ATTACHMENT II
EXHIBIT II-C – Effective Date: February 1, 2018
CHRONIC DISEASE SPECIALTY PLAN

Section I. Definitions and Acronyms

The definitions and acronyms in Attachment II, Section I, Definitions and Acronyms apply to the Specialty Plan unless specifically noted otherwise in this Exhibit.

A. Definitions

Original Medicare – Medicare fee-for-service program.

Chronic Conditions – General descriptor for one, or a combination of, the following medical conditions: Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) or Cardiovascular Disease (CVD).

Section II. General Overview

In accordance with the order of precedence listed in Attachment I, any additional items or enhancements listed in the Managed Care Plan's response to the Invitation to Negotiate are included in this exhibit by this reference.

Section III. Eligibility and Enrollment

During Phase I of this Contract, the Agency may waive requirements applicable to the "dual-eligible" population. The Agency reserves the right to review, or approve requirements when the Centers for Medicare and Medicaid Services have approved duplicative provisions for the Medicare Advantage Dual Eligible Special Needs Plan (MA D-SNP) as referenced in the Agency's contract (#FP039).

A. Eligibility

1. Phase 1 Eligibility Criteria

a. The specialty population eligible to enroll in the Specialty Plan shall consist of only those mandatory recipients specified in Attachment II and Exhibits who meet the following conditional criteria:

(1) Age twenty-one (21) years or older;

(2) Diagnosed with a chronic condition as defined in this Exhibit; and

(3) Full benefit dual eligibles enrolled in a Medicare Advantage coordinated care plan operated by the Specialty Plan or its affiliates as identified in paragraph b. below.

b. The specialty population eligible to enroll in the Specialty Plan shall consist of only those recipients enrolled in the following Medicare Advantage coordinated care plans

identified by the Centers for Medicare & Medicaid Services (CMS) contract numbers below:

(1) H5594; and
(2) H5427.

c. The Agency may amend, subject to approval of Medicare Advantage contracts by CMS for each plan year, the Medicare Advantage coordinated care plans specified in paragraph b. above.

2. Phase 2 Expansion Eligibility Criteria

a. The Agency, at its sole discretion, may expand the specialty population eligible to enroll in this Specialty Plan to include those mandatory and voluntary recipients specified in Attachment II and Exhibits who are full benefit dual eligibles covered under Original Medicare (i.e. recipients not enrolled in a Medicare Advantage Plan).

b. Full benefit dual eligibles covered under Original Medicare included in the expanded specialty population must also meet the following conditional criteria:

(1) Age twenty-one (21) years or older; and

(2) Diagnosed with chronic condition as defined in this Exhibit.

3. Phase 3 Expansion Eligibility Criteria

a. The Agency, at its sole discretion, may expand the specialty population eligible to enroll in the Specialty Plan to include those mandatory and voluntary recipients specified in Attachment II and Exhibits who are Medicaid-only recipients who may benefit from improved coordination and continuity of care to recipients with chronic conditions.

b. Medicaid-only recipients included in the expanded specialty population must also meet the following conditional criteria:

(1) Age twenty-one (21) years or older; and

(2) Diagnosed with chronic condition as defined in this Exhibit.

4. Implementation Plans and Expansion of Eligibility

a. The Agency, at its sole discretion, shall determine the time frames for the phased implementation of the specialty population eligible to enroll in the Specialty Plan. The Specialty Plan shall develop a proposed implementation plan at least one-hundred-eighty (180) days prior to the implementation of any phase of eligibility and enrollment for consideration by the Agency. Each implementation plan shall address the relevant actions required by the Specialty Plan and the Agency, and proposed time frames, for enrollment of the specified specialty population in the Specialty Plan. The Specialty Plan shall submit the implementation plan for Phase 1 eligibility and enrollment to the Agency by May 1, 2014. The Specialty Plan and the Agency shall cooperate in good faith on the development and review of implementation plans for any subsequent expansion of the specialty population.

b. The Agency, in conjunction with the Centers for Medicare & Medicaid Services (CMS) may conduct a readiness review prior to any expansion of the eligible specialty population to assess the Specialty Plan's readiness and ability to provide services to such additional eligible recipients. The plan readiness review may include, but is not limited to, desk and onsite review of plan policies and procedures, and corresponding documents, the plan's provider network and corresponding contracts, a walk-through of the plan's operations, system demonstrations, and interviews with plan staff. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency. The Agency will not enroll additional recipients in the expanded specialty population into the Specialty Plan until the Agency has determined it meets plan readiness requirements as established by the Agency.

c. Prior to enrolling any expanded specialty population recipients in the Specialty Plan, the Agency may establish additional Contract requirements it deems in the best interest of the state and the Medicaid recipients it serves.

