
# EPSDT Program Plan

# 2018-2019

## Overview

Well Sense Health Plan (The Plan, Well Sense) has a variety of initiatives targeting providers and members (New Hampshire Medicaid and New Hampshire Health Protection Program) to support compliance with the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) requirements for Medicaid members under the age of 21. Well Sense endorses the current Bright Futures clinical practice guideline, an evidence-based guideline for pediatric routine preventive care visits, which was developed by the American Academy of Pediatrics. CMS has recognized Bright Futures as a pediatric periodicity schedule that meets the EPSDT requirements for Medicaid programs.

The Plan's Quality Department is responsible for the Well Sense EPSDT Program Plan. The Quality Department, including the dedicated Well Sense Quality Manager, ensures that all elements of the EPSDT Plan are implemented. The Quality Department works with all business units who own aspects of the EPSDT Plan, including but not limited to Provider Relations, the Customer Care Center, Care Management, Marketing and Communications, Clinical Informatics, Beacon Health Options (the Plan's behavioral health partner), Business Integration and the Well Sense Medical Director. The Quality Department conducts an ongoing analysis of EPSDT Plan effectiveness and works with stakeholders to develop the annual plan, building on the previous year's results and identified opportunities for improvement.

## Well Sense Approach

The Well Sense Quality Department coordinates provider-focused efforts to support the EPSDT Program Plan with the Plan's Provider Relations Department (under the leadership of the Director of Contracting and Provider Engagement for New Hampshire) and the Marketing and Communications Department.

## Provider Focused Efforts

- The Plan reviews EPSDT screening rates annually; this analysis is a key factor in selecting well visit measures for the Plan's Payment Reform Program, which targets well-child visit measures to promote compliance with EPSDT periodicity schedules.
- Provider newsletters are used to remind providers of EPSDT requirements and educate providers regarding available resources to support them in meeting these requirements.
- Provider responsibilities and requirements regarding EPSDT services are set forth in the provider manual, which also contains instructions for accessing the Bright Futures periodicity schedules online and Plan requirements for adhering to EPSDT schedules.
- The Plan educates providers on EPSDT requirements during orientation meetings and at ad-hoc visits.
- Well Sense generates Care Gap Reports for providers for their panel members due for a well visit in the coming months, by age category. The reports also include children who are

overdue for appointments. These reports are mailed to providers semi-annually, or more frequently upon request.

- Provider Relations Consultants support all of our providers in meeting EPSDT requirements, including providers engaged with children requiring long term outpatient treatment. Plan medical directors outreach to key outliers as necessary.
- Well Sense sets medical record documentation standards for EPSDT through enforcement of our Standards for Medical Record Documentation Policy (see *Attachment A*) and Medical Record Charting Standards as described in section 14.7 of the Well Sense Provider Manual (see *http://wellsense.org/providers/provider-manual*).
- The Plan provides reminders of the importance of dental care to members via member education mailings, and works with DHHS on reminders as requested.

## *Member Focused Efforts*

The Well Sense Quality Department coordinates member-focused efforts to support the EPSDT Program Plan with the Plan's Customer Care Center (i.e., Member Services Department), Care Management, and the Marketing and Communications Departments.

- New members receive a welcome call within the first thirty days of enrollment. As part of this call, members are advised of EPSDT services, the benefits of preventive health care and how to access non-emergency medical transportation (NEMT). During the welcome call, members also receive more general benefit information, and help selecting a PCP. Additionally, members are asked about their health care needs. Customer Care Representatives may answer any additional member benefit questions, and guide the member through accessing the member website.
- Members are mailed a welcome kit within ten days of enrollment. The welcome kit includes a welcome letter, the member handbook, and a brochure on how to access non-emergency medical transportation. The member handbook, sent as part of the member welcome kit, includes information on EPSDT services and benefits. Specifically the handbook provides information on scheduling appointments, finding a provider, accessing behavioral health (BH) services through Beacon Health Options, and accessing NEMT through the Plan's NEMT vendor, Coordinated Transportation Solutions (CTS). The member handbook is also available on the Well Sense member website.
- Member newsletters and member mailings contain information about annual EPSDT requirements, and provide assistance in obtaining timely well child visits.
- Targeted member mailings are sent to parents/guardians prior to their child's first, third, fourth, fifth, and sixth birthdays. The targeted mailings encourage parents/guardians to keep their child's immunization schedule current. It also contains information on the importance of immunizations and how to catch up if they have fallen behind in the schedule. A refrigerator magnet outlines the immunization schedule and explains when and why the child needs vaccines.
- Member materials emphasizing the need for focused screenings, such as lead screenings, are mailed to members (parents/guardians) in need of selected screenings and/or their

parents /guardians. These materials also promote healthy eating and encourage regular well-visits.

