**ATTACHMENT II**
**EXHIBIT II-C – Update:July 1, 2020**
**CHILDREN WITH SPECIAL HEALTH CARE NEEDS SPECIALTY PLAN**

The provisions in **Attachment II** and **Exhibit II-A** apply to this Specialty Plan, unless otherwise specified in this Exhibit.

## Section I. Definitions and Acronyms

### A. Definitions

**PACC Annual Recertification Period —** The Agency-determined date by which enrollees participating in the PACC model must be annually recertified as medically eligible for the PACC model. To recertify, the child's PCP or specialty physician must recertify that the child remains diagnosed with a potentially life-threatening condition and is at risk of death prior to reaching twenty-one (21) years of age.

**Program of All-Inclusive Care for Children (PACC) —** A palliative care model providing pediatric palliative care to enrollees of the Specialty Plan who have special health care needs and a potentially life-threatening condition. Services are provided from the time of diagnosis throughout the treatment phase of their illness, including end-of-life care, to reduce hospitalizations. PACC is the name of the national program model.

### B. Acronyms

**PACC —** Program of All-Inclusive Care for Children

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## Section II. General Overview

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

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## Section III. Eligibility and Enrollment

### A. Eligibility

#### 1. Specialty Population Eligibility Criteria

The specialty population eligible to enroll in the Specialty Plan shall consist of only those recipients who meet the following criteria:

a. Identified pursuant to a rule(s) promulgated by DOH; and

b. Provided to the Agency by DOH.

### B. Enrollment

#### 1. Specialty Plan-Specific Verification of Eligibility

a. The Specialty Plan shall review its X12-834 enrollment files to ensure that all enrollees are eligible to receive services from the Specialty Plan, including that:

(1) Each enrollee of the Specialty Plan is residing in the same region in which they were enrolled; and

(2) Each enrollee of the Specialty Plan is not ineligible for services under the Specialty Plan, in accordance with this Section.

b. The Specialty Plan shall notify the Agency of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Specialty Plan, within five (5) business days of receipt of the enrollment file.

### C. Disenrollment

1. Involuntary Disenrollment

In addition to the provisions in **Attachment II** and **Exhibit II-A**, the following are acceptable reasons for which the Specialty Plan may submit involuntary disenrollment requests:

1. The enrollee is no longer clinically eligible to participate in the Specialty Plan.

2. The enrollee no longer meets the age qualifications (under the age of twenty-one (21) years) to participate in the Specialty Plan.

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## Section IV. Marketing

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

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## Section V. Enrollee Services

There are no additional enrollee services provisions unique to the Specialty Plan.

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## Section VI. Coverage and Authorization of Services

### A. Required Benefits

#### 1. Program for All-Inclusive Care for Children (PACC)

a. Effective February 1, 2019, the Specialty Plan shall provide the following PACC services in accordance with the Section 1115 Managed Medical Assistance waiver, which include the following:

(1) Support Counseling;

(2) Expressive Therapies;

(3) Respite Support;

(4) Hospice Nursing Services;

(5) Personal Care;

(6) Pain and Symptom Management;

(7) Bereavement Services; and

(8) Volunteer Services.

b. The Specialty Plan shall provide PACC services to up to nine hundred forty (940) enrollees of the Specialty Plan per state fiscal year who voluntarily elect to receive PACC services and are referred for PACC services by their primary care physician or specialty physician as specified in s. 409.912(11), F.S.

c. The Specialty Plan shall ensure the enrollee's family selects one (1) PACC provider from among all participating PACC providers available in the enrollee's region.

(1) The Specialty Plan shall permit the enrollee to change to another PACC provider one (1) time during the annual re-certification period, if another PACC provider is available. The Specialty Plan shall ensure such changes meet all of the following criteria:

(a) Are documented in the enrollee's medical record and plan of care;

(b) Are signed by the enrollee or the enrollee's authorized representative;

(c) Include the effective date of the change; and

(d) Identify the current PACC provider and newly selected PACC provider.