B. Enrollment

1. Phase 1 Specialty Population Enrollment

a. The Specialty Plan shall report, in a format and timeframe prescribed by the Agency, recipients meeting specialty population eligibility criteria enrolled in the Medicare Advantage coordinated care plans specified in paragraph Section A.1.

b. Recipients meeting specialty population eligibility criteria shall be enrolled in the Specialty Plan following the Agency identifying recipients eligible for the Specialty Plan in the Florida Medicaid Management Information System (FMMIS). The Agency shall update FMMIS to indicate recipient eligibility for the Specialty Plan on the penultimate Saturday of each month.

2. Specialty Plan Enrollment for Expansion Phases

The Agency reserves the right to amend the Contract to incorporate additional enrollment provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

C. Disenrollment

The Specialty Plan shall submit involuntary disenrollment requests to the Agency or its designee, in a format and timeframe prescribed by the Agency, for each enrollee that does not meet specialty population eligible criteria for the Specialty Plan, to include the reasons for disenrollment from the Medicare Advantage coordinated care plans specified in paragraph Section A.1.

D. Marketing

The Specialty Plan shall cooperate with the Agency in integrating marketing requirements with Medicare Advantage marketing standards for the specialty population eligible to enroll in the Specialty Plan under the Phase 1 eligibility criteria. The Specialty Plan shall notify the Agency of changes in Medicare Advantage marketing standards within five (5) business days of

receiving notice of such changes from the Centers for Medicare & Medicaid Services (CMS). The Agency reserves the right to amend the Contract to incorporate additional marketing provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

Section IV. Enrollee Services and Grievance and Appeal System

The provisions in Enrollee Services and Grievance and Appeal System apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Specialty Plan shall cooperate with the Agency in integrating enrollee services and grievance procedures with Medicare Advantage requirements for the specialty population enrolled in the Specialty Plan under the Phase 1 eligibility criteria. The Agency reserves the right to amend the Contract to incorporate additional enrollee services and grievance procedures provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

Section V. Covered Services

The provisions in Section V, Covered Services apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Specialty Plan shall cooperate with the Agency in integrating care coordination/case management standards with the Specialty Plans Medicare Advantage model of care for the specialty population eligible enrolled in the Specialty Plan under the Phase 1 eligibility criteria. The Agency reserves the right to amend the Contract to incorporate additional covered services provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

Section VI. Provider Network

The provisions in Section VI, Provider Network apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Agency reserves the right to amend the Contract to incorporate additional provider network provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

Section VII. Quality and Utilization Management

The provisions in Section VII, Quality and Utilization Management apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Specialty Plan shall cooperate with the Agency in integrating quality and utilization management standards with Medicare Advantage requirements for the specialty population eligible to be enrolled in the Specialty Plan under the Phase 1 eligibility criteria. The Agency reserves the right to amend the Contract to incorporate additional quality and utilization management provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

A. Performance Measures (PMs)

1. Specialty Plan-Specific Performance Measure Requirements

a. In addition to the provisions set forth in Attachment II and its Exhibits, the Specialty Plan shall collect data, and report on, additional performance measures that are germane to the Specialty Plan population.

b. The Specialty Plan shall collect and report the following additional performance measures:

HEDIS	
1	Care for Older Adults – (COA)

c. The Specialty Plan is not required to report the following Managed Medical Assistance Plan performance measures:

- Adolescent Well-Care Visits – (AWC)
- Annual Dental Visit - (ADV)
- Cervical Cancer Screening - (CCS)
- Childhood Immunization Status – (CIS)
- Follow-up Care for Children Prescribed ADHD Medication – (ADD)
- Immunizations for Adolescents – (IMA)
- Chlamydia Screening In Women – (CHL)
- Prenatal and Postpartum Care – (PPC)
- Medication Management for People with Asthma – (MMA)
- Well-Child Visits in the First 15 Months of Life – (W15)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Live – (W34)
- Children and Adolescents' Access to Primary Care Practitioners – (CAP)
- Lead Screening in Children – (LSC)
- Frequency of Ongoing Prenatal Care – (FPC)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia – (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents – (APC)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications – (SSD)
- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk – (SEAL)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – (WCC)
- Contraceptive Care – Postpartum Women Ages 15-20 – (CCP-CH)
- Contraceptive Care – Postpartum Women Ages 21-44 – (CCP-AD)

