Overview of Provider Contracting

Humana, ChoiceCare and HBHN Policy
NNO 702-009-36

Humana

ChoiceCare® NETWORK

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Other Affected Functional Areas Primary Department: Provider Contracting	x	Legal	x	Compliance		Commercial Sales/Administration
		HR	x	Service Fund		Medicare Sales / Administration
		Info Systems		Billing/Enrollment	x	Provider Process and Services
		Clinical Operations	x	Service Operations		Product Development / Group Contracts
		Finance				

Scope:

All Humana, ChoiceCare or Humana Behavioral Health Network (HBHN) associates contracting with providers.

Statement:

All new provider contracts and amendments (with the exception of Vision, Dental, & Puerto Rico) should be originated and executed through Merlin.

This policy is corporate guidance that contractors should follow, outlining standard processes, procedures, requirements, approvals and associated documents required when contracting with providers.

No person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the CONTRACTOR's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of Provider. The contractor shall show proof of such non-discrimination, upon request, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

NOTE: There may be state-specific policies that support this policy, please refer to each state's policies for detailed information applicable to that state.

Note: Any notification of a facility addition to and/or removal from an agreement as a Participating Provider must be consented to by both parties via an amendment.

Attachments:

1. Provider Type Contract/Credentialing Grid
2. Provider Contract Effective Date Schedule
3. Network Learning Resource Group (NLRG) Quick Reference Guide

Resources:

A. Credentialing and Recredentialing Policy in Policy Source

B. Provider Contracting Guidelines at go/NNOLearning > Resources

C. In addition to the guidelines outlined in this policy for provider contracts, the following NNO policies should be referenced (Hi! > go/NNO Policies and Procedures page):

NNO 700-004 – Standard Provider Contract Approval/Change Process
NNO 702-001 – Provider Contract Reference Tools
NNO 702-004 – Risk Contracting with Delegation Implementation Guidelines
NNO 702-018 – Provider Contract Retroactive Dates or Rate Changes
NNO 702-027 – Overview of Specialty Contracting Process
NNO 702-028 – Overview of Hospital Contracting Process
NNO 702-030 – Electronic Remittance Advice
NNO 702-032 – Network Participation Requests
NNO 702-037 – Letters of Agreement
NNO 702-038 – Downstream/Sub-delegation Agreement Compliance Review Process
NNO 702-044 – Provider Network Availability and Access

NNO 702-057 – Essential Community Providers
NNO 703-005 – Provider Changes of Control, Agreement Assignments, Bankruptcies, Tax Identification Numbers and Name Changes
NNO 703-018 – Complaints on Provider Offices and Facility Sites
NNO 703-016 – Provider Terminations and Member Notifications

Contacts:

1. National Contracting, VP — Rick Buono — 502-580-2162
2. PPI (Financial Recovery), Service VP — Harold Davis — 502-580-7686
3. National Delegation Associates — Refer to go/delegationcompliance
   Delegation Compliance Lead — Debbie Briggs dbriggs@humana.com
4. Contract Approval Committee SharePoint site
   (Hospital Contract Approval Process link on top right covered in NNO 702-028)

Standard: Provider Contracting

Purpose:

To create a consistent process for contractors to follow for provider participation agreements.
Note: For specialty and hospital contracts refer to the following policies:
NNO 702-027: Overview of Specialty Contracting (formerly Ancillary Provider Contracting)
NNO 702-028: Overview of Hospital Contracting

Requirement:

Network Requirements: The business needs and regulatory requirements (including state specific laws, rules and regulations) of each market network and membership requirements, as determined on a market-by-market basis, dictate the numbers and types of physicians and other providers with whom the market contracts, so long as such needs do not discriminate in terms of participation, reimbursement, or indemnification against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Leaders at each local market determine specific network configurations (for example, if a network is “open” or “closed” for a provider specialty type). The process outlined in NNO 702-

032 should be followed for responding to non-participating provider requests to join the network(s).

Date Stamp and Contract Submission:

Completed and signed contracts must be date stamped on the coversheet on the date received. This is automatically tracked for MERLIN contracts.

