# Medical Necessity Guidelines: Community Support Programs (CSP) for Chronically Homeless Individuals (CHI) and Social Innovation Financing (SIF)

*Effective: January 1, 2021*

| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request. | **Yes ☐ No ☒** |
|---|---|

**Applies to:**

**COMMERCIAL Products**

☐Tufts Health Plan Commercial products; Fax: 617.972.9409
☐Tufts Health Freedom Plan products; Fax: 617.972.9409

CareLink℠–Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**TUFTS HEALTH PUBLIC PLANS Products**

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

***The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

**SENIOR Products**

Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List

Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

**Note:** Tufts Health Plan requires notification for certain behavioral health services. In addition, Providers may be required to provide updated clinical information to qualify for continued service.

The provider must submit notification to the plan within one week of initiation of services. Submitted documentation must indicate that the member meets the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness, as noted below*. Once initial notification is submitted, documentation of homelessness must be submitted annually for the member to qualify for continued Chronically Homeless Individuals (CHI) and Social Innovation Financing (SIF) services.

**Note**: In the absence of specific LCD/NCD guidance for specific CSP for CHI and SIF services, the above guidelines will also apply to **Tufts Health Plan Senior Care Options and Unify.**

This guideline will specifically address CSP-CHI and SIF services for the following products:

- Tufts Health Together
- Tufts Health Unify
- Tufts Health Plan Senior Care Options (SCO)

Community Support Programs (CSP) provide an array of services delivered by community-based, mobile, paraprofessional staff, supported by a clinical supervisor, to Members with psychiatric or substance use disorder diagnoses and/or to Members for whom their psychiatric or substance use disorder diagnoses interfere with their ability to access essential medical services. These programs provide support services that are necessary to ensure Members access and utilize behavioral health services. CSPs do not provide clinical treatment services, but rather provide outreach and support services to enable Members to utilize clinical treatment services and other supports. The CSP service

plan assists the Member with attaining his/her goals in his/her clinical treatment plan in outpatient services and/or other levels of care and works to mitigate barriers to doing so.

In general, a Member who can benefit from CSP services has a mental health, substance use disorder, and/or co-occurring disorder that has required psychiatric hospitalization or the use of another 24-hour level of care, or has resulted in serious impairment with a risk of admission. CSP services are used to prevent hospitalization. Usually in combination with outpatient and other clinical services, they are designed to respond to the needs of individuals whose pattern of service utilization or clinical profile indicates high risk of readmission into any 24-hour behavioral health inpatient/diversionary treatment setting. 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 community tenure. Such services may include:

- 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;
- Providing temporary 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 benefits, housing, and health care;
- Collaborating with Emergency Services Programs/Mobile Crisis Intervention (ESPs/MCIs) and/or outpatient providers; including working with ESPs/MCIs to develop, revise, and/or utilize Member crisis prevention plans and/or safety plans as part of the Crisis Planning Tools for youth; and
- Fostering empowerment, recovery, and wellness, including linkages to recovery- oriented peer support and/or self-help supports and services.

These outreach and supportive services are directed primarily toward adults and vary according to duration, type, and intensity of services, depending on the changing needs of each individual. Children and adolescents are eligible for CSP services; however, their needs may be better served by services within the Children's Behavioral Health Initiative (CBHI) or Behavioral Health for Children and Adolescents (BHCA).

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

**CSP-CHI** is a more intensive form of CSP for chronically homeless individuals who have identified a Permanent Supportive Housing (PSH) housing opportunity. Once PSH is imminent with members moving within 120 days, members receiving CSP may receive CSP-CHI services. CSP-CHI 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, 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. Please note CSP-CHI may also be referred to as SIF.

**Social Innovation Finance Program (SIF)** is a program that has a focus on providing low-threshold, permanent supportive housing to eligible Members who would otherwise rely on costly emergency resources, enabling them to address their often complex health issues more effectively than they would on the streets or in shelters. They provide support services to Members who are experiencing chronic homelessness, as defined by the Department of Housing and Community Development (HUD). Members will also meet eligibility for the SIF program if they have been screened in as eligible by the Massachusetts Housing and Shelter Alliance, based on a screening tool used by SIF Program providers. These Members are homeless and generally high-cost users of emergency services. The programs are community-based service coordination and support programs that coordinate the behavioral and medical health needs and community tenure sustainment needs of the Members. These face-to-face, intensive, individualized support services include but are not limited to:

- Assisting Members in enhancing daily living skills
- Providing service coordination and linkages
- Assisting Members with obtaining benefits, housing and healthcare
- Developing a crisis plan
- Providing crisis intervention and intervention

- Fostering empowerment and recovery, including linkages to peer support and self-help groups

## CLINICAL COVERAGE CRITERIA

In order for the member to qualify for additional coverage of CHI and SIF services, the member must meet criteria for CSP. Tufts Health Plan may cover CSP services for CHI and SIF if **ALL** of the following criteria are met:

1. The Member demonstrates symptomatology consistent with a DSM-5 diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;

   **AND at least one (1) of the following:**

2. The Member is at risk for admission to 24-hour behavioral health inpatient/diversionary services, as evidenced by one or more of the following:
   a. Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days
   b. Multiple ESP and/or emergency department (ED) encounters within the past 90 days
   c. Documented barriers to accessing and/or consistently utilizing essential medical and behavioral health services

**OR**

3. The Member is referred by a primary care provider clinician (PCPC) for assistance with necessary medical follow-up.

**Additionally, for CSP-CHI and SIF**

4. The member meets the definition of chronic homelessness. Chronic Homelessness: a definition established by the U.S. Department of Housing and Urban Development (HUD) of 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 of 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.

