SUBJECT: Member notification when Provider or Practitioner leaves network

POLICY INFORMATION:

<table>
<thead>
<tr>
<th>Policy #:</th>
<th>169</th>
</tr>
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<tbody>
<tr>
<td>Approval Date:</td>
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</tr>
<tr>
<td>Effective Date:</td>
<td>02/01/2011</td>
</tr>
<tr>
<td>Revision:</td>
<td>1.0</td>
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<td>Issuing Department:</td>
<td>HCM Contracting Policy</td>
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<tr>
<td>Business Owner(s):</td>
<td>Darren Ketchale</td>
</tr>
<tr>
<td>Contact:</td>
<td>Kathy McCausey</td>
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POLICY IMPACT:

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PURPOSE:

Provide guidelines for notification of members when a provider or practitioner leaves the network. These guidelines apply to regulatory requirements (State and Federal) and accreditation standards. Additionally, they provide continuity and coordination of care for members when providers or practitioners terminate from the network.

POLICY STATEMENT:

DEFINITIONS:

HMO/PPO

Organizational Providers: (to include Facility)

Institutional providers and suppliers of healthcare services, including behavioral health care organizations. Organizational Providers include, but are not limited to: hospitals, nursing homes, skilled nursing facilities (SNF), home care agencies, free standing surgical centers (including free standing abortion centers). Behavioral health organizations include, but are not limited to: mental health and chemical dependency hospitals, residential treatment facilities and ambulatory settings including, Partial Hospital Programs, Intensive Outpatient Programs, Crisis Stabilization Centers, and clinics and Community Mental Health Centers. Behavioral Health organizations can be free-standing or hospital-based.

In networks where Medicare Advantage products are offered, the organizational providers must include: laboratories, rehabilitation agencies (comprehensive outpatient rehabilitation facilities, outpatient physical therapy, and speech pathology providers), renal disease services, outpatient diabetes self-management training providers, portable x-ray suppliers, rural health clinics and federally qualified health centers.
Gated/Non-Gated

Gated Health Benefit Product – Commercial Plan which contains a Primary Care Physician as a component of the Plan design regardless of whether selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan and regardless of whether an individual Member has selected a Primary Care Physician. Gated Product includes but is not limited to: HMO, QPOS, USAaccess, Elect Choice, Managed Choice POS, Aetna Choice POS II, and Aetna Select.

Non-Gated Health Benefit Product – Commercial Plan which DOES NOT allow for the designation and/or use of a Primary Care Physician in the administration of the benefit Plan. Non-Gated Product includes but is not limited to: Open Choice PPO and National Advantage Practitioner with PCP role in Enterprise Provider Database (EPDB). These can include Internal Medicine, General Practice, Family Practice, Pediatricians, Nurse Practitioners, Physician Assistants and OB/GYNs.

Primary Care Physician (PCP)

PCP for the HMO member is defined as a family practice, internal medicine, pediatrician, or general practice as elected by the member. Also, applicable to states with OB/GYN and/or Nurse Practitioners regulations, which include, but may not be limited to Alabama, Arkansas, California, DC, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Minnesota, Nebraska, Nevada, North Carolina, North Dakota, South Carolina, Utah, Virginia, Wyoming- see Regional/State Specific addendum for additional detail.

Specialist

Participating practitioner in EPDB with a role of Specialist or none

Allied Health Practitioners

Healthcare practitioners, other than physicians, dentists, chiropractors, or podiatrists, who are prepared through an appropriately accredited higher educational institution, who are duly licensed, registered or certified by national or state regulatory bodies and whose practice is regulated by state law. Examples include, but are not limited to: optometrists, physical therapists, dietitians, nutritionists, and acupuncturists. In the managed care industry the terms Allied Health Practitioner, Allied Health Professional or Allied Health Personnel are sometimes used synonymously. These practitioners have a role of “specialist” or “none” in EPDB.

Allied Behavioral Health Practitioner

An independent practitioner who is duly licensed or certified and recognized under state law, and is contracted to provide mental health or chemical dependency services to Aetna members. These practitioners have a role of “specialist” or “none” in EPDB.

