



## **Participating Provider Agreement**

**ATLANTIS HEALTH PLAN, INC.**  
Participating Provider Agreement

THIS PARTICIPATING PROVIDER AGREEMENT (this "Agreement") is made and entered into on the date set forth on the signature page hereto, by and between Atlantis Health Plan, Inc., a New York corporation licensed as a health maintenance organization ("HMO"), and Provider named on the signature page hereto ("Provider"). This is the only agreement between the parties regarding the arrangement established.

**WHEREAS**, HMO is organized and certified under the laws of the State of New York to operate as a health maintenance organization; and

**WHEREAS**, Provider is a Provider who, or group of Providers each of whom, is duly licensed, without restriction or limitation, to practice medicine or osteopathy in the State of New York; and

**WHEREAS**, HMO and Provider mutually desire to enter into an agreement whereby Provider shall provide or arrange for certain health care services to Members as more explicitly described hereinafter.

**NOW, THEREFORE**, in consideration of the mutual promises and covenants herein contained; the parties agree as follows:

## **1 DUTIES OF PROVIDER**

1.1 **PROVISION OF COVERED SERVICES.** Provider shall provide the Medically Necessary Covered Services to Members as described in Attachment B to this Agreement.

### **1.2 MEMBER RECORDS**

1.2.1 **DEPARTMENT AND HMO ACCESS AND CONFIDENTIALITY.** Provider agrees that the New York State Department of Health (the "Department"), the United States Department Health and Human Services and HMO shall have the right to inspect at all reasonable times, all records, including specifically any medical records, maintained by Provider pertaining to Members, and to copy any or all of such records (in the case of the Department, at no charge to the Department) for the purposes of assessing quality of care, coordinating medical care evaluations and audits, determining on a concurrent basis the Medical Necessity and appropriateness of care provided to Members, and in the case of the Department for such other purposes as the Department shall determine. Provider further agrees to cooperate in the transfer of Members' medical records to other Participating Providers, and to assume any cost associated therewith; and to the NYSDOH, at no expense to the State, for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals and as otherwise required by State law.

Provider agrees that Members' medical records and information shall be treated as confidential so as to comply with all applicable state and federal laws and regulations regarding the confidentiality of medical records and information. This provision shall survive the termination of this Agreement.

1.2.2 **MEDICAL RECORD RETENTION.** Provider shall retain all medical records prepared and/or maintained by Provider for and with respect to each Member receiving medical and/or health care services from Provider for a period which shall end not less than six years after the last date on which such Member received medical services from Provider, or six years after such Member shall have achieved the age of majority under New York law, whichever period is longer.

1.2.3 **MEDICAL RECORD REVIEW.** Provider shall permit a representative of the HMO staff to concurrently review medical records of Members who are inpatients of any hospital or other medical or health care facility and to whom the Provider provides medical and/or health care services pursuant to this Agreement.

1.2.4 **CONSENT FOR DISCLOSURE OF MEDICAL RECORDS.** Provider agrees that consent for disclosure of medical records to HMO, any independent practice association designated by HMO (to the extent

necessary for preauthorization and concurrent utilization review activities, provider claims processing, and payment), the Department, and Federal monitoring and oversight agencies will be obtained from, or on behalf of, Members prior to disclosure of information. In most cases arising under this Agreement this consent shall have been obtained by or on behalf of HMO at the time of a Member's enrollment.

1.3 UTILIZATION REVIEW AND QUALITY ASSURANCE. Provider shall cooperate with and participate in HMO's Quality Assurance and Utilization Review Programs. HMO shall communicate the policies and procedures of its programs in writing to Provider. HMO shall not delegate utilization review or quality assurance functions, or any other responsibilities imposed on HMO by applicable law, to an IPA (independent practice association) through a management contract or otherwise. An IPA shall not function as a utilization review agent of HMO. Provider agrees to adhere to HMO's Quality Assurance Program which includes, but is not limited to the following requirements:

1.3.1 CREDENTIALS. Provider shall (i) maintain all licenses and certifications required to satisfy his or her duties hereunder, (ii) provide copies of all such licenses and certifications to HMO for verification and credentialing purposes, and (iii) cooperate with HMO in the periodic re-credentialing procedures outlined in the Quality Assurance Program, all as provided below in section 1.12 of this Agreement.

For services performed with the assistance of another person, Provider acknowledges that each and every person who assists him/her is (i) the Provider's employee or under direct supervision of the Provider, (ii) possesses the license/certificate/authority and required qualifications to assist a Provider, and (iii) has not been convicted of a criminal offense (other than a misdemeanor traffic violation).

