

APPENDIX B

APPLICANT'S CONTRACT/COMPLIANCE EXPERIENCE

Appendix B documents an Applicant's experience and compliance history that ODJFS believes is relevant to providing the type and level of services necessary to care for Ohio's population of Medicare-Medicaid enrollees. An Applicant must report experience and compliance as required in this Appendix. This may include the experience/compliance of the Applicant and/or any entity within its corporate family and/or a partner as defined in Section III.A of this RFA.

This Appendix is divided into two parts: Part I requests information regarding Applicant's statewide experience with Medicare and Medicaid, and Part II requests information regarding current health plan operations for Medicare Advantage, Medicaid, and commercial insurance in those regions for which an Applicant is applying. Appendix B will produce a separate score for each region for which the Applicant has applied. The final score for Appendix B will be a combination of the score from Part I and the score for Part II associated with a particular region. For example, if an Applicant applied for the Central and East Central regions, ODJFS would calculate two Appendix B scores; one score for the Central region and one score for the East Central Region. Each of the scores would be comprised of the score from Part I and the score from Part II associated solely with the region being applied for.

Part I: Statewide Experience (Maximum Points: 5,000)

(1) Applicants must submit no more than a total of **five (5)** "Applicant Contract /Compliance Experience Forms" that reflect combined information regarding Medicare and Medicaid lines of business related to the Applicant and/or any entity within its corporate family and/or its partner within the selected state; and

(2) If an Applicant operates Medicare and/or Medicaid lines of business in more than 5 states then the Applicant may choose which five states' experience to report; and

(3) If an Applicant does not operate a Medicare and/or Medicaid lines of business in at least five states then the Applicant must complete and submit forms representing Medicare and/or Medicaid business in all states in which it operates these lines of business.

INSTRUCTIONS FOR COMPLETING AN "APPLICANT STATEWIDE CONTRACT/COMPLIANCE EXPERIENCE FORM"

The following are instructions for each section of the form by item number:

Item 1: Name of Applicant – The name of the health insuring corporation(s) as it appears on the Certificate of Authority issued, or the Certificate of Authority application currently under review, by the Ohio Department of Insurance (ODI). **Name of Individual Completing This Form** – The name of the individual completing the form.

Item 2: Name of State – One of the fifty states or federal district of the United States of America where the Applicant or a member of its corporate family or its partner was/is contracted to provide the managed care services for the line of business reported in this copy of the form.

Item 3: 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 or its partner 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 (April 24, 2012) then the applicant would report CY 2009 = 3 months, CY 2010 = 12 months, and CY 2011 = 12 months.

Item 4: Coverage & Line of Business – Check all applicable boxes. If the Applicant provided services during the identified calendar year under contract for any of the following lines of business (i.e. Medicaid, Medicare) then check the appropriate box.

- a. Medicaid – See Section III.A Definitions of this RFA.
- b. Medicare – Medicare as defined in Section III.A Definitions of the RFA and are coordinated care plans (such as health maintenance organization (HMO), provider sponsored association (PSO), and/or preferred provider organization (PPO) plans).

The following definitions apply to the services:

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

Primary Care/Specialty Care: Primary care includes 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 Ohio Revised Code § 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 and internal medicine. Acceptable PCCs include Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs), and the acceptable group practices/clinics specified by ODJFS. Specialty care includes 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.

Home Health: Home health services include home health nursing, home health aide and skilled therapies.

Pharmacy: Pharmacy services include generic and brand name drugs.

Dental: Dental services include examinations, diagnostic services, preventive services, restorative, endodontic, periodontic, orthodontic, oral surgery and other dental services.

Vision: Vision care services include examinations, fittings, and dispensing of ophthalmic materials (including contact lenses, low vision aids, etc.).