This includes:

- Doctoral or master’s level psychologists who are state certified or state licensed.
- Master’s level clinical social workers who are state certified or licensed.
- Master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or state licensed.
- Master or Bachelor’s level Applied Behavior Analysts (ABA) who are board certified via the Behavioral Analyst Certification Board
- Other behavioral health care specialists, who are licensed, certified or registered by the state to practice independently, e.g., licensed marriage counselor, licensed pastoral counselor.
Some state laws/regulations and/or accrediting entities require the health plan, or in some instances, practitioners to provide written notice to members who are affected by the termination of a practitioner at least thirty (30) calendar days prior to the termination effective date. This applies when a practitioner terminates a contract with the organization even if that practitioner is a member of a group whose contract with the organization continues. If a member selects a group or practice site rather than an individual practitioner, this applies to the selected group or practice site. State laws/regulations may require notification of the termination of other practitioner and provider types and/or different notification period than required under National Committee for Quality Assurance (NCQA) or other accrediting agencies.

Aetna's automated member notification system delivers letters to members when standard termination reasons are used, in most states for most provider terminations. Members will receive notification/retraction letters when providers are reinstated back to the original effective date in the same networks from which they were previously terminated. Delegated entities follow the timeframe outlined by Medicare in Procedure 162 - Medicare Member Termination Letter Policy.

Regional and Local Market Network will be responsible for developing specific addenda to this Policy (if applicable) to document Regional or State-Specific/business exceptions in cases where the automated system is bypassed or does not support member notifications.

Regional and Local Market Network will coordinate delivery of non-standard letters either locally or through partnership with Communications, Promotion, and Education (CPE) contacts, and will be responsible to manage tracking, mailing, archival, storage, and retrieval of specific letters and membership listings to meet regulatory or accrediting audit needs for cases where the automated system is bypassed for any reason.

Through Regional addenda and supporting business procedures, each Region will designate specific points of contact to coordinate retrieval of non-standard letters, as-needed.

Notification to the member is based on the criteria below:

- HMO and PPO requirements include notice to fully insured and self insured members.
- Gated requirements for HMO and PPO apply to any practitioner designated in a role of PCP in the system, specialists (e.g. OB/GYN), specialty group practices, and allied health practitioners based on PCP assignment in the system.
- Non-gated PPO members not required to elect PCPs will be identified to receive notification if they have had at least one claim in the twelve (12) months prior to Termination Effective Date with the terminating family practice, internal medicine, pediatrician, or general practice physician. - Current system enhancement due February 2011.
- If an HMO or PPO member has accessed or elected a PCP or specialty group or practice site (i.e. CAP Office) rather than an individual practitioner, a letter is generated only if the entire group terminates.
- For HMO, Network facilitates the notification to PDS for “member moves” when the group is structured under a ‘CAP Office’. When the Cap Office is closed as a result of this activity, member letters are automatically generated for any members remaining in that office.
- All HMO and PPO members whose terminating specialist, specialty group practice, hospital, facility and/or allied health practitioner submitted at least two (2) claims in the twelve (12) month period prior to the termination date should receive notification.
- Letters are not sent to members for notification of terminations of radiologists, pathologists, anesthesiologists or emergency room physicians or other hospital based practitioners unless required by state regulations.
- Aetna Behavioral Health takes additional steps in assisting the member in selecting a new behavioral health practitioner if the practitioner is terminated for a quality of care issue.
BACKGROUND/GENERAL INFORMATION:
Aetna is bound by regulatory laws to provide written notice to members who are affected by the termination of a provider or practitioner. Typically, notification is required at least thirty (30) calendar days prior to the termination effective date. This notification applies when a provider or practitioner terminates a contract with the organization even if that practitioner is a member of a group whose contract with the organization continues. This notification also applies when a member selects a group or practice site rather than an individual practitioner.

The health plan is to provide members with guidance in selecting a new practitioner or practice site when the practitioner whose contract is terminated is the member’s PCP or PCP Practice Site or, when the visit criteria is met as described in the policy.

- A Specialist or Specialty Group, or
- An Allied Health Practitioner, or
- An Allied Behavioral Health Practitioner
- Provider (Facility)

For HMO, Network facilitates the notification to PDS for “member moves” when the group is structured under a ‘CAP Office’. When the Cap Office is closed as a result of this activity, member letters are automatically generated for any members remaining in that office.

If the member is in an active course of treatment with the PCP or specialist, the member may also be provided the opportunity to continue with the treating practitioner for a period of time (see Related Policies below).

Aetna Behavioral Health takes additional steps in assisting the member in selecting a new behavioral health practitioner if the practitioner is terminated for a quality of care issue (see Related Policies below). Please note that State laws/regulations may require notification of the termination of other practitioner and provider types and/or a different notification period than that required under Center for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), or other accrediting agencies.