Contracts must be created, executed and submitted via Merlin/Icertis, to Provider Network Operations for loading upon receipt of all signatures and In accordance with the effective date schedule (Attachment 2).

If a contract requires retroactive effective date and /or has rate changes, refer to the process and procedure contained with *Provider Contract Retroactive Dates or Rate Changes* NNO 702 018.

Provider Notices: Refer to the guidelines and process outlined in NNO 703-005 for notices received from providers regarding contractual and demographic changes. Refer to the guidelines and process outlined in NNO 703-016 Provider Terminations and Member Notifications for notices regarding contractual terminations.

NOTE: If an Essential Community Provider (ECP) indicates they do not contract with any payors, written documentation of the ECP's position must be maintained for a period of 10 years. If MERLIN/Icertis is used, an audit trail will be maintained (Refer to NNO 702-057 ECP policy).

Letters of Agreement:

Refer to LOA – Interim Provider Agreements section of this policy. All other LOAs (including Member Specific LOAs), refer to NNO 702-037.

Contract Language:

Standard provider contract language has been developed and approved by Humana's business areas and Law Department. Contractual language has been filed with each state's Department of Insurance (DOI), when required. Contractors should use the language the most current version for their geographic area when negotiating/renegotiating contractual relationships with providers. All current, approved Humana, ChoiceCare and/or HBHN standard provider contract language is available within Merlin and on the NNO SharePoint site. National Delegation Addendums and Delegation Request Forms are available at go/delegationcompliance.

Network Language Resource Group (NLRG) and market Presidents (or designee) must approve all modifications to the following language in contracts:

a. Hold Harmless
b. Network Rental Language
c. Termination without Cause for both parties
d. Rad Site & Rad Consult Language
e. Binding Arbitration
f. Claims Contestation
g. Overpayment Recovery
h. Deeming into New Products / New Product Notification
i. Administer Networks in which provider is not selected (i.e., HPN)
j. Unilateral Modification Rights

k. Medical Malpractice Limits
l. Preauthorization, Utilization Management and Penalty

The following sections of the contract cannot be modified or deleted:

- State Coordinating Provisions
- Medicare Advantage Provisions
- Medicaid and/or Dual (MMP) program attachments
- Sequestration Language

If advice is needed on legal issues related to a specific contract change, the NLRG should be contacted.
Escalation process: When consensus cannot be reached on changes to the MA Provisions, Senior Leadership has final approval of all changes. (See Attachment 3).

Downstream/Sub-Delegation Contract and Review: Prior to contracting a t downstream/sub-delegation contract, the review process outlined in NNO 702-038 *Downstream/Sub-Delegation Agreement Compliance Review Process* must be completed. For any contract language review, contractor should send via email to the NLRG.

Site Survey: If required by Medicaid or specific state mandate, a site survey may be required for each office location before a provider's contract is executed. It is the contractor's responsibility to ensure compliance to this requirement and recorded, as applicable.
A site visit must occur if there has been a complaint regarding the office site (all accredited lines of business). Refer to NNO 703-018.

- Florida Medicaid: Provider office site visits are required for all PCPs and OB/GYNs upon initial credentialing and recredentialing (practitioners must be recredentialed every three years).
- IL Dual Demonstration Programs: Site visits are required for all PCPs upon initial credentialing.

Amendments: It is the guidance and recommendation of corporate leadership to replace the older contract agreements (4+ years) with the most up to date and approved standard contract language and/or state specific or federal addendums or provisions. Contractors must ensure when amending agreements that the contract agreement is up to date and if not, contractor must amend the agreement to include any out of date language, addendums or providers. For further guidance, see NNO 700-004 *Standard Provider Contract Approval/Change Process.*

Authorized Signers: All contracts must be signed by the appropriate authorized signer(s): market Presidents, Regional VP PE, and/or authorized designees. If there is an exception (i.e., contract must be signed on a specific date and the authorized signer is not available), the authorized signer may designate another person to sign the contract for them. If designee signs a contract with a signature other than their own, designee must place their initials after the signature name.

Reimbursement: The contract should not deviate from reimbursement strategies developed by each market or contracting team, unless approved by NLRG, RVPPE, market finance and any applicable approval committees, including CAC. Standard reimbursement is determined by using a variety of methodologies and factors as listed in this section.

