# Timely Access to Care Protocol for Providers of Intensive Care Coordination (ICC), In-Home Therapy (IHT), Therapeutic Mentoring (TM), Family Support and Training (FS&T), and In-Home Behavioral Services (IHBS)

This protocol is to ensure that families receive a consistent response to referrals received by all Intensive Care Coordination (ICC), In-Home Therapy (IHT), Therapeutic Mentoring (TM), Family Support and Training (FS&T), and In-Home Behavioral Services (IHBS) providers. It also supports the integrity of the waitlist data collected by the MCEs. To this end, ICC/IHT/TM/FS&T/IHBS providers are requested to incorporate the following into their practices, effective immediately.

This protocol outlines expectations regarding referral and waitlist processes for providers. It is divided into six sections: (I) Escalation Protocols, (II) Referral Outreach Response and Initial Contact Requirements, (III) Initiation of Services and Waitlist Enrollment Protocols (IV) Referral and Waitlist Log, (V) Waitlist Management, and (VI) Access to Care-Related Definitions. Referred families include those who: (1) have not yet received an outreach response and/or initial contact, (2) are choosing to wait for a particular provider, and (3) are waiting for the first available provider agency to service them.

## I. Escalation Protocols

1. Providers must create an internal protocol to appropriately assess and escalate Members who present as high-risk, either during the initial call or during the monthly waitlist calls. The escalation protocol includes a warm hand-off process to Youth Mobile Crisis Intervention (YMCI) for those Members who require an immediate crisis intervention. **Referrals should be assessed for urgency and risk, and waitlist prioritization should take this into account.**

## II. Referral Outreach Response and Initial Contact Requirements

1. Referral Outreach Response and Initial Contact Activities:
    a. All outreach and contact must be offered in the Member's preferred language. The provider is required to use an interpreter if they do not have internal resources.
    b. All outreach and contact need to be performed by program staff who are sufficiently trained and qualified to assess appropriate level of care and who have the capacity to effectively manage and/or triage crisis, safety, and risk.
    c. Providers may engage in activities concurrently to the extent clinically indicated and appropriate.
    d. All follow-up communications should be made using the mode of communication preferred by the Member, including Health Insurance Portability and Accessibility (HIPAA)-compliant calling or texting.
2. Referral Outreach Response: The provider must engage in outreach activities for Members waiting for initial contact pursuant to Section V. The provider must engage in outreach response to referral as follows:
    a. ICC providers outreach the Member within 24 hours of referral.
    b. IHT providers outreach the Member within 24 hours of referral.
    c. TM/FS&T/IHBS providers outreach the Member within five calendar days of referral.
3. Initial Contact: Initial contact must include screening for appropriateness of the referral, determining if the Member is interested in the service, assessing urgency and risk, and offering a face-to-face appointment to initiate services, if available.

## III. **Initiation of Services and Waitlist Enrollment**

1. Initiation of Services.
    a. If the Member the provider agree **that the service is not clinically appropriate or needed**, the provider helps the family take the following actions:
        i. Offer the contact information for alternative providers in the region who are accepting new clients, including but not limited to the local Community Behavioral Health Center (CBHC), the Behavioral Health Help Line (BHHL), and contact information for the Member's MCE for any additional assistance in accessing care.
        ii. Inform the Member and any outside referral source that if the service becomes appropriate or needed at a later date, the Member can contact the provider at that time.
        iii. Make note of the Member in the referral and waitlist log as "referred *out* and no longer waiting."
    b. If the Member and the provider agree that the services is **clinically appropriate and needed**, the provider will take the following actions:
        i. If the provider is not at capacity and can offer an appointment, the provider must initiate services as soon as possible based on the clinical needs of the Member. Fourteen days is the Medicaid standard for timely provision of services established in accordance with 42 CFR 441.56(e). The 14-day standard begins at the time at which the provider has made initial contact with the Member following referral regarding treatment.
        ii. If the provider is at capacity and cannot offer an appointment, then the provider offers to add the Member to their waitlist.
2. Waitlist Enrollment
    a. If the service **is clinically appropriate and needed**, and the provider is at capacity and cannot offer an appointment within the Medicaid standard of 14 days, the provider must:
        i. Inform the Member and referral source that they have a waitlist.
        ii. Inform the Member of the approximate wait time to support an informed decision around choosing to wait to initiate services.
        iii. Review current availability of other providers within proximity of the Member via the Massachusetts Behavioral Health Access (MABHA) website and ask the Member if they would like to receive services from the first available provider within a reasonable distance or if they prefer to wait solely for this provider.
            - **If the Member chooses to wait solely for this provider**, the provider notes the Member's referral status as "choosing to wait" on their referral and waitlist log and includes the reason the Member provided for choosing to wait solely for this provider.
            - **If the Member chooses to wait for the first available provider**, the provider connects the Member to providers who are reporting availability on MABHA (and those with availability per other sources such as communications between providers) and notes the Member's referral status as 'waiting for first available provider on their referral and waitlist log.
        iv. Offer contact information for alternative providers in the region who are accepting new clients, including but not limited to the local CBHC, local YMCI, the BHHL, and contact information for the Member's MCE for any additional assistance in accessing care.
        v. Offer the Member the ability to opt out of follow-up calls if they prefer not to be contacted until an appointment is available.

