UnitedHealthcare Community Plan

Medicaid Managed Care Rule Update
Frequently Asked Questions

Key Points

• The Centers for Medicare & Medicaid Services (CMS) established the Medicaid Managed Care Rule and an update to it under 42 CFR, part 438.10(h) that requires managed care organizations (MCOs) like UnitedHealthcare Community Plan to include additional information in our care provider directories:
  ◦ Website URL (if applicable)
  ◦ Disability access for patients
  ◦ Languages spoken in addition to English and use of sign language
  ◦ Indication if a medical interpreter is available to help a member with language translation
  ◦ Culture competency awareness acknowledgment
  ◦ Indication if new patients are being accepted
• The Medicaid Managed Care Rule applies to:
  ◦ Physicians and specialists
  ◦ Hospitals
  ◦ Pharmacies
  ◦ Behavioral health care providers
  ◦ Long-term services and support (LTSS) providers
• The Medicaid Managed Care Rule applies to Medicaid plans.
• It **doesn't** affect Medicare Advantage plans.

Overview

Since UnitedHealthcare Community Plan administers Medicaid managed care plans on behalf of CMS, we're required to follow the rules that govern them. CMS updated many of the rules governing Medicaid managed care to align with those of other major sources of coverage including coverage through Qualified Health Plans and Medicare Advantage plans. CMS made those changes final in July 2017.

The Medicaid Managed Care Rule also was established to:

- Promote the delivery of quality care and services
- Strengthen efforts to reform the delivery of care to individuals covered under Medicaid and Children's Health Insurance Plans (CHIP)
- Strengthen beneficiary protections
- Enhance policies related to program integrity

Update to the Rule

The Medicaid Managed Care Rule now requires that we include specific information in our provider directories about:

- Web URL, if applicable
- Open access for members with disabilities
- Languages spoken in addition to English
- Indication if a practice has a medical interpreter available to help a member with language translation
- Whether physicians have completed cultural competency training
- Indication if you are accepting new patients

We've created this frequently asked questions document to help answer questions you may have about the Medicaid Managed Care Rule and what you'll need to do.

Frequently Asked Questions and Answers

Medicaid Managed Care Rule: The Details

Q1. What is the CMS Medicaid Managed Care Rule?

A. CMS issued updates to the Medicaid Managed Care Rule, which were finalized in July 2017. All MCOs are required to follow the Rule for administering Medicaid managed care plans. CMS updated many of the rules governing Medicaid managed care to align with those of other major sources of coverage including coverage through Qualified Health Plans and Medicare Advantage plans. The Rule also:
- Promotes the quality of care
- Strengthens efforts to reform the delivery of care to individuals covered under Medicaid and Children's Health Insurance Plans (CHIP)
- Strengthens beneficiary protections
- Enhances policies related to program integrity

Q2. What do I need to know about the updates to the Medicaid Managed Care Rule?

A. CMS updated its Medicaid Managed Care Rule to require that the following information be listed in a paper and online provider directories that members use:
- Website URL (if applicable)
- Disability access for patients
- Languages spoken in addition to English and use of sign language
- Indication if a medical interpreter is available to help a member with language translation
- Cultural competency awareness acknowledgment
- Indication if new patients are being accepted

Q3. How does providing the additional information affect me?

A. Since you participate in our network and provide services to UnitedHealthcare Community Plan members, keeping our directory updated with information your current contact information required under the Medicaid Managed Care Rule. We also want to be sure our members have accurate information about our network care providers when they use our directory.

Q4. How is UnitedHealthcare Community Plan collecting the new information required under the Medicaid Managed Care Rule?

A. We'll reach out to you by email, phone or fax to update the information we need to comply with the Medicaid Managed Care Rule.

Q5. What types of care providers are affected by the update to the Medicaid Managed Care Rule?

A. The following types of care providers are required to have their information updated:
- Physicians and specialists
- Hospitals
- Pharmacies
- Behavioral health care providers
- LTSS providers

Q6. Are there types of providers that are excluded from the requirements of the Medicaid Managed Care Rule?

A. Yes. Vendors that offer transportation services are excluded from the requirements of the rule.

Q7. How will UnitedHealthcare Community Plan educate care providers about the requirements for the Medicaid Managed Care Rule?

A. The specific ways to educate care providers about the Rule may very state to state. We'll have information available through:
- Our Provider Advocates
- Presentations at town hall events
- Online at UHCCommunityPlan.com > Health Care Professionals > Maryland

Access for Members with Disabilities

Q8. Why are you asking for information from me about disability access?

A. UnitedHealthcare Community Plan and our care providers need to comply with the Americans with Disabilities Act (ADA). This includes ensuring safe and appropriate physical access to buildings, services and equipment for members with disabilities, such as:
- Open access to building and parking
- Accessible equipment such as exam tables, weight scales and diagnostic equipment
- Individual assistance with the examination process
- Accommodations for the member's family, friends or attendants to assist
- Creation of signage that follows ADA guidelines

Language Services Requirement

Q9. What is the language services requirement of the Medicaid Managed Care Rule?

