FLORIDA LTC MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS FLORIDA LTC MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between United Behavioral Health ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of Florida Medicaid program (the "State Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Medicaid Contract", as defined herein). In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by State and requested by Health Plan, comply with federal or State regulations, Subcontractor will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 Affiliate: Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

2.2 Agency: State of Florida, Agency for Health Care Administration (AHCA).

2.3 Covered Person: An individual who is currently enrolled with Health Plan for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.4 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

2.5 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of Florida, Inc., UnitedHealthcare Insurance Company or one of its Affiliates.

2.6 State: The State of Florida or its designated regulatory agencies.

2.7 State Contract: Health Plan's contract with Agency for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 State Program: The Florida Medicaid program. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Subcontractor, Health Plan and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see s. 395.002, F.S.).

(b) Emergency Services: Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility

(c) Medically Necessary or Medical Necessity: Services that include medical, allied, or long-term care, goods or services furnished or ordered to:

1. Meet the following conditions:

    a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
    b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
    c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
    d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
    e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

3. The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

(d) Emergency Mental Health Services: Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, whish is the level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S. and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

(e) Emergency Transportation: The provision of emergency transportation services in accordance with s. 409.9089 (13)(c)4., F.S.

(f) Sick Care: Non-urgent problems that do not substantially restrict normal activity but could develop complications if left untreated (e.g., chronic disease).

(g) Urgent Behavioral Health Care: Those situations that require immediate attention and assessment within twenty-three (23) hours even though the Covered Person is not in immediate danger to self or others and is able to cooperate in treatment.

(h) Urgent Care: Services for those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or do substantially restrict a Covered Person's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

(i) Well Care Visit: A routine medical visit for one of the following: child health check-up visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals and any other routine visit for other than the treatment of an illness.

3.2 Medicaid Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Health Plan's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor and Health Plan must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Subcontractor and Health Plan will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Health Plan and/or Subcontractor for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Health Plan and/or Subcontractor cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Health Plan and/or Subcontractor is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Agency nor Covered Persons shall be in any manner liable for the debts and obligations of Health Plan and/or Subcontractor and under no circumstances shall Health Plan and/or Subcontractor, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. Provider shall indemnify, defend and hold the Agency and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive the termination of

the Agreement for any reason, including breach due to insolvency. The Agency may waive this requirement for itself, but not for Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a state agency or sub-unit as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Health Plan delegates credentialing to Provider, Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Subcontracts. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Health Plan, to meet any additional State Program requirements that may apply to the services.

Any contracts, agreements or subcontracts entered into by Provider for purposes of carrying out any aspect of the Agreement shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of the Agreement and this Appendix.

3.10 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract Provider shall retain all records including, as applicable, grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR438.606, 42 CFR 438.608, and 42 CFR 438.610 and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Health Plan if the Agreement is continuous.

3.11 Records Access. Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or federal fraud investigators.

3.12 Government Audit; Investigations. Provider acknowledges and agrees that the Agency, DOEA, MPI, MFCU, CMS, the Office of Inspector General, the Comptroller General, U.S. DHHS, and Attorney General's Office or their authorized representatives or designees shall have the right to inspect or otherwise evaluate and audit all of the following related to the State Contract, and Provider shall cooperate fully in an investigation by the Agency, MPI, MFCU, or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the State Contract:

(a) Pertinent books,
(b) Financial records,
(c) Medical/case records, and
(d) Documents, papers and records of any provider involving financial transactions.

The above-referenced entities shall also have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time.

3.14 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act; section 1557 of the

Patient Protection and Affordable Care Act; and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434, 42 CFR 438.6, 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104-106, as may be amended from time to time.

(c) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(d) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

3.15 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.16 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of

Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.17 Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals or owners, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider is obligated under 42 CFR §1001.1901(b) to screen all employees, contractors, and/or subcontractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded to provide items or Covered Services under the Agreement. Provider shall immediately report to Subcontractor and Health Plan any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Subcontractor and/or Health Plan, as applicable, will terminate the Agreement immediately and exclude from its network any provider who has been excluded or has been terminated from the Medicare, Medicaid or CHIP program in any state. Subcontractor and/or Health Plan, as applicable, may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.18 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned

suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.19 Cultural Competency and Access. Provider shall participate in Subcontractor and Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.20 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan to submit to the State Program for prior approval before use. In addition, Provider will comply with the marketing requirements set forth in the State Contract in Section III.D.

