

Provider Terminations and Member Notifications

Humana and ChoiceCare Policy
NNO 703-016-18



Published Date:	07/30/2004		Accountable Dept:	National Network Operations		
Current Revision:	02/04/2020		Business Domain:	13 Provider Network and Claims		
Next Revision Date:	02/04/2021		Business Area:	13.02 Provider Management		
Other Affected Functional Areas Primary Department: Provider Contract Administration	x	Legal	x	Compliance	x	Commercial Sales/Administration
		Human Resources	x	Service Fund	x	Medicare Sales/Administration
		Information Systems	x	eEnrollment		Provider Process and Services
	x	Clinical Operations	x	Service Operations		Product Development/Group Contracts
		Finance	x	LRID		

Scope:

All providers who have a contractual relationship with Humana/ChoiceCare. This includes, but is not limited to, all commercial, Medicare Advantage (MA), Medicaid and dual eligible Medicare-Medicaid, Humana Behavioral Health Network (HBHN) lines of business; and providers contracted under a letter of agreement (LOA) or memorandum of understanding (MOU) if the provider is listed as participating in the Provider Directory.

NOTE: Humana and ChoiceCare are separate legal entities and the term notice for each Humana ChoiceCare should go out separately on the appropriate letterhead for each legal entity. They should not be combined.

This policy is mainly for non-major terms. For Major Terms, fill out intake form: Step 1: Go to [SharePoint Link](#) or go to Hi! and type [go/majorterms](#)

Step 2: Scroll down to Provider Term Member Communication Process Documents. Follow the document titled "Completing an Intake Form."

NOTE: In order to meet the 30 day CMS regulation for member notifications for major terminations, the Intake Form must be received in the Major Termination Inbox 120 days prior to the contract term date.

For questions, send an email to Camille Pelayo at cpelayo1@humana.com

For non-major terms, follow Member Notification flowchart or step-by-step written process (see Attachments 2 & 3).

Statement:

This policy defines the provider non-renewal, termination and member notification processes.

Definitions:

Medicare Significant Network Change: a change that impacts a significant percentage of members and/or providers or may result in the network no longer meeting network adequacy standards within the geographic area served by the network. If the market believes the termination could possibly be a Medicare Significant Network Change, please contact the Medicare Regulatory Compliance representative at least 120 days prior to the termination effective date. The

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

Regulatory Compliance representative will notify the CMS Plan Manager at least 90 days prior to the termination effective date of a possible Medicare Significant Network Change.

The determination of whether a particular network change is a Medicare Significant Network Change requires an analysis of individual market composition and the specific circumstances surrounding the network change, including, but not limited to, the number of members impacted, size of service area, and the availability of other network providers (network adequacy).

Major Termination: a change (any line of business) that involves 1) any hospital, or 2) impacts a large number of providers (25 or more), or 3) any other network change that may have a negative impact on the network, causing the network to be at risk for not meeting state or federal access requirements.

Mid-Year Network Change: any change in network (i.e., provider termination) that is not effective January 1 of a given year (the first day of the reporting period). Humana/ChoiceCare must report to CMS (Part C Reporting) all mid-year terminations of primary care physicians (PCPs), certain specialists (*cardiologists, endocrinologists, oncologists, ophthalmologists, pulmonologists, rheumatologists, urologists*), and facilities (*acute inpatient hospitals and skilled nursing facilities*) terminated during the reporting period whether the termination was provider initiated or Humana/ChoiceCare initiated and whether or not the termination was “with cause” or “without cause.”

Non-Renewal means the provision of a provider’s contract that permits the participation agreement to expire and not to renew, with appropriate notice, after the end of a given term.

NOTE: While it has the same effect as termination (i.e. the provider will no longer be a participating provider in Humana/ChoiceCare/HHB networks), allowing a contract to expire and not be renewed in some instances does not trigger the same regulatory scrutiny and requirements as a mid-term termination, is sometimes more advantageous to Humana than a contract termination, and should be considered in any discussion around termination.

Decredentialed Provider: see “APEX Decredentialed” at go/NNOLearning. Provider notification is required (Letters 23-27) and letters to members meeting claims requirement.

Provider on the CMS Preclusion List (Medicare only): See “CMS Preclusion” at go/NNOLearning Process Documentation. Use Provider term letter 28 and Letter 29 for Retraction). Member notifications follow the process documented in this policy.

Provider letters including Florida Medicaid for Decredentialed or Sanctioned providers must be reviewed by the Law Dept prior to mailing.

Florida Medicaid only: The section of the AHCA contract affecting provider terminations and member notifications is attached (see Resource H).

Louisiana Medicaid only: For the section of the LDH/Louisiana Department of Health contract impacting provider terminations and member notifications, see Resource I.