Section VIII. Administration and Management

The provisions in Section VIII, Administration and Management apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Agency reserves the right to amend the Contract to incorporate additional administration and management provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

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Section IX. Method of Payment

The provisions in Section IX, Method of Payment apply to the Specialty Plan unless specifically noted otherwise in this Exhibit. The Agency shall not be responsible for making payment to the Specialty Plan for any benefits provided to recipients enrolled in the Specialty Plan under the Phase 1 eligibility criteria required to be covered by the Medicare Advantage coordinated care plans specified in paragraph Section A.1. The Agency shall adjust applicable capitation rates to reflect changes in the Medicare Advantage coordinated care plans rates for each plan year. The Agency reserves the right to amend the Contract to incorporate additional method of payment provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

Section X. Financial Requirements

A. Insolvency Protection

There are no additional insolvency protection provisions unique to the Specialty Plan.

B. Surplus

There are no additional surplus provisions unique to the Specialty Plan.

C. Interest

There are no additional interest provisions unique to the Specialty Plan.

D. Third Party Resources

There are no additional third party resources provisions unique to the Specialty Plan.

E. Assignment

There are no additional assignment provisions unique to the Specialty Plan.

F. Financial Reporting

There are no additional financial reporting provisions unique to the Specialty Plan.

G. Inspection and Audit of Financial Records

There are no additional inspection provisions unique to the Specialty Plan.

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Section XI. Sanctions

A. Contract Violations and Non-Compliance

The Specialty Plan shall notify the Agency of sanctions, penalties or other enforcement actions imposed by the Centers for Medicare & Medicaid Services (CMS within two (2) business days of receiving notice of such actions from CMS.

B. Performance Measure Action Plans (PMAP) and Corrective Action Plans (CAP)

There are no additional PMAP and/or CAP provisions unique to the Specialty Plan.

C. Performance Measure Sanctions

In addition to the provisions set forth in the MMA Exhibit, the Specialty Plan shall report, in a format and timeframe prescribed by the Agency, performance measures for the specialty population enrolled in the Specialty Plan under the Phase 1 eligibility criteria which include all measures required by the quality rating system for Medicare Advantage plans established by the Centers for Medicare & Medicaid Services (CMS) applicable to the Medicare Advantage coordinated care plans specified in paragraph Section A.1. The Agency will review the Specialty Plan's data related to the performance measures specified heretofore to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year the Contract. In addition to the provisions set forth in the MMA Exhibits, the Agency reserves the right to determine performance measure shall be subject to the sanction provisions for the Specialty Plan performance measures.

D. Other Sanctions

The Agency reserves the right to amend the Contract to incorporate additional sanction provisions prior to expanding the specialty population eligible to enroll in this Specialty Plan in any expansion phase.

E. Notice of Sanctions

There are no additional notice provisions unique to the Specialty Plan.

F. Dispute of Sanctions

There are no additional dispute provisions unique to the Specialty Plan.

Section XII. Special Terms and Conditions

The Special Terms and Conditions in Section XII, Special Terms and Conditions apply to the Specialty Plan unless specifically noted otherwise in this Exhibit.

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Section XIII. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to this Specialty Plan are specified below.

B. Issues and Amounts

1. Specialty Plan Liquidated Damages

a. In addition to the provisions set forth in Attachment II and its Exhibits, if the Specialty Plan fails to perform any of the services set forth in the Contract, the Agency may assess liquidated damages for each occurrence listed in the Issues and Amounts Table below.

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
1.	Failure to report Medicare Advantage plan enrollment for each eligible recipient as required by Section III.B. of this Exhibit.	$150 per day for every day beyond the enrollment date.
2.	Failure to report Medicare Advantage plan disenrollments for each ineligible enrollee as required by Section III.C. of this Exhibit.	$150 per day for every day beyond the disenrollment date.
3.	Failure to notify the Agency of changes in Medicare Advantage marketing requirements as required by Section III.D of this Exhibit.	$250 per occurrence.
4.	Failure to report performance measures in a format and timeframe prescribed by the Agency as required Section XI.C. of this Exhibit,	$500 per occurrence.
5.	Failure to notify the Agency of sanctions, penalties or other enforcement actions as required by Section XI.A of this Exhibit.	$1,000 per occurrence.

b. In addition to the provisions set forth in Attachment II and its Exhibits, the Agency will review the Specialty Plan's data related to the performance measures specified

heretofore to determine acceptable performance levels and may establish liquidated damages for these measures based on those levels after the first year the Contract.

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