- Member education materials promoting general health, including dental health, are sent to members and/or their parents/guardians. Dental health information is available on the Plan web site, and members aged 4-65 can request and receive a free dental kit every year.
- Pregnant members at risk for an adverse maternal-child outcome receive care management through the Sunny Start Maternal Child Health program. The pregnant member's care manager will also manage the complex newborn after delivery, creating a "Nurse in the Family" approach. During post-partum management and for management of the complex newborn, the care manager promotes safety and provides education toward completing preventive and well visit appointments, immunizations, and other EPSDT services. Transportation is also coordinated by the care manager, as appropriate.
- At-risk members are identified for referral to care management in real-time as they access services in key categories, including EPSDT and behavioral health services.
- A Quality Outreach Coordinator (QOC) calls members 18-21 years of age, and parents/guardians of members 3-17 years of age, that are due or overdue for a well visit. The QOC promotes the importance of annual well visits to keep up to date with recommended immunizations and screenings.

***Verbal and Written Communication with Members***

- Through the member welcome letter, welcome call, member handbook, and information available on the Plan website, members are advised on how to contact Well Sense and how to have materials translated into their preferred language. The Well Sense member website is Americans with Disabilities Act (ADA) compliant.
- Verbal communication with members through the Plan's Customer Care Center, including the member welcome call, can be conducted in a number of languages directly with native-speaker representatives, or in up to 150 languages through third party translation via a language line service. There are also TTY/TDD lines in place for members who are deaf or hard of hearing.
- Written member materials are available in English and Spanish, and can be translated into other languages upon request. Materials are also available in Braille or large font upon request. Materials are written in easy to understand language at the sixth grade reading level.
- Written member communications are accompanied by a "babel card" that contains instructions in the prevalent languages of the population on how to have the information contained in the communication translated.
- As part of Race/Ethnicity/Language data collection, primarily through the Health Needs Assessment and also as a standard part of customer care and care management interactions, the Plan captures members' preferred written and spoken language, which could include (Braille or American Sign Language).

## *Provider Responsibilities*

PCPs are responsible for providing EPSDT screening services, and for following up to ensure the member obtains necessary care identified during each well visit. These requirements are outlined in the Provider Manual and the Provider's Participation Agreement with the Plan. The provider is required to document all services provided in the medical record.

EPSDT services are provided to Medicaid eligible children less than 21 years of age. Services shall include a comprehensive history, measurements, an unclothed physical exam, developmental and behavioral health assessments and screenings, immunizations, laboratory tests and health education as outlined in the current Bright Futures Periodicity Schedule.

***Vision Services***
At a minimum, vision services include screening, diagnosis and treatment for defects in vision, including eyeglasses.

***Dental Services (Covered by NH Medicaid directly, with the exception of fluoride varnish)***
At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services.

***Hearing Services***
At a minimum, hearing services include screening, diagnosis and treatment for defects in hearing, including hearing aids.

***Other Necessary Health Care Services***
Well Sense covers additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary, regardless of whether the service is covered by the Plan. These medical necessity criteria are applied to requests for services not otherwise covered under the New Hampshire Medicaid program. As defined under NH Administrative Rule He-W 546.01f, 'medically necessary' "means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service."

In addition, reviews of requests for services take into consideration each member's unique circumstances. These may include co-morbidities, treatment progress, and psychosocial factors as well as the local delivery system.

***Diagnostic Services***
When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services are covered. Necessary referrals should be made without delay and the Plan requires providers to follow-up to ensure the member receives a complete diagnostic evaluation.

***Treatment***
Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

***Health Education***
Health Education services shall include informing members (and/or parents/guardians) of:

- Availability of EPSDT health screenings without cost
- Importance of preventive care, including vaccinations
- Periodicity schedule and depth and breadth of services
- How and where to access services
- Services provided without cost
- Availability of nutritional services
- Availability of assistance with transportation and scheduling upon request

***Population Management***
In an ongoing effort to support providers, the Plan generates a semi-annual PCP report of well child visit rates, including a listing of their members by age category that will be due for a well visit in the upcoming months. The reports include those members who are not in compliance with the periodicity schedule. PCPs are required to contact the member listed on the report (parent and/or guardian) by telephone or mail to schedule an appointment.