Attachments:

1. [Provider Termination Member Notification Request Form](#)
2. [Provider Termination and Member Notification flowchart](#)

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

3. [Step by Step written process](#)
4. [Scenario Selection and Regulations for Physician & Facility Terms](#)
5. [Provider Template Letters](#)
6. [Mass Membership Move Form](#)
7. [Member Notification Letters](#)
8. Retraction & Correction letters:
 - [MA members: Retraction letter \[ME0528\]; Correction Letters \[ME2626, 3497 or 3677\]](#)
 - [Commercial members: Retraction letter \[014\]; Correction Letter \[021\]](#)
 - [FL Medicaid members: Retraction letter \[ME3200\]; Correction Letter \[MD0399\]](#)
 - [Retraction/Correction Letter request](#)

Resources:

- A. [Continuity of Care State Requirements and Regulations](#)
- B. [NNO Learning Process Documentation](#)
- C. [Clinical Policy 05-004 HCS Continuity of Care](#)
- D. [NCQA Health Plan Standards](#)
- E. [42 CFR 422.111\(e\) –Code of Federal Regulations-MA Disclosure Requirements](#)
- F. [42 CFR 422.202 – Code of Federal Regulations-MA Participation Procedures](#)
- G. [45 CFR 156.230\(d\)-Code of Federal Regulations-Provider Transitions](#)
- H. [Florida Medicaid AHCA contract section](#) - AHCA Contract No. FP059, Attachment II, Section VIII. Provider Services; C. Provider Credentialing and Contracting; 7.
- I. [Louisiana Department of Health Model Contract References](#)
- J. [NNO 703-009](#) - Physician Review Panel Determination of MA Physician Terminations or Non-Renewals

Standard: Provider Terminations

Purpose: To provide a standard process for all contracting associates to follow for provider terminations and non-renewals.

Requirement: **Humana/ChoiceCare Initiated Provider Terminations and Non-Renewals:**
Humana/ChoiceCare notifies providers of Participation Agreement any (contract) termination or non-renewal according to the terms outlined in the Participation Agreement or if not specified, then no less than 90 calendar days prior to the effective termination date or as otherwise required by state or federal regulations or accreditation requirements. Participation Agreements with a term specific end date, which are not extended or amended to include an evergreen (automatic) annual renewal period prior to the start of the notice period, are considered Humana/ChoiceCare initiated terminations.

NOTE: Contractors must check the notice requirements in the Agreement. If the contract contains additional contractual obligations for notice that have been negotiated to the standard model template notice requirements, Humana/ChoiceCare must comply with the additional contractual notice requirements in order for the notice to be legally effective.

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

The notification must be in writing and include the following information:

- Effective date of the termination;
- Reason for the termination or non-renewal, and if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Humana/ChoiceCare to maintain network adequacy. Note: A defensible and non-discriminatory “reason” must be provided even for terminations or non-renewals that are “without cause”; and
- Physician’s/physician group’s right to request a review of this decision by a Physician Review Panel for all Medicare Advantage lines of business, and commercial, Medicaid and dual Medicare/Medicaid lines of business when required by the state regulation.

Provider Initiated Terminations and Non-Renewals:

Provider must provide Humana/ChoiceCare with notice according to the terms outlined in the Participation Agreement regarding any termination or non-renewal to allow Humana/ChoiceCare to comply with the member notification timeframes required by applicable state and/or federal law, accreditation standards, state Medicaid and/or dual eligible Medicare-Medicaid contract requirements. The notification to Humana/ChoiceCare must be in writing and comply with the contractual requirements for notice to initiate the Participation Agreement termination.

Network Adequacy Review:

The following tools should be used by Contractors to monitor network adequacy:

- [Quarterly MA/MMP Network Adequacy reports](#) (Non-Major/Non-Significant terminations)
- [Quarterly Commercial Network Adequacy reports](#) (Non-Major/Non-Significant terminations)

If termination impact on network adequacy for a specific service area cannot be determined from current network adequacy snapshots, request a termination-specific network adequacy analysis from the HSD Corporate Team

- [MA/MMP Ad Hoc Request Form](#)
- [Commercial Ad Hoc Request Form](#)
- Medicaid—State-managed adequacy analysis
FL – Sharon Coleman
IL ICP – Tanya Casper & Delores Perez
KY – Majid Ghavami

Provider Terminations or Non-Renewals Resulting in Inadequate Networks:

In the absence of a sufficient number or type of participating providers or facilities to provide a particular covered health care service, Humana/ChoiceCare will use its best efforts to ensure members obtain the covered service from a provider or facility within reasonable proximity of the member at no greater cost to member than if the service were obtained from network providers and facilities. For Medicare Advantage provider terms, please contact Medicare Regulatory Compliance if a provider term or non-renewal results in an inadequate network to discuss possible notification to CMS.

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

Standard: Member Notification of Provider Terminations

Purpose: To provide a standard process for all contracting associates to notify members when a provider is terminating from the network or when the provider's contract will not be continued after a non-renewal date.

