Optum

Quick Reference Guide

Timely Access to Care Protocol

For providers of ICC, IHT, FIT, TM, FS&T and IHBS

Timely Access to Care protocol has several goals:

- Help ensure families receive a consistent response to referrals
- Support the integrity of the waitlist data collected by the managed care entities (MCEs)

The following providers should incorporate this protocol into their practices immediately:

- Intensive Care Coordination (ICC)
- In-Home Therapy (IHT)
- Family-Based Intensive Treatment (FIT)
- Therapeutic Mentoring (TM)
- Family Support and Training (FS&T)
- In-Home Behavioral Services (IHBS)

This guide outlines Timely Access to Care best practices – specifically referral and waitlist protocol.

Key Access to Care Definitions

- **Choosing to wait for a particular provider** – When a member declines service from the first available provider to receive care from a particular provider later. Not applicable to ICC.
- **Date of the first available face-to-face appointment** – Date of the first appointment offered regardless of acceptance or not. This includes situations when the member declines 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 when the member declines an appointment offered with a translator to wait for a staff member who speaks their language.
- **Declined service** – When a member indicates verbally, in writing or with a lack of response to repeated outreach that they are not interested in services at this time.
- **Initial contact** – Date the provider directly communicates with the member. For self-referred members, this is the same as the referral date.
- **Initiation of services** – Date the member provides written consent to participate in services and meets with the assigned staff.
- **Member** – Can include the appropriate parent/guardian/caregiver if the youth is under the age of 18.
- **Member not yet reached** – Member who's been referred, but the provider has not yet made initial contact.
- **Not MassHealth-eligible** – Youth who is not eligible for MassHealth Standard, CommonHealth or Family Assistance
- **Opting out of waitlist calls** – When a member says they do not want to receive monthly waitlist status calls and has received information about relevant and appropriate community resources while awaiting care.
- **Outreach response** – Date the referred provider first reaches out to the member. For self-referred families, this is the same as the referral date. Outreach type is the member's preferred communication as noted in the referral. Outreach does not inherently indicate contact with member.

- **Referrals** – Referral source (if not a self-referral) calls, faxes or otherwise communicates with the provider on behalf of a member. Referral source believes the service is appropriate for the member and that member is interested in it.
- **Referred families** – Families where the following 3 criteria are true:
  - Have not yet received an outreach response and/or initial contact, and
  - Are choosing to wait for a particular provider, and
  - Are waiting for the first available provider agency to service them
- **Referral date** – Date referral was made to the provider. Includes voicemail messages.
- **Referred on and no longer waiting** – Member who is connected to another provider who can provide services to the member immediately. Not applicable to ICC.
- **Referred out and no longer waiting** – Members who are referred to a more clinically appropriate service.
- **Waiting for first available provider (waiting)** – When a member is waiting for the first available appointment date from the first available provider close to their zip code. Not applicable to ICC.
- **Zero total capacity** – Site with zero youth enrolled and zero openings.

Escalations and referral outreach

Escalation process

1. Providers must create an internal process 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 should include a warm hand-off to Youth Mobile Crisis Intervention (YMCI) for members who require immediate crisis intervention.
2. **Referrals and waitlist prioritization should be assessed based on urgency and risk.**

Referral outreach and response

Referrals, outreach and follow-up communication must:

- Be offered in the member's preferred language. The provider is required to use an interpreter if they don't have internal resources.
- Be done by staff trained and qualified to assess level of care and who can effectively manage and/or triage crisis, safety and risk
- Be made using the member's preferred mode of communication, including HIPAA-compliant calling or texting
- Referral outreach response – The provider must engage in referral outreach activities for members awaiting initial contact pursuant to Section V and as follows:
  - ICC/IHT/FIT/IHBS providers must contact member within 24 hours of referral.
  - TM/FS&T providers must contact member within 5 calendar days of referral.

Providers may engage in activities concurrently to the extent they are clinically indicated and appropriate.

Initial contact and initiating service

Initial contact requirements

Initial contact must include screening to assess:

- Whether referral is appropriate
- If member is interested in the service
- Urgency and risk

Providers should offer a face-to-face appointment to initiate care, if available.

Initiating service

If the member and provider agree the service:

- **Is not clinically appropriate or needed**, the provider should help the family take the following actions:
  1. Provide contact information for:
     - Alternative providers in the region who are accepting new patients, including but not limited to, the local Community Behavioral Health Center (CBHC) and the Behavioral Health Help Line (BHHL)
     - Member's MCE for any additional assistance in accessing care
  2. Inform 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, and
  3. Note member in the referral and waitlist log as "referred *out* and no longer waiting"

- **Is clinically appropriate and needed**, the provider should take the following actions:
  1. Providers not at capacity that can offer an appointment should initiate services as soon as possible based on the member's clinical needs. Fourteen days is the Medicaid standard for timely provision of services established in statute 42 CFR 441.56(e). The 14-day standard starts when the provider makes initial contact with the member following treatment referral, and
  2. Providers at capacity that cannot offer an appointment should add the member to their waitlist.