Tufts Health Plan may continue coverage for CSP services when **ALL** of the following criteria are met:

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

1. Severity of illness and resulting impairment continue to warrant this level of care in order to maintain the Member in the community and continue progress toward CSP service plan goals and clinical treatment plan goals;
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. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5 diagnosis (inclusive of psychosocial and contextual factors and disability, as applicable), which is amenable to continued services at this level of care. Conditions that would not be appropriate for continued CSP services are:
   a. Permanent cognitive dysfunction without acute DSM-5 diagnosis
   b. Primary substance use disorder requiring treatment in a specialized level of care
   c. Medical illness requiring treatment in a medical setting
   d. Impairment with no reasonable expectation of progress toward CSP service plan goals at this level of care
   e. Chronic condition with no indication of need for ongoing services at this level of care to maintain stability and functioning;
4. CSP services are rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the CSP service and discharge plans;
5. CSP service planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. CSP 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 service plan is updated and implemented with consideration of all applicable and appropriate services and treatment modalities;

6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of CSP services and clinical treatment services have not yet been achieved, or adjustments in the CSP service plan to address lack of progress are documented;
8. The Member is actively participating in the CSP service plan and related treatment services, to the extent possible consistent with the Member's condition;
9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in CSP services as required by the CSP service plan, or there are active efforts being made and documented to involve them;
10. When medically necessary, the Member has been referred to appropriate psychopharmacological services;
11. There is documented, active discharge planning starting with admission to the CSP program; and
12. There is documented, active coordination of services with other behavioral health providers, the PCP, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue.

**Additionally, for CSP-CHI and SIF**

13. the member is engaged in one of the following CSP-CHI and or SIF services:
    a. Pre-Tenancy: engaging the member and assisting in the search for an appropriate and affordable housing unit;
    b. Transition into Housing: assistance arranging for and helping the member move into housing; and
    c. Tenancy Sustaining Supports: assistance focused on helping the member remain in housing and connect with other community benefits and resources.

A member may be discharged from CSP services for **ANY** one of the following:

1. The Member no longer meets admission criteria or meets criteria for a less or more intensive level of care;
2. CSP service plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care;
3. The Member or Member and parent and/or legal guardian is/are not utilizing or engaged in the CSP service. 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, parent, and/or guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care;
4. Consent for the CSP service is withdrawn. In addition, it has been determined that the Member, parent, and/or guardian 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 that allow the Member to be maintained in a less-restrictive treatment environment have been secured;
6. Member is not making progress toward CSP service plan goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or
7. Member is no longer at risk for admission to a 24-hour behavioral health inpatient/diversionary level of care as defined in Admission Criterion 2.

**Additionally, for CSP-CHI and SIF**

8. The member is no longer involved in Pre-Tenancy, Transition info Housing or Tenancy Sustaining Supports as outlined above in criterion 13 of the Continued Stay Criteria.

**Please note that psychosocial, occupational, and cultural and linguistic factors may change the risk assessment and should be considered when making level of care decisions.*

## LIMITATIONS

Tufts Health Plan will not cover CSP for CHI/SIF services when Any one of the following criteria are met:

1. The Member is at acute risk to harm self or others, or sufficient impairment exists to require a more-intensive level of service beyond community-based intervention
2. The Member has severe medical conditions or impairments that would prevent beneficial utilization of services
3. The Member is receiving similar supportive services and does not require this level of care
4. The Members and his/her parent/guardian/caregiver when applicable, does not consent to Community Support Program services.

## CODES

The following CPT/HCPCS code(s) are associated with this service:

**Table 1: CPT Codes/HCPCS:**

| CPT Code | Description |
|---|---|
| H2016-HK | Comprehensive community support services for chronically homeless individuals, per diem (for CSP-CHI) |
| H2016-HE | Comprehensive community support services, per diem (for SIF) |

The following ICD-10 diagnosis codes are associated with CSP-CHI and SIF:

**Table 2: ICD-10 Codes:**

| ICD-10 Code | Description |
|---|---|
| Z59.0 | Homelessness |

## REFERENCES


1. Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth MassHealth Managed Care Entity Bulletin 44, October 2020, accessed at https://www.mass.gov/doc/managed-care-entity-bulletin-44-community-support-program-for-chronically-homeless-0/download on December 8, 2020.


## APPROVAL HISTORY

- January 20, 2021: Reviewed and approved by the Integrated Medical Policy Advisory Committee with an effective date of January 1, 2021.

## BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services