FLORIDA MMA/LTC MEDICAID PROGRAM
REGULATORY REQUIREMENTS APPENDIX
DOWNSTREAM PROVIDER

THIS FLORIDA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Members under the State of Florida Medicaid program (the "State Medicaid Program") as governed by the State's designated regulatory agencies and pursuant to one or more of United's State Medicaid Contracts. 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 contracts outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that United shall be permitted to unilaterally initiate such additions, deletions or modifications, to be effective immediately unless written notice of such amendment is required under law.

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 **Covered Services** means health care service or product for which a Member is enrolled with United to receive coverage under the State Contract.

2.2 **Medicaid Agency** or Agency means the single State agency administering or supervising the administration of the State Program.

2.3 **State** is state administering the applicable Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs, or its designated regulatory agencies.

2.4 **State Contract** is the contract between United and the Medicaid Agency for the purpose of providing and paying for Covered Services to Members enrolled in the State Program.

2.5 **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 United 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 Members shall be made on an individualized basis and in accordance with the following definitions:

i) 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.).

ii) 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

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

a) Meet the following conditions:

1) Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2) 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;
3) Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
4) 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
5) Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

b) 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.

c) 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.

iv) 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, which 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.

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

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

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

viii) 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 Member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

ix) 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 provider to participate in United's Medicaid. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately or upon expiration of the sixty (60) day period without enrollment of the Provider and will notify affected Members that Provider is no longer participating in the network. United 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 Member 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 United for payment of Covered Services provided to Members pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Members harmless in the event that United 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 Member is not liable to Provider for any services for which United 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 Members for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Agency nor Members shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Members for Covered Services.

Acute Care Providers shall look solely to United for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the Florida State Medicaid Plan and the Florida Coverage and Limitations Handbooks and in accordance with this Contract as follows:

i) If capitated, then to United for compensation;
ii) If fee-for-service, then to the Agency or its fiscal agent, unless the service is a transportation service for which United receives a capitation payment from the Agency. For such capitated transportation services, United shall require providers to look solely to United.

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 Members 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 Members, 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 United delegates credentialing to Provider, United will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements. Provider shall have a process for establishing and verifying additional credentialing and recredentialing criteria, and have written procedures that include all requirements listed below:

(a) Process to verify physicians have good standing of privileges at the hospital designated as the primary admitting facility by the physician or, if the physician does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.
(b) Process to verify physicians have Valid Drug Enforcement Administration certificates, where applicable.

(c) Process to verify physicians have an attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than three thousand (3,000) patients per physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.

(d) Process to verify physicians have a good standing report on a site visit survey. For each provider, documentation in the credentialing files regarding the site survey that include: (i) Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards; (ii) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and (iii) Evidence that the Managed Care Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards.

(e) Process to verify physicians have an attestation to the correctness/completeness of the provider's application.

(f) Process to verify physicians have Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.

(g) Process to verify physicians have a statement from each provider applicant regarding any physical or behavioral health problems that may affect the provider's ability to provide health care and any history of chemical dependency/substance abuse.

(h) Process to verify physicians have current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.

(i) Process to verify physicians have proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.

(j) Process to verify providers are recredentialed at least every three (3) years using information from ongoing provider monitoring.

(k) Process to verify physicians have evidence of specialty board certification, if applicable.

(l) Process to verify hospital ancillary providers are not required to be independently credentialed if those providers serve Managed Care Plan enrollees only through the hospital.

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 United, 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 Members. 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 Member. 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 United if the Agreement is continuous.

3.11 Records Access. Subcontractor and 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 Members. Subcontractor and Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or federal fraud investigators. Subcontractor and Provider agrees that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed under the State Medicaid Contract.

3.12 Government Audit; Investigations. Provider acknowledges and agrees that the United States Department of Health and Human Services (DHHS), 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:

i) Pertinent books,
ii) Financial records,
iii) Medical/case records, and
iv) 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. Moreover, Provider agrees to fully cooperate in any investigation by the Department, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.

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 Members 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:

i) 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.

ii) 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.

iii) 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."

iv) 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. Neither United nor 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 Member. 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:

i) 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.

ii) 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:

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

ii) 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 United 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. United will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. United 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 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 United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Members 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 United 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 United'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 United'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 United any information necessary for United 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 United, in the format specified by United and 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 United and the State. Data must be provided at the frequency and level of detail specified by United or the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United'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 United and submit timely, complete and accurate encounter data to United to comply with United'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 accurate and include all services furnished to a Member, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful, and upon United'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 United 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 United. Provider understands and agrees that each claim Provider submits to United 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 Member 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 the United Member.

Moreover, Provider must submit timely, complete, and accurate claims to United in accordance with the requirements of State Contract Section X.D., Information Management and Systems, at a minimum. As applicable, public health providers must contact United before providing health care services to United Members and provide United with the results of the office visit, including test results.