3.21 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State contract and shall cooperate and assist the State Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Subcontractor and Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.22 Data; Reports. Provider shall cooperate with and release to Subcontractor and/or Health Plan any information necessary for Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Health Plan, in the format specified by Subcontractor, Health Plan and/or the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Health Plan and the State. Data must be provided at the frequency and level of detail specified by Subcontractor, Health Plan or the State. By submitting data to Subcontractor and/or Health Plan, Provider represents and attests to Subcontractor, Health Plan and the State that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Encounter Data. Provider agrees to cooperate with Subcontractor and Health Plan and submit timely, complete and accurate encounter data to Subcontractor and Health Plan to comply with Health Plan's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be provided within the timeframes specified and in a form that meets Subcontractor, Health Plan and State requirements. By submitting encounter data to Subcontractor and/or Health Plan, Provider represents to Subcontractor and/or Health Plan that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.24 Claims Information. Provider shall promptly submit to Subcontractor and/or Health Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and, if applicable, shall seek such third party liability payment before submitting claims to Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor and/or Health Plan constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim. Claims information must be accompanied by an itemized accounting of the individual claims, included in the payment including, but not limited to the enrollee's name, the date of service, the procedure code, the service units, the amount for reimbursement and the identification of Subcontractor and/or Health Plan.

3.25 Insurance Requirements. Provider shall secure and maintain during the term of the Agreement worker's compensation insurance in accordance with the Florida's Worker's Compensation Law, for all of its employees connected with work under this Agreement. In addition, Provider shall secure and maintain during the term of the Agreement general liability and/or malpractice insurance as required by the State Contract and State laws and regulations.

Provider shall notify Subcontractor and Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes.

3.26 Quality; Utilization Management. Provider shall cooperate with Subcontractor and Health Plan's peer review, grievance, quality improvement program and utilization management activities, and recognizes that Health Plan or its subcontractor will provide monitoring and oversight of Provider, including monitoring of services rendered to Covered Persons as agreed upon between Subcontractor, Health Plan and Provider based on services provided. If Health Plan has delegated credentialing to Provider, Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the Agency's credentialing requirements as set forth in the State Contract.

3.27 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with Health Plan and other managed care contractors to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

In addition, Covered Persons may be immediately transferred to another Provider if the Covered Person's health or safety is in jeopardy.

3.28 Continuity of Care. Provider shall cooperate with Subcontractor and Health Plan and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with Health Plan terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider.

3.29 Advance Directives. Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

3.30 National Provider ID (NPI). Provider shall have a unique Florida Medicaid provider number IN ACCORDANCE WITH s. 1173(B) OF THE SOCIAL SECURITY ACT, AS ENACTBD BY s. 4707(A) OF THE BALANCED BUDGET ACT OF 1997. Provider shall submit his/her/its NPI, as well as NPI(s) for its physicians and other health care providers, to Health Plan within fifteen (15) business days of receipt to allow Health Plan to report such NPI(s) in its provider network report to the Agency (or the Agency's Choice Counselor/Enrollment Broker) and in its Provider Directory in a manner to be determined by the Agency and in accordance with the State Contract.

3.31 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other

provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Health Plan any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.33 Community Outreach Materials. Any materials related to the State Contract that are displayed by Provider must be submitted to the Agency for written approval before use .

3.34 Pregnancy. Provider shall immediately notify Health Plan of a Covered Person's pregnancy, whether identified through medical history, examination, testing, claims or otherwise.

3.35 Telemedicine. If Provider has been approved by Health Plan to provide services through telemedicine, Provider shall have protocols to prevent fraud and abuse.

3.36 Background Screening. Provider acknowledges and agrees that it is subject to background screenings and shall cooperate with requested by Subcontractor and/or Health Plan related to such in accordance with the State Medicaid Contract.

If Provider is a Direct Service Provider, Provider shall pass a Level 2 criminal history background screening in accordance with s. 430.0402, F.S. and chapter 435, F.S., as amended, prior to delivering services under the Agreement. Provider shall ensure that all employees, contractors and volunteers of Provider who meet the definition of Direct Service Provider under s. 430.0402, F.S. shall also pass a Level 2 criminal history background as a condition of employment, volunteerism or contracting and prior to delivering any services to Covered Persons. Provider shall submit to Health Plan a signed affidavit attesting to Provider's compliance with this section or with the requirements of Provider's licensing agency if the licensing agency requires Level 2 background screening of Direct Service Providers.

