



## **Group Agreement**

## ATLANTIS HEALTH PLAN

### Physician Group Participating Provider Agreement

**THIS Physician GROUP 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, a/an Physician Group/Independent Practice Association organized and existing under the Corporation Law of the State of New York ("PG"). 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, PG is a/an Physician Group/Individual Practice Association which has entered into contractual arrangements with physicians and certain other health care providers and has as its primary objective to arrange for and facilitate the provision and delivery of health services to New York residents and other persons, including HMO's Members; and

WHEREAS, the parties hereto desire to enter into an agreement upon the terms and subject to the conditions hereinafter set forth concerning PG's arranging for the delivery of health care services to Members and the administration by HMO of a comprehensive prepaid program of health care;

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

#### **1 DUTIES OF PG**

1.1 PROVISION OF COVERED SERVICES. PG shall, through PG Participating Providers, provide Medically Necessary Covered Services to Members as described in Attachment B to this Agreement upon the terms and subject to the conditions provided for in this Agreement.

#### 1.2 MEMBER RECORDS.

1.2.1 DEPARTMENT AND HMO ACCESS AND CONFIDENTIALITY. PG agrees, and shall cause every PG Participating Provider to agree, that the New York State Department of Health (the "Department") and HMO shall have the right to inspect at all reasonable times, all records, including specifically any medical records, maintained by PG or any PG Participating Provider pertaining to Members, and to copy any or all of such records, at no charge, any or all of each records for the purposes of assessing quality of care, coordinating medical care evaluations and audits, preauthorization, concurrent review, quality assurance, payment processing, 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. PG further agrees, and shall cause every PG Participating Provider to further agree, to cooperate in the transfer of Members' medical records to other PG Participating Providers and to other HMO 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.

PG agrees, and shall cause every PG Participating Provider to agree, 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. PG shall require PG Participating Providers to obtain any consents for Members that may be required by law for the release of Member records under this Agreement.

1.2.2 MEDICAL RECORD RETENTION. PG shall, and shall cause every PG Participating Provider to, retain all medical records prepared and/or maintained for and with respect to each Member receiving medical and/or health care services through PG pursuant to this Agreement for a period which shall end not less than six years after the last date on which such Member received such services, 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. PG shall, and shall cause every PG Participating Provider to, 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 any PG Participating Provider provides medical and/or health care services pursuant to this Agreement.

1.3 UTILIZATION REVIEW AND QUALITY ASSURANCE. PG shall, and shall cause every PG Participating Provider to, cooperate with and participate in HMO's Quality Assurance Program and Utilization Review Program. A PG shall not function as a utilization review agent of HMO. PG shall, and shall cause every PG Participating Provider to, adhere to HMO's Quality Assurance Program which includes, but is not limited to the following requirements:

1.3.1 CREDENTIALS. PG shall, and shall cause every PG Participating Provider to, maintain all licenses and certifications required to satisfy his, her, or its duties hereunder, and to provide copies of all such licenses and certifications to HMO for verification and credentialing purposes. PG shall, and shall cause every PG Participating Provider to, cooperate with HMO in the periodic recredentialing procedures outlined in the Quality Assurance Program.

1.3.2 STANDARDS OF CARE. PG shall, and shall cause every PG Participating Provider to, 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. PG shall, and shall cause every PG Participating Provider to, adhere to accepted standards of medical practice and HMO's standards as described in the Quality Assurance Program in rendering service to Members.

1.3.3 HOSPITAL PRIVILEGES. Physicians 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 physician without admitting privileges at a contracted hospital uses an admitting panel or can provide evidence that there will be another HMO network physician with admitting privileges who will admit the patient. Exceptions may also be made for physicians who do not normally obtain hospital-admitting privileges.

1.4 NON-DISCRIMINATION. Neither PG nor any PG Participating Provider shall discriminate against any Member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, type of illness or condition, or source of payment.

1.5 MEMBER HOLD HARMLESS. PG agrees, and shall cause every PG Participating Provider to agree, that in no event, including, but not limited to non-payment by HMO, insolvency of HMO or breach of this Agreement, shall PG or any PG Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person acting on his/her/their behalf, for services provided pursuant to this Agreement. This provision shall not prohibit PG or any PG Participating 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 the Member (and any person financially responsible for medical care provided to that Member) shall first have been advised 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 Physician and any Member or any person acting on behalf of any Member.