RELATED POLICIES:
- Member Notification when Provider or Practitioner leaves network - Procedure #170
  - Specific ‘State-Requirements-Quick Reference Guide’- #170
  - Summary of Product and Systems- #170

RELATED COMMUNICATIONS:
- Network Communication – January 31, 2011

RELATED TRAINING AND/OR WEBSITE POSTINGS
- Network Strategy and Customer Solutions website: Member Letter Process Member letter process
  http://actnet.aetna.com/hps/cpe/education.htm
- Share Point:
  https://aetpsps.aetna.com/sites/ProviderTermProcess/default.aspx

APPROVAL TO IMPLEMENT:
Darren Ketchale

Signature (electronic) 01/24/2011 Date
SUBJECT: Member Notification when Provider or Practitioner leaves the network

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PURPOSE:

The purpose of this document is to outline the procedures as well as the roles and responsibilities for Provider Network Terminations/Member Notifications in order to create a nationally consistent process from an End to End perspective.

PROCEDURE:

The scope of these guidelines includes par providers that are in EPDB and members who are in the Data Migrator/Claim Book of Record. Dental, Pharmacy, SRC, Medicaid, Custom Networks and Aetna Student Health are not in scope.

The Roles and Responsibilities define only those duties related to provider terminations/member notification.

ROLES AND RESPONSIBILITIES:

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<td>Provider/Network/Call Center</td>
<td>• Provider will initiate termination from Aetna’s network:</td>
</tr>
<tr>
<td></td>
<td>• Call Center/CAM submit request via Smart Front End to terminate participation.</td>
</tr>
<tr>
<td></td>
<td>• Network submits requests for termination to Provider Data Services (standard method via Smart Front End).</td>
</tr>
<tr>
<td>QualityMgmt/Credentialing</td>
<td>• Provider will be terminated, if they fall out of the re credentialing cycle or Quality of Care Issues.</td>
</tr>
<tr>
<td>Network</td>
<td>• Documents data of receipt of request for provider termination (if received by provider).</td>
</tr>
<tr>
<td></td>
<td>• Indicates in their request whether this termination is to follow the standard termination (reason code) or suppress letters (reason code with prefix &quot;SUPPLTRS&quot;), when appropriate, as driven by business need.</td>
</tr>
<tr>
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<td>• Submits request via SFE to terminate participation or in some instances submits request to appropriate mailbox (for bulk terminations).</td>
</tr>
<tr>
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<td>• For capitated PCP terminations, HMO or Medicare networks, notifies PDS Cap Unit via email to coordinate member moves and closure of CAP office if applicable. This may vary by state.</td>
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| PDS Analyst                   | - Reviews request, follows-up with Network as necessary (validation if termination request does not originate from Network) and completes termination in system(s).  
- Upon request from Network, performs mass member moves to reassign Aetna members or to remove members from the provider that is terminating, and notifies Network upon completion.  
- If applicable, members should be moved from the Cap Office before the Cap Office closure takes place. Not moving members prior to closing Cap Office will result in Aetna members receiving PCP termination letters. |
| EPDB System/Vendor            | - Identifies provider terminations posted each day and analyzes data in various systems (EPDB, Data Migrator, Claim Book of Record, OMS Letter Template selection) to determine whether termination letters will be sent.  
- Automated file delivered to the Vendor for printing and mailing (5 Days processing time).  
- System will 'hold' the member letter file until the appropriate lead time has been reached (State Specific/ Provider Type specific).  
- If termination letters have been generated and network reinstatement occurs, the system will generate retraction letters. |
| PDS Business Operations       | - Owns automated member notification system  
- Interfaces with Production and Enhancement (P&E) to manage enhancements to system based on regulatory or accrediting agency (i.e. NCQA) changes, or as driven by business needs  
- Maintains 'Provider Term Letters' service mailbox, addresses questions, issues, concerns for constituents around letter generation, member listings, scope, etc.  
- Requests for manual retraction letters (CAP Office re-opens, or other business specific needs by exception) are coordinated via the 'Provider Termination Letters' mailbox. |
| National Account Network      | - Generates the plan sponsor letter that Sales sends out.  
- Runs disruption reports for specific plan sponsors (high-volume terminations).  
- Partners with Network and manages activities in accordance with CPE SOP. |
| Strategy                      | Account Managers                                                               |
| Account Managers              | - Generate letters to Plan Sponsor in Network Communication, as driven by business needs. |
| Business Compliance/Regulatory Compliance | - Reviews and updates state regulatory requirement grid at least annually.  
- Notifies PDS Business Operations of revised regulatory requirements.  
- Reviews and approves revisions to letters and policies and procedures.  
- Conducts compliance assessments on member notification process and system as needed to ensure compliance  
- Generates compliance reports by state as needed.  
- Manages review and approval of any custom letters on an exception basis in accordance with CPE Standard Operating Procedure (see Related Procedures). How can we get this in a place where it is accessible to everyone. Ellen Fields is point person to assist us with this one. |
| CPE                           | - Maintains a communication process.  
- In the event that a custom mailing is approved through Business Compliance, the process of managing letter development and deliver will be coordinated by CPE, during which network will be involved in the details.  
- Assists in management of custom letters (exceptions only, approved by Business Compliance) through mailing house.  
- Assists in development of new letters or modifications to letters, whether automated or manual.  
- Ensures Business, Legal, and Compliance review/approval of custom letters. |
WORK FLOW:
- Network identifies provider terminations.
- Provider termination data is entered into Smart Front End (SFE) or submitted to Provider Data Services via email or Provider Data Change Form (PDF). During SFE submission process, network must include ‘original receipt date’ indicating date provider notified health plan of (voluntary) termination.
- Each night the system identifies provider terminations posted earlier that day and analyzes data to determine whether termination letters will be sent.