1.3.2 STANDARDS OF CARE. Provider shall provide service to Members in a courteous, prompt manner, in a clean, comfortable office environment with staff who are mindful of Members' needs for dignity, respect and confidentiality. Provider shall adhere to accepted standards of medical practice and HMO's standards as described in the Quality Assurance Program in rendering service to Members, as provided below in section 1.12 of this Agreement.

1.3.3 HOSPITAL PRIVILEGES. Providers shall maintain staff privileges at a minimum of one hospital with whom HMO contracts, and shall notify HMO within two business days of the loss or restriction of such privileges. Exceptions may be made if the Provider without admitting privileges at a contracted hospital uses an admitting panel or can provide evidence that there will be another HMO network Provider with admitting privileges who will admit the patient. Exceptions may also be made for Providers who do not normally obtain hospital-admitting privileges.

1.4 NON-DISCRIMINATION. Provider shall not discriminate against any Member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment, or type of illness or condition.

1.5 MEMBER HOLD HARMLESS. Provider agrees that in no event, including, but not limited to non-payment by HMO, insolvency of HMO or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person (other than HMO) acting on his/her/their behalf, for services provided pursuant to this Agreement for the period covered by the premium paid by, for, or on behalf of, such Member. This provision shall not prohibit Provider from collecting co-payments, as specifically provided in the evidence of coverage, or fees for uncovered service delivered on a fee-for-service basis to a Member provided that Provider shall have advised the Member (and any person financially responsible for medical care provided to that Member) that the service is uncovered and of the Member's (or the financially responsible person's) liability therefore prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supercede any oral or written agreement now existing or hereafter entered into between Provider and any Member or any person acting on behalf of any Member.

1.5.1 This provision shall not prohibit Provider from collecting deductibles from Members, provided, however that such deductibles may be collected only when the Member is the beneficiary of a point of service (POS) contract.

1.5.2 Where Provider is uncertain as to whether a service is among the Covered Services provided for in this Agreement (including Attachment B to this Agreement), Provider shall make reasonable

efforts to contact HMO and obtain a coverage determination prior to advising a Member (or any person financially responsible for medical care provided to that Member) as to coverage and liability for payment and prior to providing the service.

1.5.3 If emergency treatment is necessary, notice of the treatment, and verification of Member eligibility and whether a service is among the Covered Services may be by telephone. If Provider cannot notify HMO and verify Member eligibility and whether a service is among the Covered Services prior to emergency treatment, Provider agrees to notify HMO as soon as possible, but in no event later than forty-eight (48) hours, or two business days, after the emergency treatment; provided, however, that if Provider is unable to notify HMO because Member's medical condition prevents Member from communicating to Provider the Member's enrollment with HMO, then Provider shall be excused from notifying HMO of such Member's treatment until such time as Provider, using reasonable best efforts, can determine such information.

1.6 INSURANCE AND INDEMNIFICATION. Provider shall, at its sole cost and expense, procure and maintain such policies of general liability and professional liability and other insurance as shall be necessary to insure Provider and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the provision of services by Provider under this Agreement. The coverage limits of such general liability and professional liability insurance shall meet all requirements imposed from time to time by applicable law or the HMO, whichever requirements shall be more stringent. Copies of such policies shall be delivered to HMO upon request. Provider further agrees to indemnify and hold HMO harmless against any claims or liabilities arising under general liability and/or professional liability of Provider (but not against any claims or liabilities arising with respect to the general liability and/or professional liability of HMO).

1.7 CLAIMS SUBMISSION. Provider shall submit all claims and encounter forms to HMO within ninety (90) days of the date of service.

1.8 GRIEVANCE PROCEDURE. Provider will cooperate with and participate in HMO's Grievance Procedure when requested by HMO, as provided below in section 1.12 of this Agreement, and agrees to abide by the decisions of HMO's Grievance Committee. The purpose of the procedure, as more fully described in the Provider Manual, is to address Member complaints and to resolve formal Member grievances.

1.9 ACCESS TO BUSINESS RECORDS. Upon request, and at reasonable times, Provider shall make available to HMO and to any appropriate governmental authority such business records and information as may be required to comply with applicable law governing Provider's and/or HMO's operations and or information relating directly to any determination required by this Agreement. All such information shall be held by the receiving party in confidence and shall only be used in connection with the administration of this Agreement.

