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One Care:

Implementation Council Meeting

Executive Office of Health & Human Services

MassHealth Demonstration to Integrate Care for Dual Eligibles

Tuesday, February 12, 2019, 10:00 AM – 12:00 PM

Boston Society of Architects

290 Congress Street, Boston, MA, Suite 200

Slide 2

**Provider Network Requirements**

Plans must:

* Ensure adequate access to medical, behavioral health, pharmacy, community based services, and LTSS providers1
* Contact a member’s out-of-network providers, including providers during the continuity of care period, and provide them with information on becoming in-network providers2
* At a member’s request, provide for a second opinion from a qualified health care professional at no cost to the member3
* Include providers who address the linguistic, cultural, and other unique needs of any minority, homeless person, individuals with disabilities, or other special populations
  + Including the capacity to communicate with members in languages other than English, as well as those who are Deaf, hard-of-hearing or deaf blind4
* Demonstrate to MassHealth and CMS that the provider network meets access requirements annually
  + Every year, plans submit their provider network to CMS for review to ensure that they meet county-specific proximity requirements by provider and facility type
  + Medicare standards try to make sure that members have the necessary providers within a reasonable amount of travel time or distance5

*1Page 73; 2Page 75; 3Page77; 4Page 77 of the December 28, 2015 contract, available at* [*www.mass.gov/one-care-administrative-information*](http://www.mass.gov/one-care-administrative-information) *under “One Care Three-Way Contract and Memorandum of Understanding”*

5 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.htm>

Slide 3

**Time and Distance Standards – Medicare Primary**

**For services where Medicare would be the primary payer, Medicare time and distance standards apply:**

* **Primary Care Providers**
  + Maximum time/distance to travel is 15 minutes/10 miles
  + Members must have a choice of at least 2 PCPs\*
* **Hospitals**
  + Maximum time/distance to travel is 45 minutes/30 miles
  + Members must have a choice of at least 2 hospitals
    - The contract amendment will clarify the exception: if only one hospital available within a given county, then the second hospital may be within 50 miles
* **Nursing Facilities**
  + Maximum time/distance to travel is 35 minutes/20 miles
  + Members must have a choice of at least two nursing facilities
    - Except if there is only one nursing facility available within a given county, then the second nursing facility may be within 50 miles

*\*Non-English speaking members must have a choice of at least 2 PCPs and at least 2 BH providers in their chosen language if such provider capacity exists throughout the service area*

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**Time and Distance Standards – MassHealth Primary**

**For BH and LTSS services not purchased by Medicare, MassHealth time and distance standards apply:**

* **Outpatient and Diversionary Behavioral Health Providers**
  + Maximum time/distance to travel is 30 minutes/15 miles
  + Members must have a choice of at least two behavioral health providers\*
* **Community LTSS Providers**
  + Maximum time/distance to travel is 30 minutes/15 miles
  + Members must have a choice of at least two LTSS providers
    - Except that with MassHealth approval, the plan may offer only one community LTSS provider per covered service

*\*Non-English speaking members must have a choice of at least 2 PCPs and at least 2 BH providers in their chosen language if such provider capacity exists throughout the service area*

Slide 5

**Single-Case Agreements**

Plans must:

* Offer single-case out-of-network agreements to providers under the following circumstances:
  + The plan’s network does not have an otherwise qualified provider to provide the specified services; or
  + Transitioning the care in-house would require the member to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the member’s condition; or
  + Transitioning the member to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or
  + Transitioning the member to another provider would require the member to go through a substantial change in recommended treatment
* In these circumstances, the provider must be:
  + Not willing to enroll in the plan’s provider network
  + Currently serving members, and
  + Willing to continue serving them at the plan in-network rate of payment1

*1Page 75-76 of the December 28, 2015 contract, available at* [*www.mass.gov/one-care-administrative-information*](http://www.mass.gov/one-care-administrative-information) *under “One Care Three-Way Contract and Memorandum of Understanding”*

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One Care

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