subsidiaries including direct government clients of Cenpatico Behavioral Health, LLC.

Arizona	
a.	**Trade Name:** Bridgeway Health Solutions, LLC
b.	**Brief Description of the Scope of Work** • Acute Care: Full-risk managed care for Acute Care services for TANF, SCHIP and SSI/ABD members. Services provided include medical, pharmacy, emergency transportation, dental, and some optical. Behavioral health is carved-out for the Acute Care contract; however, Bridgeway provides coordination for those services. • LTSS: Full-risk long term managed care services for SSI/ABD members. Services include Home and Community-Based Services (HSBS), and institutional long term care services, medical, pharmacy, BH, emergency transportation, dental, and some optical.
c.	**Duration of the Contract** • Acute Care: October 2007 to September 2011; Two year renewal option • LTSS: October 2006 to October 2010; Renewed through September 30, 2012
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
Acute Care	17,695	17,552	17,339	14,900	N/A
LTSS	3,112	3,059	2,604	2,100	1,600

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, 24/7 Nurse Advice Line, and Transportation

Arizona	
a.	**Trade Name:** Bridgeway Health Solutions, LLC
b.	**Brief Description of the Scope of Work** SNP: Full-risk managed care services for SNP Full Dual Eligible members. Services provided include Medicare Part A, Part B, Part D (hospital, medical, pharmacy), dental and vision
c.	**Duration of the Contract** Jan. 2008 - present, renewed yearly, indefinitely
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SNP Full Dual Eligible	1,760	1,773	716	193	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, 24/7 Nurse Advice Line, and Transportation

GRANITE STATE HEALTH PLAN

Arizona	
a.	**Trade Name:** Cenpatico, LLC
b.	**Brief Description of the Scope of Work** Functions as a Regional Behavioral Health Authority providing a full continuum of mental health and substance abuse services, including inpatient, outpatient, step-down, and community mental health center services; as appropriate, service may be provided at home or in member's natural setting through community-based services
c.	**Duration of the Contract** July 2005 to June 2010; contract re-awarded with expansion July 2010 to June 2013 with renewals
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF and SCHIP, SSI/ABD, SMI and low-income uninsured	175,500	174,650	120,100	105,000	99,900

e.	**Annual Contract Payments**

Population	YTD 2011	2010	2009	2008	2007
TANF and SCHIP, SSI/ABD, SMI and low-income uninsured	$133.1 million	$124 million	$120.2 million	$113.1 million	$101.4 million

f.	**Subcontractor Role** Pharmacy and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Florida	
a.	**Trade Name:** Sunshine State Health Plan
b.	**Brief Description of the Scope of Work** Full-risk managed care services for TANF and SSI/ABD members. Services provided include medical, behavioral health including substance abuse, Long Term Services and Supports, pharmacy, dental, and vision.
c.	**Duration of the Contract** TANF/SSI: December 2008 to August 2012; renewable through the state's recertification process; Membership operations began in February 2009. LTSS: December 2010 to August 2011; option to renew the contract for up to three years.
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF and SSI	187,000	192,900	102,600	N/A	N/A
LTSS	1,800	2,000	N/A	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

Georgia	
a.	**Trade Name:** Peach State Health Plan, Inc.
b.	**Brief Description of the Scope of Work** Peach State Health Plan provides full-risk managed care services for TANF and SCHIP Members. Services provided include medical, behavioral health including substance abuse, dental, vision, and pharmacy.
c.	**Duration of the Contract** July 2005 to June 2010; renewable for two additional one-year terms; Membership coverage began in 2006.
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF and SCHIP	297,984	305,800	309,700	288,300	287,900

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Georgia	
a.	**Trade Name:** Peach State Health Plan, Inc.
b.	**Brief Description of the Scope of Work** SNP Full Dual Eligible: Full-risk managed care for SNP Full Dual Eligible Members. Services provided include Medicare Part A, Part B, Part D (hospital, medical, pharmacy).
c.	**Duration of the Contract** July 2005 to June 2010; renewable for two additional one-year terms; Membership coverage began in 2006. Jan. 2011 to renewed annually
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SNP Full Dual Eligibles	15	N/A	N/A	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management and 24/7 Nurse Advice Line

Illinois	
a.	**Trade Name:** IlliniCare Health Plan
b.	**Brief Description of the Scope of Work** IlliniCare provides full-risk managed care services for SSI/ABD members. Services provided include medical, behavioral health including substance abuse, dental, vision, and pharmacy.
c.	**Duration of the Contract** May 2011 to April 2016
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SSI/ABD	13,580[25]	N/A	N/A	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Vision, Disease Management, Pharmacy, Dental, Transportation, and 24/7 Nurse Advice Line

[25] Membership numbers are based on 10-Q as of October, 2011. IlliniCare enrollment began May 1, 2011.