(2) The Specialty Plan shall permit the enrollee to disenroll from PACC and convert to full hospice care. The Specialty Plan shall include in the enrollee's medical record a signed statement by the enrollee or the enrollee's authorized

representative to document the enrollee's choice to receive hospice services and discontinue PACC services. The Specialty Plan shall ensure the AHCA Form 5000-21 (5000-21S), Florida Medicaid Hospice Care Services Election Statement is complete and submitted to the hospice provider.

d. The Specialty Plan shall ensure initial assessments and the plan of care for PACC services shall be completed in accordance with Section VI.E.6. of this Exhibit:

e. The Specialty Plan shall ensure PACC services meet all of the following criteria:

(1) Are provided In accordance with a written plan of care that includes at least two (2) different PACC services during each three (3) month period to qualify for participation in the PACC;

(2) Are provided without limits on the length of time an enrollee can participate in PACC;

(3) Are recertified annually by the enrollee's primary care physician or specialty physician; and

(4) Are provided in the home whenever possible, but may be provided in the school or hospice facility at the enrollee's request. PACC services shall not be provided in a nursing facility or hospital.

## B. Expanded Benefits

### 1. Specialty Plan-Specific Expanded Benefits

The Specialty Plan shall offer any specialty plan-specific expanded benefits to eligible enrollees in the applicable managed care program, subject to any Agency-approved service limitations set forth in **Attachment I, Exhibit I-A** of this Contract.

## C. Excluded Services

There are no additional excluded services provisions unique to the Specialty Plan.

## D. Coverage Provisions

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

## E. Care Coordination/Case Management

### 1. Care Coordination/Case Management Program Description

a. In addition to the provisions set forth in **Attachment II and its Exhibits**, the Specialty Plan shall provide care coordination/case management to enrollees appropriate to the needs of persons meeting the Specialty Plan eligibility criteria. The Specialty Plan shall develop, implement and maintain an Agency-approved care coordination/case management program specific to the specialty population.

b. The Specialty Plan shall submit a care coordination/case management program description annually to the Agency, at a date specified by the Agency. The care coordination/case management program description shall, at a minimum, address:

(1) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work, pharmacy, and specialty health personnel in case management processes;

(2) Maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees;

(3) Case manager selection and assignment, including protocols to ensure new enrollees are assigned to a case manager immediately;

(4) Protocols for initial contact with enrollees, as well as requirements for the frequency and type of ongoing minimum contacts with enrollees;

(5) Surrogate decision-making, including protocols if the enrollee is not capable of making his/her own decisions, but does not have a legal representative or authorized representative available;

(6) Outreach programs that make a reasonable effort to locate and/or re-engage enrollees who have not received follow-up care for ninety (90) days or more;

(7) Enrollee access to case managers, including provisions for access to back-up case managers as needed;

(8) Assessment and reassessment of the acuity level and service needs of each enrollee;

(9) Care planning for pediatric and psychiatric treatment that is tailored to the individual enrollee and is in agreement with evidenced based guidelines for pediatric and psychiatric treatment;

(10) Coordination of care through all levels of practitioner care (primary care to specialist);

(11) Monitoring compliance with scheduled appointments, laboratory results and medication adherence;

(12) Coordination with and referrals to providers of other related services for enrollees of the Specialty Plan;

(13) Interventions to avoid unnecessary use of emergency departments, inpatient care, and other acute care services;

(14) Patient education to assist enrollees in better management of their health issues including the principles of recovery and resiliency.

(15) Linking enrollees to community or other support services.

**2. Care Coordination/Case Management Staff Qualifications**

a. The Specialty Plan shall have sufficient care coordination/case management staff, qualified by training, experience and certification/licensure applicable to the Specialty Plan population.

b. The Specialty Plan shall establish, subject to Agency approval, qualifications for all care coordination/case management staff that include clinical training, licensure and a minimum number of years of relevant experience. The Specialty Plan may request a waiver for staff without the aforementioned qualifications on a case-by-case basis. All such waivers must be approved in advance, in writing by the Agency.

