APPENDIX F

APPENDIX F
APPLICANT'S MANAGED CARE EXPERIENCE

TO BE COMPLETED BY THE APPLICANT

The Applicant must complete a separate APPENDIX F for each state where the Applicant has contracted with a state agency to provide managed care services since January 2015.

State: _____

Name of Health Plan in This State*:_____The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Applicant for this Pennsylvania RFA, the Applicant must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix F. The Applicant must be able to document that both entities are under the control of the same corporate family.

Name of Applicant: _____

Name of Individual Completing This Appendix F:

_____

Does the Applicant have experience since January 2015? If the Applicant has experience since January 2015 where they were the primary party who contracted with a state agency to provide managed care services, then the Applicant is to check "Yes" and complete the remainder of this Appendix F. If the Applicant was not the primary contractor and/or the Applicant is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Applicant is to check "No" and is not to complete the remainder of this Appendix F.

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APPLICANT'S MANAGED CARE EXPERIENCE

CONTRACT YEAR Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		**CONTRACT YEAR 2015-2016**	**CONTRACT YEAR 2016-2017**	**CONTRACT YEAR 2017-2018**	**CONTRACT YEAR 2018-2019**
PRIMARY CONTRACTOR Place an "x" in the box if the Applicant is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Applicant and the state agency, and the Applicant must be the party held accountable by the state agency for meeting the provisions of the contract.		YES □ NO □	YES □ NO □	YES □ NO □	YES □ NO □
POPULATION Place an "x" in this box for each population group included in the contract between the Applicant and the state agency. If the Applicant places an "x" next to "OTHER", the Applicant is to provide clarification under the Additional Explanation section of this Appendix F. TANF = Temporary Aid to Needy Families ABD = Aged, Blind and Disabled	TANF				
	AGED, BLIND, DISABLED				
	OTHER*				

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SERVICES Place an "x" in the one box that describes the services the Applicant was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Applicant was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Applicant was only required to cover up to 30 days in a long term care facility for their members and any additional needed long term care coverage was provided through the state's traditional Medicaid program). If the Applicant places an "x" next to any Services option marked with an asterisk, the Applicant is to provide clarification.	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*				
	Behavioral Health Only				

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Additional Explanation: If you checked any of the boxes under headings with an (*), provide clarification below: **Name of Health Plan:** **Population:** **Services:**				