Behavioral Health: Providing access to mental health and substance abuse services including, but not limited to, acute/sub-acute psychiatric inpatient, medication management, day/residential rehabilitation, intensive outpatient, day treatment, partial hospitalization, crisis stabilization, opioid maintenance therapy. For more information, please see Appendix E

of Attachment 1 of this RFA: Ohio's Demonstration Proposal to Integrate Care for Medicare-Medicaid Enrollees.

LTC Institutional: Long-term nursing facility services which are designed to meet an individual's medical, personal, social and safety needs.

Home- and Community-Based Services (HCBS): A range of home and community services and supports designed to meet an individual's medical, personal and safety needs as an alternative to long term nursing facility care to enable a person to live as independently as possible.

Durable Medical Equipment: Includes medical supply, durable medical equipment, orthosis, prosthesis, or related services.

Item 5: ABD Medicaid – If the Medicaid experience being reported includes experience providing services the ABD Medicaid population then check the box for the appropriate year(s). See Section III.A Definitions of this RFA.

Item 6: Member Months – A member month is defined as 1 member being enrolled for 1 complete 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 (i.e., Medicaid and/or Medicare) that is being reported.

Item 7: Administrative Expense Ratio – Applicant is to report the Administrative Expense Ratio for CY 2011 or if there is no experience reported for CY 2011 then the most current calendar year for which there is experience must be reported. The Administrative Expense Ratio is calculated by dividing total non-medical expense by total revenue (Administration Expense/Revenue). Expenses for activities that improve health quality should not be considered as “non-medical expense” for this purpose. Any pass-through, portion of a sales or HIC tax that is reimbursed back to the Applicant by a state agency should not be included in either the non-medical expense or the total revenue (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). Applicant should report the Medicare and Medicaid lines of business as separate administrative expense ratios, if applicable.

Item 8: Participant-Directed Care – Is a model for individuals who receive long term services and supports that allows the enrollee greater choice and control along a continuum of hiring, firing, training, supervising or paying independent providers. If the Applicant had experience entering into and administering participant-directed care arrangements, then check the one box that best represents the number of months experience since January 2009.

Item 9: Accreditation – Check the appropriate box if the Applicant for the reported state has a current accreditation level of Accredited, Commendable or Excellent with the National Committee for Quality Assurance (NCQA). If there are multiple product lines with various levels of accreditation then report only the highest level of accreditation for the reported state.

Item 10: Applicant subject to any official governmental action revoking/proposing to revoke its licensure. Check “Yes” if a government entity issued a written notice since January 1, 2007 stating it

will, or may, revoke a license of one of the health plans for which experience is being reported on Appendix B.

Item 11: New Member Freeze – If 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 12: 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 13: Contract Denial/Termination/Nonrenewal - The Applicant must check this box if a state or the federal government initiated and executed a denial or 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 14: Sanctions imposed under 42 CFR 438.730 or 42 CFR 422.510 – 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 or termination of contract under 42 CFR 422.510 that affected any part of the experience reported on the form.

Applicant Statewide Contract/Compliance Experience Form

A separate form for each state

Item 1: Name of Applicant: _____

Name of Individual Completing the Form: _____

Item 2: Name of State: _____

Item 3: Calendar Year (CY)	CY 2009 Full Months: _____	CY 2010 Full Months: _____	CY 2011 Full Months: _____
Item 4: Coverage	Line of Business	Line of Business	Line of Business
Hospital (includes inpatient and outpatient services)	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Primary Care /Specialty Care	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Home Health	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Pharmacy	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Dental	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Vision	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare

Behavioral Health	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
LTC Institutional	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
HCBS	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Durable Medical Equipment	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Item 5: ABD Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Item 6: Member Months			
Medicaid	_____	_____	_____
Medicare	_____	_____	_____
Item 7: Administrative Expense Ratio and Reporting Year	Medicare: _____ Medicaid: _____ Year: _____ Year: _____		
Item 8: Participant-Directed Care	(check no more than one box) More than 12 months <input type="checkbox"/> 1 – 12 months <input type="checkbox"/>		
Item 9: Accreditation	NCQA <input type="checkbox"/> • Accredited <input type="checkbox"/> • Commendable <input type="checkbox"/> • Excellent <input type="checkbox"/>		