***Office Equipment Requirements***
Providers should have the following equipment available to adequately perform EPSDT screening exams:

- Weight scale for infants
- Weight scale for children and adolescents
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2
- Measuring board or device for measuring height in the vertical position for children aged 2 or older
- Blood pressure apparatus with infant, child and adult size cuffs
- Screening audiometer
- Devices for measuring hematocrit or hemoglobin or ability to send blood samples to a laboratory for testing
- Age appropriate eye charts
- Developmental and behavioral screening tools
- Ophthalmoscope and otoscope

## *Compliance Monitoring Performed by Well Sense*

Well Sense contracted providers are responsible for following up on missed appointments, including missed referral appointments identified through screenings and follow up on any

abnormal screening exams. This responsibility is communicated to providers in section 4.10 of the Well Sense Provider Manual, in the provider's Participation Agreement with Well Sense, and through the Provider Relations department's conversations with providers throughout the year.

Well Sense monitors providers' compliance with this requirement, and other EPSDT requirements, via the following methods:

- Random medical record audits as appropriate to ensure follow ups are occurring, and that full EPSDT visits are being performed
- Monitoring Health Effectiveness Data and Information Set (HEDIS) Effectiveness of Care measures, including Well Child Visit Encounter Rates, Childhood Immunization Status, Immunizations for Adolescents and Lead Screening in Children (these measures are also aligned with the Plan's Payment Reform Plan)

The Quality Department, in conjunction with the Well Sense Medical Director, reviews results of the medical record audits with Provider Relations staff to identify any issues. Network Development staff give education and support to providers and monitor corrective action plans developed for identified deficiencies, as needed.

## *Well Sense EPSDT Reporting*

Well Sense reports EPSDT-related HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, which are used internally and with Well Sense providers to identify trends and opportunities for improvement.

Well Sense uses other data and reporting that may capture information related to EPSDT services, such as member grievances and appeals data, member requests for access to PCP or specialist, and the annual Lead Time Study that measures appointment access to providers and performance against appointment wait time standards (as outlined in the provider manual and the Plans' Access and Availability policies.)

BOSTON MEDICAL CENTER HealthNet Plan
bmchp.org | 888-566-0008

WELL SENSE HEALTH PLAN
wellsense.org | 877-957-1300

Administrative Policy

# Policy Title: Standards for Medical Record Documentation for Network Providers

**Version Effective Date:** 9/14/16.

| Product Applicability | ☒ **All Plan+ Products** |
|---|---|
| **Well Sense Health Plan**<br>☒ New Hampshire Medicaid<br>☐ NH Health Protection Program<br>☐ _____ | **Boston Medical Center HealthNet Plan**<br>☒ MassHealth<br>☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct<br>☒ Senior Care Options<br>☐ _____ |

Note: Disclaimer and audit information is located at the end of this document.

## I. Policy Summary

The purpose of this policy is to establish minimal medical record standards to facilitate communication, coordination and continuity of care and to promote efficient and effective treatment. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including National Committee for Quality Assurance (NCQA).

## II. Definitions

## III. Policy

The Plan requires that the medical records of network providers be maintained in a manner that is current, detailed and organized to permit effective and confidential patient care and quality review. Medical records must be legible, documented accurately and comprehensively, and accessible to healthcare providers. This includes the transfer of medical information when a member changes to another provider. In addition, the Plan establishes specific medical record criteria as follows:

## Procedure

I. **Medical Record Standards:** The Plan requires that the medical records of network providers be maintained in a manner that is current, detailed and organized to permit effective and confidential patient care and quality review. Medical records must be legible, documented accurately and comprehensively, and accessible to healthcare providers. This includes the transfer of medical information when a member changes to another provider. In addition, the Plan establishes specific medical record criteria as follows:

A. Confidentiality of medical records: All network providers will be required to ensure that member records that include personal health information (PHI) are treated as confidential in compliance with state and federal laws and regulations. Network Provider staff must receive periodic training in confidentiality of member information. In addition the records must be:

1. Stored securely
2. Accessed only by authorized personnel
3. Stored and accessed according to the Health Insurance Portability and Accountability Act (HIPAA)
4. Available and retrievable

B. Medical Record Documentation Standards: All network providers will be required to ensure that they comply with the following documentation standards:

1. Standard medical record content: Each medical record must include the following information:
   - Allergies, adverse reactions and drug contraindications or documentation of no known allergies, prominently displayed
   - Documentation of whether any member over age 18 has executed an advance directive
   - Problem list
   - Medications
   - Health Risk Assessment/Risk Screening
   - History and physical exam
   - All orders, including changes to existing orders, documented, signed and dated
   - Evidence that age appropriate preventive services are in accordance with
     - EPSDT for children and adolescents up to age 21, including behavioral health screening, (if applicable to product line) or
     - Recognized clinical practice guidelines for adults
   - Documentation of clinical findings at each visit
   - Working diagnosis consistent with findings
   - Evaluation at each visit
   - Treatment plans and goals consistent with diagnosis
   - All abnormal subjective and objective findings are appropriately addressed; unresolved problems from previous visits have documentation of a follow-up plan including return visits, telephone calls or other medium with the timeframe designated.