1.10 COORDINATION OF BENEFITS. Provider shall cooperate with HMO regarding the coordination of benefits and subrogation procedures in instances where the Member is covered by auto insurance, workmen's compensation or other health insurance. With respect to Members eligible for medical assistance, Provider shall maintain and make available to HMO records reflecting collection of coordination of benefits proceeds by Provider, and amounts thereof. It is understood and agreed by Provider that HMO is subject to audits under the Medicaid program (including without notice) by the Office of the Comptroller of the State of New York, including audits for coordination of benefits collected for Members receiving medical assistance benefits and therefore must have records concerning collection of coordination of benefits proceeds available.

1.11 MAINTENANCE OF/ACCESS TO BUSINESS RECORDS. This section is included in this Agreement because of the possible application of section 1861 (v) (1) (I) of the Social Security Act (42 U.S.C.A. §Y1395x (v) (1) (I)) to this Agreement; if that section should be inapplicable to this Agreement, then this clause shall be deemed not to be part of this Agreement and shall be of no force or effect.

1.11.1 Until the expiration of four years after the furnishing of any service pursuant to this Agreement, Provider will make available, upon written request of Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of this Agreement and any books, documents, records, or other data of Provider that are necessary to certify the nature and extent of costs incurred by Provider with respect to such service.

1.11.2 If Provider carries out any of the Provider's duties under this Agreement through a subcontract with a related organization involving a value or cost of \$10,000 or more over a period of 12 months or more, Provider will cause such subcontract to contain provisions requiring that until the expiration of four years after the furnishing of any service pursuant to that subcontract, the related organization will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of that subcontract and any books, documents, records, or other data of that related organization that may be necessary to certify the nature and extent of costs incurred by that related organization and/or Provider with respect to such service.

1.11.3 If Provider or any related organization (as referred to above in this section) is requested to disclose any books, documents, or records relevant to this Agreement for the purpose of an audit or investigation, Provider and/or such related organization shall notify HMO of the nature and scope of such request and upon request of HMO shall make available to HMO, at commercially reasonable times and locations, all such books, documents, or records for review and copying.

1.12 COMPLIANCE WITH HMO'S RULES, POLICIES, AND PROCEDURES. Provider shall comply fully with and abide by the rules, policies, and procedures that HMO has established or will establish and has provided to Provider at least thirty (30) days in advance of implementation, including:

1.12.1 Quality improvement/management (including, but not limited to the Quality Assurance Program);

1.12.2 Utilization management, including but not limited to, the Utilization Review Program, pre-certification procedures, referral process, or protocols, and reporting of clinical encounter data;

1.12.3 Member grievances (including, but not limited to, the Grievance Procedure); and

1.12.4 Provider credentialing.

1.13 CONTINUATION OF TREATMENT

1.13.1 Inpatient Care: In the event of HMO or Provider insolvency or termination of the contract for any reason, Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period.

1.13.2 Ongoing Care: Pursuant to PHL §4403(6)(e) in the event of termination the Plan allows members to continue in ongoing care with this provider for a transitional period of up to 90 days from the date of termination or exhaustion of benefits, whichever occurs first. If the member has entered the second trimester of pregnancy by the date of termination, the transitional period shall include the provision of post-partum care directly related to the delivery and upon the member's request, delivery at hospital. The member, their designee, or the treating provider should call Atlantis to request such transitional care. The provider must agree to certain requirements for Atlantis to approve this request.

Continuation of treatment is permitted if:

- (a) This agreement is terminated for reasons unrelated to quality of patient care, fraud, or disciplinary action; and
- (b) The Member has a life threatening or degenerative and disabling condition or disease or has entered the second trimester of pregnancy.
- (c) The provider continues to accept the rates specified in this agreement's fee schedule as payment in full, comply with the Plan's quality assurance requirements and provide medical information as requested by the Plan.

## **2 DUTIES OF HMO**

2.1 **COMPENSATION.** HMO agrees to compensate Provider for Covered Services provided to Members in accordance with the terms and conditions set forth in Attachment C to this agreement. HMO may unilaterally modify these rates upon 90 day notification to Provider.

2.2 **ADMINISTRATIVE PROCEDURES.** HMO shall make available to Provider a manual of administrative procedures including any changes thereto (Provider Manual) describing requirements for record keeping, reporting, referrals, and other administrative duties of the Provider required under this Agreement.

2.3 **TIMELY PROCESSING OF CLAIMS.** HMO agrees to process claims for payment within thirty days of receipt of the claim, provided that the claim is submitted with sufficient documentation. Where the claim requires additional documentation, HMO shall make payment within thirty days of receipt of the documentation required to approve the claim.

2.4 **ELIGIBILITY VERIFICATION.** HMO shall provide a system for the verification of Member's eligibility to receive Covered Services, and a description of what Covered Services a Member is entitled to receive.