3.37 Provider Withdrawal. Provider shall submit a written notice of withdrawal from Health Plan's network at least ninety (90) calendar days before the effective date of such withdrawal.

3.38 Compliance. Provider shall comply with all Provider contract requirements as set forth in the State Contract including Section IV, B., of Attachment D-II of the State Contract.

3.39 Compensation. Provider shall look solely to Subcontractor and/or Health Plan for compensation for Covered Services rendered, with the exception of nominal cost sharing and patient responsibility, pursuant to the Medicaid State Contract and the Medicaid Provider General and Coverage and Limitations Handbooks:

(a) If capitated, then to Health Plan for compensation;

(b) If fee-for-service or long term care, then to the Agency or its Agent, unless the service is a transportation service for which Health Plan receives a capitation payment from the Agency. For such capitated transportation services, Provider shall to look solely to Health Plan.

Provider is prohibited from assessing late fees.

3.40 Training. Provider agrees to complete abuse, neglect and exploitation training, including training to identify victims of human trafficking, as provided by Subcontractor and/or Health Plan.

3.41 Agreement and Amendments. Any agreement or amendments to the Agreement shall be in writing, signed and dated by the parties, except that the Agreement may be unilaterally amended by Subcontractor and Health Plan upon written notice to the Provider to comply with federal or State regulations.

3.42 Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by Subcontractor, Health Plan or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor and/or Health Plan constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State, Subcontractor or Health Plan provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Subcontractor and/or Health Plan performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor and/or Health Plan upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.43 Electronic Visit Verification (EVV). Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.44 Clinical Laboratory Improvements Act (CLIA) certification or waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Subcontractor or Health Plan. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.45 Non-Discrimination. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

3.46 Health Records. Provider agrees to cooperate with Subcontractor and/or Health Plan to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.47 Overpayment. Provider shall report to Subcontractor and/or Health Plan when it has received an overpayment and will return the overpayment to Subcontractor and/or Health Plan within 60 calendar days after the date on which the overpayment was identified. Provider will notify Subcontractor and/or Health Plan in writing of the reason for the overpayment.

3.48 Employment. Provider shall comply with Section 274A of the Immigration and Nationality Act. The Agency will consider the employment by Provider of unauthorized aliens a violation of this Act. If Provider knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of the Agreement. Provider shall be responsible for including this provision in all subcontracts issued as a result of the Agreement.

3.49 Work Authorization Program. The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. Provider shall only employ individuals who may legally work in the United States (U.S.) – either U.S. citizens or foreign citizens who are authorized to work in the U.S. Provider shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired during the term of the Agreement and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to the Agreement.

3.50 Provider Eligibility. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Subcontractor or Health Plan under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Provider shall submit copies of all applicable licenses to Subcontractor and/or Health Plan as required by the State Contract.

3.51 Provider Materials and Template Agreements. Provider shall submit materials and template agreements in compliance with the State Contract.

3.52 Claims Processing. If Subcontractor and/or Health Plan delegates claims processing to Provider, Provider shall maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers. All payments to providers must be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the managed care plan. In addition, an adequate record system must be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered. All claims adjudication activities shall comply with 24 CFR 438.8(k)(3). If Provider is at financial risk and/or is delegated to process and pay claims, Provider shall maintain a surplus account to meet its obligations.

3.53 Agreement Termination. If Provider desires to terminate the Agreement, Provider must submit at least 90 days advance written notice to Subcontractor and/or Health Plan. In the event of conflict between this provision and the Agreement, this provision shall control.

3.54 Code of Conduct; Conflict of Interest. Provider agrees to comply with all Code of Conduct and Conflict of Interest guidelines required by the State Contract.

3.55 Safeguarding Information. Provider shall safeguard information about Covered Persons in accordance with 42 CFR, Part 438.224, as may be amended from time to time.

3.56 Exculpatory Clause. Provider shall not hold Covered Persons or the Agency liable for any debts of Provider. This clause shall survive termination of the Agreement for any reason, including beach due to insolvency.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Nursing Facilities and Hospice. Bed hold days shall be consistent with Medicaid fee-for-service bed hold day's policies and procedures.