Requirement: **Member Notification**

Humana/ChoiceCare provides written notification to members who are seen on a regular basis. Regular basis is a member currently receiving care from, or has received care within the past three (3) months for members affected by the termination (6 months for Florida Medicaid), or assigned and/or attributed to the PCP whose Participation Agreement is being discontinued, irrespective of whether the Participation Agreement is being discontinued due to a termination for cause or without cause, or due to a non-renewal. Humana/ChoiceCare sends the member notice at least 30 calendar days prior to the termination effective date (or as required by state and federal law, accreditation standards and/or state Medicaid contract requirements) or otherwise practical. The standardized and approved member notification letters must be used as written and without changes.

If a provider notifies Humana/ChoiceCare of their intent to terminate or non-renew their participation less than 30 calendar days prior to the effective date, Humana/ChoiceCare shall notify the affected members as soon as possible, but no later than 30 calendar days after receipt of the notification. Member data will be pulled once for mailing in these instances, as well as for retroactive terminations.

Member notices may not be required for Medicare and commercial terminations, if the term or non-renewal occurred more than 6 months (12 months for OB/GYNs) prior to Humana/ChoiceCare being notified. Discuss with the Regulatory Compliance Risk Advisor to ensure that compliance with federal requirements are met and if member notification letters need to be sent.

Per regulations, if Humana/ChoiceCare has more than 60 days advance notice of a provider termination or non-renewal, Humana/ChoiceCare should notify affected members at least 30 days in advance of the Participation Agreement effective date of the termination or non-renewal, but preferably more than 30 days in advance. To improve member experience, member notices will be sent by the letter process team when APEX task is received. Process team will continue to pull membership data and send notices each day until 30 days prior to the termination date.

If there is a Medicare Significant Network Change, affected members should be notified more than 30 days in advance of the effective date of termination or non-renewal. If the provider is a PCP or PCP group (for example, general medicine, family medicine, internal medicine or pediatric groups), Humana/ChoiceCare will help the member select a new PCP or reassign to a new PCP as necessary.

The notification must be in writing and include the following information:

- The provider's name and the effective termination or non-renewal date;
- The procedures for selecting another provider or the newly assigned or attributed PCP's name;
- Continuity of Care, as applicable;
- Humana Customer Care phone number; and
- Humana.com/physicianfinder.

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

For Medicare Advantage plans, excluding HMO gated provider terminations or non-renewals and individual PPO PCP terminations or non-renewals, the names and phone numbers of in-network providers who the member may access for continued care shall also be included. Up to three providers should be included in the letter based on objective criteria as developed by the Market (listed above).

PCP Reassignment

When a PCP's agreement terminates or non-renews and membership needs to be reassigned to a different PCP, all markets should have a process with defined objective criteria for determining which PCPs should receive the transferring membership. Given market and network differences, the exact criteria and process may differ, but contractors should always be cognizant of member needs when selecting providers for reassignment and at a minimum, criteria should include the following considerations:

- Distance of the new PCP from the member (must meet driving/distance access standards)
- Gender (new PCP should be same gender when feasible) unless the member requests otherwise
- Capacity (new PCP should have capacity to accept the new member)
- Cultural/language needs – PCP office is fluent in the same language as transferring member(s)
- Provider is contracted as a Value-based provider

All members assigned to a PCP will be moved in Service Fund as designated by the market, except PPO/PFFS members with assigned PCPs. When a PPO/PFFS PCP terms from the Humana network, the member is not re-assigned/transferred to another PCP. The members will be moved to an unassigned status. Questions should be referred to Service Fund.

Medicare Annual Enrollment Period (AEP)

If termination or non-renewal occurs close to the Medicare Annual Enrollment Period (AEP), October 15–December 7, (or end of year/beginning new plan year), Humana/ChoiceCare will send member notification letters prior to or at the beginning of AEP.

Retraction and Correction Notices

Retraction notices will be sent to members if Humana/ChoiceCare is able to successfully re-contract with a provider after the provider termination or non-renewal notification has been sent to members. Correction notices will be sent to members if Humana/ChoiceCare has sent a provider termination or non-renewal notification in error. Retraction and Correction Notices should be sent to the Member Notifications team via email and include the provider's name, tax identification number, and any other appropriate information. Retraction and Correction letters are available on the [NNO website](#). See "Termination Corrections or Retractions" available on go/NNO Learning process documentation

Owner: Beverly Steen

Executive Team Member: George Renaudin

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

Accountable VP / Director: Paul Davis

- Disclaimer:** Humana/ChoiceCare follows all Federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana/ChoiceCare will follow the most stringent requirement. This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/standard) is subject to change or termination by Humana/ChoiceCare at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/standard) supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source, Enterprise Solution Point, and National Network Operations, go/NNO, Policies and Procedures page to ensure no modifications have been made
- Non-Compliance:** Failure to comply with any part of Humana/ChoiceCare's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana/ChoiceCare. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations. Any unlawful act involving Humana/ChoiceCare systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet on Hi! (Sites/View Full Site Directory/Tools and Resources/Policy Source).

Humana Internal

UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.