2.5 **PROVIDER RELATIONS ASSISTANCE.** HMO shall make available to Provider a system of assistance which shall include materials explaining HMO's benefits, policies, procedures, standards, and other administrative requirements, as well as access to a provider relations representative for assistance with specific issues related to HMO and its Members.

2.6 **CONFIDENTIALITY.** HMO agrees that Members' medical records and information shall be treated as confidential so as to comply with all applicable state and federal laws and regulations regarding the confidentiality of medical records and information. This provision shall survive the termination of this Agreement.

## **3 TERM OF AGREEMENT**

3.1 **TERM.** This Agreement will commence on the date hereof for an initial one year term, and shall be automatically renewed for successive one year terms, unless either party notifies the other in writing of its intent not to renew not less than 90 days prior to the renewal date. Either party may terminate this agreement without cause with no less than 90 days written notification.

3.2 **TERMINATION.** HMO may terminate this Agreement immediately upon written notice to Provider in the event of any of the following:

3.2.1 Provider's license is no longer active or registered with the Office of Professions New York State Education Department, suspension or revocation of the Provider's license, certificate or other legal credential authorizing Provider to practice medicine or osteopathy. To practice within New York State, a professional must be licensed and REGISTERED. When a professional informs the Department, either at the time of reregistration or at any time during their current registration period, that he or she will not be practicing in New York, the record is marked INACTIVE. If a registration has lapsed without explanation, the record is marked NOT REGISTERED. If the Department has received reliable notice of the death of a licensee, that record is marked DECEASED. If the license is currently suspended, revoked, or has been surrendered pursuant to disciplinary action, the record is marked LICENSE SUSPENDED, LICENSE REVOKED, or LICENSE SURRENDERED.

3.2.2 Suspension or revocation of the Provider's DEA number or other right to prescribe controlled substances;

3.2.2 An indictment, arrest or conviction for a felony or for any criminal charge which might in any way impair Provider's capacity to carry out the duties hereunder;

3.2.3 The lapse of professional liability insurance required under this agreement;

3.2.4 Provider, if required, no longer has clinical privileges at any HMO participating hospital;

3.2.5 Repeated failure of Provider to participate in or cooperate with HMO's utilization review policies and procedures;

3.2.6 The death of Provider (if Provider is a single individual), or the death or any disability of any Provider who is a member of the group constituting Provider which renders such group unable to perform the obligations required of Provider under this Agreement for a period in excess of thirty days;

3.2.7 Failure of Provider to participate in or cooperate with HMO quality assurance program or repeated failure to provide high quality, cost effective health care to Members, as measured by the standards adopted from time to time by HMO; or

3.2.8 If Provider is suspended or permanently precluded from participating in the New York State Medical Assistance program or the Federal Medicare program.

3.2.10 If Provider fails to meet and/or comply with HMO's credentialing and re-credentialing requirements.

3.2.11 Any notice of termination provided by the HMO to Provider shall include:

- (i) the reasons for the termination;
- (ii) notice that the Provider has the right to request a hearing or review, at the Provider's discretion, before a panel appointed by the HMO;
- (iii) a time limit of not less than thirty days within which Provider may request a hearing; and
- (iv) a time limit for a hearing date which must be held within thirty days after the date of receipt of request for a hearing.

3.2.11 (a) The Hearing Panel shall be compromised of three persons appointed by the HMO. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as Provider. The Hearing Panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership panel.

(b) The Hearing Panel shall render a decision on the proposed action in a timely matter. Such decision may provisional reinstatement of Provider by the HMO, provisional reinstatement subject to conditions set forth by the HMO or termination of Provider. Such decision shall be provided in writing to Provider.

(c) A decision by the Hearing Panel to terminate Provider shall be effective not less than 30 days after the receipt by Provider of the Hearing Panel's decision.

#### **4 MISCELLANEOUS PROVISIONS**

4.1 DEFINITIONS. As used in this Agreement, the words and phrases defined in Attachment A to this Agreement shall have the meanings provided for in the definitions set forth in Attachment A to this Agreement.

4.2 COMPLIANCE WITH THE MANAGED CARE REFORM ACT OF 1996. Notwithstanding any other provision of this Agreement, the parties hereto shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996).

4.3 ASSIGNMENT. No assignment of Provider's rights and/or obligations under this Agreement shall be effective without the prior approval of HMO. HMO may assign this Agreement to any entity that controls, is controlled by, or that is under common control with HMO now or in the future, or which succeeds to its business through a sale, merger, or other corporate transaction.

4.4 NOTICES. Any notice required by this Agreement shall be given by registered or certified mail, addressed to the party to whom such notice is intended to be given, at the last known address of that party's principle place of business.