Indiana

Trade Name:
Coordinated Care Corporation Indiana, Inc. d/b/a Managed Health Services

Brief Description of the Scope of Work
MHS IN provides full-risk managed care services for TANF and SCHIP members and the Healthy Indiana Plan (HIP) uninsured program. Services provided include medical, behavioral health, dental, vision, and pharmacy*
*Pharmacy was carved out effective 1/1/2010

Duration of the Contract
May 1995 to December 2010, optional extensions. Awarded new contract in June 2010 that included expansion of services to uninsured adults scheduled to run from January 2011 to December 2014 with two one year renewals.

Number of Members and Population Types

Population	YTD 2011	2010	2009	2008	2007
TANF and SCHIP, Uninsured adults	209,400	215,800	208,100	175,300	154,600

Subcontractor Role
Behavioral Health, Vision, Disease Management, and 24/7 Nurse Advice Line

Kansas

a. **Trade Name:**
Cenpatico, LLC

b. **Brief Description of the Scope of Work**
Full continuum of mental health, including inpatient, outpatient, step-down, and community mental health center services; as appropriate, service may be provided at home or in member's natural setting through community-based services.

c. **Duration of the Contract**
May 2006 - June 2012, renewal options (the renewal options have all been exercised, a new procurement is required).

d. **Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SCHIP, including CSHCN	45,900	36,020	37,900	41,100	39,000

e. **Subcontractor Role**
24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Kentucky	
a.	**Trade Name:** Kentucky Spirit Health Plan, Inc.
b.	**Brief Description of the Scope of Work** Full-risk managed care services for TANF, CHIP and SSI/ABD members. Services provided include medical, behavioral health including, pharmacy, dental, and vision.
c.	**Duration of the Contract** TANF/CHIP/ABD/SSI - Nov. 2011 – 2014; possibility of four additional one year periods
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF/CHIP/ABD/SSI	N/A[26]	N/A	N/A	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

[26] Membership based on 10-Q as of September 2011. Kentucky enrollment began in November 2011.

GRANITE STATE HEALTH PLAN

	Massachusetts
a.	**Trade Name:** CeltiCare Health Plan of Massachusetts, Inc.
b.	**Brief Description of the Scope of Work** • CommCare: A health insurance program for low-income, working adults (up to 300% of the Federal Poverty Level) who are not eligible for Medicaid or employer-sponsored insurance. Services provided include medical, behavioral health including substance abuse, dental, vision, and pharmacy. • CommCare Bridge: A true public/private partnership that provides comprehensive coverage to approximately 27,000 legal immigrants who were previously eligible for CommCare, but lost eligibility due to budgetary cutbacks effective September 1, 2009. Services provided include medical, behavioral health including substance abuse, and pharmacy.
c.	**Duration of the Contract** • CommCare: July 2009 to June 30, 2012; Renewable through the state's recertification process • CommCare Bridge: October 2009 to June 30, 2012; Renewable through the state's recertification process
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
CommCare: Low-Income, Working Adults	19,636	14,308	1,656	N/A	N/A
CommCare Bridge: Legal Immigrants (no longer eligible for CommCare)	14,708	21,609	26,127	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Mississippi	
a.	**Trade Name:** Magnolia Health Plan
b.	**Brief Description of the Scope of Work** Magnolia provides full-risk managed care services for SSI/ABD and Foster Care members. Managed care services provided include medical, pharmacy, vision and dental services.
c.	**Duration of the Contract** Jan. 2011 - Dec. 2013
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
ABD, SSI, Foster Care	30,664	N/A	N/A	N/A	N/A