Markets have access to the following methodologies:

- fixed Medicare fee schedules,

- floating Medicare fee schedules,
- capitation,
- flat fees/carve outs,
- percent of billed charges,
- bundled payments,
- performance/care based programs and
- Medicaid fee schedules (Medicaid only)

Markets may apply a mixture of the following factors which include but are not limited to:

- Service type
- Provider specialty
- Level of provider expertise
- Geographic location
- Demand for services
- Supply of providers
- Medicare reimbursement rates
- Programs that review quality
- Comparison of rates from one or more regional or national databases or schedules for the same or similar services

In certain circumstances and with appropriate approval as listed above, rates may be negotiated using the following factor in addition to those listed above.

- Provider Practice Size
- Site of service

The above factors should apply to behavioral health/substance use disorder and medical surgical providers in a manner that is comparable to and no more stringent when determining rates.

Additional preferences when making reimbursement decisions include:

- It is preferred that physician contracts include "lab pay zero" provisions, unless otherwise approved by your leadership
- It is preferred that contracts with oncologists include oncology drugs at 100% of the 201-580 fee schedule - cannot be contracted above 100%, unless otherwise approved by your leadership
- It is preferred that physician contracts should include drugs and biologicals at 100% of the 201-544 fee schedule – cannot be contracted above 100%

Standard payment attachments are available in MERLIN/Icertis.

ERA/EFT: The contractor should encourage providers to enroll in electronic remittance advice/electric fund transfer. Refer to NNO 702-012 and NNO 702-030.

Escalator Payment Provisions: It is the preferred corporate leadership recommendation that contract agreements not include reimbursement payment escalators, and multi-year annual escalators are discouraged. If a contractor deviates from this guidance, market President or designee must approve. The contractors should maintain a master list to ensure notice to provider and submittal in the task. Contractor notifies Provider Network Operations/Load of all escalator payments, which should be sixty (60) days prior to the effective date of the specific rate increase. See NNO 702-018 *Provider Contract Retroactive Dates or Rate Changes* for further details.

Material Adverse Changes: If Humana/ChoiceCare/HBHN makes a material adverse change to a provider's existing contract, Humana/ChoiceCare/HBHN must send a ninety (90) day written notice to the provider prior to the effective date of the change. Markets should check to see if there are additional state specific requirements regarding how a material change is communicated.

Credentialing: The credentialing process must be completed as part of the contracting process. To determine the type of credentialing document, refer to the *Provider Type Contract/Credentialing Grid* (See Attachment 1).

Prospective effective dates listed in the *Provider Contract Effective Date Schedule*) are based on the requirement that the contract is received as "complete" by Provider Network Operations in the specific timeframes outlined in the Attachments to this policy. Any requests for exceptions must be approved by the appropriate RVP PE within 30 calendar days from when the task is submitted through APEX. Exception approvals from the RVP PE must reference the name and tax ID of the provider and be included in the contract submission.

In order to be considered as "complete", the agreement must contain all information required to add the provider to the directory and all required prospective payment information. Any delay in processing the contract due to missing information may result in a change to the effective date of the contract.

If the contract includes a large group (over 500 providers) or complex terms, market should initiate a call with Provider Network Operations to discuss in a preload call.

Retroactive-effective dates on contracts should be avoided. Approval must be obtained from the appropriate RVP PE prior to submission of the APEX work case and must include the effective date, facility/provider name, tax ID (roster if applicable). Refer to NNO 702-018 for further guidance.

Contractor must ensure all requirements for credentialing would have been met as of the retroactive effective date prior to submitting the agreement for retroactive approval. Senior leadership approval is not required to add a provider to an existing contract.