1.5.1 This provision shall not prohibit PG or any PG Participating 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, as specifically provided in the evidence of coverage.

1.5.2 Where Physician is uncertain as to whether a service is among the Covered Services provided

for in this Agreement (including Attachment B to this Agreement), Physician 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 Physician cannot notify HMO and verify Member eligibility and whether a service is among the Covered Services prior to emergency treatment, Physician 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 Physician is unable to notify HMO because Member's medical condition prevents Member from communicating to Physician the Member's enrollment with HMO, then Physician shall be excused from notifying HMO of such Member's treatment until such time as Physician, using reasonable best efforts, can determine such information.

1.6 INSURANCE AND INDEMNIFICATION. PG shall, and shall cause each PG Participating Provider to, procure and maintain, at his, her, or its sole cost and expense, such policies of general liability and professional liability and other insurance as shall be necessary to insure PG and each such PG Participating Provider, and their 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 PG or by any such PG Participating 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. PG agrees, and shall cause every PG Participating Provider to agree, to indemnify and hold HMO harmless against any claims or liabilities arising under general liability and/or professional liability of PG or such PG Participating 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. PG shall, and/or shall cause every PG Participating Provider to, submit all claims and encounter forms to HMO within sixty days of the date of service.

1.8. GRIEVANCE PROCEDURE. Physician 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. PG shall, and shall cause every PG Participating Provider to, make available, upon request and at reasonable times, to HMO and to any appropriate governmental authority such business records and information as may be required to comply with applicable law governing Physician'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. PG shall, and shall cause every PG Participating Provider to, 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, PG shall, and shall cause every PG Participating Provider to, maintain and make available to HMO records reflecting collection of coordination of benefits proceeds by PG or any PG Participating Provider, and amounts thereof. It is understood and agreed by PG, and PG shall cause it to be agreed by every PG Participating 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)

(l)) 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, PG shall, and shall cause every PG Participating Provider to, 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 PG or any PG Participating Provider that are necessary to certify the nature and extent of costs incurred by PG or any PG Participating Provider with respect to such service.

1.11.2 If PG or any PG Participating Provider carries out any of its 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, PG or such PG Participating 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 PG or the affected PG Participating Provider with respect to such service.

1.11.3 If PG or any PG Participating 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, PG or such PG Participating 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. Physician shall comply fully with and abide by the rules, policies, and procedures that HMO has established or will establish and has provided to Physician 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: PG agrees, and shall cause every PG Participating Provider to agree, that, except as otherwise required by statute or regulation, in the event of HMO insolvency or termination of this Agreement for any reason, any PG Participating 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 PG for Covered Services provided to Members pursuant to this Agreement in accordance with the terms and conditions set forth in Attachment C to this Agreement.

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

2.3 TIMELY PROCESSING OF CLAIMS. HMO agrees to process clean claims for payment within thirty days of receipt of the claim. 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 identification of Members, verification of a Member's eligibility to receive Covered Services, and providing a description of the Covered Services a Member is entitled to receive.

2.5 PROVIDER RELATIONS ASSISTANCE. HMO shall make available to PG, and through PG, to every PG Participating 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 effective date. The effective date is the earlier of the date on which the Agreement is executed or the date the Agreement is approved by the Department 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. 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. 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 PG in the event of any of the following:

3.2.1 Physician's license is no longer active or registered with the Office of Professions New York State Education Department, suspension or revocation of the Physician's license, certificate or other legal credential authorizing

Physician 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 re-registration 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 Physician's DEA number or other right to prescribe controlled substances;

3.2.3 Suspension or revocation of the DEA number or other right to prescribe controlled substances of any PG Participating Provider;

3.2.4 An indictment, arrest or conviction of PG or any PG Participating Provider for a felony or for any criminal charge which might in any way impair the capacity of PG or the affected PG Participating Provider to carry out its duties hereunder;

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

3.2.6 Any PG Participating Provider who is either a Primary Care Physician or a specialty Care Provider shall no longer have clinical privileges at any HMO participating hospital;

