Medical Necessity Criteria

Non-24-Hour Diversionary Services
Community Support Program for Homeless Individuals (CSP-HI)

Community Support Program for Homeless Individuals (CSP-HI) is a more-intensive form of CSP for chronically homeless individuals who have identified a Permanent Supporting Housing (PSH) opportunity. Once housing is imminent, with Members moving within 120 days, Members receiving CSP may receive CSP-HI services. CSP-HI includes assistance from specialized professionals who – based on their unique skills, education, or lived experience – have the ability to engage and support individuals experiencing chronic homelessness in searching for PSH, by preparing for and transitioning to an available housing unit, and, once housed, coordinating access to physical health, behavioral health, and other needed services geared towards helping them sustain tenancy and meet their health needs. The types of CSP-HI services available may be categorized as:

- **Pre-Tenancy:** engaging the Member and assisting in the search for an appropriate and affordable housing unit
- **Transition into Housing:** assistance arranging for and helping the Member move into housing
- **Tenancy Sustaining Supports:** assistance focused on helping the Member remain in housing and connect with other community benefits and resources

Services should be flexible, with the goal of helping eligible Members attain the skills and resources needed to maintain housing stability. CSP-HI services may be delivered within housing, at provider sites, or in the community.

CSP-HI cannot be used to cover the costs of any housing-related "goods," including, but not limited to: housing applications fees, criminal record checks, fees related to securing identification documents, transportation, security deposits, first month's rent, rent/utility arrearages, utility hookups, furnishings, moving expenses, or home modifications.

These services are designed to be maximally flexible in supporting individuals to implement their clinical treatment plans in outpatient and/or other levels of care and attain the skills and resources needed to maintain housing retention. Such services may include:

- Assisting Members with housing resources and dynamics of searching for housing including, but not limited to:
    - Obtaining and completing housing applications.
    - Requesting reasonable accommodations.
    - Dealing with poor housing history or lack of housing history, with poor or lack of credit history, or criminal record mitigation.
    - Gathering supporting documentation.
    - Negotiating and completing lease agreements.
    - Identifying resources for move-in costs (first and last month's rent, security deposits), furniture, and household goods.
    - Coordination with landlords to establish relationships with the Member regarding housing rules and requirements to maintain tenancy.
- Assisting Members in improving their daily living skills so they are able to perform them independently or access services to support them in doing so.
- Providing service coordination and linkage.
- Assist with referral and coordination to necessary healthcare providers.

- Providing assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.).
- Assisting with obtaining and maintaining financial benefits.
- Collaborating with Community Behavioral Health Centers (CBHCs), Emergency Department (ED) Evaluation Teams, and/or outpatient providers to develop, revise, and/or utilize Member crisis prevention plans and/or safety plans.
- Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services.

CSP services are expected to complement other clinical services that are being utilized by the individual and support the Member's attainment of their clinical treatment plan goals.

Definitions

Chronic Homelessness:
(*definition established by the U.S. Department of Housing and Urban Development (HUD)*)
A disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer or has had four or more episodes of homelessness (on the streets, or in an emergency shelter or safe haven) over a three-year period where the combined occasions must total at least 12 months. Occasions must be separated by a break of at least seven nights; stays in institution for fewer than 90 days do not constitute a break. To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of two or more of those conditions.

Homelessness: a condition of any Member who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or who is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals. This includes those Members who are exiting an institution (e.g., jail, hospital) where they resided for 90 days or less and were residing in an emergency shelter or place not meant for human habitation immediately before entering the institution.

Permanent Supportive Housing (PSH): a model of housing that combines ongoing subsidized housing matched with flexible health, behavioral health, social, and other support services. "Housing First" is a specific PSH approach that prioritizes supporting people experiencing homelessness to enter low-threshold housing as quickly as possible and then providing supportive services necessary to keep them housed.

Health Needs-Based Criteria (HNBC): an individual with a qualifying HNBC is defined as an individual who has one or more of the following:

- Is clinically assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).