W-9 Forms: Contractors must obtain a copy of the provider's W-9 form as follows:

- **New contracts**: Copy of provider's W-9 Form must be submitted with initial contract through Merlin/Icertis. The W-9 Form is required to verify provider's legal name and tax identification number **as it is registered with IRS**. A copy of provider's billing forms**, (**CMS 1500 or UB, is required to confirm Provider's loading screens are properly created.
- **Existing contracts**: Provider Network Operations (PNO/load) **only** requires a copy of the provider's W-9 (group and individual) for changes that impact provider's filings with the IRS. This includes changes to tax ID, name, and address for mailing

1099. However, a sample billing form may be requested for any name, TIN, or address change.

Delegation: If an entity would like to become delegated for Clinical/Health Services (UM, CCM, DM), Claims and/or Credentialing, the contractor is responsible for completing a request for delegation form (RFD), found on the delegation compliance SharePoint site via go/delegationcompliance, and sending it to delegationcompliance@humana.com mailbox. The RFD will be reviewed and processed. Claims and Clinical Health Services delegation must be approved by the Delegation Council. Contractors should follow the guidelines regarding Delegation Amendments posted on National Network Operations Website, under National Delegation (Resource A). A pre-delegation audit must be performed for each function to be delegated before the execution of a delegation agreement. Contractors should also send a copy of the executed contract along with any amendments to delegationcompliance@humana.com mailbox.

LOA-Interim Provider Agreements: Humana corporate leadership discourages the use of interim LOAs in lieu of fully executed contracts. In some instances, contractors may execute an LOA-Interim Provider Agreement while the contractor negotiates and executes a full and complete contract. If so, contractor must comply with the following guidelines and approval requirements:

a. Prior to executing an LOA in lieu of a fully executed contract, contractor must:
   - Negotiate payment rates with provider that will be the same payment rates that will be included in the final executed contract; and
   - Discuss the LOA request with Director of Contracting and Regional VP.

b. If management agrees to request, contractor must use MERLIN to create the LOA using the approved LOA templates.

c. Standard approved language must be used for all LOA-Interim Provider Agreements and LOA – any deviation from this requirement must be approved by the Law Department and the NNO Director of Contract Services.

d. A separate LOA-Interim Provider Agreement must be executed for Medicare Advantage, Medicaid and Commercial lines of business. They cannot be combined into a single LOA.

e. Commercial LOAs should not be executed unless there is a critical business need to include the provider in the network and the applicable State Coordinating Provisions must be attached.

f. Medicare Advantage LOA-Interim Provider Agreements must include the current Medicare Advantage Provisions.

g. Normal credentialing requirements apply for all providers contracted on an LOA.

h. Providers contracted on LOA's will display in the directory. (For member specific LOAs, refer to NNO 702-037).

i. If an LOA-Interim Provider Agreement is used for delegating functions to provider (e.g., credentialing, UM or any other functions that are approved by the Delegation Department); the delegation addendum must be executed as part of the LOA.

j. The LOA remains in force until either party terminates the LOA. Do not include a termination date in the LOA. However, the expectation is that the LOA will be replaced by a full contract within the following timeframes:
   - Commercial LOAs - 90 days
   - Medicare Advantage and Medicaid LOAs – 180 days

   NOTE: Once a full contract has been executed, the LOA must be termed within Merlin. The contractor can request assistance with the termination of the LOA from merlin@humana.com.

k. All completed LOAs must comply with all other guidelines and regulatory requirements related to contracting as outlined herein;

l. VP approval is required for all LOAs and the approval will be captured in MERLIN.

m. The executed LOA will be submitted through MERLIN to Humana systems for processing as a normal provider contract.

Execution of Agreements Timeline: New agreements should be fully executed by both parties within 12 or 18 months (see below) from the initiation of the drafting the agreement. Any non-executed contract that is not being actively negotiated should be withdrawn from the system by the contractor.

In MERLIN, a periodic review of all non-executed agreements will take place. During these reviews contractors with aging non-executed agreements will receive an email notice and report requesting a response as to whether an aging contract needs to be preserved. The criteria used to determine an aging contract is:

12 months – provider or specialty contracts
18 months – hospital, PHO, or IPA contracts

If no response is received from the associated marketing contractor, the contract will be withdrawn from the MERLIN system after 14 days after the notice is sent. This process will help ensure the system remains free of contracts that are no longer actively being negotiated.

Procedure: Provider Contracting

Description: Consistent process for contractors to utilize during the preparation, creation, and execution of provider agreements.

