

## Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services

In accordance with STC 15.7, this protocol describes beneficiary eligibility and needs-based criteria for individuals eligible to receive HRSN services through the Flexible Services Program (FSP), Specialized Community Support Programs (CSPs), Short-term Pre-procedure and Post-hospitalization Housing (STPHH), and the Emergency Assistance (EA) Family Shelter Program, and provider qualifications for each service. This protocol also describes infrastructure investments in the form of an HRSN Integration Fund for Social Service Organizations seeking to develop and implement HRSN services.

### A. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

1. State Flexibility in Coverage of HRSN Services and Beneficiary Qualifying Criteria
  - a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment P.  
Certain changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment P, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    - i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    - ii. The state must provide public notice.
    - iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
  - b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment P, the state must follow the process below to update the protocol:
    - i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 30 of the STC.
    - ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
    - iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart

(b). This restriction is not applicable to the process and scope of changes outlined in subpart (a).

## B. Flexible Services Program (FSP) (Effective beginning April 1, 2023)

### 1. Assessment of Needs

An ACO will perform an assessment that (1) determines a member's eligibility for Flexible Services; and (2) identifies which Flexible Service(s) the member may receive.

### 2. Flexible Service Planning

A member and the member's ACO will create a plan for a member to obtain Flexible Services specific to the member's needs. This Flexible Service Plan (FS Plan) will be in writing and agreed to by the member and approved by the ACO.

- a. ACOs shall complete the FS Plan with the member, or a representative for the member in the cases where a member is unable to participate in the completion of the plan.
- b. The FS Plan will include the recommended Flexible Service(s), the units of service(s), the goals of the service(s), steps to obtaining the services, the follow-up plan, and the individual that will be responsible for managing the member's FS Plan. The ACO may conduct periodic reassessments, such as during the follow-up plan, to determine if the FS Plan warrants updates, including inclusion of additional services or extension of services already received. Room services (i.e., rent, utilities) may not be extended beyond the limits specified in the service definitions within this document and the STCs. Other services may be renewed as clinically necessary.
- c. A parent, guardian, or caregiver of a child assessed to need Flexible Services that resides with the child may receive such services on the child's behalf when in the best interest of the child as determined through the FS Plan.

### 3. Flexible Services Availability in 2023 and 2024

The State may implement new Flexible Services and member eligibility groups, in accordance with an implementation plan set forth by the State and approved by CMS.

- a. Due to the capped nature of the demonstration authority, neither the State nor the ACOs will be expected to make Flexible Services available to each eligible member. At the State's discretion<sup>1</sup>, ACOs may (1) elect to provide Flexible Services only to members with certain health needs-based criteria or with certain risk factors from among those listed in Table 1; (2) restrict the number of members within those categories who will receive services; and (3) elect which Flexible Services they intend to offer. The State will require ACOs to estimate the number of members they

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<sup>1</sup> MassHealth complies and requires its contractors to comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping). (<https://www.mass.gov/service-details/nondiscrimination-statement>)

expect to provide Flexible Services to each year and report to the State on the actual number of members served.

- b. The State may establish requirements that the ACO must meet before ACO Flexible Service programs and funds will be approved.

4. **Additional Requirements for Providing Flexible Services:**

To provide Flexible Services pursuant to a member's FS Plan, the ACO must confirm that the member is enrolled in MassHealth (1) on the date the Flexible Services Assessment is conducted; (2) on the first date of a Flexible Services episode of care, which is a set of related Flexible Services (e.g. tenancy sustaining supports, home modifications, nutrition sustaining supports); and (3) every subsequent 90 calendar days from the initial date of service of an episode of care until the conclusion of that episode.

5. **Flexible Services Availability in 2025-2027**

At the State's discretion, ACOs may elect which Flexible Services they intend to offer. The state will follow the process set forth in STC 15.8.c.vi. related to such elections. Transparency is required by the Commonwealth for beneficiaries and providers clarifying what services are provided by each ACO (see Appendix for weblink to the services that each ACO has elected to offer).