Item 10: Since January 1, 2007, was any entities for which experience is reported on this form subject to any official governmental action for the state experience identified on this form:

a. revoking its licensure Yes or No

b. proposing to revoke its license Yes or No

Items 11, 12, 13 & 14:

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 2009	CY 2010	CY 2011
11	New Member Freeze <small>*Due to performance not market share</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Proposed Contract Termination/Nonrenewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Contract Denial/ Termination/Nonrenewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Sanctions/termination imposed under 42 CFR 438.730 or 42 CFR 422.510	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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).

In the space below, provide the names and state of incorporation of all the entities for which experience is being reported on this form (e.g. ABC Health Plan, Inc (Ohio)). Names of delegated entities do not need to be reported:

ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.

Part II: Applicant Regional Experience (Maximum Points: 15,000)

For those regions an Applicant is applying, mark all the areas of coverage for each of the counties for which Applicant, as of April 1, 2012, has an active membership and provides health plan services to that membership.

Region: Central

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Delaware	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Franklin	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Madison	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pickaway	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Union	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: East Central

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Portage	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stark	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summit	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wayne	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: Northeast

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Cuyahoga	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geauga	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lake	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lorain	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medina	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: Northeast Central

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Columbiana	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mahoning	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trumbull	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: Northwest

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Fulton	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lucas	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ottawa	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wood	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: Southwest

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Butler	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clermont	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinton	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamilton	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warren	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Region: West Central

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Clark	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greene	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Montgomery	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix B

Applicant's Contract/Compliance Experience

Scoring Methodology

The remainder of this Appendix is a description of the process that will be used by ODJFS in scoring an Applicant's responses to the questions in this Appendix. Applicants are not to fill in and return this section with their applications. However, ODJFS strongly encourages applicants to use these pages to evaluate the quality and responsiveness of their application packets prior to submission.

This appendix produces a score for each region for which the Applicant has applied. A regional score is equal to the score from Part I plus the score for the particular region calculated in Part II.

PART I: Scoring Methodology

Overview:

- Step 1: ODJFS will score each individual state Appendix B form independently not to exceed a total of 5,000 points for each state form. See below Step 1: Scoring of Individual Forms.
- Step 2: Each individual state form will be combined by multiplying individual state form scores by a set factor to derive a single score for the Applicant not to exceed 5,000. See below Step 2: Combining Individual Forms Into a Final Score.

Step 1: Scoring of Individual State Forms

1. To start, Applicants receive points for each calendar year for each line of business (LOB) by checking various boxes of "**Item 4: Coverage**". The value for each box checked is indicated in Exhibit B-1. The score is tallied by calendar year.
2. If an Applicant reports less than three (3) months of experience for any calendar year then the zero points will be given for that calendar year.
3. **Item 5: ABD Medicaid:** For any year that an Applicant has checked the ABD Medicaid box that individual calendar year score is increased by the percentage set forth in Exhibit B-1.
4. **Item 6: Member Months –** For each calendar year, the member months reported for the two lines of business (i.e. Medicaid and Medicare) are totaled. If this total is less than 36,000 Member Months then zero points will be given for that particular calendar year.
5. Individual calendar year points are added together to produce a single preliminary score for the form.