A. You're required to disclose any languages you speak in addition to English. You also need to indicate:
- If you have a medical interpreter available for members.
- Language assistance services including interpreters or translators for members who are deaf, hard of hearing, or do not speak English.
- Support may be provided through:
  - American Sign Language
  - Accessing community resources for interpreters or translators
  - Providing accommodations for family or friends who accompany members to appointments
  - Allowing for written communications and materials for information after the appointment
  - Considering cultural and social differences of the member

Cultural Competency

Q10. Why is cultural competency a requirement of the Medicaid Managed Care Rule and how does it help members?

A. Cultural competency is a set of behaviors, and attitudes that enable positive interactions in cross-cultural situations.
- **Culture** refers to patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.

- **Competence** is the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors and needs presented by people and their communities.

Health care services that are respectful of and responsive to the beliefs, practices, and cultural and linguistic needs of patients can help improve health outcomes. Culture and language may influence health, healing, and wellness beliefs including perception of illness, disease, and their causes.

Q11. What are UnitedHealthcare Community Plan's requirements for cultural competency?

A. We require our participating care providers to treat UnitedHealthcare Community Plan members the same way they'd treat any other benefit plan members. That includes no discrimination in the treatment of or quality of services provided to UnitedHealthcare Community Plan members. Providers who render care must be willing and able to:
   - Make distinctions between treatment methods consistent with the member's cultural background.
   - Maintain consistency in providing quality care across a variety of cultures

Q12. Where can I go to learn more about cultural competency?

A. If you need information about cultural competency, please visit UHCCommuntiyPlan.com or the Health and Human Services websites listed below:
   - UHCCommunityPlan.com > For Health Care Professionals > Select Your State > Cultural Competency Library

   OR
   - https://cccm.thinkculturalhealth.hhs.gov

The remaining questions address additional changes that will affect care providers offering treatment and services to members within the State of Maryland.

Medical Record Retention

Q13. What are UnitedHealthcare Community Plan's new requirements for medical record retention?

A. The medical record retention schedule will change from six years to ten years, effective Jan. 1, 2018. You're expected to maintain adequate medical, financial and administrative records related to covered services you provide to UnitedHealthcare Community Plan members, including claim records. You should save these records for at least 10 years after the covered services are provided, unless you're legally required to retain the documents for more than 10 years.

Services for Special Needs Population

Q14. How often will I be expected to update the plan of care for UnitedHealthcare Community Plan's special needs members?

A. The primary care physician and specialist must ensure that the plan of care and care modalities for our special needs population are updated annually and as a member's needs change, or upon member request.

Pharmacy Services

Q15. How will this affect the expected turnaround time for preauthorization of medical services and outpatient drugs?

A. For medical services, we'll provide a decision within two business days of receipt of all necessary clinical information, but no later than 14 calendar days from the date of your initial request. Requests meeting expedited criteria will receive a decision within 72 hours of initial request. For outpatient drugs requiring preauthorization, we'll provide a decision within 24 hours of your initial request. This change will be effective Feb. 1, 2018.

Member Appeals Process

Q16. How will the member appeals process change for UnitedHealthcare Community Plan?

A. The member appeals process will change in the following ways:

- Effective Feb. 1, 2018 members will have 60 days instead of 90 days from the date of a denial letter to file an appeal.

- If the denial is upheld, members will be instructed on how to request a State fair hearing. Members will no longer be able to request a second appeal with UnitedHealthcare Community Plan.

- Members have the right to file for continuation of benefits during an appeal or State fair hearing.

- Benefits will be provided until one of the following conditions is met:
  - The member withdraws the request for an appeal or State fair hearing;
  - The member fails to request the State fair hearing and continuation of benefits within 10 calendar days of an adverse appeal decision; or
  - The State fair hearing office issues a denial or an adverse decision against the member.

Notification of Adverse Benefit Determination

Q17. How are members notified of an adverse benefit determination?

A. Following a claim denial or adverse decision, we'll issue an explanation of benefits (EOB) notice to the member for any third-party liability, services from out-of-network care providers, additional costs for optional services and/or out-of-state services. Members aren't responsible for covered services following an adverse benefit determination or denial.

Official Notification of Provider Status Changes

Q18. What information do I have to report to UnitedHealthcare Community Plan within 10 calendar days of the event?

A. You must send notice of the following events or changes to the address noted in your agreement within 10 calendar days of your knowledge of the event/occurrence:

- Material changes to, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home or other facility
- Relocation or closing of your practice, and, if applicable, transfer of member records to another physician/facility.

Updates to Demographic Information

Q19. What specific demographic information will UnitedHealthcare Community Plan ask me to review and update in a timely manner?

- Care provider's name and any group affiliation;
- Street address(es);
- Telephone number(s);
- Days and hours of operation;
- Email address;
- Website URL;
- Specialty;
- Hospital affiliation(s);
- Acceptance of new members/patients;
- License(s) of the care provider;
- Tax identification used by the care provider;
- National Provider Identifier (NPI) of the participating care provider(s);
- Languages spoken by the care provider or a skilled medical interpreter within the practice/office and documentation that the care provider has completed cultural competence training;
- Age/Gender population served by the care provider;
- Compliance with ADA requirements for care provider's office/facility, exam room(s) and equipment to accommodate members with physical disabilities;
- Immediate notification of a departure of participating health care providers from your practice.
- If you have received the upgraded My Practice Profile on Link and have been granted editing rights by your ID administrator, you can use Link to make many of these updates.

Questions? We're here to help.

If you have additional questions, please contact Provider Services at 877-842-3210.