**OTHER STATE Medicaid Experience**

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| **Bidder Name:** |  |

**General Instructions**

Complete a copy of Other State Medicaid Experience for each state in which the Bidder, affiliate or ASO was contracted to provide managed care to Medicaid beneficiaries at any time from 2017 or later. Complete unshaded sections of the form. Include current contracts in the proposal in alphabetical order by state, followed by closed contracts in alphabetical order by state. If there are no states to report, include one copy of this form with only the Bidder’s name entered.

**Organization**

Instructions: An experience form can be completed on behalf of the Bidder, an affiliated organization and/or an Administrative Service Organization (ASO).

If the reported experience is for an affiliated organization, identify the affiliate. Otherwise enter Not Applicable. For the purpose of this form, an affiliated organization is a parent company or subsidiary of a parent company (other than the Bidder).

If the reported experience is for an ASO, identify the ASO. Otherwise enter Not Applicable.

For the purpose of this form, an ASO is a major subcontractor performing management services on behalf of the Bidder.

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| **Affiliate:** |  |
| **ASO:** |  |

**Program**

Instructions: Enter month and year for contact start and end dates. If contract is still active, enter “current” in end date box. Enter “risk” under Contract Type if organization was capitated and at financial risk for at least 50 percent of the actuarial value of services delivered under the contract. Enter “non-risk” for all other contracts. If the organization is an ASO, and the ASO itself was not at financial risk as defined on this form, enter “non-risk”, even if the underlying contract was risk-based.

If a contract is closed, enter one of the following in the Closure Reason cell: “Re-procurement – no award”, “Re-procurement – did not bid”, “Terminated prior to contract end” or “Other”. If either of the last two reasons is entered, provide an explanation of 100 words or less in the Closure Explanation cell.

| **State:** |  | | |
| --- | --- | --- | --- |
| **Program Name:** |  | | |
| **Contract Start:** |  | **Contract End:** |  |
| **Contract Type:** |  | **Closure Reason:** |  |
| **Closure Explanation:** |  | | |

**Accreditation**

Instructions: Describe any accreditation(s) held by the Bidder, affiliate or ASO (as applicable).

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**Enrollment**

Instructions: For current contracts, enter enrollment in most recent month for which enrollment data is available. For closed contracts, enter enrollment in month one of the final calendar year of the contract.

If a particular Medicaid population was not enrolled, enter 0 in the enrollment cell. Enter the sum of the preceding cells in the Total Enrollment cell.

If enrollment is mandatory for a majority of a population, enter “Mandatory” in the Mandatory/Voluntary row. If not, enter “Voluntary.”

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| **Month & Year:** |  | | |  | | |  | | |
| **Population** | **Medicaid Child** | **Medicaid Pregnant Women** | **Medicaid Expansion Adults** | | **Medicaid Parent/ Caretaker** | **Medicaid Foster Children** | | **CHIP** | **Total Enrollment** |
| **Medicaid Enrollment** |  |  |  | |  |  | |  |  |
| **Medicaid Mandatory or Voluntary** |  |  |  | |  |  | |  |  |

**Services**

Instructions: Enter “Yes” if a service was included in the capitated benefit package for a population and “No” if it was excluded. If a service was partially included and partially excluded, enter “Partial” and briefly explain in one of the comment rows. (If the included portion of services equaled ninety percent (90%) or more of the actuarial value of the service, classify as “included.”) If the organization is an ASO, enter “Yes” or “No” based on the underlying contract that the ASO was managing.

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| **Month & Year:** | |  | | | | |  | | |
| **Population/**  **Service** | | **Medicaid Child** | | **Medicaid Pregnant Women** | **Medicaid Expansion Adults** | | | **Medicaid Parent/ Caretaker** | **Medicaid Foster Children** | | **CHIP** |
| **Hospital** | |  | |  |  | | |  |  | |  |
| **Physician** | |  | |  |  | | |  |  | |  |
| **Pharmacy** | |  | |  |  | | |  |  | |  |
| **Behavioral Health** | |  | |  |  | | |  |  | |  |
| **Description of “Partial” (Insert additional rows as needed)** | | | | | | | | | | | |
| **Population** |  | | **Description** | | |  | | | | | |
| **Service** |  | |
| **Population** |  | | **Description** | | |  | | | | | |
| **Service** |  | |
| **Population** |  | | **Description** | | |  | | | | | |
| **Service** |  | |