6. The preliminary score (hereafter referred to as “score”) is multiplied by the following factors in the following order:
 - a. **Item 7:** Administrative Expense Ratio - the Medicaid and Medicare ratios reported for CY 2011, or the most recent calendar year reported on the form are compared to the administrative expense ratio provided in Exhibit B-1. If any one of the reported ratios is greater than 15% then the score is reduced by the percentage set forth in Exhibit B-1.
 - b. **Item 8:** Participant Directed Care – If the Applicant reports participant-directed care then the score is increased by the percentage indicated in Exhibit B-1.
 - c. **Item 9:** Accreditation – If the Applicant reports NCQA accreditation then the score is increased by the percentage indicated in Exhibit B-1.
 - d. **Item 10:** Subject to Official Government Action – checking the “YES” box will result in a decrease to the score as set forth in Exhibit B-1
 - e. **Items 11, 12, 13 & 14:** New Member Freeze; Proposed Contract Termination/Nonrenewal; Contract Termination/Nonrenewal; 42 CFR 438.730 Sanction – 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. Even if multiple boxes are checked, the score shall only be reduced once by 30%.
7. If the score for the individual form is greater than 5,000 then the final score for the individual form shall be 5,000. Otherwise, the preliminary form score is the final score for the individual form.

Step 2: Combining Individual Forms into a Final Score

The Applicant’s individual form scores are derived by following Step 1 and are combined into one weighted score by assigning a weight to each individual state form based on the most recently reported Member Months as follows (See Exhibit B-2 for an example):

1. Member Months from CY 2011, or the most recent calendar year reported, on the Applicant’s individual state forms are totaled (Total Member Months);
2. For each Applicant, the reported Member Months for CY 2011, or the most recent calendar year reported on the individual state form, is divided by the Applicant’s Total Member Months to get a weight for the individual state form;
3. The score for Part I, Step 1 from each Applicant’s individual “Applicant Statewide Contract/Compliance Experience Form” is multiplied by its weight as calculated in item 2 above to get a weighted score;
4. All weighted scores calculated in item 3 above are added together to get a single, preliminary weighted score for Part I for each Applicant.

PART II: Scoring Methodology

Applicants will be individually scored for each region. For each region an applicant may not score more than the maximum points of 15,000. For each region, if the applicant checked only one of the three boxes for a county (Medicare Advantage, Medicaid, and Commercial) then the score associated with the check box is the score for the county. If the applicant checked multiple boxes for a county then the checked box that awards the highest score is counted. For example, if applicant for the Central region checked the Medicare Advantage, Medicaid, and Commercial boxes for Delaware County then the Applicant would receive a score of 3,000 for Central region/Delaware County. The county points are totaled for a total score for Part II of this appendix for the specific region.

Region: Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Delaware	CEN	3,000	2,400	1,500
Franklin	CEN	3,000	2,400	1,500
Madison	CEN	3,000	2,400	1,500
Pickaway	CEN	3,000	2,400	1,500
Union	CEN	3,000	2,400	1,500

Region: East Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Portage	EC	3,750	3,000	1,875
Stark	EC	3,750	3,000	1,875
Summit	EC	3,750	3,000	1,875
Wayne	EC	3,750	3,000	1,875

Region: Northeast

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Cuyahoga	NE	3,000	2,400	1,500
Geauga	NE	3,000	2,400	1,500
Lake	NE	3,000	2,400	1,500
Lorain	NE	3,000	2,400	1,500
Medina	NE	3,000	2,400	1,500

Region: Northeast Central

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Columbiana	NEC	5,000	4,000	2,500
Mahoning	NEC	5,000	4,000	2,500
Trumbull	NEC	5,000	4,000	2,500

Region: Northwest

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Fulton	NW	3,750	3,000	1,875
Lucas	NW	3,750	3,000	1,875
Ottawa	NW	3,750	3,000	1,875
Wood	NW	3,750	3,000	1,875

Region: Southwest

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Butler	SW	3,000	2,400	1,500
Clermont	SW	3,000	2,400	1,500
Clinton	SW	3,000	2,400	1,500
Hamilton	SW	3,000	2,400	1,500
Warren	SW	3,000	2,400	1,500

Region: West Central

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Clark	WC	5,000	4,000	2,500
Greene	WC	5,000	4,000	2,500
Montgomery	WC	5,000	4,000	2,500