One Care
MassHealth+Medicare
Bringing your care together

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

Provider Network Requirements

Plans must:

- Ensure adequate access to medical, behavioral health, pharmacy, community based services, and LTSS providers[1]
- 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 providers[2]
- At a member's request, provide for a second opinion from a qualified health care professional at no cost to the member[3]
- 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 blind[4]
- 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 distance[5]

[1]Page 73; [2]Page 75; [3]Page 77; [4]Page 77 of the December 28, 2015 contract, available at 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

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*

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*

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 payment[1]

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

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