**3. Case Management Supervision**

The Specialty Plan shall establish a supervisor-to-case-manager ratio that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to the Agency upon request.

**4. Care Coordination/Case Management and Staff Training**

a. The Specialty Plan shall provide all care coordination/case managers with adequate orientation and ongoing training on subjects relevant to enrollees of the Specialty Plan. The Specialty Plan shall develop a training plan to provide uniform training to all care coordination/case management. This plan should include formal training classes as well as practicum observation and instruction for newly hired staff.

b. The Specialty Plan shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed.

c. In addition to review of areas covered in orientation, the Specialty Plan shall also provide all care coordination/case management staff with regular ongoing in-service training on topics relevant to enrollees of the Specialty Plan.

d. The Specialty Plan shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service and in-service training for care coordination/case management staff.

**5. Transition of Care**

a. The Specialty Plan shall develop and maintain transition of care policies and procedures for enrollees who are transitioning out EPSDT services which shall include provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need after the enrollee's twenty-first (21$^{st}$) birthday. If the services are not covered by Medicaid, the Specialty Plan shall inform

the enrollee, or their authorized representative, of any community programs that may be able to meet their needs and make the necessary referrals, as needed.

b. The Specialty Plan shall begin transition planning one (1) year prior to the expected date upon which an enrollee will turn twenty-one (21) years of age.

**6. Interdisciplinary PACC Team**

a. The Specialty Plan shall ensure the establishment of an interdisciplinary team for enrollees receiving PACC services. The interdisciplinary team shall be responsible for the initial assessment, the implementation and maintenance of the PACC initial plan of care, providing and suspending PACC services according to the plan of care, and reviewing and updating the PACC Plan of Care.

b. The Specialty Plan shall ensure the interdisciplinary team consists of representation from the PACC provider and the child's care coordinator.

c. The Specialty Plan shall ensure that enrollees selecting PACC services receive a PACC evaluation of service needs and assessment of the physical, social, psychological, spiritual, respite, and personal care needs of the enrollee, and the needs and dynamics of the PACC enrollee's family and/or caregiver. The PACC evaluation and assessment shall be:

(1) Conducted by the enrollee's PACC provider;

(2) Completed within ten (10) business days of the initial referral for the plan of care and receipt of authorization of services;

(3) Completed in the enrollee's home or at the PACC provider's location; and

(4) Signed by the PACC provider, the Specialty Plan care coordinator, and the family.

d. The Specialty Plan shall ensure the enrollee's plan of care is:

(1) Developed within fifteen (15) business days of receiving a referral and authorization of PACC services;

(2) Reviewed at least every ninety (90) days and documented by the interdisciplinary team leader; and

(3) Signed by the PACC provider, the Specialty Plan care coordinator, and the family.

e. The Specialty Plan shall ensure that copies of the initial plan of care and updates to the plan of care are provided to the Specialty Plan care coordinator, PCP and/or specialty physician, and the enrollee's family.

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## F. Quality Enhancements

There are no additional quality enhancements provisions unique to the Specialty Plan.

## G. Authorization of Services

There are no additional authorization of services provisions unique to the Specialty Plan.

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## Section VII. Grievance and Appeal System

There are no additional grievance and appeal system provisions unique to the Specialty Plan.

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## Section VIII. Provider Services

### A. Network Adequacy Standards

#### 1. Specialty Plan-Specific Network Capacity Enhancements

The Specialty Plan shall select and approve its Primary Care Providers (PCPs) that practice in one of the following areas: general practice, family practice, pediatrics, obstetricians, and internal medicine. The Specialty Plan shall ensure that physicians with training and demonstrated experience in treating persons with special health care needs are members of the provider network and can be designated as PCPs.

#### 2. Specialty Plan Network Adequacy Measures

a. Notwithstanding the Provider Network Standards established in **Attachment II**, Section VIII., Provider Services, the Specialty Plan shall comply with the regional standards for each measure as specified in the Provider Network Adequacy Measures Table, Table 1, below.