e.	**Subcontractor Role** Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

Ohio	
a.	**Trade Name:** Buckeye Community Health Plan, Inc.
b.	**Brief Description of the Scope of Work** • TANF and SCHIP: Full-risk managed care for TANF, SCHIP, and CSHCN members. Services provided include medical, limited behavioral health,dental, and vision. • SSI/ABD: Full-risk managed care services for SSI/ABD Members. Services provided include medical, limited behavioral health, pharmacy*, dental, and vision, as well as, transportation when the member must travel 30 miles or more for care. *Pharmacy carve-out began 2/1/2010
c.	**Duration of the Contract** • TANF and SCHIP: January 2004 to June 2010; renewed for annual periods from July 1 to June 30 • SSI/ABD: January 2007 to June 2010; renewed for annual periods from July 1 to June 30
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF and SCHIP	141,500	140,700	132,500	117,454	107,729
SSI/ABD	18,900	19,000	18,100	N/A	N/A

e.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Ohio	
a.	**Trade Name:** Buckeye Community Health Plan, Inc.
b.	**Brief Description of the Scope of Work** SNP Full Dual Eligible: Full-risk managed care for SNP Full Dual Eligible Members. Services provided include Medicare Part A, Part B, Part D (hospital, medical, pharmacy)
c.	**Duration of the Contract** Jan. 2008 - present, renewed yearly, indefinitely
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SNP Full Dual Eligible	500	500	200	101	N/A

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

South Carolina	
a.	**Trade Name:** Absolute Total Care
b.	**Brief Description of the Scope of Work** Absolute Total Care provides full-risk managed care for TANF, SCHIP and SSI members. Services provided include medical, behavioral health, substance abuse, dental, and vision.
c.	**Duration of the Contract** December 2007-2011; renewed annually for successive 12-month periods
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF, SCHIP, SSI	84,900	90,300	48,600	31,300	100

e.	**Subcontractor Role** Behavioral Health, Pharmacy, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Texas	
a.	**Trade Name:** Superior Health Plan Network
b.	**Brief Description of the Scope of Work** • CHIP EPO, CHIP EPO Perinate: Full-risk managed care for CHIP Exclusive Provider Organization (EPO) and CHIP EPO Perinate (unborn fetus/child of low-income women), as well as, Children with Special Health Care Needs (CSHCN) members. Services provided include medical, behavioral health including substance abuse, and vision. • CHIP and CHIP Perinate RSA Program: Full-risk managed care for CHIP RSA and CHIP RSA Perinate (unborn fetus/child of low-income women), as well as, Children with Special Health Care Needs (CSHCN) members. Services provided include medical, behavioral health including substance abuse, and vision. • Foster Care: Full-risk managed care for Medicaid Foster Care members. Services provided include medical, behavioral health including substance abuse, vision, dental, and Community Health Record.
c.	**Duration of the Contract** • CHIP EPO and CHIP EPO Perinate: September 2004 to August 2010; CHIP Rural Service Area (RSA) Programs: January 2010 to August 2013. The Operational Start Date was September 1, 2010. • Foster Care: 2007 to August 2010; coverage began April 2008; contract may be extended for up to four and a half additional years.
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
CHIP EPO and CHIP EPO Perinate (including CSHCN)	N/A	N/A	120,411	113,938	90,745
CHIP and CHIP Perinate Rural Service Area (RSA), including CSHCN	71,248	72,659	N/A	N/A	N/A
Foster Care	31,823	31,138	28,988	29,566	N/A

e.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management, Network Rental and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

	Texas
a.	**Trade Name:** Superior Health Plan, Inc.
b.	**Brief Description of the Scope of Work** • TANF: Full-risk managed care services for TANF members. Services provided include medical, behavioral health, substance abuse, and vision. • ABD/SSI Voluntary: Risk-based managed care services for ABD/SSI Voluntary members. Services provided include medical, behavioral health, substance abuse, and vision. • CHIP/CHIP Perinate: Full-risk managed care services for CHIP and CHIP Perinate Members. Services provided include medical, behavioral health, substance abuse, and vision. • STAR+PLUS: Risk-based managed care services for STAR+PLUS Members in the Bexar, Nueces and Dallas Service Areas. Services provided include medical, behavioral health including substance abuse, vision, and long term care. Superior also manages hospital care and has related state performance targets; however, hospital claims are carved out to the state.
c.	**Duration of the Contract** • TANF and ABD/SSI Voluntary: December 1999 to August 2006; CHIP: September 2002 to August 2006 • TANF, ABD/SSI Voluntary and CHIP: September 2006 to August 2010. CHIP Perinate and STAR+PLUS (Bexar and Nueces Service Areas) were added to this contract in February 2007 and are included in the current term through August 2011. • STAR+PLUS (Dallas Service Area Expansion): January 2011 to August 2013
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
CHIP/CHIP Perinate; TANF and ABD SSI Voluntary STAR+PLUS	350,854	326,027	300,724	431,700	354,400

