APPENDIX B

APPLICANT'S CONTRACT/COMPLIANCE EXPERIENCE

The purpose of Appendix B is to document an Applicant's experience and compliance history providing managed care services since January 2008. An Applicant must report experience and compliance as required in this Appendix. This may include the health plan experience/compliance of the Applicant and/or any entity within its corporate family as defined in Section IV.A Definitions/Applicable Regulations of this RFA.

Applicants must submit the following forms:

- One (1) "Applicant Contract/Compliance Summary Form"
- No more than a total of twenty (20) **"**Applicant Contract /Compliance Experience Forms" with a maximum of five (5) forms for each of the four lines of business/population categories (i.e., ABD Medicaid, CFC Medicaid (i.e, non-ABD), Medicare, and Commercial).

There are four lines of business of interest: ABD Medicaid, CFC Medicaid, Medicare, and Commercial. In the case of Medicaid, Applicants are required to divide their experience between ABD Medicaid and CFC Medicaid if possible. If breaking out the Medicaid population between ABD and CFC is not possible or feasible, the Applicant must report the Medicaid experience in a particular state as CFC Medicaid.

Applicants are required to report on all states in which health services are provided for all lines of business/populations. One "Applicant's Contract/Compliance Experience" form must be completed for each state and line of business/population (ABD Medicaid, CFC Medicaid, Medicare and Commercial) in which the Applicant provides health services. **If an Applicant has experience with a line of business/population in more than five states, then the Applicant must report all of the experience in Ohio and the four other states with the largest number of current membership.** Therefore, an Applicant may not report more than 5 forms (experience in five states) for each of the lines of business/population.

As an example, if an applicant has two (2) separately licensed Medicare health plans in the state of Ohio, one (1) Medicare plan in Texas and, in addition, the applicant has six (6) separately licensed health plans that serve the Commercial population in the six states of Ohio, Texas, New York, California, Indiana and Michigan then the applicant would need to complete (seven) 7 forms:

1 form for the Medicare experience in Ohio, (combining both Medicare contracts)
1 form for the Medicare experience in Texas,
1 form for the Commercial experience in Ohio; and
4 additional forms in which a separate form represents the Commercial experience in the four remaining states with the largest commercial membership.

INSTRUCTIONS FOR "APPLICANT CONTRACT/COMPLIANCE SUMMARY FORM"

A count of the number of total forms submitted for each of the four product lines/populations must be recorded on the form entitled: "APPLICANT CONTRACT/COMPLIANCE SUMMARY FORM." ODJFS will use this summary to determine whether all "Applicant Contract/Compliance Experience Forms" have been submitted as part of Appendix B.

INSTRUCTIONS FOR "APPLICANT CONTRACT/COMPLIANCE EXPERIENCE FORM"

The following are instructions for each section of the form:

Item 1: Name of Applicant – The name of the health insuring corporation as it appears on the license issued, or the licensure application currently under review, by the Ohio Department of Insurance (ODI).

Item 2: Name of Individual Completing This Form – The name of the individual completing the form.

Item 3: State – One of the fifty states or federal district of the United States of America where Applicant or a member of its corporate family was/is contracted to provide the managed care services for the line of business/population reported in this copy of the form.

Item 4: Line of Business/Population – Place an "X" in only one box that identifies the line of business/population that is being reported on the form. All experience for a Line of Business/Population provided within the state specified in Item 3 must be reported. Definitions of the Line of Business/Population can be found in Section IV.A Definitions/Applicable Regulations of this RFA.

Item 5: Calendar Year (CY) – Enter the total number of months for each of the indicated calendar years that the Applicant or a member of its corporate family provided services. Partial months should not be counted. For example, if the Applicant began services to members under the reported health plan in October 1, 2009 through the issuance date of this RFA (January 10, 2012) then the applicant would report CY 2008 = 0 months, CY 2009 = 3 months, CY 2010 = 12 months and CY 2011 = 12 months.

Item 6: Services and Risk – Place an "X" in each applicable box to identify the services the Applicant or member of its corporate family was/is contracted to provide. For each box that the Applicant checks, the Applicant must then place an "X" in the **one** box that describes the financial risk assumed by the corporate family (i.e., full, partial or none) in providing the services under the terms of their contract.

N/A = **if the corporate family did not provide this service then check this box.**

Full Risk = **if 80% or more of payments received for managing health care to members is at risk then check this box.**

Partial = **if less than 80%, but 20% or more of payments received for managing health care to members is at risk then check this box.**

No = **if less than 20% of payments received for managing health care to members is at risk then check this box.**

Hospital Care: Inpatient and outpatient health care services that are generally and customarily provided by hospitals.