6. **Eligibility Criteria**

ACO-enrolled members ages 0-64 who also meet at least one of the health needs-based criteria and at least one of the risk factors associated with the need for Flexible Services as determined by the Flexible Service assessment, may be eligible for Flexible Services.

<b>Table 1: FSP Eligibility Criteria</b>	
<b>Needs-Based Criteria</b>	
1)	The individual 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).
2)	The individual 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).
3)	The individual 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).
4)	The individual has repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year).
5)	Pregnant individuals who are experiencing high risk pregnancy or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period;

<b>Table 1: FSP Eligibility Criteria</b>	
6) Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors. <sup>2</sup>	
<b>Risk Factors</b>	
<p>1) <b>Risk Factor 1:</b> The member is homeless as demonstrated by one of the elements below:</p> <ul style="list-style-type: none"> <li>a) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: <ul style="list-style-type: none"> <li>i) An individual or family with 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 ground;</li> <li>ii) An individual or family living in a supervised publicly or privately operated 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); or</li> <li>iii) An individual who is exiting an institution where they resided for 90 days or less and who experienced Risk Factor (1)(a)(i) or Risk Factor (1)(a)(ii) immediately prior to entering the institution;</li> </ul> </li> <li>b) An individual or family who will imminently lose their primary nighttime residence, provided that: <ul style="list-style-type: none"> <li>i) The primary nighttime residence will be lost within 14 days of the date of Flexible Services assessment;</li> <li>ii) No subsequent residence has been identified; and</li> <li>iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing; or</li> </ul> </li> <li>c) Any individual or family who: <ul style="list-style-type: none"> <li>i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, unsafe, or life-threatening conditions that relate to violence, including physical or emotional, against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to or stay in their primary nighttime residence;</li> <li>ii) Has no other residence; and</li> <li>iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks to obtain other permanent housing.</li> </ul> </li> </ul>	

<sup>2</sup> MassHealth currently intends to implement Needs-Based Criteria #6 up to two months postpartum beginning in 2025. If MassHealth exercises its authority to implement Needs-Based Criteria #6 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

**Table 1: FSP Eligibility Criteria**

- 2) **Risk Factor 2<sup>3</sup>:** The member is at risk of homelessness as demonstrated by one of the elements below:
- a) The member is at risk of homelessness as defined by the following:
    - i) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation or a safe haven; **and**
    - ii) Meets one of the following conditions:
      - (1) Has moved because of economic reasons two or more times during the 60 days immediately preceding the Flexible Service assessment;
      - (2) Is living in the home of another because of economic hardship;
      - (3) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days.
      - (4) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
      - (5) Lives in a single-room occupancy or efficiency apartment unit in which more than two persons reside, or lives in a larger housing unit in which more than 1.5 people per room reside;
      - (6) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution);
- 3) **Risk Factor 3<sup>4</sup>:** The Member is housing unstable as demonstrated by one of the elements below:
- a) Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs to transition to another housing option.
  - b) Has utility payments in arrears or lacks income for utility payments, such that the lack of utilities may negatively impact their health.
  - c) Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost-effectively, or the housing cannot be modified cost-effectively and the member needs to transition to another housing option.
  - d) Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction; or

<sup>3</sup> MassHealth does not currently intend to implement Risk Factor 2 as a Flexible Services eligibility criterion beginning in 2025. If MassHealth exercises its authority to implement Risk Factor 2 in the future, it will notify CMS per the process laid out in Section A.1.a.

<sup>4</sup> MassHealth does not currently intend to implement Risk Factor 3.b, 3.c. or 3.e as Flexible Services eligibility criteria beginning in 2025. If MassHealth exercises its authority to implement these subparts of Risk Factor 3 in the future, it will notify CMS per the process laid out in Section A.1.a.

**Table 1: FSP Eligibility Criteria**

e) Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and cannot be cost-effectively remediated and the member needs to transition to another housing option.
4) <b>Risk Factor 4:</b> The member meets either the USDA definition of low or very low food security. <sup>5</sup>

## 7. Service Descriptions

Flexible Services consist of two services, Tenancy Preservation Supports (TPS) and Nutrition Sustaining Supports (NSS), which may include case management and transportation supports as noted below. These services are covered for eligible members when determined necessary through the Flexible Service assessment and subsequent FS Plan development.