Narrative: Divided in 2 sections:
Section 1: Contract Preparation & Guidelines
Section 2: Contract Creation & Execution

Section 1: Contract Preparation & Guidelines

Contractors and/or Designee

1. Consider Physician performance metrics including, but not limited to, cost efficiency, effectiveness indicators and patient experience results comparable to benchmarks. Physician performance metrics may include the following:

- Humana/ChoiceCare/HBHN may use "effectiveness indicators," including those developed by emerging industry guidelines and/or by nationally recognized quality organizations
- Humana/ChoiceCare/HBHN may use claims grouper methodologies to analyze the cost efficiency of a broad range of Physicians, both specialists and primary care, and use the resulting "efficiency measurement" to select Physicians for participation.

A. Reimbursement Terms: Standard payment templates are available on the National Network Operations Website and on MERLIN.

   a) Reimbursement terms for Medicare products should never exceed 100% of Medicare;
   b) Avoid reimbursement terms based on percent of charge;
   c) Avoid reimbursement terms that cannot be automated or administered
   d) Obtain approval from market leadership, including RVP PE If applicable, contractor should ensure reimbursement attachment language specifies the appropriate fee schedule number and a detailed description.

   Prior to executing any provider contract containing reimbursement terms outside market guidance and/or differ or vary from the NNO approved reimbursement, the following steps must adhere to the following:

   - Obtain approval from market leadership, including RVP PE or designee to deviate from standard reimbursement terms
   - Email NLRG and obtain approval prior to executing contract. Obtain approval from the RVP PE and Network Language Resource Group

B. Financial Recoveries/Offset/Recoupments Provision of Contract: This section within the contract may not be removed; however, if provider requests changes to this provision, contractor must obtain approval from RVP PE or designee, NLRG, and local market finance.

   If approval is obtained, notify Provider Payment Integrity (PPI-Financial Recovery) of the proposed change prior to implementation (see Contacts section).

C. Standard Contract Language: Contractor must create, execute, and load all contracts within Merlin/Icertis. NNO also has approved contract language versions available on NNO. If any changes are requested, contractor must obtain approval from NLRG. For further guidance, see the Contract Language section of this policy. All final executed contracts must be "clean" copies – no redline versions. MERLIN maintains each altered version of the agreement and amendments.

D. Amendments: are legal documents that reflect a change in the executed agreement and must be created within Merlin/Icertis. For further guidance, refer to NNO 700-004.

2. If provider will be delegated to perform claims, Clinical Health Services and/or Credentialing, on Humana/ChoiceCare/HBHN's behalf or if a vendor will be performing a specified function on Humana/ChoiceCare/HBHN's behalf, contact the Vendor and Delegation Compliance Lead regarding the delegation agreement process.(see contacts).

   Note: If the claims and/or Clinical Health Services function(s) is/are delegated, the contract must be approved by the Delegation Council.

3. If provider has contracts with downstream network of physicians or other healthcare providers, completes downstream contract review process outlined in NNO 702-038 prior to final execution of contract. Contractors are responsible for obtaining the downstream agreements and submitting the final executed version to Humana's Delegation Compliance Department via delegationcompliance@Humana.com to perform the reviews.

Section 2: Contract Creation & Execution

4. Once the agreement is created within Merlin/Icertis, is reviewed, has all appropriate approvals, and determined to be completed and compliant, the contractor moves with executing the contract within MERLIN/Icertis.

5. Transmit the agreement to all parties via MERLIN/Icertis

6. Once contractor receives a full and complete executed version, an executed version is sent to provider via Merlin and welcome packet is sent with executed version to the provider and includes the location of the following documents on Humana.com publications page:

   - *Principles of Business Ethics Excerpts for Physicians and Other Health Care Professionals* Per federal guidelines, this must be given to provider within fifteen (15) days of effective date of contract for Medicare, Medicaid and Dual Medicare/Medicaid.
   - *Provider Manual* – advise provider that Manual is available on Humana.com or mail paper copy if no access.

7. Credentialing Application – Specific state credentialing applications must be used if applicable.

   There are two options for credentialing:

   - Credentialing application with Humana or CHC network; or
   - Registration with the Council for Affordable Quality HealthCare (CAQH).

   For additional information regarding the specific requirements for credentialing and state specific credentialing applications, refer to the Credentialing page on National Network Operations Website.