Provider shall maintain Medicaid enrollment and submit required cost reports to the Agency for the duration of the Agreement.

4.2 Assisted Living Facilities and Adult Family Care Homes. Provider shall conform to the HCB characteristics pursuant the State Contract. Provider shall support Covered Person's community inclusion and integration by working with Subcontractor and/or Health Plan and Covered Person to facilitated Covered Person's goals and community activities.

Additionally, Covered Person's shall be offered services with the following options unless medical, physical or cognitive impairments restrict or limit exercise of these options:

Choice of:

(a) Private or semi-private rooms, as available;
(b) Roommate for semi-private rooms;
(c) Locking door to living unit;
(d) Access to telephone and unlimited length of use;
(e) Eating schedule; and
(f) Activities schedule; and
(g) Participation in facility and community activities.

Ability to have:

(a) Unrestricted visitation; and
(b) Snacks as desired

Ability to:

(a) Prepare snacks as desired; and
(b) Maintain personal sleeping schedule.

4.3 Assisted Living Facilities (ALF). Assisted Living Facility acknowledges and agrees to accept monthly payments from Subcontractor and/or Health Plan for Covered Services as full and final payment for all long-term care services detailed in the Covered Person's plan of care which are to be provided by Assisted Living Facility. Covered Person's remain responsible for the separate ALF room and board costs as detailed in their resident contract. As Covered Person's age in place and require more intense or additional long-term care services, ALF may not request payment for new or additional services from Covered Person, their family members or personal representative. ALF may only negotiate payment terms for Covered Services pursuant to the Agreement with Subcontractor and/or Health Plan.

4.4 Staffing. Provider shall develop and maintain policies and procedures for back-up plans in the event of absent employees, and shall maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

4.5 Adult Day Health Centers (ADHC). If Provider is an ADHC, Provider will support a Covered Person's community inclusion and integration by working with Subcontractor and/or Health Plan and Covered Person to facilitate Covered Person's personal goals and community activities.

Covered Persons accessing adult day health services with Provider shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

(a) Daily activities;
(b) Physical environment;
(c) With whom to interact;
(d) Access to telephone and unlimited length of use;

(e) Eating schedule;

(f) Activities schedule; and

(g) Participation in facility and community activities.

Ability to have:

(a) Right to privacy;

(b) Right to dignity and respect;

(c) Freedom from coercion and restraint; and

(d) Opportunities to express self through individual initiative, autonomy, and independence.

4.6 Home and Community-Based Services (HCBS) Providers. HCBS provider acknowledges and agrees to report critical incidents to Subcontractor and Health Plan in a manner and format specified by Subcontractor and Health Plan, so as to ensure reporting of such critical incidents to the State within twenty-four (24) hours of the incident.

SECTION 5
SUBCONTRACTOR AND HEALTH PLAN REQUIREMENTS

5.1 Prompt Payment. Subcontractor and/or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to s.409.967,F.S., s.409.975(6), F.S., s.409.982,F.S., s.641.3155,F.S., 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5), 42 CFR 447.45(d)(6), and 42 CFR 238.230, as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor and/or Health Plan otherwise requests assistance from Provider, Subcontractor and/or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Subcontractor and/or Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. Subcontractor and/or Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and/or Health Plan shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and/or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Subcontractor and/or Health Plan that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Subcontractor and/or Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Subcontractor and/or Health Plan shall not prohibit Provider from discussing treatment or non-treatment options with Covered Persons that may not reflect Subcontractor and/or Health Plan's position or may not be covered by Subcontractor and/or Health Plan.

Subcontractor and/or Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance and audit system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and/or Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and/or Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

5.6 Non-Exclusivity. Pursuant to Section 641.315, F.S., Subcontractor and/or Health Plan represents that it shall not, in any way, prohibit nor restrict Provider from entering into a commercial contract with any other health plan and represents that it shall not require Provider to contract for more than one Health Plan product or otherwise be excluded from participating in the Health Plan network.

5.7 Medical Necessary. Subcontractor and Health Plan represents that it will not prohibit Provider from providing services to Covered Person if such services are determined to be Medically Necessary and Covered Services under the State Contract.