Primary Care: Outpatient routine and preventive services that are generally provided by an individual physician (M.D. or D.O.), certain physician group practice/clinic

(Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in ORC 4723.43 or advanced practice nurse group practice within an acceptable specialty. Acceptable specialty types for services provided by primary care providers (PCPs) include family/general practice, internal medicine, and obstetrics/gynecology (OB/GYN). Acceptable PCCs include Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs), and the acceptable group practices/clinics specified by ODJFS.

Specialty Care: Specialized health care provided by physicians whose training focused primarily on a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.

Item 7: Member Months – A member month is defined as 1 member being enrolled for 1 month. For example, an individual who is a member of a plan for a full year generates 12 member months and a family of 5 enrolled for 6 months generates (5 X 6) 30 member months. The Applicant is to provide the total number of member months for each of the calendar years for the line of business/population that is being reported.

Item 8: Rural Service Area - Place an "X" in this box if the Applicant or a member of its corporate family provided services under the reported line of business/population to its members residing in a county that meets the federal definition of "rural" [42 CFR 412.62(f)(1)(iii)].

Item 9: Administrative Expense Ratio – Applicant is to report the Administrative Expense Ratio for CY 2011. The Administrative Expense Ratio is calculated by dividing total administrative expense by total revenue (Administration Expense/Revenue). Any portion of a sales or HIC tax that is reimbursed back to the Applicant by a state agency should not be counted as an administrative expense (e.g. Ohio's managed care sales and use tax collected by the Ohio Department of Taxation or the HIC tax collected by the Ohio Department of Insurance).

Item 10: Accreditation –Check "Yes" if the line of business/population in the reported state has a current accreditation level of Accredited, Commendable or Excellent with the National

Committee for Quality Assurance (NCQA) or currently passed accreditation (i.e., not conditional) with Utilization Review Accreditation Commission (URAC) for any of the following programs: case management, claims processing, disease management, drug therapy management, health call center, health plan, health provider credentialing, health utilization management, Medicare Advantage deeming program, or pharmacy benefit management. **Applicants that check YES for accreditation with URAC must identify each accredited program.**

Item 11: Performance Payments for Improved Health Outcomes. If an Applicant made payments to medical providers that were in addition to the normal, conventional fee for service used by the Applicant then the amount must be reported in Item 11. Such performance payments would be for the purpose of improving the delivery of health care in order to achieve improved health outcomes, and may include a care management fee to support Patient Centered Medical Homes, Pay for Performance payments to providers, or alternative payment arrangements to support ACO's. The Applicant may only report the amount of payment for one of the two identified calendar year periods (CY 2010 or CY 2011). The choice of which year's results (CY 2010 or CY 2011) and whether to report the percentage of total payment made during the calendar year or the total dollar amount of additional payments made to providers during the calendar year is at the discretion of the Applicant. Applicants are encouraged to refer to the scoring methodology when making their reporting choices.

Item 12: Applicant subject to any official governmental action revoking/proposing to revoke its licensure or excluded from participation. Check "Yes" if a government entity issued a notice since January 1, 2008 stating it will, or may, revoke a license of one of the health plans for which experience is being reported on Appendix B, or, if a state or federal agency took action since January 1, 2008 excluding from participation in Medicaid or Medicare one of the health plans for which experience is being reported on Appendix B.

Item 13: New Member Freeze – If the a government entity barred enrollment of new consumers or forced disenrollment of existing consumers into the health plan for reasons related to poor/unacceptable performance in delivering services, then place a check in the

boxes when the freeze/reduction was in effect. Do not check a box if a reduction/freeze was the result of market share or other reason not directly related to negative performance of the corporate family or its delegated entity. For example, Ohio Medicaid has the right to freeze an MCP's membership based on inadequate performance.

Item 14: Proposed Contract Termination/Nonrenewal – The Applicant must check this box if a state or the federal government proposed in a written/typed communication to terminate or not renew its contract with the Applicant or member of the corporate family for reasons related to negative performance of the corporate family or its delegated entity.

Item 15: Contract Termination/Nonrenewal - The Applicant must check this box if a state or the federal government initiated and executed a termination or nonrenewal of its contract with the Applicant or member of the corporate family for reasons related to negative performance of the corporate family or its delegated entity.

Item 16: Sanctions imposed under 42 CFR 438.730 – The Applicant must check this box for the applicable year(s) the Center for Medicare and Medicaid Services (CMS) issued a sanction under 42 Code of Federal Regulation 438.730 that affected any part of the experience reported on the form.