- Reports of ancillary services including lab and radiology, signed and dated with follow up plan for any abnormal findings
- Consult reports, signed and dated, with follow up plan for any abnormal findings
- Documentation of contact with state agencies (if applicable to product line)
- Notation of contact with family members, guardians or significant others

2. Primary Care Physician's (PCP) records must include, in addition to the standard medical record content:
   - All services provided directly by the PCP, Nurse Practitioner or Physician's Assistant
   - All ancillary services and diagnostic tests ordered by the provider with results
   - All diagnostic and therapeutic services for which a member was referred by a provider, including, but is not limited to: home health nursing reports, specialty physician reports, hospital discharge reports, physical therapy reports
   - Preventive care services must include documentation that contains pertinent recommendations for mammograms, pap smears, adult and pediatric immunizations, adolescent guidance and any other preventive health standards adopted by the Plan
   - Age appropriate risk screening should include, but not be limited to cigarettes, alcohol, substance abuse, neglect, abuse and cognitive issues, as appropriate. Assessments and ongoing monitoring of enrollees at risk of hospitalization should be in accordance with written protocols.
   - Documentation of over or under utilization of pharmaceutical or specialty services, if applicable
   - Prominent display of advance directives and health care proxy indicating patient wishes regarding treatment, where appropriate
   - All contact with state agencies and the enrollee's family, guardian or significant others are documented

3. Pediatric medical records must include, in addition to the standard medical record content:
   - Immunization flow charts in accordance with guidelines established by the American Academy of Pediatrics
   - Growth and developmental charts including body mass index (BMI) percentile or BMI percentile chart
   - Appropriate developmental screenings, including behavioral health screenings, using one of the state approved forms, (if applicable)
   - Evidence that a referral was offered, if applicable
   - Anticipatory guidance
   - Evidence that the Early Periodic Screening and Diagnosis and Treatment Program (EPSDT) schedule is being followed, including notation of dental care (if applicable to product).

4. Behavioral Health medical records must include, in addition to the standard medical record content:
   - History of presenting problem
   - Chief complaints and symptoms
   - Past mental health and/or substance abuse history
   - Past medical history
   - Family history, social history, and linguistic and cultural background
   - Current substance use

- Mental status exam
- Present medications and any allergies
- Diagnosis
- Level of functioning
- Treatment plan
- Name of PCP

5. Inpatient Hospitalization Medical Records

   a) Inpatient Medical/Surgical Services
      - Identification of the member
      - Name of the member's physician
      - Date of admission and dates of application for and authorization of benefits (if applicable to product line), if application is made after admission
      - Plan of care required under 42 CFR 456, which must include diagnoses, symptoms, complaints and complications indicating the need for admission, a description of the functional level of the member, any orders for medications, treatments, restorative and rehabilitative services, activities, social services and diet. Plans for continuing care and discharge, as appropriate, must be documented.
      - Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133
      - Date of operating room reservation, if applicable
      - Justification of emergency admission, if applicable
      - Reason and plan for continued stay, if the attending physician believes continued stay is necessary
      - Other supporting material that the BMCHP's Utilization Management staff, such as the Plan's Medical Director, or his/her designee, believes appropriate to be included in the record
      - A care transition record should be provided to the PCP or other outpatient specialist within 24 hours, or alternatively, to the subsequent facility when members are transferred to other settings of care

   b) Inpatient– Behavioral Health Services

      - Identification of the member
      - Name of the member's physician
      - Date of admission and dates of application for and authorization of Benefits, (if applicable to product line) if application is made after admission
      - Plan of care required under 42 CFR 456.172
      - Initial and subsequent continued stay review dates under 42 CFR 456.233 and 456.234
      - Reason and plan for continued stay, if the attending physician believes continued stay is necessary
      - Other supporting material that BMCHP's Utilization Management staff, such as the Plan's Medical Director, or his/her designee, believes appropriate to be included in the record.
      - For members who meet criteria for a personal care assistant, (PCA) it must be supported by documentation in the medical record.
        - An order for these services must be signed off by the PCP or other treating

provider, the agency and the member
  - The agency is required to maintain records of the PCA services provided to the member and the time initiated and completed
  - An agency RN must perform an assessment and develop a plan of care including type, frequency, duration and volume of services needed
  - An agency RN must review the plan of care every 60 days and obtain physician approval of any changes