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 United 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 United's peer review, grievance, quality improvement program and utilization management activities, and recognizes that United or its subcontractor will provide monitoring and oversight of Provider, including monitoring of services rendered to Members as agreed upon between United and Provider based on services provided. If United has delegated credentialing to Provider, Provider shall ensure that

all licensed medical professionals are credentialed in accordance with United's and the Agency's credentialing requirements as set forth in the State Contract.

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

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

3.28 Continuity of Care. Provider shall cooperate with United:

i) in the event an immediate transfer to another primary care physician (PCP) or health plan is warranted if the Member's health or safety is in jeopardy.

ii) to provide Members 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 United terminates during the course of a Member's treatment by 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 United within fifteen (15) business days of receipt to allow United 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.

Notwithstanding the foregoing, the following types of providers need not provide United with an NPI: (i) Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of health care (examples include taxis, home and vehicle modifications, insect control, habilitation and respite services); and (ii) Individuals or businesses that only bill or receive payment for, but do not furnish, health care services or supplies (examples include billing services, repricers and value-added networks).

3.31 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United 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 United 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 community outreach materials related to the State Medicaid Contract that are displayed by Provider shall be submitted to United to submit to the Agency for written approval prior to use.

3.34 Pregnancy. Provider shall immediately notify United of a Member's pregnancy, whether identified through medical history, examination, testing, claims or otherwise.

3.35 Telemedicine. If Provider has been approved by United to provide services through telemedicine, Provider shall have protocols to prevent fraud and abuse. Provider shall implement telemedicine fraud and abuse protocols that address:

i) Authentication and authorization of users;

ii) Authentication of the origin of information;

iii) Prevention of unauthorized access to the system or information;

iv) System security, including the integrity of information that is collected, program integrity and system integrity; and

v) Maintenance of documentation about system and usage

3.36 Background Screening. Provider acknowledges and agrees that it is subject to background screenings and shall cooperate with requested by United 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 Members. Provider shall submit to United 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 United'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 United 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:

i) If capitated, then to United for compensation;

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

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 United.

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 United upon written notice to the Provider to comply with federal or State regulations. The agreement must specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement.

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 United 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 United 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 or United 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. United 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 United 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 United. 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 Members 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 United to maintain and share a health record of all services provided to a Member, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.47 Overpayment. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment and cooperate with United audits related to overpayments.

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 United 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 Members. Provider shall submit copies of all applicable licenses to United 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 United 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 42 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 United. 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 Members in accordance with 42 CFR, Part 438.224, as may be amended from time to time.

3.56 Exculpatory Clause. Provider shall not hold Members 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.

3.57 Primary Care Physician (PCP) Network. If Provider has agreed to participate in United's network as a PCP, Provider fully accepts and agrees to perform the responsibilities and duties associated with the PCP designation.

3.58 Pharmacy Providers. For pharmacy contracts, the pharmacy benefits manager should provide the following electronic message alerting the pharmacist to provide Medicaid recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the Preferred Drug List (PDL):

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected.

SECTION 4
ADDITIONAL REQUIREMENTS

4.1 Hospital Requirements. If Provider is a hospital, it shall notify United of Member pregnancies and births where the mother is a Member. Provider shall be responsible for completing the DCF Excel spreadsheet and submitting it to the appropriate DCF Member Call Center. United's name must be indicated as the referring agency when the DCF Excel spreadsheet is completed.

4.2 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.

4.3 Hospitals. If Provider is a hospital it agrees to the following:

i) The hospital contract shall include rates in accordance with s. 409.975(6), F.S.

ii) The hospital contract shall include a clause that states whether United or the hospital will complete the DCF Excel spreadsheet for unborn activation and include Provider-Preventable Conditions (PPC) reporting requirements as specified in the State Contract, Section V, Covered Services.

4.4 Assisted Living Facilities and Adult Family Care Homes. Provider shall conform to the HCB characteristics pursuant the State Contract. Provider shall support Member's community inclusion and integration by working with United and Member to facilitated Member's goals and community activities.

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

Choice of:
i) Private or semi-private rooms, as available;
(b) Roommate for semi-private rooms;
ii) Locking door to living unit;
iii) Access to telephone and unlimited length of use;
(e) Eating schedule;
iv) (f) Activities schedule; and
v) (g) Participation in facility and community activities.

Ability to have:
i) Unrestricted visitation; and
ii) Snacks as desired.

Ability to:
i) Prepare snacks as desired; and
ii) Maintain personal sleeping schedule.

4.5 Assisted Living Facilities (ALF). Assisted Living Facility acknowledges and agrees to accept monthly payments from United for Covered Services as full and final payment for all long-term care services detailed in the Member's plan of care which are to be provided by Assisted Living Facility. Member's remain responsible for the separate ALF room and board costs as detailed in their resident contract. As Member'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 Member, their family members or personal representative. ALF may only negotiate payment terms for Covered Services pursuant to the Agreement with United.