In the context of Flexible Services, “assisting” is defined as: (1) helping a member to locate services; and/or (2) providing support, education, and/or coaching directly to the member in regard to a particular service(s).

**Table 2: Service Descriptions**

Benefit Categories	Description of Services
<b>Tenancy Preservation Supports</b>	
Pre-tenancy supports	<p>Pre-tenancy supports include one or more of the following:</p> <ol style="list-style-type: none"> <li>1. Assessing and documenting the member’s preferences related to the tenancy the member seeks and the accommodations needed by the member.</li> <li>2. Assisting the member with budgeting for tenancy/living expenses and assisting the member with obtaining discretionary or entitlement benefits and credit.</li> <li>3. Assisting the member with obtaining, completing, and filing applications for community-based tenancy.</li> <li>4. Assisting the member with understanding their rights and obligations as a tenant.</li> <li>5. Assisting the member with locating and obtaining services needed to establish a safe and healthy living environment.</li> <li>6. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed.</li> <li>7. Assisting the member with locating, obtaining, and/or providing the member with transitional goods including</li> </ol>

<sup>5</sup> <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/>

<b>Table 2: Service Descriptions</b>	
<b>Benefit Categories</b>	<b>Description of Services</b>
	<p>one or more of the following: move-in expenses (security deposit; utility set-up fees/deposits and up to six months of unresolved utility arrearages [the combination of arrears payments and prospective payments for utilities cannot exceed 6 months per demonstration] if necessary to set up services in new residence; and first month's coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet, and phone (inclusive of land line phone service and cell phone service) ), deposits or one-time start-up payments of miscellaneous fees outlined in the lease, housing deposits, moving costs, relocation expenses, costs for filing applications, costs related to obtaining and correcting needed documentation to access housing, one time household set up expenses needed to establish community-based tenancy (pantry stocking<sup>6</sup>, initial supply of toiletries, initial supply of cleaning supplies, and household goods and furniture), and services necessary for member's health and safety in housing (eradication/remediation of mold/pests, or other medically necessary home modifications that are necessary for the individual's health and safety, cleaning prior to occupancy).<sup>7</sup></p>
Tenancy sustaining supports	<p>Tenancy sustaining supports include one or more of the following:</p> <ol style="list-style-type: none"> <li>1. Assisting the member with communicating with the landlord and/or property manager regarding the member's disability, and detailing the accommodations needed by the member.</li> <li>2. Assisting with the review, update, and modification of the member's tenancy support needs on a regular basis (e.g., assessing the member's needs on a quarterly basis or more frequently, as needed) to reflect current needs and address existing or recurring barriers to retaining community tenancy.</li> <li>3. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit.</li> </ol>

<sup>6</sup> State and its vendors will align with Supplemental Nutrition Assistance Program (SNAP) coverable goods for pantry stocking as of July 1, 2024.

<sup>7</sup> Until July 1, 2024, broker or rental agent fees to help locate housing will be an allowable pre-tenancy support.



<b>Table 2: Service Descriptions</b>	
<b>Benefit Categories</b>	<b>Description of Services</b>
	<ol style="list-style-type: none"> <li>4. Assisting the member with obtaining appropriate sources of tenancy training.</li> <li>5. Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing the member to appropriate sources of legal services.</li> <li>6. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed.</li> <li>7. Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources.</li> </ol>
Home Modifications	Home Modifications consist of limited physical adaptations to the member's community-based dwelling that are for the primary benefit of the beneficiary and are not normally considered the responsibility of the landlord when clinically necessary to ensure the member's health, welfare, and safety, or to enable the member to function independently in a community-based setting (e.g., installation of grab bars and hand showers, doorway modifications, in-home environmental risk assessments, refrigerators for medicine such as insulin, HEPA filters, vacuum cleaners, pest management supplies and services, air conditioner units, heat pumps, hypoallergenic mattress and pillow covers, traction or non-skid strips, night lights, and training to use such supplies and modifications correctly). <sup>8</sup>
<b>Nutrition Sustaining Supports</b>	
Nutrition sustaining supports (NSS) <sup>9</sup>	<p>NSS include one or more of the following:</p> <ol style="list-style-type: none"> <li>1. The provision of healthy, well-balanced, home-delivered meals for the member up to 3 meals a day for up to 6 months at a time. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months</li> </ol>

<sup>8</sup> Home Modifications are only allowed under Flexible Services when they fall outside of the state plan coverage of medical equipment or appliances under Home Health Services. Flexible Service Home Modifications will not duplicate or supplant other MassHealth benefits.