3. **If the provider has zero total capacity, they should notify the Member and assist the family to connect to another provider with capacity. Members must not be placed on a waitlist.**

## IV. Referral and Waitlist Log

1. The provider keeps a referral and waitlist log of all referrals received and updates that information for Members placed on the waitlist. The referral and waitlist log must be provided to MCEs upon request. The referral and waitlist log must minimally include the following information:
    a. Member name
    b. Parent/guardian/caregiver name
    c. Member contact information
    d. Referral date
    e. Referral source name
    f. Referral source contact information
    g. Reason for referral
    h. Dates of outreach attempts
    i. Date of initial contact
    j. Dates of monthly calls to Members on the waitlist
    k. Date of the Member's choice to opt out from monthly calls to Members on the waitlist, if applicable
    l. Outcome of the monthly calls, including assessment of ongoing medical necessity and steps taken to link the Member to other services, etc.
    m. Date of the first available face-to-face appointment to initiate services offered
    n. Referral status:
        i. Referred *out* and no longer waiting
        ii. Referred *on* and no longer waiting
        iii. Declined service
        iv. Not MassHealth-eligible
        v. Choosing to wait for provider
        vi. Waiting for first available provider
        vii. Level of post-referral activity (outreach response/initial contact/waitlist) Services initiated (including the dates services were initiated)

## V. Waitlist Management

1. Providers are required to follow up monthly with all Members in the following categories: (1) Members not yet reached, (2) Members waiting for the first available provider, (3) Members choosing to wait for a particular provider, and (4) Members waiting for a specific request. Provider follow-up communication should be made using the mode of communication preferred by the Member, including HIPAA-compliant calling or text. **Follow up must be made by program staff who are sufficiently trained and qualified to assess the appropriate level of care and who have the capacity to effectively manage and/or triage crisis, safety, and risk**. For these Members, the provider should engage in and document the following activities:
    a. **Member not yet reached** – The provider must:
        i. Engage in assertive outreach to the Member via phone and/or other means of contact.
        ii. Contact the Member monthly at a minimum, leaving a message, when possible, with best time and method for follow up.
        iii. Send an outreach letter to the Member stating they will be removed from the waitlist if they don't respond by a certain date. Each provider should have a

policy about sending outreach letters after not being able to make initial contact, though outreach letters are recommended to include reference to community resources such as the Behavioral Health Help Line.

iv. Note the Member "declined services" in the referral and waitlist log if the Member has not responded to assertive outreach attempts but the specified date.

b. **Waiting for first available provider** – The provider contacts the Member monthly and:
   i. Re-assesses medical necessity/appropriateness for the service.
   ii. Determines whether the Member has received an appointment date with another provider.
   iii. Offers the Member an updated list of names/numbers of alternate providers, specifying which ones are reporting availability per MABHA (and those with availability per other sources such as communications between providers).
   iv. Coordinates with other providers to link the waiting Member to those who have availability to start services.
   v. Connects the family to other services and relevant community resources, including but not limited to the BHHL and local CBHC that might be appropriate while they wait for the referred service.
   vi. Contacts the Member's MCE for assistance when there are no providers with availability in the MABHA system within a reasonable distance from the Member.
   vii. Offers the Member the ability to opt out of follow-up calls if they prefer not to be contacted until an appointment is available.