e.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Texas	
a.	**Trade Name:** Celtic Insurance Company, Inc.
b.	**Brief Description of the Scope of Work** A statewide public/private partnership established by the Texas 81st Legislature that provides a new health insurance option for small employers in Texas under the Healthy Texas initiative. Healthy Texas serves employer groups with 2-50 employees with annual wages at or below $32,490.
c.	**Duration of the Contract** Nov. 2010 - Nov. 2012
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
Small Employer Group	1,500	78	N/A	N/A	N/A

e.	**Subcontractor Role** Pharmacy, Vision, Disease Management, and 24/7 Nurse Advice Line

Texas	
a.	**Trade Name:** Superior Health Plan, Inc.
b.	**Brief Description of the Scope of Work** Special Needs Plan (SNP) Full Dual Eligible: Full-risk managed care for SNP Full Dual Eligible Members. Services provided include Medicare Part A, Part B, Part D (hospital, medical, pharmacy), dental, vision, hearing, and transportation.
c.	**Duration of the Contract** Jan. 2008 - present, renewed yearly, indefinitely
d.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SNP Full Dual Eligible	1,034	892	169	45	N/A

e.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management, Transportation, and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

Wisconsin	
a.	**Trade Name:** Managed Health Services Insurance Corporation
b.	**Brief Description of the Scope of Work** Full Managed Care Organization; medically necessary physical health care services including but not limited to physician, FQHC/RHC, hospital inpatient and outpatient, laboratory, diagnostic, pregnancy and obstetrical, physical and speech therapy, home health and others; mental health and substance abuse; dental; vision; transportation; pharmacy* * In February 2008, pharmacy for all drugs filled at a pharmacy carved out; in January 2009, injectables carved out.
c.	**Duration of the Contract** • TANF, SCHIP SOBRA, refugees, children in state care and custody, MC+ poverty children, and waiver uninsured parent population: January 1991, Recertification occurs every two years. • SSI/ABD: April 2005, Recertification occurs every two years.
e.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
TANF, SCHIP, SOBRA, refugees, children in state care and custody, MC+ poverty children, and waiver uninsured parent population	73,986	67,070	127,294	117,361	125,004
SSI/ABD	7,834	7,852	7,529	7,483	6,939

h.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management, and 24/7 Nurse Advice Line

Wisconsin	
a.	**Trade Name:** Managed Health Services Insurance Corporation
b.	**Brief Description of the Scope of Work** SNP Full dual eligible - Part A, Part B, Part D (hospital, medical, pharmacy)
c.	**Duration of the Contract** Jan. 2008 - present, renewed yearly, indefinitely
e.	**Number of Members and Population Types**

Population	YTD 2011	2010	2009	2008	2007
SNP Full Dual Eligible	1	1	1	1	N/A

h.	**Subcontractor Role** Behavioral Health, Dental, Vision, Disease Management ,and 24/7 Nurse Advice Line

GRANITE STATE HEALTH PLAN

MISSION STATEMENT

Granite State Health Plan will provide better health outcomes at lower costs.

GRANITE STATE HEALTH PLAN

6.7 Bidder's References

GRANITE STATE HEALTH PLAN

6.7 Bidder's References

The Proposal must include relevant information about at least three (3) similar or related contracts or subcontracts awarded to the Bidder and must also include provider network references and client testimonials. Particular emphasis should be placed on previous contractual experience with government agencies and administrative data sets. DHHS reserves the right to contact any reference so identified. The information must contain the following:

- *Name, address, telephone number, and website of the customer*
- *A description of the work performed under each contract*
- *A description of the nature of the relationship between the Bidder and the customer*
- *Name, telephone number, and e-mail address of the person whom DHHS can contact as a reference*
- *Dates of performance*

Granite State Health Plan, as a newly formed entity, does not yet have references. Please refer to the following tables for the references of Centene health plan subsidiaries state clients and network providers in Arizona, Georgia, Massachusetts and Texas.