<sup>9</sup> MassHealth does not currently intend to implement NSS #2, #4, or #7 as Flexible Services supports beginning in 2025. If MassHealth exercises its authority to implement these NSS components in the future, it will notify CMS per the process laid out in Section A.1.a.



Table 2: Service Descriptions	
Benefit Categories	Description of Services
	<p>postpartum<sup>10</sup>, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.<sup>11</sup></p> <ol style="list-style-type: none"> <li>2. Assisting the member with obtaining discretionary or entitlement benefits and credit.</li> <li>3. Providing, or assisting with locating nutrition education and skills development.</li> <li>4. Assisting or providing the member with transportation to any of the nutrition sustaining support services or supporting the member's ability to meet nutritional and dietary needs.</li> <li>5. Assisting the member with locating, obtaining, and/or providing the member with purchase of cooking supplies needed to meet nutritional and dietary need.</li> <li>6. Assisting or providing the member with access to foods that meet nutritional and dietary need that cannot otherwise be obtained through existing discretionary or entitlement programs for up to 6 months at a time. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum<sup>12</sup>, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For</li> </ol>

<sup>10</sup> For members that are pregnant/postpartum, MassHealth currently intends to offer NSS #1 up to two months postpartum, or for up to 6 months with an option for renewal for up to 6 months, beginning in 2025. If MassHealth exercises its authority to implement NSS #1 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

<sup>11</sup> The definition of a household for the purpose of this intervention must align with the Commonwealth's SNAP definition of a household.

<sup>12</sup> For members that are pregnant/postpartum, MassHealth currently intends to offer NSS #6 up to two months postpartum, or for up to 6 months with an option for renewal for up to 6 months, beginning in 2025. If MassHealth exercises its authority to implement NSS #6 up to the full 12 months postpartum in the future, it will notify CMS per the process laid out in Section A.1.a.

Table 2: Service Descriptions	
Benefit Categories	Description of Services
	<p>the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.<sup>13</sup>.</p> <p>7. Assisting the member in maintaining access to nutrition benefits including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during appeals of benefit actions and directing a member to appropriate sources of legal services. No legal services will be provided.</p>

#### 8. Additional Criteria for HRSN Housing Services

In addition to the eligibility criteria detailed in Section B.6, MassHealth may define additional criteria for the HRSN Housing services. Such criteria may specify:

- a. Diagnoses (e.g., home remediations meant to improve air quality such as HEPA filters for members with uncontrolled asthma),
- b. Members over a certain age (e.g., providing a subset of services to members aged 55+), and
- c. Degree of risk of homelessness (e.g., tenancy sustaining supports for members facing eviction or who have a lease violation).
- d. Certain services may only be available to members who are also receiving other specific services.

MassHealth also may expand the clinical criteria for two of the Specialized CSP Services (CSP-HI and CSP-TPP) to include ACO-enrolled members with any health needs-based criteria (HNBC) as described in Table 1 of Section B.6.

#### 9. Additional Criteria for HRSN Nutrition Services

In addition to the eligibility criteria detailed in Section B.6, MassHealth may define additional criteria for the HRSN Housing services. Such criteria may specify:

- a. Diagnoses (e.g., medically tailored food for members with diabetes),
- b. Degree of ability to prepare meals (e.g., home delivered meals if the member is unable to prepare their own meal), and

<sup>13</sup> The definition of a household for the purpose of this intervention must align with the Commonwealth's SNAP definition of a household.

