STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

Managed Care Organization Transmittal No. 34
July 29, 2002

TO: Managed Care Organizations

FROM Susan Tucker, Executive Director
Office of Health Services
Maryland Medical Assistance Program

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: Reporting Process for Termination of Provider Groups

Effective February 8, 2002, managed care regulation 10.09.65.17(B)(3)(b) required Managed Care Organizations (MCOs) to report any provider contract termination affecting 50 or more members to the Department. This transmittal serves to clarify the information the Department requires when such a termination occurs.

An MCO must provide written notice to the Department (mail, e-mail, or fax) at least 30 days prior to the effective date of termination; or if less than 30 days notice is given by the terminating provider or subcontractor, within 5 days of receipt of notice. Such notice should be sent to the Chief of the Division of HealthChoice Management and Quality Assurance (DHMQA) and contain the following information:

1. Date of termination;
2. Name or names of providers or subcontractors terminating;
3. Number of enrollees affected; and
4. MCO's plan for transitioning enrollees to other providers to include:

a. Copy of letter sent to members;
b. List of providers that members will be re-assigned to or offered as alternatives (as appropriate); and
c. Process for ensuring continuity of care for members in a current course of care.

Additionally, if the provider termination affects more than 100 members, the notice shall be accompanied by a completed Contract Termination Survey including its attachments. An MCO should complete the appropriate sections of the survey for the type of termination that is occurring. This survey was developed to assist the Department in addressing issues brought to its attention that arise as a result of any termination. A copy of the survey is attached to this transmittal and is also available electronically upon request.

If you have questions regarding the contents of this transmittal, please contact the Division of HealthChoice Management and Quality Assurance at (410) 767-1482.

Attachment

CONTRACT TERMINATION SURVEY

Payor Information

1 MCO Involved:

____

2. MCO contact person(s) responsible for transition related questions:

Name:______________________ Telephone #______________________

Email______________________ Fax #______________________

Provider Information:

Provider Involved:

____

2. Type of contract: Primary ☐ Specialty ☐ Multi-Specialty ☐
List the specialty(s):

____

____

3. Does this practice specialize in a particular population(s)? Yes ☐ No ☐
If so, please specify:

____

____

4. Provider contact person(s) responsible for transition related questions

Name ______________________ Telephone # ______________________

Email ______________________ Fax # ______________________

General Information

Contract being terminated: (Please list exact name of contracting entity)

____

2 Effective date of the termination

____

Does this meet COMAR 10.09.63.06 notification requirements? Yes No ☐

3. Party requesting termination of the contract: Provider ☐ MCO Other
Please supply a copy of the relevant termination letter.

4. This termination affects

All providers on the contract
Just specific providers on the contract

Please list affected providers

____

____

____

____

Do you believe continuity of care provisions are applicable to the affected members?
Yes ☐ No ☐

If yes, why?

____

____

____

6. Number of members affected by this termination: ______________________

7. Are enrollees with special needs affected by this termination? Yes ☐ No ☐
   If yes, please specify:

   - ☐ Enrollees under 21 years of age
   - ☐ Pregnant enrollees
   - ☐ HIV enrollees
   - ☐ Enrollees under case management
   - ☐ Enrollees in a course of care
   - ☐ Enrollees with scheduled appointments
   - ☐ Other (describe)

8. Are there an adequate number of providers in the MCO catchment area affected by this termination to provide adequate access to care for the affected members? Yes ☐ No ☐

9. Please explain your rationale for believing that these remaining providers will ensure access:

   - ☐ Providers are in same LAA
   - ☐ Provides are in same zip code
   - ☐ Providers are not in same LAA or zip code but are accessible by public transportation
   - ☐ Other, please describe

   ____

   ____

   ____

   ____

Coordination of Care

. Explain the process you will use to ensure continuity of care for members who are:

   a. In a current course of care.

   ____

   ____

   b. Scheduled for an appointment after the termination date.

   ____

   ____

   Please note if this process is different for any specific population.

   ____

   ____

2. Identify person(s) responsible for the implementation and follow-up of the continuity of care process as detailed in 1 above:

- At MCO:

Name: Telephone #____________________

Email: Fax #____________________

- At Provider:

Name: Telephone #____________________

Email: Fax #____________________

<u>**Notification**</u>

What provisions have been made for notice to affected members?

a. Notification Description

b. Do you plan other enrollee notification strategies? Yes ☐No ☐
   If yes, specify:

   Strategy

2. Are the providers involved also planning to notify enrollees? Yes ☐No ☐
   If so, please attach a copy of their letter.

3. What provisions have been made for notices to affected providers?

   a. Notification Description

b. Do you plan other provider notification strategies? Yes ☐ No ☐
If so, specify:

Strategy Date

Tertiary Care Services

1. Are the terminating providers specialists employed by the faculty of any of the following institutions? Yes ☐ No ☐

☐ Johns Hopkins Hospital
☐ University of Maryland Medical System
☐ Sinai Hospital

☐ Any Other Faculty/Tertiary Hospital
Name________________________________
____

2. If yes above, which of the following will you still be contracted with after this termination?

☐ Johns Hopkins Hospital
☐ University of Maryland Medical System
☐ Sinai Hospital

☐ Any Other Faculty/Tertiary Hospital
Name________________________________
____

3. Please list any pediatric sub-specialty(s) that will not be available from your remaining faculty contracts:

Data Requests

1 Please provide an Excel spreadsheet, which includes for each member affected:
- Member's name
- Member's MA number
- Member's Zip Code
- Member's PCP of record
- Member's special needs category, if any

See Attachment

2. Please provide an Excel spreadsheet that includes for each terminated provider:
   - Provider's name
   - Provider's MA number
   - Provider's specialty
   - Provider's office address(es) & zip code(s)

See Attachment

3. For each type of contract specified in **Provider Information**, please provide an Excel spreadsheet that includes the following information for those providers who will remain in your network after this contract terminates and who will ensure that access is maintained in the area(s) where the terminating providers are located:

   - Provider's name
   - Provider's MA number
   - Provider's specialty
   - Provider's office address(es) &zip code(s)
   - Same LAA as terminating provider or adjacent LAA