GRANITE STATE HEALTH PLAN

	Bridgeway Health Solutions
a.	**Reference Name, Address, Phone # and website:** Arizona Health Care Cost Containment System 801 E. Jefferson Street, MD 4100 Phoenix, AZ 85034 (602) 417-4111 Website: www.azahcccs.gov
b.	**Brief Description of Work Performed:** • Acute Care: Full-risk managed care for Acute Care services for TANF, SCHIP and SSI/ABD members. Services provided include medical, pharmacy, emergency transportation, dental, and some optical. Behavioral health is carved-out for the Acute Care contract; however, Bridgeway provides coordination for those services. • LTSS: Full-risk long term managed care services for SSI/ABD members. Services include Home and Community-Based Services (HSBS), and institutional long term care services, medical, pharmacy, BH, emergency transportation, dental, and some optical.
c.	**Relationship between Centene and Reference:** State client of Centene health plan subsidiary, Bridgeway Health Solutions
d.	**Contact Name, Phone Number and email address:** Tom Betlach Director, AHCCCS Phone: 602-417-4111 e-mail: Thomas.betlach@azahcccs.gov
e.	**Dates of Performance:** • Acute Care: October 2007 to September 2011; Two year renewal option • LTSS: October 2006 to October 2010; Renewed through September 30, 2012
f.	**Provider Network Reference:** Jeffreys B. Barrett, N.H.A. Administrator Maravilla Care Center 8825 South 7th Street Phoenix, AZ 85042 Phone: 602-243-6121 e-mail: Jeffreys.Barrett@pcitexas.net
g.	**Client Testimonial:** Ms Tellez [CM Supervisor], I would like to say a few things about Ms Braslins [care manager] and how our family really appreciate the help and cooperation she has given us in supporting our mother. I cannot say enough positive things about work ethic and understanding of what families are dealing with when caring for a senior family member. It is people like her that make people like myself to believe there is still good hard working caring individuals out in the world. Again just wanted to say thanks for Leigh and Bridgeway support. Regards, Arnold [NAME]

GRANITE STATE HEALTH PLAN

	CeltiCare Health Plan of Massachusetts
a.	**Reference Name, Address, Phone # and website:** The Commonwealth Health Insurance Connector Authority 100 City Hall Plaza Boston, MA 02108 Phone: 617-933-3059 Website: www.mahealthconnector.org
b.	**Brief Description of Work Performed:** • CommCare: A health insurance program for low-income, working adults (up to 300% of the Federal Poverty Level) who are not eligible for Medicaid or employer-sponsored insurance. Services provided include medical, behavioral health including substance abuse, dental, vision, and pharmacy. • CommCare Bridge: A true public/private partnership that provides comprehensive coverage to approximately 27,000 legal immigrants who were previously eligible for CommCare, but lost eligibility due to budgetary cutbacks effective September 1, 2009. Services provided include medical, behavioral health including substance abuse, and pharmacy.
c.	**Relationship between Centene and Reference:** Private Sector client of Centene health plan subsidiary, CeltiCare Health Plan of Massachusetts
d.	**Contact Name, Phone Number and email address:** Michael Norton Commonwealth Care, Senior Program Manager The Commonwealth Health Insurance Connector Authority Phone: 617-933-3059 E-mail address: Michael.Norton@state.ma.us
e.	**Dates of Performance:** • CommCare: July 2009 to June 30, 2012; Renewable through the state's recertification process • CommCare Bridge: October 2009 to June 30, 2012; Renewable through the state's recertification process

GRANITE STATE HEALTH PLAN

f.	**Provider Network Reference:** Mark Girard, M.D., M.B.A. President of Steward Medical Network 500 Steward Health Care System Boylston St. Boston, MA 02116 Phone: 617 419 4700 Mark.Girard@caritaschristi.org
g.	**Client Testimonial:** Question: How do you feel about the CeltiCare Health Plan? Answer: With the plan I feel very well, I can not complain. A day does not go that I do not take my medicine and go to the doctor. While I have the high blood pressure and sinusitis. I speak to my friends about the plan. I show them the card and do not stop promoting the health plan because the reality is, this is a dream. I am very grateful to the plan. Thank God. It gave me new life. I felt badly with the high blood pressure, very weak. Now when I return to the doctor I will call my dear insurance and report how I feel regarding my high blood pressure and the sinusitis. I was also tested for the prostate and everything came out very well. Thank you for the visit from my insurance. I am very happy. They are all very kind, many human relations, like spend time with the sick and the patient feels better because of it. Wife: Before having this plan my husband the almost died. He felt very badly. Didn't have any strength, had dizziness, he almost dies from the high blood pressure. After he obtained this insurance his high blood pressure was controlled, and my husband is alive because of this insurance. Question: Before having the CeltiCare Health Plan, what did you do to go to the doctor ? Answer: I didn't go. As I had no insurance, could not pay for the medicines or visits to the doctor.