**TABLE 1**
**PROVIDER NETWORK ADEQUACY MEASURES TABLE**
**CHILDREN WITH SPECIAL HEALTH CARE NEEDS SPECIALTY PLAN**

| Measure | | Region | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2 | 4 | 5 | 6 | 7 | 9 | 10 | 11 |
| The Managed Care Plan agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard. | Standard | 10 | 10 | 6 | 10 | 10 | 10 | 10 | 10 |
| The Managed Care Plan agrees that no more than ___ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Hospital based specialists are not included in this standard. | Standard | 15 | 15 | 15 | 10 | 15 | 15 | 10 | 15 |

#### 3. Facilities and Ancillary Providers

For PACC services, the Specialty Plan shall limit its network to those hospice providers that meet the following requirements:

a. Are licensed under Chapter 400, Part VI, Florida Statutes, with pediatric palliative care programs, and

b. Meet current Florida PACC Model Guidelines, based on the Children's Hospice International PACC Standards and Guidelines.

## B. Network Management

The Specialty Plan shall address the availability and accessibility of specialty providers relevant to the specialty population in its annual network plan submitted to the Agency in accordance with **Attachment II** and its Exhibits.

## C. Provider Credentialing and Contracting

### 1. Provider Training Verification

The Specialty Plan shall require formal training or verification of completed training for network providers in the use of behavioral health assessment tools, assessment instruments and in techniques for identifying individuals with unmet behavioral health needs, and evidence-based practice, the dependency system, and trauma-informed care.

## D. Provider Services

### 1. General Provisions

The Specialty Plan shall develop and implement, subject to Agency approval, a continuing education program that provides ongoing education with continuing education (medical and non-medical) to network providers, at no cost to such providers, on topics including, but not limited to, evidence-based practice.

### 2. Additional Provider Handbook Requirements

a. In addition to the provisions set forth in **Attachment II**, Section VIII., Provider Services, the Specialty Plan shall include Specialty Plan-specific information regarding proposed policies and procedures, to include information on:

(1) Specialized provider education requirements;

(2) Requirements for care in accordance with the most recent clinical practice guidelines for pediatric and psychiatric treatment;

(3) Treatment adherence services available from the Specialty Plan;

(4) Primary care provider criteria including procedures for required use of approved assessment instruments for behavioral health;

(5) Specialist Case Management policies and procedures including role of the provider in the Specialty Plan’s medical case management/care coordination services;

(6) Referral to services including services outside of the Specialty Plan’s covered services and services provided through interagency agreements;

(7) Collaboration with DCF and CBCs to facilitate obtaining medical and case plan information and records; and

(8) Quality measurement standards for providers and requirements for exchange of data.

**3. Provider Education and Training**

The Specialty Plan shall ensure all PACC providers have a formal training program to orient new staff regarding the PACC model and include ongoing training opportunities for all staff involved in the program. The Specialty Plan shall ensure PACC providers document staff completion of the specialized pediatric palliative care training within twenty-four (24) months of staff participation in the PACC model.

**E. Claims and Provider Payment**

1. The Specialty Plan is exempt from the provisions of **Attachment II**, **Exhibit II-A**, Section VII.E.20. for monthly payments to qualified Florida cancer hospitals.

2. The Specialty Plan shall make the MMA hospital inpatient and outpatient exemption payments as specified in **Attachment I**, Section III.E., and **Attachment II**, **Exhibit II-A**, Section VIII.E.21., to qualified hospitals.

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## Section IX. Quality

### A. Quality Improvement

#### 1. Specialty Plan-Specific Quality Improvement Plan Requirements

a. In addition to the requirements set forth in **Attachment II** and its Exhibits, the Specialty Plan's Quality Improvement (QI) Plan shall include measurement of adherence to clinical and preventive health guidelines consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical and evidence-based practice guidelines for pediatric and psychiatric treatment.