APPLICANT CONTRACT/COMPLIANCE SUMMARY FORM

(Cover Page for Appendix B Filing)

Instructions:
Applicants are to complete this form to serve as a reference for ODJFS. This form will enable ODJFS to know how many Appendix B forms to expect; (i.e. if the Applicant checks "Medicare", and places a "3" in the "Number of States" box, ODJFS would expect three (3) separate Applicant Contract/Compliance Experience Forms representing Medicare experience in three states.)

Applicants are to check which line of business/population(s) for which they have reported experience and fill in the number of states represented by the forms.

Line of Business/Population	Check Box if Experience Reported	Number of States (No more than 5 forms per Line of Business/Population)
Medicaid		
ABD	☐	
CFC	☐	
Medicare	☐	
Commercial	☐	

Applicant Contract/Compliance Experience Form

A separate form for each state and line of business/population

Item 1: Name of Applicant: _____

Item 2: Name of Individual Completing the Form: _____

Item 3: Name of State: _____

Item 4: Line of Business/Population (check only one box):

a) ABD Medicaid ☐
b) CFC Medicaid ☐
c) Medicare ☐
d) Commercial ☐

Item 5: Calendar Year (CY)	CY 2008 Full Months: _____	CY 2009 Full Months: _____	CY 2010 Full Months: _____	CY 2011 Full Months: _____
Item 6: Services & Risk:				
Hospital Care (includes inpatient and outpatient services)	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Primary Care	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Specialty Care	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Home Health	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Pharmacy	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No

Dental	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Vision	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Behavioral Health	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No	☐ - N/A ☐ - Full ☐ - Partial ☐ - No
Item 7: Member Months				
Item 8: Rural Service Area	☐	☐	☐	☐
Item 9: Administrative Expense Ratio				
Item 10: Accreditation	No: ☐ Yes: ☐ (if "Yes"check the boxes that apply) **NCQA** ☐ • Accredited ☐ • Commendable ☐ • Excellent ☐ URAC ☐ • Case management ☐ • Claims processing ☐ • Disease management ☐ • Drug therapy management ☐ • Health call center ☐ • Health plan ☐ • Health provider credentialing ☐ • Health utilization management ☐ • Medicare advantage deeming program ☐ • Pharmacy benefit management ☐			

Applicant Contract/Compliance Experience Form

Item 11: Has the Applicant made any additional payments for services directly related to improving health outcomes above the compensation for services rendered by the medical provider? Examples include additional payments for patient centered medical homes, accountable care organizations or pay for performance to providers. If so, report the additional total payment made to medical providers and the payment date for either CY 2010 or CY 2011 below:

Payment Year (check one box): ☐ **CY 2010 or** ☐ **CY 2011**

Additional Payment Amount: $_____ or % of Total Payments: _____

Item 12: Was Applicant subject to any official governmental action revoking or proposing to revoke its licensure since January 1, 2008 or excluded from participation by a state or federal agency (for the state and population identified on this form)?

☐ Yes or ☐ No

<u>If experience reported on this form is relating to ABD Medicaid, CFC Medicaid, or Medicare line of business/population then provide a response to the following:</u>

Items 13, 14, 15 & 16:
Was the health plan subject to any of the following regulatory actions? ☐ Yes ☐ No

If Yes, check the applicable action for the calendar year(s) that the action was in effect:

Item:		CY 2008	CY 2009	CY 2010	CY 2011
13	New Member Freeze *Due to performance not market share	☐	☐	☐	☐
14	Proposed Contract Termination/Nonrenewal	☐	☐	☐	☐
15	Contract Denial/ Termination/Nonrenewal	☐	☐	☐	☐
16	Sanctions imposed under 42 CFR 438.730	☐	☐	☐	☐

Provide the primary contact information, including the name, telephone and fax numbers, for the agency that proposed and/or assessed the above regulatory action(s).

_____

_____

<u>ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.</u>

Appendix B
Applicant's Contract/Compliance Experience
Scoring Methodology

The following score sheet and related scoring methodology will be used by ODJFS to evaluate each Applicant's submitted information for this Appendix. Applicants are NOT to fill out and return the "Score Sheet" for this or any section. The score sheets are presented within this RFA to establish the criteria, and their relative importance within the entire RFA scoring process, on which applications will be evaluated and through which the successful applicant will be selected. Applicants are strongly encouraged to use all score sheets to evaluate their own application packages for completeness, quality, and compliance with instructions and requirements prior to submitting them to ODJFS.

Overview:

Step 1: ODJFS will score each individual Appendix B form independently not to exceed a total of 30,000 points for each form. See below **Step 1: Scoring of Individual Forms**.