4.5 PROPRIETARY INFORMATION. Provider recognizes that all material provided to it by HMO is the proprietary information of HMO and Provider shall not disclose or release such material. In addition, Provider shall not use or assist others in using any of HMO's proprietary information including, but not limited to lists of Members, directly or indirectly to further the business purposes of any other health insurer or health care delivery system.

4.6 GOVERNING LAW. This Agreement shall be construed and enforced in accordance with the laws of the State of New York.

4.7 RELATIONSHIP OF THE PARTIES. The relationship between HMO and Provider is that of independent contractors, and neither shall be considered an agent or representative of the other for any purpose. HMO and Provider will each be liable solely for their own activities and neither HMO nor Provider shall be liable for the activities of the other.

4.8 PROMOTIONAL MATERIALS. Except as provided in this paragraph, neither HMO nor Provider shall use the other's name, symbols, trademarks or service marks in advertising or promotional materials without the other party's prior written consent. HMO shall have the right to use the name of Provider for purposes of marketing, informing Members of the identity of Provider, and otherwise to carry out the terms of this Agreement. Provider shall likewise have the right to use HMO's name in its information or promotional materials for the purpose of carrying out the terms of this Agreement.

4.9 AMENDMENTS; DEPARTMENT APPROVAL REQUIRED. No amendment of this Agreement shall be legally binding or otherwise effective unless the same shall be in writing and executed on behalf of both HMO and Provider. Any material amendment to this Agreement shall require prior approval of the Department and shall be submitted to the Department for review in connection with any request for such approval at least 30 days in advance of anticipated execution. Material amendments shall include, but not be limited to:

4.9.1 Any change to a provision of the Agreement (including any attachment hereto) required by applicable law or regulation;

4.9.2 Any change to or addition of a risk sharing arrangement;

4.9.3 The addition of an exclusivity, most favored nation, or non-compete clause;

4.9.4 Any proposed sub-delegation/subcontracting of the existing contractual obligations of Provider;

4.9.5 Any proposed subcontracting of the statutory or regulatory responsibilities of HMO;

4.9.6 Any proposed revocation of approved delegations as set forth in sections 4.9.4 or 4.9.5 of this Agreement.

4.10 INCORPORATION OF STANDARD CLAUSES. The New York State Department of Health "Standard Clauses" attached to this Agreement as Appendix A, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail.

4.11 All New York State Department of Health required revisions will be incorporated into contract and if so directed by the Department of Health, the contract will be terminated.

THE PARTIES ACKNOWLEDGE by their execution of this Agreement that they have read, and agree to, the entire contents of this Agreement including the Attachments and Appendices hereto. The parties further acknowledge and agree to be bound by the terms and conditions of this Agreement including the Attachments and Appendices, which taken together, constitute the entire Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

**PROVIDER**  
Name of Provider  
Address  
City, State ZIP

**ATLANTIS HEALTH PLAN, INC.**  
**ATLANTIS HEALTH PLAN, INC.**  
**45 Broadway, Suite 300**  
**New York, NY 10006**

\_\_\_\_\_  
PRINTED NAME

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PRINTED NAME

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NPI #

**ATLANTIS HEALTH PLAN, INC.**  
Participating Provider Agreement

**Attachment A**  
Definitions

1. **COVERED SERVICES.** Those medical and hospital services and benefits to which Members are entitled under the terms of the applicable individual Member or group contract issued by HMO.
2. **EMERGENCY CONDITION.** A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.
3. **ENROLLMENT FORM.** The form signed by an individual to signify his or her intent to become a Member, or to have dependents become Members of HMO. The release signed by the Member as part of this form shall be deemed by a provider to be sufficient to allow access by HMO to all clinical records without additional releases from Members.
4. **GRIEVANCE PROCEDURE.** The procedure annexed as Attachment E of this Agreement, describing HMO's compliance with the New York State Department of Health's standards for the prompt resolution of Member problems, complaints and grievances, as described in the Provider Manual.
5. **MEDICAL DIRECTOR.** A duly licensed Provider who has been designated by HMO to monitor, review and provide clinical supervision for the utilization review and quality assurance functions for covered services prescribed and recommended by Providers to Members.
6. **MEDICALLY NECESSARY; MEDICAL NECESSITY.** Services required to identify and treat a Member's illness or injury and which, as determined by HMO's Medical Director, are (a) appropriate and necessary for the diagnosis, quantification, or treatment of a Member's medical condition, illness, disease or injury; (b) appropriate with regard to standards of good medical practice as recommended and accepted by the medical community; (c) not solely for the convenience of the Member, the Provider, or the Member's family; and (d) the most appropriate supply or level of service which can be safely provided to the Member. When specifically applied to an inpatient, it further means that the Member's medical symptoms or condition requires that the Member cannot be treated as an outpatient.
7. **MEMBER.** An individual who has entered into a contract with HMO (or on whose behalf a contract has been entered into) for the provision of Covered Services.
8. **PARTICIPATING PROVIDER.** A health services provider who has entered into a contract with HMO for the provision of Covered Services to Members.
9. **PRIMARY CARE PROVIDER.** A duly licensed doctor of medicine or osteopathy who has been successfully credentialed by HMO and who will, under the terms of this Agreement, be responsible for the supervision, coordination and provision of initial and basic care to Members who have selected that provider. The Primary Care Provider will also initiate referrals for specialty care needed by a Member and maintain overall continuity of a Member's care.
10. **PROVIDER MANUAL.** A Manual of HMO's policies, procedures, and administrative practices published by HMO and distributed to Providers from time to time.
11. **SANCTIONS POLICY.** The HMO policy annexed hereto as Attachment D of this Agreement, describing the