- c. Degree of food insecurity (e.g., members with the highest level of food/nutrition needs based on a food security screening).
- d. Certain services may only be available to members who are also receiving other specific services (e.g., a member can only receive NSS #3 if they are also receiving NSS #1 or #6; see Table 2 for a description of these services)

#### 10. Flexible Service Provider Minimum Qualifications

Providers of Flexible Services must possess the following qualifications, as applicable.

<b>Table 3: Flexible Services Provider Minimum Qualifications</b>	
<b>Service Type</b>	<b>Qualifications</b>
Tenancy Preservation Supports	<p>Tenancy Preservation Supports providers must meet both of the following criteria:</p> <ol style="list-style-type: none"> <li>1. Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or lived experience; or training in the field of service.</li> <li>2. Knowledge of principles, methods, and procedures of services included under Tenancy Preservation Supports (as applicable to the position), or comparable services meant to support a member's ability to obtain and sustain residency in an independent community setting.</li> </ol>
Nutrition Sustaining Supports	<p>Nutrition Sustaining Supports providers must meet both of the following criteria:</p> <ol style="list-style-type: none"> <li>1. Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or lived experience; or training in the field of service.</li> <li>2. Knowledge of principles, methods, and procedures of services included under Nutritional Sustaining Supports (as applicable to the position), or comparable services meant to support a member's ability to obtain or maintain food security.</li> </ol>

#### C. Social Service Organization (SSO) Funding

##### 1. HRSN Integration Fund

In accordance with STC 15.17, entities may apply for and utilize funding from the HRSN Integration Fund to support infrastructure needs associated with the implementation of FSP and Specialized CSP.

- a. The State will establish an application process for eligible entities to submit proposals for HRSN Integration funding. For an application to be considered, it must be:

- i. from an entity that is providing or is eligible to provide Flexible Services or Specialized CSP, or an organization that provides centralized administrative functions to providers of Flexible Services and Specialized CSP (e.g., a hub); and
    - ii. for funding based on one of the categories outlined in Section C.1.c.
  - b. The State will review the applications and distribute the funding to the awardees based on factors such as the number of applicants, the level of need, and the quality of the application.
  - c. Awardees may spend their funding to support the following areas, as approved by the State:
    - i. Technology (e.g., electronic referral systems, shared data platforms, EHR adaptations or data bridges, screening and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems, technical systems to support the establishment and operation of hubs);
    - ii. Developing and implementing business and operational practices to support delivery of Flexible Services or Specialized CSP (e.g., developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation, establishing organizational workflows, meeting provider qualifications, establishing and implementing hubs and associated workflows);
    - iii. Workforce development (e.g., cultural competency training, trauma-informed training, Community Health Worker certification, training staff on new policies and procedures); and
    - iv. Outreach and education (e.g., design and production of outreach and education materials, translation, obtaining community input).
  - d. The State may also utilize HRSN Integration Funds to provide technical assistance to entities that provide or are eligible to provide Flexible Services and Specialized CSP, and hub organizations in the form of one-on-one support, trainings, or learning communities, including providers, entities, and hub organizations who were not awarded HRSN Integration Fund funding.
2. [ACO Administrative Payments to FSP Providers](#)
- a. As part of their payments for Flexible Services, ACOs may include administrative payments to FSP providers to support the necessary capacity and infrastructure to implement the FSP and to support ongoing administration/overhead of the provision of Flexible Services. This includes but is not limited to personnel for FSP, Health Information Technology, software, assessments and reporting costs surrounding FSP.
  - b. The Commonwealth will report on its HRSN infrastructure investments, including its oversight of SSOs (including SSOs providing both FSP and Specialized CSP) receiving infrastructure investments, in its demonstration quarterly and annual reports.

### 3. Additional Payment Details

- a. For providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN providers may submit claims or invoices with additional required documentation to the member's ACO or any entity administering HRSN services.
- b. ACOs and entities administering HRSN services will pay HRSN providers according to Section 11 of the Commonwealth's HRSN Implementation Plan.
- c. ACOs and entities administering HRSN services may also pay HRSN services providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

## D. Specialized Community Support Programs (Specialized CSP) (Effective beginning April 1, 2023)

### 1. Assessment of Needs

A Specialized CSP provider performs a needs assessment that (1) determines a member's eligibility for services; and (2) identifies ways to support the member in mitigating barriers to accessing and utilizing clinical treatment services and attaining the skills and resources to maintain community tenure. This needs assessment informs the development of a Specialized CSP Service Plan. For CSP for Individuals with Justice Involvement (CSP-JI) services, the needs assessment must also include determination of criminogenic needs.