c. **Choosing to wait for a particular provider** – The provider contacts the Member monthly and:
   i. Re-assesses medical necessity/appropriateness for the service.
   ii. Determines whether the Member has received an appointment date with another provider.
   iii. Discloses the approximate wait time to the Member to support an informed decision around continuing to choose to wait for the provider.
   iv. Determine whether the Member continues to prefer to wait for this provider or if they would prefer to receive services from the first available provider within a reasonable distance.
   v. If the Member now chooses to wait for the first available provider, the provider:
      - Changes their status in the referral and waitlist log accordingly.
      - Follows the procedure noted above under Section V.2.
   vi. If the Member continues to choose to wait for a specific provider, the provider:
      - Outreaches to the referral source to inform them of the wait time and the fact that the Member is declining to be served by the first available provider.
      - Connects the Member to other services and relevant community resources, including but not limited to the BHHL and local CBHC that might be appropriate while they wait for the referred service.

d. **Waiting for a specific request** – For Members who are requesting to wait for a specific specialty (not including language) or staff/team *and* the family declines to be assigned to another available staff, the provider adds them to their waitlist log as outlined above but *does not* report these Members in their monthly MABHA waitlist entry. The provider contacts the Member monthly and:
   i. Re-assesses medical necessity/appropriateness for the service.
   ii. Re-assesses if the Member is still requesting a specific staff/team or specialty.

iii. If the Member continues to choose to wait for a specific staff/team or specialty, the provider:
    - Outreaches to the referral source to inform them of the wait time and the fact that the Member is declining to be served by the first available staff.
    - Maintains the Member on their referral and waitlist log as outlined but <u>*does not*</u> report these Members in their monthly MABHA waitlist entry.

e. If the Member no longer wants to wait for their specific request but continues to choose to wait for a specific *provider*, the provider:
    i. Outreaches to the referral source to inform them of the wait time and the fact that the Member is declining to be served by the first-available provider.
    ii. Resumes reporting the Member in their monthly MABHA reporting.
    iii. Follows the procedure Section V.c.
f. If the Member now chooses to wait for the first available provider, the provider:
    i. Changes their status in the referral and waitlist log accordingly.
    ii. Resumes reporting the Member in the monthly MABHA report.
    iii. Follows the procedure in Section V.b.

## VI. Access to Care-Related Definitions

1. **Choosing to wait for a particular provider**: When a Member indicates that they do not want to seek services with the first available provider and/or they are "choosing to wait" to receive the services through a particular provider. *This is not applicable to ICC.
2. **Date of the first available face-to-face appointment:** This is the date of the first appointment offered regardless of whether the appointment date is accepted or declined. This includes situations where the Member declines in order to wait for a specific staff Member, a staff Member with a certain expertise, and/or a staff Member of a certain gender. This does not include instances where the Member declines an appointment offered with a translator in order to wait for a staff Member who speaks their language.
3. **Declined service**: When a Member indicates that they are not interested in services at this time, either verbally, in writing, or by not responding to outreach attempts.
4. **Initial Contact**: The date the provider directly communicates with the Member. For self-referred Members, this is the same as the referral date.
5. **Initiation of services**: The date the Member providers written consent to participate in services and meets with the assigned staff.
6. **Member**: Can include the appropriate parent/guardian/caregiver if the youth is under the age of 18.
7. **Member not yet reached**: A Member for whom a referral has been made, but the provider has not yet completed initial contact.
8. **Not MassHealth-eligible**: A youth who is not eligible for MassHealth Standard, CommonHealth, or Family Assistance.
9. **Opting out of waitlist calls**: When a Member indicates that they do not want to receive the monthly calls regarding their status on the waitlist and has received comprehensive information about relevant community resources that might be appropriate while the Member is waiting for services.
10. **Outreach Response**: The date the provider first reaches out to the Member in response to a referral for services. For self-referred families, this is the same as the referral date. Outreach takes place in the preferred mode of communication noted by the Member in the referral. Outreach does not inherently indicate contact with Member.
11. **Referrals**: Calls, faxes, or other communications to the provider on behalf of a Member, where the referral source (if not a self-referral) believes the Member is appropriate for and interested in the service.

12. **Referral date**: The date the referral was made to the provider, including voicemail messages.
13. **Referred on and no longer waiting**: A Member who is connected to another provider able to begin serving the Member immediately. *This is not applicable to ICC.
14. **Referred out and no longer waiting**: Members who are referred to a more clinically appropriate service.
15. **Waiting for first available provider (Waiting)**: When a Member is waiting for the first available appointment date to be offered to them by the first available provider within proximity of the Member's zip code. *This is not applicable to ICC.
16. **Zero total capacity**: A site with zero youth enrolled and zero openings.