Notification process and timeframe requirements used to inform managed care plan enrollees, caregivers and legal representation of changes in healthcare providers

From YouthCare contract:

5.7.7.3 Contractor shall give at least sixty (60) days written notice in advance of its nonrenewal or termination effective date of a Provider to the Provider and to each Enrollee served by the Provider. The notice shall include a name and address to which the Provider or an Enrollee may direct comments and concerns regarding the nonrenewal or termination. In the notification to the Enrollee, Contractor will provide direction regarding how the Enrollee may select a new Provider. Contractor may provide immediate written notice when a Provider's license has been disciplined by a State licensing board.

Notification process and timeframe requirements used to inform managed care plan enrollees, caregivers and legal representation of changes in coverage

From YouthCare contract:

4.9 **Enrollee Welcome Packet**. Within five (5) business days after receipt of the 834 audit file from the Department confirming that an enrollment was accepted, Contractor shall send an Enrollee welcome packet to the Enrollee. The packet shall include all basic information as set forth in 5.21.1.1:

5.21.1 **Basic information**. "Basic information" as used herein shall mean information regarding:

5.21.1.1 the types of benefits and the amount, duration, and scope of such benefits available under this Contract, with sufficient detail to ensure that Enrollees understand the Covered Services they are entitled to receive, including behavioral-health services and EPSDT screenings and services;

5.21.1.2 the procedures for obtaining Covered Services, including authorization and Referral requirements, and any restrictions Contractor may place on an Enrollee pursuant to section 4.19;

5.21.1.3 any benefits to which an Enrollee may be entitled under the HFS Medical Program that are not provided under Contractor's plan and specific instructions on where and how to obtain those benefits, including any restrictions on an Enrollee's freedom of choice among Network Providers, as provide by the Department;

5.21.1.4 the extent to which after-hours coverage and Emergency Services are provided, including the following specific information:

5.21.1.4.1 definitions of "Emergency Medical Condition," "Emergency Services," and "Post-Stabilization Services" that are consistent with the definitions set forth herein;

5.21.1.4.2 the fact that prior authorization is not required for Emergency Services;

5.21.1.4.3 the fact that, subject to the provisions of this Contract, an Enrollee has a right to use any hospital or other setting to receive Emergency Services;

5.21.1.4.4 the process and procedures for obtaining Emergency Services; and

5.21.1.4.5 the location of Emergency Services and Post-Stabilization Services Providers that are Network Providers;

5.21.1.5 the procedures for obtaining Post-Stabilization Services in accordance with the terms set forth in section 5.20.1.2;

5.21.1.6 the policy on Referrals for specialty care and for Covered Services not furnished by an Enrollee's PCP;

5.21.1.7 cost sharing, if any;

5.21.1.8 the rights, protections, and responsibilities of an Enrollee as specified in 42 CFR § 438.100, such as those pertaining to enrollment and disenrollment and those provided under State and federal law;

5.21.1.9 Grievance and fair-hearing procedures and time frames, provided that such information must be submitted to the Department for Prior Approval before distribution;

5.21.1.10 Appeal rights and procedures and time frames, provided that such information must be submitted to the Department for Prior Approval before distribution;

5.21.1.11 Contractor's website URL and the types of information contained on the website, including certificate of coverage or document of coverage, Provider directory, and the ability to request a hard copy of these through Enrollee services;

5.21.1.12 a copy of Contractor's certificate of coverage or document of coverage;

5.21.1.13 names, locations, telephone numbers, and non-English languages spoken by current Network Providers, including identification of those who are not accepting new Enrollees;

5.21.1.14 information on NF Covered Services and HCBS Waiver Covered Services to Enrollees receiving or determined to need Covered Services under Service Package II;

5.21.1.15 Enrollee packets, which the State or its designee will provide to Contractor, and which Contractor shall distribute to Enrollees receiving Covered Services from Personal Assistants or other Individual Providers under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. Contractor shall educate Enrollees regarding the content of the Enrollee packets.

5.21.2 **Obligation to provide basic information**. Contractor shall provide basic information to the following Participants, and shall notify such Participants that translated materials in Spanish and other prevalent languages are available and how to obtain them, once a year:

5.21.2.1 to each Enrollee or Prospective Enrollee within thirty (30) days after Contractor receives notice of the Enrollee's enrollment and within thirty (30) days before a significant change to the basic information; and

5.21.2.2 to any Potential Enrollee who requests it.