3.2.7 Repeated failure of PG or any PG Participating Provider to participate in or cooperate with HMO's utilization review policies and procedures;

3.2.8 The death of any PG Participating Provider (if such PG Participating Provider is an individual), or the death or any disability of any individual who is a member or employee of a group constituting a PG Participating Provider which renders that PG Participating Provider unable to perform the obligations required of it pursuant to this Agreement for a period in excess of thirty days;

3.2.9 The failure of PG or any PG Participating Provider to participate in or cooperate with HMO's quality assurance program or the repeated failure of PG or any PG Participating Provider to provide high quality, cost effective health care to Members, as measured by the standards adopted from time to time by HMO; or

3.2.10 If PG or any PG Participating Provider is suspended or permanently precluded from participating in the New York State Medical Assistance program or the federal Medicare program.

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

- (i) the reasons for the termination;
- (ii) notice that the Physician has the right to request a hearing or review, at the Physician's discretion, before a panel appointed by the HMO;
- (iii) a time limit of not less than thirty days within which Physician 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.

3.2.12 (a) The Hearing Panel shall be comprised 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 Physician. 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 Physician by the HMO, provisional reinstatement subject to

conditions set forth by the HMO or termination of Physician. Such decision shall be provided in writing to Physician.

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

3.3 Notwithstanding any other provision to the contrary contained in this Agreement, Physician agrees that in the event of any termination of this Agreement, Physician shall continue to provide care to Members then under the care of Physician pursuant to the terms of this Agreement for 90 days from the date of termination, or until such time as HMO makes other arrangements, whichever first occurs. The provisions contained in this section shall survive the termination of this Agreement for any reason.

3.4 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

#### **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 PG'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 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. PG and every PG Participating Provider recognize that all material provided by HMO is the proprietary information of HMO and neither PG nor any PG Participating Provider shall disclose or release such material. In addition, neither PG nor any PG Participating Provider shall 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 PG and every PG Participating Provider is that of independent contractors, and neither shall be considered an agent or representative of the other for any purpose. HMO, PG, and every PG Participating Provider, will each be liable solely for its own activities and neither HMO, nor PG, nor any PG Participating Provider, shall be liable for the activities of the other. . Except as specified otherwise herein, all disputes arising under this Agreement shall be resolved in a court of competent jurisdiction located in the City of New York.

4.8 PROMOTIONAL MATERIALS. Except as provided in this paragraph, neither HMO, nor PG, nor any PG Participating Provider, shall use the other party'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 PG and every PG Participating Provider for purposes of marketing, informing Members of the identity of PG and its PG Participating Providers and otherwise to carry out the terms of this Agreement. PG and every PG Participating

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; MATERIAL DEPARTMENT APPROVAL REQUIRED. HMO may change the provisions of this Agreement and/or attachments by giving PG 30 days prior written notice of the amendment. The amendment will go into effect 30 days after such notice has been issued to the PG unless PG objects in writing within 30 days of such notice. If the parties cannot resolve the issue(s) cited in the PG's objection prior to the effective date of the amendment, HMO will have sole discretion to continue the Agreement without the amendment taking effect or terminate the Agreement pursuant to the terms outlined in 3.1 of this Agreement.

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.

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 hereto. The parties further acknowledge and agree to be bound by the terms and conditions of this Agreement including the Attachments, which taken together, constitute the entire Agreement.

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

**Name of Facility**  
**Address**  
**City, State ZIP**

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

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**ATLANTIS HEALTH PLAN**  
**PG 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. **HMO PARTICIPATING PROVIDER.** A Primary Care Physician, Specialty Care Provider, or other health care services provider who has entered into a contract with HMO for the provision of Covered Services to Members.
6. **PG PARTICIPATING PROVIDER.** A Primary Care Physician, Specialty Care Provider, or other health care services provider who has entered into a contract with PG for, among other things, the provision of Covered Services on behalf of PG to Members pursuant to this Agreement.
7. **MEDICAL DIRECTOR.** A physician duly licensed to practice as such in the State of New York 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 physicians to Members.
8. **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.
9. **MEMBER.** An individual who has entered into a contract (or on whose behalf a contract has been entered into) with HMO for the provision of Covered Services.
10. **PRIMARY CARE PHYSICIAN.** 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 Physician will also initiate referrals for specialty care needed by a Member and maintain overall continuity of a Member's care.
11. **PROVIDER MANUAL.** A Manual of HMO's policies, procedures, and administrative practices published by HMO and distributed to Providers from time to time.

12. **SANCTIONS POLICY.** The HMO policy annexed hereto as Attachment D of this Agreement, describing the circumstances, which can lead to the sanctioning of a **PG** Participating Provider, and the due process available to the Provider in appealing such a sanction
13. **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.
14. **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.
15. **UTILIZATION REVIEW PROGRAM.** An ongoing peer review process of review of the appropriateness and necessity of health care services rendered to Members.

**ATLANTIS HEALTH PLAN**  
**PG PARTICIPATING PROVIDER AGREEMENT**

Attachment B  
Description of Physician Services

- I. **PRIMARY CARE SERVICES.** PG Participating Providers who are credentialed by HMO, as Primary Care Physicians shall supervise, coordinate, and provide initial and basic care to Members. Primary care physicians shall also initiate referral for specialty care, and maintain continuity of care for Members on his or her panel. Primary Care Physicians shall provide:
  - A. Office visits during normal office hours.
  - B. Emergency consultative care on a twenty-four hour basis.
  - C. Continuous health care coverage on a twenty-four per day, seven day per week basis, with reasonable access to PCP or back-up medical care when participating physician is unavailable.
  - D. Referrals when necessary, to other PG Participating Providers and to other HMO Participating Providers.
  
- II. **SPECIALTY CARE SERVICES.** PG Participating Providers who are credentialed by HMO, as Specialty Care Providers shall provide specialty care medical services to Members referred to such Specialty Care Providers in accordance with standards established by HMO. Specialty Care Providers shall keep Member's Primary Care Providers informed as to the Members' condition, progress and status.

**ATLANTIS HEALTH PLAN**  
PG PARTICIPATING PROVIDER AGREEMENT

Attachment C  
Fee Schedule

*Please contact Atlantis Health Plan.*

**ATLANTIS HEALTH PLAN**  
**PG PARTICIPATING PROVIDER AGREEMENT**

Attachment D  
Sanctioning Policy for PG Participating 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 PG 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 PG 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 PG Participating Provider. A reasonable period of time appropriate to the specific nature of the problem, will be afforded to the PG Participating Provider in order to demonstrate compliance.
- B. A second warning letter will be sent to the PG Participating Provider if repeated behavior, demonstrating non-compliance with the HMO's requirements occurs. At this point, the HMO will preclude the PG Participating Provider from receiving new Members.
- C. Should the PG 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 PG 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 PG Participating Provider. A copy of this policy delineating the PG Participating Provider's rights will also be contained in this notice.
  - 2. The PG Participating Provider has the right to request a hearing regarding the proposed action as long as that PG Participating Provider requests the hearing by detailing the actions he/she chooses to protest in writing within thirty (30) days of receiving notice of the proposed action.
  - 3. The PG 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 PG 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 PG 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 PG Participating Provider fail to appear without demonstrating good cause, the right to a hearing

will be forfeited. If however, the PG Participating Provider is able to demonstrate good cause, the PG 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 physicians who are not Members of the Quality Assurance Committee. Under no circumstances, however, will individuals on the panel be in direct economic competition with the PG Participating Provider in question.

D. PROVIDER RIGHTS DURING THE HEARING.

The PG 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 PG 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.

E. PROVIDER APPEAL.

Upon receiving the written decision of the hearing panel, the PG Participating Provider may request, within thirty (30) days and by certified mail, an appeal. If the PG 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 Director's will review the matter and render a final written decision to the PG Participating Provider.

F. SUMMARY ACTIONS.

HMO allows the Medical Director, with the approval of the President of the HMO, to immediately revoke panel membership or PG Participating Provider status, in whole or in part, subject to subsequent notice and hearing when failure to take such action, may result in an imminent danger to the health of any Member. 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 AMBULATORY SURGICAL CENTER 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 AMBULATORY SURGICAL CENTER 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	
160 West Broadway	
New York, New York 10013	

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 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 physicians, 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 Physician 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 physician or physician 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.