circumstances which can lead to the sanctioning of a Provider, and the due process available to the Provider in appealing such a sanction.

12. **SPECIALTY CARE PROVIDER.** A duly licensed doctor of medicine or osteopathy who has been successfully credentialed by HMO and who will, under the terms of this Agreement, provide specialty care services to Members referred to such provider.
13. **QUALITY ASSURANCE PROGRAM.** An ongoing peer review process and plan which functions to define, monitor, review, and recommend corrective action for assuring the quality of health care services rendered to Members.
14. **UTILIZATION REVIEW PROGRAM.** The review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.
15. **DEPARTMENT.** The New York State Department of Health.

**ATLANTIS HEALTH PLAN, INC.**  
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**Attachment B**  
Description of Provider Services

- A. **PRIMARY CARE SERVICES.** Providers who are credentialed by HMO as Primary Care Providers shall supervise, coordinate, and provide initial and basic care to Members. Primary Care Providers shall also initiate referral for specialty care, and maintain continuity of care for Members on his or her panel. Primary Care Providers shall provide:
1. Office visits during normal office hours.
  2. Twenty-four (24) hour coverage and back up coverage when the Primary Care Provider is unavailable. Primary Care Providers may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
  3. Arrange for and/or provide inpatient care at HMO contracted hospitals.
  4. Referrals when necessary, to other HMO Participating Providers.
- B. **SPECIALTY CARE SERVICES.** Providers who are credentialed by HMO, as Specialty Care Providers shall provide specialty care medical services to Members referred to Provider, in accordance with standards established by HMO. Provider agrees to keep Member's Primary Care Providers informed as to the Members' condition, progress and status.

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**Attachment C**  
Fee Schedule

*Please contact Atlantis Health Plan.*

**ATLANTIS HEALTH PLAN, INC.**  
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**Attachment D**  
Sanctioning Policy for Providers

HMO's primary goal is to promote the provision of quality health care services to Members consistent with accepted standards and protocols. If a Member receives services from a Participating Provider which vary from the recommended standard treatment protocol of the general medical community and the HMO Quality Assurance and Credentialing Criteria, the sanctions defined below may be implemented. In appropriate circumstances, and in all circumstances wherein the same is required by applicable law, the National Practitioner Data Bank will be notified of any formal sanctions imposed for a period of thirty (30) days or more.

**I. FORMAL WARNINGS**

When HMO believes that the actions of a Participating Provider are inconsistent with the policies of the HMO, the following process will occur:

- A. A letter describing the quality concerns of the Quality Assurance Committee and subsequent required corrective actions will be forwarded to the Participating Provider. A reasonable period of time appropriate to the specific nature of the problem, will be afforded to the Participating Provider in order to demonstrate compliance.
- B. A second warning letter will be sent to the Participating Provider if repeated behavior, demonstrating non-compliance with the HMO's requirements occurs. At this point, the HMO will preclude the Participating Provider from receiving new Members.
- C. Should the Participating Provider fail to conform to the second letter within the specified time frame, HMO will commence the formal sanctioning procedure.
- D. Should serious variations from recognized standards occur, the HMO's Medical Director or Quality Assurance Committee may choose to institute the formal sanctioning procedure immediately.