### B. Performance Measures (PMs)

#### 1. Specialty Plan-Specific Performance Measure Requirements

In addition to the provisions set forth in **Attachment II** and its Exhibits, the Specialty Plan shall collect data and report on the following additional nationally-recognized performance measures from the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, Table 2, below, which shall be certified by a qualified auditor.

| TABLE 2 | |
|---|---|
| **CHILD CORE SET** | |
| 1 | Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH) |
| 2 | Contraceptive Care – Most and Moderately Effective methods: Ages 15-20 (CCW-CH) |
| 3 | Developmental Screening in the First Three Years of Life (DEV-CH) |

### C. Performance Improvement Projects

There are no additional performance improvement projects provisions unique to the Specialty Plan.

### D. Satisfaction and Experience Surveys

#### 1. Enrollee Satisfaction Survey

a. In lieu of the requirements of **Exhibit II-A**, Section IX.D.1.a, the Specialty Plan shall conduct an annual CAHPS survey for a time period specified by the Agency, using the Child CAHPS Health Plan Survey with Children with Chronic Conditions (CCC) supplemental items.

b. In lieu of the requirements of **Exhibit II-A**, Section IX.D.1.b. and in addition to the Child CAHPS with CCC supplemental items, the Specialty Plan shall include item MH2 through MH4 (related to Behavioral Health) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires. The Managed Care Plan shall include the following item in its Child CAHPS surveys:

(1) How would you rate the number of doctors you had to choose from?

Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

## E. Enrollee Record Requirements

There are no additional enrollee record requirements provisions unique to the Specialty Plan.

## F. Provider-Specific Performance Monitoring — PACC-Specific Performance Monitoring

1. The Specialty Plan shall submit to the Agency on an annual basis, by August 15, a summary of the Specialty Plan's PACC quality improvement activities and findings for the immediate preceding state fiscal year, as well as a summary on the status of any unresolved issues from the prior year. This summary must, at minimum, include the following:

    a. Copies of quality improvement meeting minutes;

    b. Any new PACC policies, procedures or clinical guidelines developed during the year, and any changes to existing policies, procedures or clinical guidelines;

    c. Results of any clinical records reviews conducted in the year for the PACC;

    d. Performance improvement plans developed or implemented for the PACC as a result of complaints, grievances, adverse incidents, monitoring or quality improvement activities; and

    e. Additional quality improvement initiatives for the PACC that occurred during the year.

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## Section X. Administration and Management

There are no additional administration and management provisions unique to the Specialty Plan.

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## Section XI. Method of Payment

### A. General Provisions

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

### B. Fixed Price Unit Contract

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

### C. Payment Provisions for the Specialty Plan

1. The Specialty Plan shall submit invoices for the federal share of funding needed. The Specialty Plan shall submit the invoices to the Contract Manager with documentation of payments made as follows:

    a. Administrative invoices shall be submitted at least monthly for documented administrative expenses. Administrative expenses include, but are not limited to, subcontract and staffing costs.

    b. Services invoices shall be submitted at least monthly, based on enrollment.

    c. For all accurate and timely invoices submitted by the 18th of each month, the Agency will process the invoices for payment to the DOH within ten (10) business days of receipt, pending the availability of funds.

    d. After the first of each month, the DOH shall receive and reconcile the enrollment number to the amount paid via invoice for prior months. Supplemental invoices will be submitted to the Agency for payment and adjustment of additional enrollments and disenrollments as evidenced in the X12 834 file and calculation of daily enrollment.

2. The Agency shall pay the applicable per member per quarter (PMPQ) rate for each eligible enrollee based on the enrollment at the start of the quarter for which payment is issued, as determined by the Agency. The total quarterly amount paid to the Specialty Plan shall be a manual payment. The Specialty Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Specialty Plan has received PMPQ payment or for whom the Agency has assured the Specialty Plan that the payment is forthcoming.

    a. The Agency shall pay the Specialty Plan through the Medicaid fiscal agent, or through the DFS, in accordance with the terms of this Contract, subject to the availability of funds. To accommodate payments, the Specialty Plan shall be a state agency or eligible for enrollment, and enrolled as a Medicaid provider with the fiscal agent. Payments made to the Specialty Plan resulting from this Contract include quarterly payments, as specified below.

    b. The Agency shall submit the Title XIX legislative budget amendment to the Office of Budget and Planning, Executive Office of the Governor, by the fifth working day of the second month of each quarter.

    c. In accordance with ss. 409.968, 409.976 and 409.983, F.S., the PMPQ rates reflect historical utilization and spending for covered services projected forward.

d. The Agency shall not include utilization and expenditures for services by a provider outside the United States in the development of PMPQ rates.