5.8 Medicare Crossover Claim. Subcontractor and Health Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceed 3 years.

5.9 Agreements/Subcontracts. Subcontractor and Health Plan shall comply with all Agency procedures for the review, approval and submission of provider agreements/subcontracts. All model agreements/subcontracts and amendments must be submitted by Subcontractor and/or Health Plan to the Agency for approval at least 90 days in advance of the proposed effective date.

5.10 Covered Person Materials and Information. Subcontractor and/or Health Plan shall be responsible for submitting copies of Covered Person materials to the Agency and the approximate number of impacted enrollees.

5.11 Responsibility under State Contract. Neither the Agreement nor this Appendix in any way relieves Health Plan of any responsibility for the provision of services or duties under the State Medicaid Contract. Health Plan shall assure that all services and tasks related to the Agreement are performed in accordance with the terms of the State Medicaid Contract. Health Plan shall identify in the Agreement any aspect of service that may be subcontracted by Provider.

5.12 Provider Insolvency. Subcontractor and/or Health Plan shall immediately advise the Agency of the insolvency of a Provider or of the filing of a petition in bankruptcy by or against a Provider.

5.13 Network Delegation. Subcontractor and/or Health Plan shall not delegate provider network management to Provider if it is an owner or has controlling interest in providers included in the network of providers rendering services under this Agreement.

5.14 Cost Avoidance. Subcontractor and/or Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with the State Medicaid Contract.

5.15 Minority Subcontracts or Vendors. The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as vendors and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Subcontractor and/or Health Plan can contact the Office of Supplier Diversity online at http://osd.dms.state.fl.us/ for information on minority vendors who may be considered for subcontracting opportunities. Unless waived by AHCA, Subcontractor and/or Health Plan shall provide AHCA with a monthly report summarizing the business it does with minority subcontractors or vendors. Such report shall be provided to AHCA by the 15th day after the reporting month.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan has provided or delivered to Provider. The applicable

provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Health Plan and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor and Health Plan and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, disenrollment, outreach and educational activities.

Mandatory populations for enrollment shall include but are not limited to:

(a) Eligible recipients age eighteen (18) or older in any of the following programs or eligibility categories are required to enroll if they have been determined by Comprehensive Assessment and Review for Long-Term Care Services (CARES) to meet the nursing facility level of care:

(1) Temporary Assistance to Needy Families (TANF);

(2) SSI (Aged, Blind and Disabled);

(3) Institutional Care;

(4) Hospice;

(5) Aged/Disabled Adult waiver;

(6) Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:

(i) Received care from Children's Medical Services prior to turning age 21;
(ii) Age 21 and older;
(iii) Cognitively intact;

(iv) Medically complex; and
(v) Technologically dependent.

(7) Assisted Living waiver;

(8) Nursing Home Diversion waiver;

(9) Channeling waiver;

(10) Low Income Families and Children;

(11) MEDS (SOBRA) for children born after 9/30/83 (age 18 — 20);

(12) MEDS AD (SOBRA) for aged and disabled;

(13) Protected Medicaid (aged and disabled);

(14) Dually Eligibles (Medicare and Medicaid);

(15) Individuals enrolled in the Frail/Elderly Program component of Health Plan Healthcare HMO; and

(16) Medicaid Pending for Long-Term Care Managed Care HCBS waiver services.

Voluntary populations for enrollment shall include but are not limited to:

(a) Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to enroll if they have been determined by CARES to meet the nursing facility level of care:

(1) Traumatic Brain and Spinal Cord Injury waiver;

(2) Project AIDS Care (PAC) waiver;

(3) Adult Cystic Fibrosis waiver;

(4) Program of All-Inclusive Care for the Elderly (PACE) plan members;

(5) Familial Dysautonomia waiver;

(6) Model waiver (age 18 — 20);

(7) Medicaid for the Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in Developmental Disabilities (DD) waiver;

(8) Recipients with other creditable coverage excluding Medicare, and;

(9) Recipients on DD HCBS Waitlist.

6.4 Termination. The parties acknowledge and agree the Agency or Health Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) calendar days of receipt of notice from Health Plan specifying such failure and requesting such provider abide by the terms and conditions thereof, and; Any provider whose participation is terminated pursuant to the provider contract for any reason shall utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the agency or Health Plan is created as a result of Health Plan's act of terminating, or decision to terminate, any provider under State Contract.

6.5 Provider Network. Parties agree to test the provider network verification (PNV) file for proof of network adequacy.