

APPENDIX D

**APPENDIX D
APPLICANT’S MANAGED CARE EXPERIENCE**

TO BE COMPLETED BY THE APPLICANT

The Applicant must complete a separate APPENDIX D for each state where the Applicant has contracted with a state agency to provide managed care and managed long- term services and supports (MLTSS) since January 2020.

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’s for this Pennsylvania RFP, the Applicant must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix D. 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 D:

Does the Applicant have experience since January 2020? If the Applicant has experience since January 2020 where they were the primary party who contracted with a state agency to provide managed care services and MLTSS, then the Applicant is to check “Yes” and complete the remainder of this Appendix D. 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 D.

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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 2020-2021	CONTRACT YEAR 2021-2022	CONTRACT YEAR 2022-2023	CONTRACT YEAR 2023-2024	
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 <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
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 D. TANF = Temporary Aid to Needy Families DUAL = Dually eligible for Medicare and MA. LTSS = Long-term Services and Supports	TANF				
	DUAL				
	LTSS				
	Other				

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<p>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 additionally 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.</p>	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*				
	Behavioral Health Only				
	LTSS				

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CONTRACT YEAR	CONTRACT YEAR 2020-2021	CONTRACT YEAR 2021-2022	CONTRACT YEAR 2022-2023	CONTRACT YEAR 2023-2024
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.				

Additional Explanation:

If you checked any of the boxes under headings with an (*), provide clarification below:

Name of Health Plan:

Population:

Services: