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**Member Rights**    WellCare members have the right to:

- Receive all the benefits to which they are entitled under their WellCare contract.
- Receive quality health care through their Primary Care Physician in a timely manner and in a medically appropriate setting.
- Considerate and respectful care.
- Care and treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, or medical problem.
- Confidentiality of medical records and condition, with the authority to approve or refuse the disclosure of such information.
- All information needed to give informed consent prior to the start of any procedure or treatment.
- Access to written medical records as described by State law.
- When it is not advisable to give written medical records to the member, the information is to be made available to an appropriate person acting on the member's behalf.
- To receive complete, current, and reasonably understandable information concerning a diagnosis, treatment and prognosis from a physician or other provider.
- Refuse treatment and be informed by their WellCare physician of the medical consequences.
- Refuse to participate in research.
- Express concerns and complaints about the care and services provided by physicians and other providers, and have WellCare investigate and respond to these concerns and complaints.

- Voice grievances and recommend changes in benefits and services to staff, administration, and/or the State Department of Insurance or State Department of Health without fear of reprisal.
- Appeal any decision made by WellCare regarding the denial of services, authorizations, or the continuance of services or treatment already in progress.
- To be provided with information about WellCare, its services, and its participating physicians.
- Change physicians in accordance with provisions of the member's contract.
- Be informed, upon request, of all prescribed medications, the reasons for the medication, and the expected effects of the medication.
- Request a second opinion.

**For Healthy Choice and Family Health Plus members:**

A member may request a Fair Hearing regarding adverse LDSS determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a clinical treatment or other Benefit Package service by the Plan.

**External Appeal** A member may also request a Fair Hearing for failure by the Plan to act with reasonable promptness with respect to such services.

An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider have the right to request an external appeal.

Healthy Choice, Family Health Plus, and Child Health Plus members have the right to an External Appeal. To be eligible for an External Appeal, a member must have

received a Final Adverse Determination letter as a result of the Plan's internal utilization review process.

Members may also file an External Appeal when the Plan and the member both agree to waive the internal appeal process. If this occurs, the Plan will send a letter to the member that contains instructions for filing an External Appeal. This letter will be sent to the member within 24 hours of the agreement to waive the internal appeal process. An External Appeal may also be filed by a member's health care provider in connection with retrospective adverse determinations.

Enrollees and their providers have the right to file an External Appeal when:

- When the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary, **and**
- The health care plan has rendered a final adverse determination with respect to such health care service, **or**
- Both the plan and the enrollee have jointly agreed to waive any internal appeal.

An External Appeal may also be filed when:

- The member has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on internal appeal or both the Plan and the member agree to waive the internal appeal process; and
- The member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard

health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial; and

- The member's attending provider, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to the condition or disease, must have recommended either (a) a health service or procedure [including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B)] that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation; and
- The specific health service or procedure recommended by the attending provider would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

To request an External Appeal, a member must complete the application attached to the Final Adverse Determination letter and mail it to the New York State Insurance Department within 45 days of the member's receipt of the Final Adverse Determination. In cases where the Plan and the member agree to waive the internal appeal process, the member must request an External Appeal within 45 days of receiving written confirmation from the Plan that the internal appeal process has been waived.

### **Member Responsibilities**

#### **WellCare members have the responsibility to:**

- Provide their Primary Care Physician (PCP) with complete and honest information about their health status and health concerns.

- Have all care provided, arranged, and/or authorized by their PCP.
- Inform their PCP if there are changes in health status, or call their PCP when they need medical care, even if it is after-hours.
- Obtain services authorized by their PCP.
- Share with their PCP or a WellCare Member Service Representative any concerns they may have about the medical care or services received.
- Learn how their health care works.
- Use the emergency room only for true emergencies.
- Permit the Plan to review their medical records in order to comply with federal, state, and local government regulations regarding quality assurance.
- Keep scheduled appointments with providers or give adequate notice of lateness or cancellations.
- Respect Plan staff and providers.
- Cooperate with those providing health care services to themselves or their covered dependent(s).
- Provide patient information needed by professional staff, which will enable staff to care for the member or their covered dependent(s).
- Follow instructions and guidelines given by those providing health care services.
- Follow procedures and abide by policies established by the Plan.

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**Medically  
Necessary  
Services**

All care received by WellCare members must be “medically necessary”. This means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.

“Medically necessary” services are those recommended by the member’s treating physician and determined by the Plan’s Medical Director to meet the following criteria:

- The services are appropriate and consistent with the diagnosis and treatment of the member’s medical condition;
- The services are required for the direct care and treatment of that condition;
- The services are not primarily for the convenience of the member, the member’s family, or the provider; and
- The services are provided in accordance with general standards of good medical practice as evidenced by: reports in peer-reviewed medical literature, reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data, and any other relevant information brought to the Plan’s attention.

These standards are used by the Plan to determine whether benefits are covered. If services are denied by the Plan’s Medical Management Department, the Initial Adverse Determination letter will include notice of the availability, upon request of the member or the member’s designee, the clinical review criteria relied upon to make such a determination. The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, the Plan in order to render a decision on an appeal.

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**Medical  
Records****Medical Record Transfer**

Upon a change of PCP, the member will be asked to sign a form entitled "Request for Medical Information". The "Request for Medical Information" form will be sent to the original PCP, who will be instructed to forward copies of all medical records to the new PCP's office. Current and outstanding laboratory and x-ray reports must be included with these medical records.

In the event of a change in PCP during an emergency situation, either a WellCare Member Services Representative or a WellCare Health Services Coordinator will call the original PCP's office and request that a complete copy of the member's medical record be forwarded to the new PCP. A written request will follow by mail within 24 hours of the initial phone contact.

**Medical Record Retention**

Providers must retain medical records for a period of no less than 6 years after the date of services rendered to members. In the case of a minor, medical records must be retained for three years after majority or six years after the date of the service, whichever is later. If records are under review or audit, they must be maintained until such review or audit is complete. The right to access described herein shall extend through 6 years from the final date of the applicable contract period or completion of audit, whichever is later, provided, however, that such access may be required for a longer time period if:

- CMS or DOH determines that there is a special need to retain a particular record or group of records for a longer period and CMS or DOH provides notice to Provider at least 30 days before the normal disposition date; and
- CMS or DOH determines that there has been a termination, dispute, fraud or similar fault, in which case, the retention may be extended to 6 years from the date of any resulting final resolution of the matter; or

- CMS, DOH or the NYS Department of Insurance (“DOI”) determines that there is a reasonable possibility of fraud, in which case it may perform the inspection, evaluation or audit at any time.

**Out-of-Plan  
Authorizations**

Members will receive referral services from contracted providers whenever possible. The enrollee may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment. These participating providers may request a referral to an out-of-network provider by contacting the Plan’s Member Services or Medical Management Departments. WellCare Case Managers may authorize treatment by a non participating provider when no participating provider of that service is reasonably available.

The Plan’s Medical Management Department will authorize referrals to non-participating providers in the following circumstances:

1. The service is determined to be medically necessary by the member’s PCP; and
2. The member’s care cannot be provided in an identified WellCare Center of Excellence; and
3. WellCare approves the plan of treatment in consultation with the member’s Primary Care Physician and the non-participating physician.
4. For the following specialties, an out-of-plan referral is available if no participating provider is available within two hour driving time from the member’s home:
  - Pediatric Cardiology
  - Pediatric Endocrinology
  - Pediatric Gastroenterology
  - Pediatric Rheumatology
  - Retinal Surgery
5. For any specialty not listed above, an out-of-plan referral is available if no participating provider is available within 30 minutes travel time/30 miles

travel distance from the member's home or 2 hours travel time in rural areas.

6. Special requests for out-of-plan referrals (e.g., due to unique qualification of the provider or prior involvement of the provider in a complex treatment regimen) may be approved by WellCare's Medical Director.
7. If the Plan determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of a member, the Plan shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the Plan in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

Case Managers will forward any referrals made to out-of-plan providers with appropriate location, credentials, and qualifications to Provider Relations for consideration of recruitment into WellCare.

### **Standing Referral to Specialist**

Members who require ongoing care from a specialist may obtain a standing referral to such specialist.

To be eligible for a standing referral, the member must be agreeable to it and have a medical condition meeting at least two of the following criteria:

- The condition is expected to require care for at least six months;
- The condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment; and/or
- The primary condition may impact the treatment of other medical conditions. Typical conditions in this category would include severe asthma, brittle

diabetes, unstable seizure disorders, medical management of selected transplants, AIDS, unstable angina, or chronic pain syndrome.

To qualify for a standing referral, a specialist must meet all of the following criteria:

- He or she agrees to serve as the primary specialist for the specified condition.
- The specialist has special training and experience in managing the specific condition.
- He or she is currently credentialed with WellCare.
- He or she is familiar with WellCare's policies and procedures and willing to send a periodic (i.e., every six months) report to WellCare's Medical Director and the member's PCP.

In general, the physician must be a specialist or sub-specialist in a primary care specialty (Pediatrics, Internal Medicine), or part of an academic team providing a comprehensive plan of care.

The member may not elect to use a non-participating specialist unless there is no appropriate participating provider available within 45 minutes travel from the member's home.

If the member is authorized for a standing referral to a nonparticipating provider, no additional cost is incurred by the member except for that which the member would otherwise pay for services received within the network.

### **Specialist as Primary Care Physician**

In some cases, members may obtain a referral to a specialist who is responsible for coordinating that member's primary and specialty care. To be eligible, either upon enrollment into WellCare or upon diagnosis, the member must have either a life threatening condition or disease or a degenerative and disabling condition or disease which requires specialized medical care over a prolonged period of time. The primary care provider, in

consultation with WellCare's Medical Director, must agree that the member's care would most appropriately be coordinated by a specialist and must agree to a treatment plan.

While acting as primary care provider, the specialist may treat the member without referral from the original PCP and may authorize referrals, procedures, tests, and other medical services, subject to terms of the treatment plan.

### **Specialty Care Centers**

WellCare has established contracts with several Specialty Care Centers, which are nationally renowned centers of excellence. These centers provide specialized treatment for conditions that has been shown to significantly affect medical outcomes.

Enrollees with (a) a life-threatening condition or disease; or (b) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a Specialty Care Center with expertise in treating the disease or condition. Both the PCP or specialist and WellCare must determine that the member's care would most appropriately be provided at a Specialty Care Center. In addition, there must be evidence that the requested service is a covered benefit under the member's plan and medically necessary.

Requests for referrals to Specialty Care Centers for experimental or investigational therapy must meet the standards set forth in the WellCare Experimental and Investigational Therapy policy.

A provider or member may request authorization for coverage of services at a Specialty Care Center. The request must be submitted in writing to WellCare, unless a delay could cause harm to the member. In such urgent cases, the request may be filed by telephone. A written request must include the following information:

- Name and WellCare identification number of the member;
- Diagnosis of the condition for which the member is

seeking care at a Specialty Care Center;

- Listing of any significant comorbid conditions affecting the need for specialized care;
- A treatment history including the names of any specialists involved in the member's care; and
- Name, location, and qualifications of the Specialty Care Center for which the authorization is being requested.

WellCare's Medical Director will evaluate each request for appropriateness, considering the member's condition. The Medical Director will respond in writing to each request for authorization of services at a Specialty Care Center. This response will include notice of:

- The authorization decision.
- The clinical rationale for the authorization determination.
- Appeal and complaint rights. This includes the right to file a complaint by calling WellCare's toll-free telephone number or by writing to WellCare's Member Services Department and the right to have an authorized designee file a complaint on the member's behalf. The member will also be notified of the right to file an expedited appeal or complaint when a delay could reasonably be expected to harm him/her.
- The time frames for resolution of the complaint or appeal.

The location of service is known to have a significant effect on the outcome of treatment for several serious medical conditions. WellCare may require, at the discretion of the WellCare Medical Director, information on the types of treatments to be provided at the Specialty Care Center. For a listing of WellCare's contracted Specialty Care Centers, please contact the Medical Management Department.

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Any services authorized under this policy will be available to the member at no charge other than the applicable co-payments.

**Reversals of Pre-Authorized Treatment**

WellCare may reverse a pre-authorized treatment, service, or procedure on retrospective review when:

- the relevant medical information presented to WellCare upon retrospective review is materially different from the information that was presented during the pre-authorization review; and
- the relevant medical information presented to WellCare upon retrospective review existed at the time of the preauthorization but was withheld from WellCare or not made available; and
- WellCare was not aware of the existence of the information at the time of the pre-authorization review; and
- had WellCare been aware of the information, the treatment, service, or procedure being requested would not have been authorized under the same criteria utilized during the preauthorization review.

**After-Hours OB Coverage**

Obstetricians (OBs) shall provide arrangements for emergency consultation and care for pregnant enrollees after-hours.

To assure access and availability, one of the following must be provided:

- 24-hour answering service;
- Answering system with option to page the physician; and/or
- An advising nurse with access to the provider or on-call physician.

**Transitional Care for New**

A new enrollee whose health care provider is not a member of the WellCare network will be permitted to

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**Members**

continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period. The transitional period extends up to 60 days from the date of enrollment. If a new enrollee is pregnant and has entered her second trimester of pregnancy at the effective date of enrollment, the transitional period includes the provision of post-partum care directly related to the delivery.

New members may continue their course of treatment with the nonparticipating provider if the following criteria are met:

1. The enrollee elects to continue to receive care from a nonparticipating health care provider by notification to WellCare; and
2. The services are authorized by WellCare; and
3. The enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition as defined below:
  - Chronic condition which is expected to require care for at least one year.
  - Condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment.
  - The primary condition may impact on the treatment of other medical conditions. Typical conditions would include severe asthma, brittle diabetes, unstable seizure disorders, medical management of selected transplants, AIDS, unstable angina, chronic pain syndrome; and
4. The non-participating health care provider agrees to accept the WellCare fee schedule as full rate of reimbursement less any applicable member co-payment; and
5. The non-participating provider agrees to adhere to

the WellCare's quality assurance requirements and agrees to provide medical information about care being provided; and

6. The non-participating provider agrees to adhere to WellCare's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization. The nonparticipating provider must have a treatment plan approved by WellCare.

### **Transitional Care When a Provider Leaves the Network**

If a provider leaves WellCare's network for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board impairing the provider's ability to practice, members may continue an ongoing course of treatment with that provider during a transitional period. The transitional period extends up to 90 days from the date the provider's contractual obligation terminates. If the member is pregnant, and she has entered her second trimester of pregnancy, the transitional period includes the provision of post-partum care directly related to the delivery.

Members whose health care provider leaves the network may continue obtaining medical services from the terminated provider if the following criteria are met:

1. The enrollee elects to continue to receive care from a nonparticipating health care provider by notification to WellCare; and
2. The services are authorized by WellCare; and
3. The enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition as defined below:
  - Chronic condition which is expected to require care for at least one year.
  - Condition is optimally managed by close monitoring of clinical or laboratory parameters and adjustment of medication or other treatment.

- The primary condition may impact on the treatment of other medical conditions. Typical conditions would include severe asthma, brittle diabetes, unstable seizure disorders, medical management of selected transplants, AIDS, unstable angina, chronic pain syndrome; and
- 4. The non-participating health care provider agrees to accept the WellCare fee schedule as full rate of reimbursement less any applicable member co-payment; and
- 5. The non-participating provider agrees to adhere to the WellCare's quality assurance requirements and agrees to provide medical information about care being provided; and
- 6. The non-participating provider agrees to adhere to WellCare's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization. The nonparticipating provider must have a treatment plan approved by WellCare.

**Member  
Transportation  
Assistance**

WellCare provides its members a non-emergent transportation benefit to cover pick up and drop off services, to and from medical appointments. This benefit is administered through delegated vendors. Members or providers seeking to arrange transportation services should contact the Plan's Customer Service department for assistance at 800-288-5441.

**Provider  
Performance  
Appraisal**

Quality of Care data is linked to the Re-credentialing process. Information is supplied as requested to ensure evaluations are based on the most current data. The Quality Improvement Department will be responsible for collection, maintenance and distribution of information via Provider Performance Appraisal forms and will include the following:

Area of Concern	PCP>50 Members	PCP<50 Members	Specialists	Source of Info/ Comments
Accessibility Availability	X	X	As available	1. Complaints 2. Provider
Under or Over Utilization	As available	As available	As available	1.PCP Encounter rate 2.Utilization data 3.QI health improvement data
Risk Mgmt, Ambulatory Sensitive Conditions Sentinel Events	X	X	X	1.Incident Reporting 2.UM Data 3.Any QI issues/level of concern after resolution
Member Satisfaction	As available	N/A	N/A	Use Complaints rate as proxy
Site Reviews	X	X	As available	Medical Record/Site Review Database
Member Complaints	X	X	X	Complaint Database

WellCare, in accordance with state and federal contracts and regulations, will facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization of services.

The process shall determine over and under utilization of services whereby the Medical Director institutes a corrective action plan for both the provider and the Plan.

The following tools will be utilized for monitoring:

1. Inpatient Daily Census
2. Monthly Inpatient Utilization Reports
3. Funding Reports
4. Pharmacy Reports

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5. Physician profiling
  6. Case management

WellCare's Utilization Management Department monitors the Inpatient Daily Census report for all non-participating providers, hospital stays for outliers, and Quality of Care issues. These include all readmissions, any complications, and/or unexpected deaths. The Medical Director communicates with the Concurrent Review staff on any of the above. He or she will contact the PCP for any issues arising out of the review.

The Medical Director will issue a monthly report on the Inpatient Utilization for all lines of business and have a corrective action plan as needed for WellCare. The report shall contain the following filters:

1. Average length of stay by line of business
2. Admissions per thousand by line of business
3. Days per thousand by line of business
4. Skilled nursing facility utilization with the same filters

A comparison is made to established goals, established professional standards and the previous month's data.

- Pharmacy Data: A monthly report is generated, demonstrating monthly pmpm for prescription drug and injectable drug utilization and cost per line of business. The Medical Director will compare the report results to local and national standards and develop a corrective action plan as needed.
- Ancillary Service utilization data will be pulled monthly with the following filters:
  - a. Home Health Referrals and cost pmpm per line of business
  - b. DME pmpm and cost pmpm per line of business
  - c. Lab services utilization pmpm and cost pmpm per line of business

The Medical Director will compare WellCare's results to industry standards and develop a corrective action plan as needed.

- Physician Profiling: The physician profiling reports will be monitored on a quarterly basis for a designated provider population. The report generated will contain the following:
  - a. Efficiency index
  - b. ETG (Episodic Treatment Group) Report
  - c. HEDIS Measurements
  - d. Ancillary service utilization
  - e. Inpatient Services utilization
  - f. Pharmacy utilization

WellCare will provide any information and profiling data used to evaluate the provider's performance and shall make available on a periodic basis and upon request of the healthcare professional the information, profiling data and analysis used to evaluate provider performance.

Any issues arising out of these reports are discussed with the PCP by the Medical Director on an as-needed basis, or in a meeting coordinated with the Provider Relations Department.

Over- and under- utilization data and reports are reported at the Medical Management Committee for review and recommendations. The recommendations and results are then communicated to the Quality Improvement Council and then to the Board of Directors.

Each provider is given the opportunity to discuss the unique nature of the provider's professional patient population, which may have bearing on the provider's profile, and to work cooperatively with WellCare to improve performance.

### **Corrective Action and Termination Policy**

WellCare may initiate a corrective action and/or termination for any participating individual physician, provider IPA, and/or group whenever a practitioner engages in, or

exhibits acts, statements, or demeanor which are reasonably likely to be:

- Detrimental to patient safety or quality of care;
- Contrary to state or federal laws or regulations; and/or
- Contrary to WellCare bylaws, policies, procedures or standards.

Corrective actions may be initiated by the Plan's Executive Management, the Medical Director, Board of Directors, or by any one of the standing committees including the Clinical Quality Improvement Committee, Credentialing Committee, and Quality Improvement Council. A review action will be taken after reasonable efforts have been made to obtain the facts of the matter and after adequate notice of the proposed action and the reasons for the proposed action. WellCare will issue a notice of hearing rights and procedures, as appropriate. However, adequate notice will not be given if it is detrimental to patient safety.

WellCare may choose to not renew a provider's contract at the expiration of the contract period or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, or any time with 60 days written notice, or as specified in the provider contract.

The Plan may terminate a provider for cause with 60 days notice or as specified in the provider contract. The Plan may also terminate a provider's contract immediately following a determination of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice. Again, adequate notice will not be given if it is detrimental to patient safety.

### **Medicaid/FHP**

Providers that are sanctioned by the DOH's Medicaid Program will be excluded from participation in the Plan's Medicaid panel.

No provider will be terminated solely because he/she has:

- advocated on behalf of a member;
- appealed a the Plan's decision;
- disclosed to a member, or a member's designee, any information regarding a condition or course of treatment, including the availability of other therapies, consultations or tests;
- disclosed to a member, or a member's designee, information regarding the provisions, terms, or requirements of the plan's products as they relate to the member;
- filed a complaint, made a report or commented to an appropriate governmental body regarding the policies or practices of which the provider believes may negatively impact upon the quality of, or access to, patient care; and/or
- requested a hearing pursuant to this policy  
Practitioners shall inform The Plan's' Medical Director in writing upon discovery or notification of any of the following actions taken against the practitioner:
  - loss of license;
  - sanctions, restrictions, and/or limitations in scope of practice as defined by the state licensing agent;
  - loss or limitation of hospital privileges;
  - loss or surrender of a DEA license or CDS certificate
  - loss of malpractice insurance; and/or
  - professional liability claims settlement.

**Corrective Action and Termination for Cause**

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Requests for an Administrative Review for Corrective Action will be made in writing and will be forwarded to either the Medical Director for clinical concerns or the Director of Network Management/Quality Improvement for Administrative issues. Review requests may include, but are not limited to:

- documentation of repeated complaints from members, where after notification the provider has failed to correct the problem;
- repeated failure to follow procedure after notice of expectation and correct procedure;
- misrepresentation of Credentials in application process or failure to submit documents on re-credentialing;
- documented material breach of contract;
- breach of ethics (e.g. breach of confidentiality, receiving remuneration for patient referral);
- intentional submission of duplicate or false claims for payment;
- documentation of professional misconduct and/or unprofessional conduct;
- failure to participate in quality assurance process; and/or
- any other deficiency that is determined to indicate substandard or unacceptable future performance in the quality of care or service.

The request must be submitted with all appropriate documentation of the issue, associated correspondence with the provider, including prior attempt to resolve the issue, and documentation of the provider's non-compliance.

The request will be reviewed by Medical Management or

the Quality Improvement Committee or a designated subcommittee for clinical issues or an Administrative Review Board for non-clinical issues. The Administrative Review Board is an ad hoc committee and will consist of the Medical Director; the Executive Director and the Director of Network Management.

The QIC or Administrative Review Board shall direct such investigation or may delegate the investigation to the Medical Director or Peer Review Subcommittee. The process may include:

- written rebuttal from the practitioner(s) involved;
- a conference with the practitioner(s);
- meeting with the individual or group requesting the action, or any other individuals who may have knowledge of the event involved.

The request for review may be rejected at any point in this process if it is determined that the issue is not substantiated by the documentation.

If the investigation concludes that a corrective action is warranted, the appropriate committee will document the findings and a letter will be sent within 30 days of the decision in a certified letter to the practitioner(s) involved for a response prior to initiation of a corrective action. The practitioner(s) will have 30 days from receipt of this letter to respond. The response will be reviewed by the initiating Committee to determine what further action should be taken, if any.

The Committee may recommend one or more of the following actions after completion of the review process:

- rejection of the request for corrective action;
- a verbal warning to the provider(s) involved;
- a formal letter of reprimand with request for plan of corrective action;

- additional education and/or training;
- a probationary period of proscribed duration with retrospective review of cases, medical records, and professional behavior;
- financial sanctions;
- non-renewal, suspension or termination of plan participation; and/or
- automatic suspension or termination may be imposed if the circumstances are determined to warrant this action.

Once a decision has been made to administer a corrective action or terminate a provider for cause, the provider will receive written notification of the proposed action which shall include:

- the reasons for the proposed action;
- notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by the Plan;
- notice that the provider has 30 days within which to request his hearing; and
- notice that the hearing must be held within 30 days after the date of the receipt of a request for a hearing.

The practitioner(s) will have the right to a fair hearing upon notification of the determinations or recommendations.

In all instances where the committee convenes and/or investigates for corrective action, complete documentation will be maintained in the Quality Improvement file and Credentialing file. This will include the substance of the complaint and a written plan for follow up if applicable on a monthly, quarterly or semiannual basis, along with the person and committee assigned responsibility to implement

the follow-up plan. The assigned Committee will review the provider at the prescribed intervals and documentation will be maintained in the file.

**Immediate Terminations**

A provider may be terminated immediately from the Plan's network if any of the following situations occurs:

- in the opinion of the Medical Director there is a threat of imminent harm to patient care;
- the provider ceases to be duly licensed to practice in the State of New York;
- the provider is the subject of a determination of fraud; and/or
- the provider is deceased or retires from active participation in a medical practice.

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or review.

The Medical Director, the Chief Executive Officer, or the Chairman of the Board may evoke immediate termination by notification to the provider and to the Credentialing office.

In accordance with Federal and State regulatory requirements, Credentialing is responsible for making appropriate reports on behalf of the MCO to the

appropriate professional disciplinary agency and to the National Practitioner Data Bank.

**Provider Fair Hearing for Terminations**

The provider will receive written notification of the proposed action which shall include notice that the provider

has the right to request a hearing or review within 30 days of receipt of the notice, and that the hearing must be held within 30 days after the date of receipt of a request for a hearing. If the provider fails to request a hearing within the specified period, this shall constitute a waiver of the right for a hearing.

The hearing panel shall be appointed by the Medical Director and be comprised of three or more persons, at least one-third of whom shall be clinical peers in the same discipline with a same or similar specialty as the provider under review.

Following a hearing, the hearing panel shall render a decision on the proposed action within 10 business days. Decisions of the hearing panel may include reinstatement, provisional reinstatement with specified conditions or termination. Such decision shall be provided in writing to the provider. A decision to terminate shall be effective no less than 30 days after receipt by the provider of the hearing panel's decision, or 60 days from the receipt of the notice of termination.

### **Non-Renewals or Voluntary Terminations**

Either the Plan or a provider may exercise a right of non-renewal at the expiration of the contract period with 60 days written notice or as otherwise specified in the provider contract. In the case of provider contracts without a specific expiration date, either party may exercise a right of non-renewal on each January first occurring after the contract has been in effect for at least one year or as otherwise specified in the provider contract.

Notification of non-renewal to providers will contain an explanation of the right of non-renewal, the time frames involved, and verification that non-renewal does not constitute termination. The provider shall remain obligated to provide continuing care to members currently receiving treatment for the term of the notice. Under certain circumstances, authorization may be obtained for continued care beyond the effective date of the end of the provider's affiliation with the Plan.

**Notice to Members**

The Plan has a duty to notify members under the care of a provider of the change in the provider's status once:

- the Plan receives notice from a provider of elective termination or non-renewal;
- the Plan provides a written notice of the election of nonrenewal;
- the Plan provides a written notice of the decision to terminate and the provider has waived their right to a hearing;
- the Plan provides a written notice of the decision following a fair hearing requested by a provider.

Within 15 days after the Plan receives notice from a provider of elective termination or non-renewal, or after the Plan provides a written notice of the election of non-renewal, the Plan will provide written notice to each member who has chosen the provider as his or her primary care provider. If the provider is a specialist and the Plan is aware of any member who is in an ongoing course of treatment, the Plan shall provide written notice to the member. Each notice shall describe the procedures for continuing care and for choosing an alternate provider.

Members shall have the right to continue an ongoing course of treatment with the health care provider for a transitional period of up to 90 days from the date the member is notified of the provider's disaffiliation with the Plan, or, if the member has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery, provided the health care provider agrees:

- to continue to accept reimbursement at the previous negotiated rate;
- to adhere to the Plan's quality improvement requirements;

- to otherwise adhere to the Plan's policies; and
- procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization.

**Credentialing**

In accordance with State requirements, credentialing application procedures and minimum qualification requirements used by the Plan are made available to providers upon request.

**Adverse Reimbursement**

Prior to any adverse reimbursement change to your contract, you will receive a written notice from the Plan at least 90 days prior to the change.

If you object to the change that is the subject of the notice, you may, within 30 days of the date of the notice, give written notice to the Plan to terminate the contract effective upon implementation of the adverse reimbursement change.

Please note there are statutory exceptions that do not require the plan to send you a written notice. There are as follows:

- 1) The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
- 2) The change is provided for in your contract through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.