8. Reviews the information received from provider and verifies the following:
   - Coversheet includes all requested information;
   - Provider has included copy of W-9 form (s); and
   - All credentialing information is current and complete.

   Note: If the agreement or credentialing application is incomplete, contractor notifies provider in order to obtain the required information within thirty (30) days of notice or within the timeframe indicated below per state regulations:

   AZ: 7 calendar days
   AR, RI: 15 calendar days
   MD: 10 days
   NC: 15 days
   NH: 15 business days
   NM: 10 working days
   OH: 21 days

OK: 10 calendar days
TN: 5 business days
NC: if missing or incomplete information is not received within sixty (60) days of notification to the provider, the application must be closed and written notification sent to the provider that the application has been closed.

9. Completes contracts in MERLIN as follows:

   a. Determines type of contract to be created, as appropriate: Business party (Humana, ChoiceCare, HBHN) and Provider Type (Physician, IPA, PHO, value based, etc.).

      NOTE: A group contract should be executed for providers that are part of a group instead of individual contracts.

   b. Enter provider's tax identification and name or group name in MERLIN exactly as it is on the W-9 Form and registered with the IRS, to automatically populate the contract cover sheet.
   c. Complete MERLIN/Icertis interview to prepare contract for editing and/or negotiation
   d. Send to Director of Contracting or designated approver and NLRG, as required
   e. Once all approvals are completed, send contract for provider and RVP PE signatures in MERLIN/Icertis.

RVP PE or authorized signer

10. Reviews and signs contract. Determines effective date based on the Provider Contract Effective Date Schedule (Attachment 2) and enters the date in the contract template

Contractor

11. Processes completed contracts, credentialing application and any other attachments as follows:

   a. Complete MERLIN tasks and transmit all attachments (contract, W-9, Roster, Cred App, etc.) to APEX
   b. When notified via APEX that credentialing is complete and contract has been loaded into the system, provider will receive a copy of the contract via MERLIN and/or in Welcome Packet (includes: Welcome Letter, Credentialing Approval Letter, *Doing Business with Humana* flyer, and copy of executed contract).
   c. Files and stores executed contracts. MERLIN-generated contracts, Letters of Agreement and amendments are maintained automatically. When creating an agreement outside of MERLIN/Icertis is unavoidable, the agreement must be submitted for loading through APEX (outside of MERLIN/Icertis) using an Exception Request.
   d. Conducts New Provider Orientation for providers as appropriate.

RETROACTIVE EFFECTIVE DATE:

Contractor

12. Determines if a special circumstance exists which might necessitate a retroactive effective date. (Refer to NNO 702-018)

   - If a special circumstance exists, follows suggested actions as outlined in NNO 702-018, attempting to avoid a retroactive effective date. If contract is to have a retroactive effective date, forwards contract along with documentation to appropriate RVP PE to request

approval within 30 calendar days prior to the task/work case submission. Approval from the RVP PE must reference the name and tax ID of the provider and be included in the contract submission. Process continues with step 4.

- If a special circumstance does not exist and a retroactive effective date is not required, completes negotiations and enters the effective date in the contract. Obtains signed contract.

RVP PE

13. Receives request for approval from contractor for contracts with retroactive effective dates (if applicable). Reviews, makes determination, and advises contractor.

Contractor and Provider Network Operations Department

14. Adheres to the advice and direction of the RVP PE regarding contracts with retroactive effective dates.

Contractor

15. Completes processing of contract as outlined in this policy.

Owner:	Beverly Steen	**Executive Team Member:**	George Renaudin
Accountable VP / Director:	Paul Davis		

Disclaimer:

Humana/ChoiceCare/HBHN 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/HBHN 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/HBHN at any time. Humana/ChoiceCare/HBHN 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 or National Network Operations SharePoint site go/NNO, Policies and Procedures page to ensure no modifications have been made

Non-Compliance:

Failure to comply with any part of Humana/ChoiceCare/HBHN's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana/ChoiceCare/HBHN. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations. Any unlawful act involving Humana/ChoiceCare/HBHN systems or information may result in Humana/ChoiceCare/HBHN 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).