3. In the event that the Specialty Plan does not provide the covered services listed under this Contract, or provides only a portion of the covered services, the Agency reserves the right to withhold payments until such times as the Specialty Plan demonstrates that the covered services have been provided.

4. The Specialty Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, will be required. Funds previously paid shall be adjusted when calculations are determined to have been in error, or when payments have been made for enrollees who are determined not to have been eligible for Specialty Plan during the period for which the payments were made, or for adjustments referenced in C.1.d. (supplemental enrollments evidenced in the X12 834-A file and calculation of Daily Enrollment). In such events, the Specialty Plan agrees to refund any overpayment in accordance with 42 CFR 438.608(c)(3), and the Agency agrees to pay any underpayment.

5. The Agency shall adjust PMPQ rates to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (See s. 409.968(3), F.S.).

6. Notwithstanding the requirements specified in this Section, if it is determined that any provision of the Method of Payment process is out of compliance with federal law, the Agency and the Specialty Plan will establish a mutually-agreed upon expense settlement process that complies with federal law.

7. The Specialty Plan may submit enrollees identified with an HIV/AIDS diagnosis to the Agency in a format and transmittal method approved by the Agency as specified in the Agency's Managed Care Plan Report Guide. See **Attachment II**, Section XIII., Reporting Requirements, of this Contract.

8. Kick payment provisions in **Attachment II**, Section XI.C.3. are not applicable to the Specialty Plan.

9. The Prescribed Drugs High Risk Pool (PDHRP) provisions in **Exhibit II-A**, Section XI.C.4., are not applicable to the Specialty Plan.

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## Section XII. Financial Requirements

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

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## Section XIII. Sanctions

### A. Contract Violations and Non-Compliance

There are no additional provisions unique to the Specialty Plan.

### B. Corrective Action Plans (CAP)

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

### C. Performance Measure Sanctions

In addition to the provisions set forth in **Exhibit II-A**, 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 of the Contract. In addition to the provisions set forth in the MMA Exhibits, the Agency reserves the right to determine performance measure groups which shall be subject to the sanction provisions for the Specialty Plan performance measures.

### D. Other Sanctions

There are no additional other sanction provisions unique to the Specialty Plan.

### 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.

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## Section XIV. Liquidated Damages

### A. Damages

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

### B. Issues and Amounts

#### 1. Specialty Plan-Specific 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, Table 3, below.

| TABLE 3 | | |
|---|---|---|
| **LIQUIDATED DAMAGES ISSUES AND AMOUNTS** | | |
| **#** | **MMA PROGRAM ISSUES** | **DAMAGES** |
| 1. | Failure to verify specialty population eligibility criteria of an enrolled enrollee within the timeframes in the Specialty Plan's policies and procedures. | **$150** per day for every day beyond the enrollment date. |
| 2. | Failure to comply with required Specialty Plan policies and procedures subject to Agency approval pursuant to the Contract. | **$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 performance related to the performance measures specified heretofore to determine acceptable performance levels and may set liquidated damages for these measures based on those levels after the first year of the Contract.

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## Section XV. Special Terms and Conditions

There are no additional special terms and conditions applicable to the Specialty Plan.

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## Section XVI. Reporting Requirements

### A. Required Reports

The Specialty Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to the Specialty Plan as specified in the Summary of Reporting Requirements Table, Table 4, below, and the Managed Care Plan Report Guide.

**TABLE 4**
**SUMMARY OF REPORTING REQUIREMENTS**

| Report Name | Program Type | Frequency |
|---|---|---|
| PACC Enrollment Report | MMA Program | Quarterly |
| PACC Data Report | MMA Program | Quarterly |

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