GRANITE STATE HEALTH PLAN

	Peach State Health Plan
a.	**Reference Name, Address, Phone # and website:** Georgia Department of Community Health 2 Peachtree Street, NW Atlanta GA 30303-3159 Phone: 404-657-7793 website: www.dch.georgia.gov
b.	**Brief Description of Work Performed:** Peach State Health Plan provides full-risk managed care services for TANF and SCHIP Members. Services provided include medical, behavioral health including substance abuse, dental, vision, and pharmacy.
c.	**Relationship between Centene and Reference:** State client of Centene health plan subsidiary, Peach State Health Plan
d.	**Contact Name, Phone Number and email address:** Jerry Dubberly, State Medicaid Director Phone: 404-657-7793 e-mail: jdubberly@dch.ga.gov
e.	**Dates of Performance:** July 2005 to June 2010; renewable for two additional one-year terms; Membership coverage began in 2006.
f.	**Provider Network Reference:** D. A. Kavka Executive Director **Georgia Association for Primary Health Care** 315 W. Ponce De Leon Avenue Suite 1000 Decatur, GA 30030 Phone: 404.659.2898 e-mail: dkavka@gaphc.org
g.	• I love the coverage. It takes good care of my kids. D. F. • I love Peach State. They are always there when I need questions answered. This is the best program that I have been involved with. N. S. • I love Peach State Health Plan because of the different programs they offer. They always help you with whatever problem you are having. Y. J. • I love the care Peach State provides. They always answer the phone when you call. They also work with my doctor very well. R. D. • Great service. Great doctors! L. W. • I like Peach State because it is affordable and it provides my children with the best healthcare coverage. H. P.

GRANITE STATE HEALTH PLAN

	Superior HealthPlan
a.	**Reference Name, Address, Phone # and website:** Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316 Phone: 404-657-7793 website: www.dch.georgia.gov
b.	**Brief Description of Work Performed:** • HIP EPO, CHIP EPO Perinate: Full-risk managed care for CHIP Exclusive Provider Organization (EPO) and CHIP EPO Perinate (unborn fetus/child of low-income women), as well as, Children with Special Health Care Needs (CSHCN) members. Services provided include medical, behavioral health including substance abuse, and vision. • CHIP and CHIP Perinate RSA Program: Full-risk managed care for CHIP RSA and CHIP RSA Perinate (unborn fetus/child of low-income women), as well as, Children with Special Health Care Needs (CSHCN) members. Services provided include medical, behavioral health including substance abuse, and vision. • Foster Care: Full-risk managed care for Medicaid Foster Care members. Services provided include medical, behavioral health including substance abuse, vision, dental, and Community Health Record. • TANF: Full-risk managed care services for TANF members. Services provided include medical, behavioral health, substance abuse, and vision. • ABD/SSI Voluntary: Risk-based managed care services for ABD/SSI Voluntary members. Services provided include medical, behavioral health, substance abuse, and vision. • CHIP/CHIP Perinate: Full-risk managed care services for CHIP and CHIP Perinate Members. Services provided include medical, behavioral health, substance abuse, and vision. • STAR+PLUS: Risk-based managed care services for STAR+PLUS Members in the Bexar, Nueces and Dallas Service Areas. Services provided include medical, behavioral health including substance abuse, vision, and long term care. Superior also manages hospital care and has related state performance targets; however, hospital claims are carved out to the state.
c.	**Relationship between Centene and Reference:** State client of Centene health plan subsidiary, Superior HealthPlan
d.	**Contact Name, Phone Number and email address:** Mr. Billy Millwee State Medicaid Director Deputy Director of Health Services Operations Phone: 512-491-1869 e-mail: billy.millwee@hhsc.state.tx.us
e.	**Dates of Performance:** • CHIP EPO and CHIP EPO Perinate: September 2004 to August 2010; CHIP Rural Service Area (RSA) Programs: January 2010 to August 2013. The Operational Start Date was September 1, 2010. • Foster Care: 2007 to August 2010; coverage began April 2008; contract may be extended for up to four and a half additional years. • TANF and ABD/SSI Voluntary: December 1999 to August 2006; CHIP: September 2002 to August 2006