### 2. Specialized CSP Service Planning

The Specialized CSP Service Plan must be person-centered and must identify the member's needs and individualized strategies and interventions (e.g., clinical interventions, services, and benefits) for meeting those needs. As appropriate, the Service Plan must be developed in consultation with the member and member's chosen support network including family, and other natural or community supports and, as appropriate and available, must incorporate records from referring and existing providers and agencies. The Service Plan must be in writing and must identify the staff responsible for implementing the Service Plan.

### 3. Specialized CSP Eligibility Criteria

Fee for service (FFS) and managed care enrolled MassHealth members who meet the health needs-based criteria and the risk factors as set forth below, may be eligible for Specialized CSP services. The State may limit availability of Specialized CSP services to eligible members based on the availability of full federal financial participation, and requirements for federal funding, pursuant to EOHHS' Section 1115 Demonstration waiver and any other applicable federal statute, regulation, or payment limit.

**Table 4: Specialized Community Support Program (CSP) Eligibility Criteria**

**Needs-Based Criteria**

Table 4: Specialized Community Support Program (CSP) Eligibility Criteria
<p>Members must meet both of the following needs-based criteria:</p> <ol style="list-style-type: none"> <li>1) The member has a behavioral health diagnosis, which requires and can reasonably be expected to respond to the intervention.</li> <li>2) The member does not require a more intensive level of service, including requiring structure or supervision beyond the scope of the Specialized CSP service, or have medical conditions or impairments that would prevent utilization of Specialized CSP services, including posing an imminent risk to self or others</li> </ol>
Risk Factors
<p>Members must meet the first risk factor listed below to indicate need for behavioral health diversionary services and the risk factor(s) for at least one of the Specialized CSP services:</p> <ol style="list-style-type: none"> <li>1) The member is at risk for admission to 24-hour behavioral health inpatient or diversionary services, as determined by the following:             <ol style="list-style-type: none"> <li>a) Within the past year for CSP-JI services, or the past 180 days for other Specialized CSP services, discharge from a 24-hour behavioral health inpatient or diversionary level of care, including discharge from a correctional institution infirmary or crisis stabilization unit for detoxification or close mental health observation within a correctional institution, or discharge from a residential treatment unit in a correctional institution;</li> <li>b) Within the past year for CSP-JI services, or the past 90 days for other Specialized CSP services, more than one acute behavioral health services encounter, including Adult or Youth Mobile Crisis Intervention Services (AMCI/YMCI), Adult or Youth Community Crisis Stabilization Services (Adult CCS/YCCS), Emergency Department (ED) services, behavioral health urgent care provider services, or encounters with restoration centers; or</li> <li>c) Documented barriers to accessing or consistently utilizing medical and behavioral health services.</li> </ol> </li> </ol> <p>Risk factor(s) for Specialized CSP Services:</p> <ol style="list-style-type: none"> <li>2) CSP for Homeless Individuals (CSP-HI)             <ol style="list-style-type: none"> <li>a) The member is chronically homeless, as defined by the U.S. Department of Housing and Urban Development (HUD); or</li> <li>b) The member is a frequent user of acute MassHealth services, as defined by the State, and is homeless, as defined by HUD in section (1)(i)-(iii) of the definition of “homeless” in 24 CFR 91.5.</li> </ol> </li> <li>3) CSP for Individuals with Justice Involvement (CSP-JI)             <ol style="list-style-type: none"> <li>a) The member is a member with justice involvement, defined as a member who has been released from a correctional institution within the past year; or an individual under the supervision of the Massachusetts Probation Service, Massachusetts Parole Board or both; and</li> <li>b) The member has barriers to accessing or consistently utilizing essential medical and behavioral health services, as evidenced by one or more of the following:                 <ol style="list-style-type: none"> <li>i) The member demonstrates antisocial behaviors, including criminal activity that has led, or could lead, to criminal justice involvement; lack of concern</li> </ol> </li> </ol> </li> </ol>