- Is clinically assessed to have a complex physical health need, which is defined as persistent, disabling, or progressively life-threatening physical health condition(s), requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).
- Is clinically assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).
- Has repeated incidents of emergency department use (defined as two or more visits within six months, or four or more visits within a year).
- Is pregnant and who is experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period.
- Is pregnant or postpartum up to two months postpartum, without additional clinical factors.

Criteria

Admission Criteria

The following criteria are necessary for admission to this level of care; the Member must meet 1, 2, and 3 below:

1. Clinical
    a. The Member must meet criteria for the general Community Support Program. Presence of medical necessity can be verified by diagnosis or Member attestation.
    b. For dates of services on or after January 1, 2025, a Member enrolled in an Accountable Care Partnership Plan or Primary Care ACO (as administered through the MassHealth-contracted behavioral health vendor) meets the medical necessity criteria by demonstrating either:
        i. Meeting the clinical criteria for CSP, as verified by diagnosis or Member attestation; or
        ii. The Member has a Health Needs-Based Criterion as verified by diagnosis or Member attestation.
2. Housing status: The Member must meet one of the following criteria when the services begin:
    a. The Member is experiencing chronic homelessness; or
    b. Is experiencing homelessness and is a frequent user of acute health services, as defined by:
        i. Four or more ED visits within the past 12 months from the date of evaluation for CSP-HI services; or
        ii. Three or more acute and/or psychiatric hospital inpatient admissions within the past 12 months from the date of evaluation for CSP services.
3. Imminent Housing: The Member must meet one of the following criteria when services begin.
    a. The Member must have identified a Permanent Supportive Housing (PSH) opportunity and will be moving into housing within 120 days.
    b. The Member is receiving homeless medical respite services in accordance with 130 CMR 458.00.
    c. The Member is being discharged from homeless medical respite services in accordance with 130 CMR 458.410, has identified a PSH opportunity, and will be moving into housing within 120 days of discharge from homeless medical respite services.

Exclusion Criteria

Any *of the following criteria may be sufficient for exclusion from this level of care:*

1. The Member is receiving similar supportive services and does not require this level of care; or
2. The Member, and their parent/guardian/caregiver when applicable, does not consent to CSP-HI services.

Continued Stay Criteria

All *of the following criteria are necessary for continuing in treatment at this level of care:*

1. The Member has ongoing need for assistance with maintaining living skills to ensure long-term housing tenancy.
2. The Member's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available.
3. CSP-HI service planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. CSP-HI service planning includes family, support systems, social, educational, occupational, medical, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all planned services is documented. The CSP-HI service plan is updated and implemented with consideration of all applicable and appropriate services and treatment modalities.
4. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice.
5. Progress in relation to specific symptoms, impairments, or barriers is clearly evident and can be described in objective terms, but goals of CSP-HI services and clinical treatment services have not yet been achieved, or adjustments in the CSP-HI service plan to address lack of progress are documented.
6. The Member is actively participating in the CSP-HI service plan and related treatment services, to the extent possible consistent with the Member's condition.
7. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in CSP-HI services as required by the CSP-HI service plan, or there are active efforts being made and documented to involve them.
8. When medically necessary, the Member has been referred to appropriate outpatient or community-based services.
9. There is documented, active coordination of services with other behavioral health providers, community-based services, the PCP, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue.

Discharge Criteria

Any *of the following criteria is sufficient for discharge from this level of care:*

1. The Member no longer meets admission criteria, has been housed, and is able to maintain tenancy independently.
2. CSP-HI service plan goals and objectives have been substantially met, and/or a safe, continuing care program has been arranged, and the Member is utilizing other community resources.
3. The Member is not utilizing or engaged in CSP-HI services.
4. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member has the capacity to make an informed decision, and the Member does not meet the criteria for a more-intensive level of care.
5. Support systems have been identified and are being utilized that assist the Member to maintain housing.