GRANITE STATE HEALTH PLAN

	• TANF, ABD/SSI Voluntary and CHIP: September 2006 to August 2010. CHIP Perinate and STAR+PLUS (Bexar and Nueces Service Areas) were added to this contract in February 2007 and are included in the current term through August 2011. • STAR+PLUS (Dallas Service Area Expansion): January 2011 to August 2013
f.	**Provider Network Reference:** Dr. Ernesto Parra El Centro del Barrio 527 N Leona San Antonio, TX 78207 Phone: (210)358-3710
g.	Client Testimonial: T.K. was having difficulties with his power w/c (received through DADS). It was undersized and he had fallen out of it and ended up in ER. From the time I first talked to him, it took just a few days, and our contracted vendor, had the seating assessment done, we got approved through Dr Layland and delivered. TK was so thankful he wanted to send us some pics. TK also wanted me to tell everyone at Superior HealthPlan. "God Bless You All"!

GRANITE STATE HEALTH PLAN

6.9 Performance Bond and Insurance

GRANITE STATE HEALTH PLAN

6.9 Performance Bond and Insurance

Bidder shall, at time of Contract award, 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.

As required by § 420-B:25 of the New Hampshire Insurance Law, prior to issuance of Granite State Health Plan, Inc.'s (GSHP) Certificate of Authority an initial net worth of $6,000,000 will be met. Centene will fund $5,500,000 of this amount in unimpaired paid-in capital stock and will deposit $500,000 of securities approved by the Commissioner at a financial institution designated by the Commissioner. The risk based capital requirement of 200% of ACL will be met once operations commence. This requirement will be met by a capital infusion from Centene Corporation ("Centene"), parent company of GSHP.

The GSHP Articles of Incorporation authorize the issuance of 100 shares of common stock, no par value per share ("Shares"). It is presently proposed that Centene will acquire 100 shares of GSHP's common stock, which will constitute 100% of the issued and outstanding shares.

GRANITE STATE HEALTH PLAN

6.11 Subcontractor Letters of Commitment

6.11. Subcontractor Letters of Commitment (If applicable)

If subcontractors are part of this proposal, signed letters of commitment from the subcontractor are required as part of the RFP. The Bidder shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract, regardless of whether or not it proposes to use any subcontractors. The Bidder and any subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the State. The State reserves the right to approve or reject subcontractors for this project and to require the Bidder to replace subcontractors found to be unacceptable.

Granite State Health Plan will be subcontracting out the following services for the New Hampshire Medicaid Care Management Program.

Three non-affiliate vendors:

- National Imaging Associates - management of radiology services
- Teledoc – telehealth services
- Access2Care - non-emergent medical transportation

We will also subcontract with five affiliate vendors:

- Cenpatico Behavioral Health - behavioral health and outpatient therapy services
- NurseWise – 24/7 clinical information and nurse triage services
- Nurtur Health - disease management
- US Script – pharmacy benefit management; and
- OptiCare - vision services subcontractor

Please refer to the subsequent pages for the signed letters of commitment from all subcontractors Granite State Health Plan will be solely responsible for meeting all requirements and terms and conditions specified in this RFP, our proposal and any resulting contract. Granite State Health Plan and all subcontractors agree to commit to the entire contract period stated within the RFP. Granite State Health Plan realizes the State reserves the right to approve or reject subcontractors for this project and to require Granite State Health Plan to replace subcontractors found to be unacceptable.

USscript

U.S. SCRIPT, INC.
2425 West Shaw Avenue
Fresno, California 93711
TELEPHONE: 800-413-7721
FACSIMILE: 559-244-3785
WEBSITE: usscript.com

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

US Script, Inc. ("US Script") states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for US Script includes operating a pharmacy benefits management company that provides a network of contracted pharmacies, a mail order pharmacy service, providing prescription drug formularies, prescription drug utilization management, claims administration, and member and provider services.

Please contact me at 314-725-4706, extension 25186 with any questions or concerns.

Respectfully,

Leon Luttschwager
President and Chief Operating Officer

Cenpatico
Improving Lives.

504 Lavaca Street, Suite 850
Austin, Texas 78701
512.406.7200
Fax: 866.694.3730
www.cenpatico.com

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

Cenpatico Behavioral Health, LLC ("Cenpatico") states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for Cenpatico includes:

- The administration of mental health and substance abuse benefits, claims administration and claims payment, behavioral health utilization management; service coordination services; operation of a behavioral health crisis hotline; provider contracting and credentialing; and, quality improvement activities.
- The administration of Specialty Therapies and Rehab Services (STRS), including all aspects of managing the delivery of outpatient Speech, Physical and Occupational Therapies: utilization management, care coordination; provider network and credentialing; claims administration and payment; provider services, including clinical training.