c) Medical Record Organization and Availability: Network providers are required to ensure that medical records are organized and stored in a manner that allows easy retrieval and that limits access to authorized personnel only. All provider sites are expected to maintain medical records according to standard industry practice that includes, but is not limited to:
   - Provider site has a central file where the medical records are located
   - Medical records are organized in a logical manner by individual patient or another acceptable medical record filing system
   - Medical record charts are organized in chronological order
   - Medical record charts contain a completed demographic data sheet
   - Provider site has an appropriate documentation system that includes patient name and identification number on every page of the medical record
   - Medical records have signed entries with name and credential of the practitioner who saw the member.
     - Services completed entirely by a midlevel clinician should be signed by the midlevel clinician; (Practice is required to have a documented process to reflect physician supervision of midlevel clinicians)
     - Counter signature by the supervising physician should be used when required by state or federal law or facility, e.g. Countersignature by the supervising physician is documented for interns and residents; (42 CFR 415.170). If a primary care exception has been formally approved (42 CFR 413.86 (f)(4)(ii), interns and residents may see patients for specific lower levels of service without the supervising physician involvement, if the primary care center has attested in writing that specified conditions under 42 CFR 413.86 (i). are met.
   - Medical record entries must be legible
   - Medical records include consistent formats and forms
   - Medical records have dated entries with month, day and year
   - Medical records must be maintained for the period of time required by state law

## IV. Policy Distribution

The standards for medical record documentation will be distributed to contracted providers in the appropriate section of the provider manual.

## V. Improving Medical Record Keeping

To ensure appropriate and adequate medical record documentation, and to improve medical record keeping, the Plan will periodically assess medical record documentation. This will be accomplished by conducting a review of sample medical records from provider groups identified by the Plan, having taken into consideration practitioner panel volume or other criteria as needed to sample and assess records to ensure compliance with standards. Reviews will be

undertaken by a Plan representative periodically or as deemed necessary for quality improvement purposes. A single site visit may be considered sufficient for provider groups that maintain more than one practice site. Network providers should meet all requirements of medical record keeping. If a provider's compliance rate is under the Plan's current acceptance standard (see Medical Record Review Program document) the reviewer will notify the provider site. Such notice will identify deficiencies and request a plan for improvement or correction where applicable. This notice is shared with the Chief Medical Officer, the Quality department, Provider Relations and the Credentialing Committee for consideration in recredentialing. The Plan may re-audit sites that require improvement after sufficient time in order to ensure that compliance has occurred. If problems persist, the Chief Medical Officer will initiate further action.

## VI. Responsibility and Accountability

Office of Clinical Affairs under the direction of the Chief Medical Officer and Vice President of Finance Operations.

| Original Approval Date | Original Effective Date | Approved by |
|---|---|---|
| 09/10/2007 | 09/10/2007 | Quality Improvement Committee |
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| Policy Revisions History | | | |
|---|---|---|---|
| **Review Date** | **Summary of Revisions** | **Revision Effective Date** | **Approved by** |
| 03/01/11 | Inclusion of standards for inpatient medical records, as per MH Contract Amendment 1 | 03/01/11 | Quality Improvement Committee |
| 09/21/11 | Updated for Commercial Product | 09/21/11 | Quality Improvement Committee |
| 10/24/12 | Updated for NH EPSDT , added PCP extenders, NP and PA, updated countersignature requirements for physicians in training | 10/24/12 | Quality Improvement Committee |
| 9/14/16 | Updated for SCO | 09/14/16 | Quality Improvement Committee |

## VII. Next Review Date

09/2019

## VIII. Other Applicable Policies

## IX. Reference to Applicable Laws and Regulations

Legal and Regulatory References

- 130 CMR 450.150
- 211 CMR 52.101, QI 13
- 211 CMR 52.09: Standards for Quality Management Improvement
- 42 CFR 413.86 (i)
- 42 CFR 413.86 (f)(4)(ii) (Primary Care Exemption)
- 42 CFR 415.170 (Countersignature of teaching physicians)
- 42 CFR 415.172(b) (Medical Record Signature Requirements)
- 42 CFR 456
- 42 CFR 441.50-.62
- CMS 1902 and 1905
- American Health Information Management Association
- Contract between the Massachusetts Executive Office of Health and Human Services (EOHHS), and Boston Medical Center Health Plan, Inc.
- Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center Health Plan, Inc.
- Contract between the NH Department of Health and Human Services and Boston Medical Center Health Plan, Inc.

## X. Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs. Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to Food and Drug Administration (FDA) and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including

member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.