Step 2: All forms for each of the four lines of business/populations (ABD, CFC Medicaid, Medicare and Commercial) will be combined into one score using "Member Months" to derive a single score for each Line of business/population not to exceed 30,000 for each business line/population. See below **Step 2: Combining Individual Forms for Each Line of Business/Population.**

Step 3: The individual scores for each of the four business lines/populations will be assigned a weight and combined into a single score for Appendix B that will not

exceed 30,000. See below **Step 3: Combining Line of Business/Population Scores into a Final Score.**

Step 1: Scoring of Individual Forms

1. To start, Applicants receive points for each calendar year by checking various boxes of **Item 6**, Services & Risks as indicated in Exhibit B-1. The score is tallied by calendar year.

2. Should an Applicant report less than three (3) months of experience for any calendar year then the score for that calendar year shall be made zero.

3. The individual calendar scores obtained above are multiplied by percentages outlined in Exhibit B-1 in the following order:

   a. **Item 7**: Member Months – Any calendar year with less than 600,000 member months is reduced by the percentage shown in Exhibit B-1.

   b. **Item 8**: Rural Service Area – if the rural service area box is marked then the corresponding calendar year is increased by the percentage shown in Exhibit B-1.

4. Individual calendar year scores are added together to produce a single preliminary score for the form.

5. The preliminary score (hereafter referred to as "score") is multiplied by the following factors in the following order:

   a. **Item 9**: Administrative Expense Ratio - the ratio reported for CY 2011~~0~~, or the most recent calendar year reported on the form is compared to the administrative expense ratio provided in Exhibit B-1. If the reported ratio is

greater than the range provided in Exhibit B-1 then the score is reduced by the percentage set forth in Exhibit B-1.

b. **Item 10**: Accreditation – Should the Applicant indicate that there is accreditation then the score is increased by the percentage indicated in Exhibit B-1. But, in no case will the increase due to accreditation exceed (10%) ten percent.

c. **Item 11**: An Applicant that has made payments to medical providers related to improving health outcomes during either CY 2010 or CY 2011, a minimum of 1% of total payments for the reported experience or $5,000,000 in additional payments for the reported experience, will receive an increase in scoring as set forth in Exhibit B-1.

d. **Item 12**: Subject to Official Government Action Revoking or Proposing to Revoke – checking the "YES" box will result in a decrease to the score as set forth in Exhibit B-1.

e. **Items 13, 14 & 15**: New Member Freeze; Proposed Contract Termination/Nonrenewal; Contract Termination/Nonrenewal – Should any of the boxes be checked in for any year and for any item then the score will be decreased by the percentage indicated in Exhibit B-1.

6. If the experience reported on the form is for Ohio, then the score is increased by the percentage stated in Exhibit B-1 at Item 3.

Step 2: Combining Individual Forms for Each Line of Business/Population

1. For each line of business/population (ABD Medicaid, CFC Medicaid, Medicare, Commercial), scores from all individual forms derived by following Step 1 are combined into one score for the line of business/population by assigning a weight to each individual form based on the most recently reported Member Months as follows (See Exhibit B-2):

a. For each line of business/population, Member Months from CY 2011, or the most recent calendar year reported on the form, are totaled (Total Member Months);
b. The reported Member Months for each of these individual forms is divided by the Total Member Months to get a weighting for each form;
c. The score for each form is multiplied by its weight to get a weighted score;
d. All weighted scores are added together to get one score for the line of business/population.

2. If there is only one form submitted for a particular line of business/population then the score is reduced by the percentage shown at the bottom of Exhibit B-2.

3. In order for a particular line of business/population (i.e. ABD, CFC, Medicare or Commercial) for a reported state to be considered during the scoring process, Item 7 (i.e. CY 2008, CY 2009, CY 2010 or CY 2011) must contain a minimum of 36,500 member months. If Item 7 contains fewer than 36,500 member months then the line of business/population will not be considered in the scoring and will not be used in Step 3 below.

Step 3: Combining Line of Business/Population Scores into a Final Score

1. The line of business/population scores calculated (and countable) in Step 2 are combined to derive a final, single score for Appendix B using the percentages as outlined in Exhibit B-3.

2. The percentages used to combine line of business/population scores depends on which lines of business/populations received a score. For example, if an Applicant submitted forms representing experience with CFC Medicaid and Medicare (i.e. no experience with ABD Medicaid or Commercial) then Line 9 of Exhibit B-3 would be used. The CFC Medicaid score would be multiplied by 80% and the Medicare score would be multiplied by 5%. The results of these two calculations would be added together to get a single score.

3. A maximum of 30,000 points may be awarded for Appendix B. Any Applicant that receives a score of more than 30,000 as a result of the calculations set forth above will be credited with 30,000.