4.6 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.

4.7 Adult Day Health Centers (ADHC). If Provider is an ADHC, Provider will support a Member's community inclusion and integration by working with United and Member to facilitate Member's personal goals and community activities.

Members 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:

i) Daily activities;
ii) Physical environment;
iii) With whom to interact;
iv) Access to telephone and unlimited length of use;
v) Eating schedule;
vi) Activities schedule; and
vii) Participation in facility and community activities.

Ability to have:

i) Right to privacy;
ii) Right to dignity and respect;
iii) Freedom from coercion and restraint; and
iv) Opportunities to express self through individual initiative, autonomy, and independence.

4.8 Home and Community-Based Services (HCBS) Providers. HCBS provider acknowledges and agrees to report critical incidents to United in a manner and format specified by United, so as to ensure reporting of such critical incidents to the State within twenty-four (24) hours of the incident. The Managed Care Plan shall not require nursing facilities or ALFs to report critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

4.9 Patient Responsibility. The amount Members must contribute toward the cost of their care. United shall utilize Patient Responsibility as calculated by the Department of Children and Families (DCF) for each enrollee, in compliance with 42 CFR 435.622 and 435.725. As applicable, Provider is responsible for collecting Patient Responsibility from Member.

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106, 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 United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract. The compensation or payment exhibit to the Agreement shall set forth the method, conditions and amount of compensation or other consideration to be received by Provider from United.

5.2 No Incentives to Limit Medically Necessary Services. United 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 Member.

5.3 Provider Discrimination Prohibition. United 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. United shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Members. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

i) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Member needs in order to decide among all relevant treatment options;

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

iv) The Member'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.

United shall not prohibit Provider from discussing treatment or non-treatment options with Members that may not reflect United's position or may not be covered by United.

United also shall not prohibit a Provider from advocating on behalf of a Member 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, United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Provider's performance under the Agreement is inadequate. United 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., United 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 United product or otherwise be excluded from participating in the United network.

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

5.8 Medicare Crossover Claim. United 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. United 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 United to the Agency for approval at least 90 days in advance of the proposed effective date.

5.10 Member Materials and Information. United shall be responsible for submitting copies of Member 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 United of any responsibility for the provision of services or duties under the State Medicaid Contract. United shall assure that all services and tasks related to the Agreement are performed in accordance with the terms of the State Medicaid Contract. United shall identify in the Agreement any aspect of service that may be subcontracted by Provider.

5.12 Provider Insolvency. United 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. United 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. United 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. United 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, United 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.

5.16 Inpatient Services. United represents that it will not prohibit Provider from providing inpatient services in a contracted hospital to a Member if such services are determined to be Medically Necessary and Covered Services under the State Medicaid Contract.

5.17 Eligibility. United shall not employ or contract with individuals on the State or federal exclusions list and shall terminate the Agreement immediately in the event Provider becomes an excluded provider. United shall use the List of Excluded Individuals and Entities (LEIE), or its equivalent, to identify excluded parties during the process of engaging the services of new providers to ensure they are not in a nonpayment status or sanctioned from participation in federal health care programs. United shall not engage the services of a provider if that provider is in nonpayment status or excluded from participation in federal health care programs under sections 1128 and/or 1128A of the Social Security Act.

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 United 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 United 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. United 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, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United 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 United 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:

i) 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:

a) Temporary Assistance to Needy Families (TANF);

b) SSI (Aged, Blind and Disabled);

c) Institutional Care;

d) Hospice;

e) Aged/Disabled Adult waiver;

f) Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:
   1) Received care from Children's Medical Services prior to turning age 21;
   2) Age 21 and older;
   3) Cognitively intact;
   4) Medically complex; and
   5) Technologically dependent.

g) Assisted Living waiver;

h) Nursing Home Diversion waiver;

i) Channeling waiver;

j) Low Income Families and Children;

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

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

m) Protected Medicaid (aged and disabled);

n) Dually Eligibles (Medicare and Medicaid);

o) Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO; and

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

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

ii) 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:

a) Traumatic Brain and Spinal Cord Injury waiver;

b) Project AIDS Care (PAC) waiver;

c) Adult Cystic Fibrosis waiver;

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

e) Familial Dysautonomia waiver;

f) Model waiver (age 18 — 20);

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

h) Recipients with other creditable coverage excluding Medicare, and;

i) Recipients on DD HCBS Waitlist.

6.4 Termination. The parties acknowledge and agree the Agency or United 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 United 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 United is created as a result of United's act of terminating, or decision to terminate, any provider under State Contract. Notwithstanding termination of the Agreement, the State Medicaid Contract shall remain in full force and effect with respect to all other applicable providers in United's network.

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