The following data elements are taken into consideration:
- Termination reason (Termination Reason Codes with ‘SUPPLTRS’ prefix do not trigger letters)
- Termination effective date
- Network termination versus relationship termination
- Letters are generated for network terminations and CAP Office Closures.
- Letters are generated daily by an external vendor.
- Exceptions to use of the automated member notification system/process will be defined through Regional/State-Specific addendum supplementing this document.

Reinstatements/Retraction Letters
Members will receive notification/retraction letters when providers are reinstated back to the original effective date in the same networks from which they were previously terminated. Delegated entities will follow the time frames as outlined in Procedure 162 - Medicare Member Termination Letter Policy

Retraction letters will be sent, even if the reinstatement is performed months or years after the original termination date.

Codes do not exist for suppressing retraction letters. The only way to prevent retraction letters from being sent is to create a new network effective date as opposed to reinstating a previously terminated network.

Care should be exercised when reactivating networks, especially if the previous network termination was not performed in error, or if a significant amount of time has lapsed since the previous termination. A new effective date should be used in these cases, to avoid retraction letters being sent and causing confusion to members.

High Level Workflow/Automated System:
Current Workflow/System Touch-Points

Provider Termination
(Voluntary / Non-Voluntary)
- Contract issues
- Business issues
- Redecrating Non-Responder
- Loss Of License
- Quality related, via CPG

Communicate Term Info to Supporting Business Area

Termination in SFE

Supporting Business Area
(PDS)
- Performs terminations in EPDB
- Batch for automation

Nightly

Automated System Runs, Identifies Members

Provider Data

Claims Data

Member Data

Letter Selection & Content

- Member Data To Image System
- Letters Created by Vendor
- Letters Generated

End
BACKGROUND/GENERAL INFORMATION:

Aetna is bound by regulatory laws to provide written notice to members who are affected by the termination of a provider or practitioner. Typically, notification is required at least thirty (30) calendar days prior to the termination effective date. This notification applies when a provider or practitioner terminates a contract with the organization even if that practitioner is a member of a group whose contract with the organization continues. This notification also applies when a member selects a group or practice site rather than an individual practitioner.

RELATED POLICIES:
- Member notification when Provider or Practitioner leaves network #169

RELATED PROCEDURES:
- Procedure #170- State addendums.

RELATED COMMUNICATIONS:
- Network Communication – January 31, 2011

RELATED TRAINING AND/OR WEBSITE POSTINGS
- Specific ‘State-Requirements-Quick Reference Guide’
- Network Strategy and Customer Solutions website: Member Letter Process Member letter process
- Education wheel: (first bullet click more and the wheel will pop up)
  http://aetnet.aetna.com/nps/_cpe/education.htm
- Share Point:
  https://aetsps.aetna.com/sites/ProviderTermProcess/default.aspx

APPROVAL TO IMPLEMENT:

Darren Ketchale
Signature (electronic) Date 01/24/2011