**II. FORMAL SANCTIONING PROCEDURE**

- A. **PROVIDER NOTIFICATION.**  
Notification in the form of a written letter regarding the proceedings will be forwarded to the Participating Provider via certified mail. Details for inclusion are as follows:
  1. Notice of a proposed professional review action regarding the qualifying event or behavior as previously defined by the HMO is sent to the Participating Provider. A copy of this policy delineating the Participating Provider's rights will also be contained in this notice.
  2. The Participating Provider has the right to request a hearing regarding the proposed action as long as that Participating Provider requests the hearing by detailing the sections he/she chooses to protest in writing within thirty (30) days of receiving notice of the proposed action.
  3. The Participating Provider may actively choose to waive his/her right to a hearing; in addition, the right to a hearing will be forfeited should the Participating Provider fail to respond to the notice of proposed action in writing within thirty (30) days as defined in number two (2) above.
- B. **NOTICE OF HEARING.**  
If the Participating Provider appropriately requests a hearing, the HMO will respond in writing by confirming the date, time and place of the hearing, which must occur within thirty (30) days of the request. Notice of the hearing date will also list any witnesses testifying on behalf of the HMO. Should the Participating Provider fail to appear without demonstrating good cause, the right to a hearing will be forfeited. If however, the Participating Provider is able to demonstrate good cause, the Participating Provider may request the hearing be postponed longer than the defined thirty (30) days.

C. CONDUCT OF HEARING.

The HMO Medical Director or his/her designee will serve as the hearing officer. Members of the panel may include Providers who are not Members of the Quality Assurance Committee. The hearing panel shall be comprised of three or more persons, including the hearing officer, provided that at least one-third of the total membership of the hearing panel shall be clinical peers in the same discipline and the same or similar specialty as the health care professional under review. Under no circumstances, however, will individuals on the panel be in direct economic competition with the Participating Provider in question.

D. PROVIDER RIGHTS DURING THE HEARING.

The Participating Provider has the following rights:

1. to present evidence determined by the hearing officer to be relevant, regardless of its admissibility in a court of law.
2. to request a formal record of the proceedings, at his or her own cost.
3. to call, examine, and cross examine witnesses.
4. to be represented by an attorney or other person of Participating Provider's choosing.
5. to submit a written statement at the close of the hearing.
6. to receive the written decision of the hearing panel, including a statement of the basis for the decision, within fifteen (15) working days of the end of the hearing. If the decision involves termination of the Participating Provider, the decision shall include reinstatement of the Participating Provider, provisional reinstatement subject to conditions set forth by the HMO, or termination of the Participating Provider. A decision by the hearing panel to terminate a Participating Provider shall be effective not less than thirty days after the receipt by the Participating Provider of the hearing panel's decision, provided, however, that for an ongoing course of treatment, a Member, at the Member's option, may chose to continue treatment pursuant to the provisions of paragraph (e) of subdivision six of section four thousand four hundred three of Article 44 of the New York Public Health Law, which shall apply to such termination.

E. PROVIDER APPEAL.

Upon receiving the written decision of the hearing panel, the Participating Provider may request, within thirty (30) days and by certified mail, an appeal. If the Participating Provider does not respond within the thirty (30) day time frame, the right to an appeal is forfeited. Within forty-five (45) days of receiving the appeal request, the HMO's Board of Directors will review the matter and render a final written decision to the Participating Provider.

F. EFFECTIVE DATE OF TERMINATION.

If the Participating Provider is at any time notified of his or her termination, in no event shall termination be effective earlier than sixty days from the receipt of the notice of termination, unless the termination is pursuant to the provisions of Section III below.

### III. SUMMARY ACTIONS

HMO allows the Medical Director, with the approval of the President of the HMO, to immediately revoke or terminate panel membership or Participating Provider status, in whole or in part, subject to subsequent notice and hearing in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other government agency that impairs the Participating Provider's ability to practice. Within thirty (30) days of any such summary action, a hearing will be held to determine the action's affirmation or rescission.

**ATLANTIS HEALTH PLAN, INC.**  
Participating Provider Agreement

**Attachment E**  
Grievance Procedure Policy

Under the provisions of Article 44 of the New York State Public Health Law and the Department of Health regulations, HMO has established a grievance process for use by Members who are in any way dissatisfied with the HMO, an HMO Participating Provider or an IPA Participating Provider. The grievance process is set forth in the Member Handbook provided to the Members. The section of the Member Handbook setting forth such procedures is attached hereto as Attachment E-1, and is incorporated herein by reference and made a part of this contract. The grievance procedures may be amended from time to time with the approval of the Department, and in accordance with New York laws and regulations, and any such amendment to the grievance procedures shall be an amendment to Attachment E-1 of this contract.