Please contact me at 512-406-7200 with any questions or concerns.

Respectfully,

Samuel A. Donaldson, PhD
President and CEO

nurtur

December 1, 2011

Granite State Health Plan, Inc.
ATTN: Brent Layton, Senior Vice President - Centene Corporation
72 North Main Street, Suite 301
Concord, NH 03301

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Corporate Headquarters
20 Batterson Park Road
Farmington, CT 06032
800 293 0056 toll-free
860 678 1600 fax

National Operations Center
4000 McEwen Road
Dallas, TX 75244
800 293 0056 toll-free
469 330 9540 fax

www.nurturhealth.com

Dear Mr. Layton:

Nurtur Health, Inc. states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for Nurtur Health, Inc. includes a comprehensive disease management program for asthma, diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD) and our smoking cessation program.

Please contact me at 860-676-3601 with any questions or concerns.

Respectfully,

Daniel D. Cave

Daniel D. Cave
President and
Chief Executive Officer

DDC/mm

NurseWise

URAC
ACCREDITED
HEALTH CALL CENTER

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

NurseWise, LP states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for NurseWise, LP includes twenty-four hour nurse advice line services.

Please contact me at 314-725-4706, extension 25355 with any questions or concerns.

Respectfully,

Kimberly Tuck

Kimberly Tuck
President and CEO

7700 Forsyth Blvd. · St. Louis, MO 63105 · Main: 314-725-4477

OptiCare
MANAGED VISION

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

OptiCare Managed Vision ("OptiCare") states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for OptiCare includes the administration of eye care benefits, including claims administration, claims payment, member services, provider contracting and credentialing, provider services, and any other specific plan-related activities.

Please contact me at (800) 334-3937 with any questions or concerns.

Respectfully,

David Lavely
President

112 Zebulon Court • P.O. Box 7548 • Rocky Mount, North Carolina 27804
800-334-3937 • www.opticare.com

Access2Care

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

Access2Care, LLC ("Access2Care") states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for Access2Care includes medical transportation and mobile health services.

Please contact me at (314) 768-1308 with any questions or concerns.

Respectfully,

Matt McCormick
Vice President

2500 Abbott Place St. Louis, MO 63143

NIA
A Magellan Health Company

December 1, 2011

Granite State Health Plan, Inc.
72 North Main Street, Suite 301
Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granite State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

National Imaging Associates, Inc. ("NIA") states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS RFP # 12-DHHS-CM-01.

The statement of work for subcontracted activities for NIA includes specialty utilization management services for high-dollar radiology services and certain plan-designated provider preferencing and profiling services.

Please contact me at (410) 953-1000 with any questions or concerns.

Respectfully,

Tina M. Blasi

Tina M. Blasi
Chief Executive Officer

NATIONAL IMAGING ASSOCIATES
6950 Columbia Gateway Drive
Columbia, Maryland 21046
TEL 800.458.2740
www.NIAhealthcare.com

Teladoc

December 5, 2011

Granit State Health Plan, Inc.

72 North Main Street, Suite 301

Concord, NH 03301

ATTN: Brent Layton, Senior Vice President, Centene Corporation

RE: Granit State Health Plan Subcontractor Letter of Commitment for New Hampshire Medicaid Care Management Services (DHHS RFP # 12-DHHS-CM-01)

Dear Mr. Layton:

Teladoc states its willingness and commitment to perform the activities listed below as a subcontractor for Granite State Health Plan for the Medicaid Care Management Program that is the subject of DHHS-CM-01.

The statement of work for subcontracted activities for Teladoc includes telehealth services.

Respectfully,

Jason Gorevic

CEO

Teladoc, Inc One Sound Shore Drive, Ste 304 · Greenwich, CT 06830
P (203) 742 1719 F (203) 769 1544 · www.teladoc.com

GRANITE STATE HEALTH PLAN

6.15 Affiliations – Conflict of Interest

GRANITE STATE HEALTH PLAN

6.15. Affiliations – Conflict of Interest

The Bidder must include a statement regarding any and all affiliations that might result in a conflict of interest. Examples of such affiliations would include hospitals and physician organizations. Explain the relationship and how the affiliation would not represent a conflict of interest.

Neither Granite State Health Plan, Inc. nor its parent company Centene Corporation, has any affiliations that might result in a conflict of interest.