Waitlists

Waitlist enrollment

If the service is clinically appropriate and needed, but the provider is at capacity and cannot offer an appointment within the Medicaid standard 14 days, the provider must:

1. Inform the member and referral source that they have a waitlist
2. Inform the member of the approximate wait time so the member can decide if they want to wait to initiate services, and
3. Using the Massachusetts Behavioral Health Access (MABHA) website, review availability of alternate providers within close proximity of the member. The provider should then 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***,* note member's referral status as "choosing to wait" on the referral and waitlist log and include the member's reason for that decision
   - **If the member would like to see the first available provider**, offer the member:
     - Contact information for alternative providers who show availability on MABHA and other sources including but not limited to, the local CBHC, local YMCI, the BHHL and based on their communication with other providers
     - Contact information for the member's MCE for any additional assistance accessing care
     - Provider should then note the member's referral status as "waiting for first available provider" on the referral and waitlist log
4. Ask the member if they'd like to opt out of follow-up calls if they prefer not to be contacted until an appointment is available.
5. Notify the member if there's zero capacity to take new appointments and help family find another provider with capacity. Members should not be placed on a waitlist.

Referral and waitlist log
The provider must maintain and update a referral and waitlist log for all referrals received and all members placed on the waitlist. The log must be provided to MCEs upon request, and at minimum, include the following information:

- Member name
- Parent/guardian/caregiver name
- Member contact information
- Referral date
- Referral source name
- Referral source contact information
- Reason for referral
- Dates of outreach attempts
- Date of initial contact
- Dates of monthly calls to waitlisted members
- Date that the waitlisted member opted out of monthly calls, if applicable
- Outcome of the monthly calls, including assessment of ongoing medical necessity and steps taken to link the member to other services, etc.
- Date of the first available face-to-face appointment to initiate services offered
- Referral status:
    - Referred *out* and no longer waiting
    - Referred *on* and no longer waiting
    - Declined service
    - Not MassHealth-eligible
    - Choosing to wait for provider
    - Waiting for first available provider
    - Level of post-referral activity (outreach response/initial contact/waitlist)
    - Services initiated (including dates services were initiated)

Waitlist management
Providers **are required** to follow up monthly with all members about:

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
Provider follow up should use the member's preferred communication method, including HIPAA-compliant calling or text. **Follow-up must be made by program staff sufficiently trained and qualified to assess the appropriate level of care. They must also have capacity to effectively manage and/or triage crisis, safety and risk**.

Follow-up for waitlisted members should follow a cadence appropriate for the service the member is waiting for, as detailed below:

- FIT: Follow-up after 7 days
- ICC: Follow-up after 30 days
- IHT, IHBS, TM, FS&T: Follow-up after 60 days

For these members, the provider should engage in and document the following activities:

1. **Enrollee not yet reached –** The provider must:
    - Engage in assertive outreach to the member via phone and/or other means of contact
    - Contact the member monthly at a minimum. Provider should leave a message, when possible, with best time and method for follow-up.
    - Send member a letter stating they will be removed from the waitlist if they don't respond by a certain date. Each provider has a policy about sending outreach letters after not being able to make initial contact. Outreach letters

should reference community resources such as the Behavioral Health Helpline.
- Note the member "declined services" in the referral and waitlist log if the member hasn't responded to outreach attempts by the specified date

2. **Waiting for first available provider –** Provider should contact member monthly to:
   - Re-assess medical necessity/appropriateness for the service
   - Confirm whether the member has received an appointment date with another provider
   - Offer member an updated list of names/numbers of alternate providers. Provider should specify which ones report availability per MABHA and other sources (e.g., communications between providers
   - Coordinate care for the waiting member with other available providers
   - While member awaits the referred service, connect the family with other relevant services and community resources, including but not limited to, the BHHL and local CBHC, and
   - Contacts the member's MCE for assistance when there are no providers with availability in the MABHA system within a reasonable distance from the Enrollee.
   - Offers the Enrollee the ability to opt out of follow-up calls if they prefer not to be contacted until an appointment is available.
3. **Choosing to wait for a particular provider** - The provider contacts the Enrollee monthly and:
   - Reassess medical necessity/appropriateness for the service
   - Determines whether the Enrollee has received an appointment date with another provider
   - Discloses the approximate wait time to the Enrollee to support an informed decision around continuing to choose to wait for the provider, and
   - Determine whether the Enrollee 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.
   - If the Enrollee now chooses to wait for the first available provider, the provider:
     - Changes their status in the referral and waitlist log accordingly, and
     - Follows the procedure noted above under Section V.2
   - If the Enrollee 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 Enrollee is declining to be served by the first available provider, and
     - Connects the Enrollee 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.
4. **Waiting for a specific request:** For Enrollees 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 Enrollees in their monthly MABHA waitlist entry. The provider contacts the Enrollee monthly and:
   - Re-assesses medical necessity/appropriateness for the service and
   - Reassess if Enrollee is still requesting a specific staff/team or specialty
   - If the Enrollee continues to choose to wait for a specific staff/team or specialty, the provider:
     - Outreaches to referral source to inform them of the wait time and the fact that the Enrollee is declining to be served by the first available staff, and
     - Maintains the Enrollee on their referral and waitlist log as outlined but

does not report these Enrollees in their monthly MABHA waitlist entry

- If the Enrollee no longer wants to wait for their specific request but 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 Enrollee is declining to be served by the first available provider
  - Resumes reporting the Enrollee in their monthly MABHA reporting, and
  - Follows the procedure Section V.3
- If the Enrollee now chooses to wait for the first available provider, the provider:
  - Changes their status in the referral and waitlist log accordingly
  - Resumes reporting the Enrollee in the monthly MABHA report, and
  - Follows the procedure in Section V.2.

Questions? We're here to help.

For additional questions, please contact the Massachusetts Provider Services Line at 1-866-860-7308, 8 a.m. – 8 p.m. ET.