**ATLANTIS HEALTH PLAN, INC.**  
Participating Provider Agreement

**Attachment E-1**

**THE GRIEVANCE PROCESS**

AHP attempts to solve your problems or complaints through the Member Services Department in an efficient manner. AHP has established the following grievance procedures for use by Members who are in any way dissatisfied with AHP or a participating provider.

Members may contact the State Insurance or Health Department at any time during the complaint process. Listed below are the toll-free telephone numbers for each Agency.

New York State Department of Health	1-800-206-8125
New York State Department of Insurance	1-800-342-3736
Consumer Services Unit	
One Commerce Plaza	
Albany, NY 12257	

Members with complaints should call the AHP Member Services Department at 866-747-8422, or write to: Atlantis Health Plan, Member Services Dept., 45 Broadway, Suite 300, New York, NY, 10006. Each complaint will be promptly investigated and AHP will provide a Member with a response to a complaint within thirty (30) days of receipt of all necessary information for disputes involving Member contract benefits and forty-five (45) days for all other disputes. If a Member's health is in danger, then AHP will give a response within forty-eight (48) hours or two (2) days. This response will be a written notice of complaint determination, which will include information about the basis of the decision, the Member's right to appeal and the appeal procedure.

Members who are dissatisfied with the Plan's handling of a complaint or who receive a claim denial from AHP, may file a Grievance. To make this process more accessible to non-English speaking Members, AHP can arrange to have an interpreter available who speaks your language. You also have the right to file a complaint orally when your dispute is about referrals or covered benefits.

The following policies apply to the filing of a complaint or Grievance:

1. The Member has the right to file a complaint regarding any dispute with AHP.
2. Qualified clinical personnel will make determination of all clinical complaints involving clinical decisions.
3. AHP will allow only qualified clinical personnel to make determinations with regard to the provision of your benefits. Any denial will be accompanied by an explanation and a basis behind the decision and further appeal rights.
4. AHP will not retaliate or take any discriminatory action against the Member because they filed a complaint or appeal.
5. The Member has the right to designate a representative to file complaints and appeals on his/her behalf.
6. The Member has a right to file a complaint verbally when the dispute is about referrals or covered benefits.

The following timeframes apply to the Grievance Procedure:

1. The Member or designee has no less than 60 business days after receipt of the notice of the complaint determination to file a written appeal.
2. Grievance appeals may be submitted in writing, on a form provided by AHP or verbally.
3. Within 15 business days of receipt of the appeal, AHP shall provide written acknowledgment including the name, address and telephone number of the individual designated to respond to the appeal. AHP will indicate what additional information, if any, must be provided for AHP to render a decision.
4. Personnel qualified to review the complaint, including licensed, certified or registered health care professionals

- who did not make the initial determination, will decide grievance appeals related to clinical matters.
5. Qualified personnel at a higher level than the personnel who made the original complaint determination will make grievance appeal determinations of non-clinical matters.
  6. Appeals will be decided and notification provided to the Member no more than:
    - 2 business days after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health.
    - 30 business days after the receipt of all necessary information in all other instances.
  7. The written notice of an appeal determination will include the detailed reasons for the determination, the clinical rationale if applicable, and instructions for any other appeal.

The notice will also inform the Member of their right to contact the State Insurance or Health Department at any time during the complaint process.

## **DOH MANDATORY APPENDIX A**

### New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

**(Revised 1/1/07)**

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

#### **A. Definitions For Purposes Of This Appendix**

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean Providers, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed and/or certified as required by applicable federal and state law.

#### **B. General Terms And Conditions**

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least 30 days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.
3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group

provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the provider at least thirty (30) days in advance of implementation, including but not limited to:
  - o quality improvement/management;
  - o utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
  - o member grievances; and
  - o provider credentialing.
5. The provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the provider is a primary care practitioner, the provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the provider is unavailable. The provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and Chapter 551 of the Laws of 2006, and all amendments thereto.
9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:
  - a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;
  - b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and
  - c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
  - d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.
  - e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with the HIV confidentiality requirements of Article 27-F of the Public Health Law.

### **C. Payment; Risk Arrangements**

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefor prior to providing the service. Where the provider has not been given a list of services covered by the MCO, and/or provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.
2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. The parties agree to comply with and incorporate the requirements of Provider Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a Provider or Provider group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

### **D. Records; Access**

1. Pursuant to appropriate consent/authorization by the enrollee, the provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment. The provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The provider shall provide copies of such records to DOH at no cost. The provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information

concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The MCO and the provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the provider agrees to obtain consent from the enrollee if the enrollee has not previously signed a consent for disclosure of medical records.

#### E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.
2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. The provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

#### **F. Arbitration**

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

#### **G. IPA-Specific Provisions**

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.