**Table 4: Specialized Community Support Program (CSP) Eligibility Criteria**

<p>for others; antisocial cognition; diagnosis with antisocial personality disorder; and/or disregard for authority, as expressed through distrust, conflict, or opposition.</p> <p>ii) The member's behavioral health and/or substance use disorders produce cyclical relapse and justice involvement, without the opportunity for treatment;</p> <p>iii) The member engages repetitively in behaviors that pose a risk of relapse to substance use and/or mental disorder;</p> <p>iv) The member has insufficient community and social supports to reinforce recovery; or</p> <p>v) The member is identified as high risk, or above, of recidivism on validated risk assessments due, at least in part, to a substance use disorder, mental health disorder or co-occurring disorder.</p> <p>4) CSP Tenancy Preservation program (CSP-TPP)</p> <p>a) The member is at risk of homelessness and is facing eviction.</p> <p>i) A member at risk of homelessness does not having sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.</p>	
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#### 4. Specialized CSP Service Descriptions

Specialized CSP services consist of three services: (1) CSP for Homeless Individuals (CSP-HI); (2) CSP for Individuals with Justice Involvement (CSP-JI); and (3) CSP Tenancy Preservation program (CSP-TPP).

All Specialized CSP services may include core CSP service components and additional service components that are specialized to each type of Specialized CSP. Members receiving Specialized CSP services may receive both the core services and the additional components, as appropriate to meet a member's individualized needs.

Specialized CSP services do not include room and board, or any housing-related goods or expenses (e.g., security or housing deposits, moving costs, utility deposits, household goods) or fees (e.g., application fees, legal fees).

**Table 5: Specialized CSP Service Descriptions**

Category	Description of Services
<b>Core Services</b>	<p>a) 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;</p> <p>b) Spending time with members and providers in the context of providing CSP services;</p> <p>c) Providing members and their families with education, educational materials, and training about behavioral health and</p>



**Table 5: Specialized CSP Service Descriptions**

	<p>substance use disorders and recovery. The provider facilitates access to education and training on the effects of psychotropic medications, and ensures that the member is linked to ongoing medication monitoring services and regular health maintenance;</p> <p>d) Coordinating services and assisting members with obtaining benefits, housing, and healthcare;</p> <p>e) Communicating with members or other parties that may include appointment reminders or coordination of care;</p> <p>f) Collaborating with crisis intervention providers, state agencies, and outpatient providers, including working with these providers to develop, revise, and utilize member crisis prevention plans and safety plans;</p> <p>g) Encouraging and facilitating the utilization of natural support systems, and recovery-oriented, peer support, and self-help supports and services;</p> <p>h) Referring members to community resources and other providers for services; and</p> <p>i) Discharge planning, from the CSP service, to expedite a member-centered disposition to other levels of care, services, and supports, as appropriate.</p>
<b>CSP-HI</b>	<p>a) pre-tenancy supports, including engaging the member and assisting in the search for an appropriate and affordable housing unit, including one or more of the following: such as</p> <ol style="list-style-type: none"> <li>1. Assessing and documenting the member's preferences related to the tenancy the member seeks and the accommodations needed by the member.</li> <li>2. Assisting the member with budgeting for tenancy/living expenses and assisting the member with obtaining discretionary or entitlement benefits and credit.</li> <li>3. Assisting the member with obtaining, completing, and filing applications for community-based tenancy.</li> <li>4. Assisting the member with understanding their rights and obligations as a tenant.</li> <li>5. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed.</li> </ol> <p>b) support in transition into housing, including assistance arranging for and helping the member move into housing, including one or more of the following: such as:</p> <ol style="list-style-type: none"> <li>1. Assisting the member with locating and obtaining services needed to establish a safe and healthy living environment.</li> <li>2. Assisting the member with locating and obtaining one-time household set-up costs and move-in expenses; and</li> </ol> <p>c) tenancy sustaining supports, including assistance focused on helping the member remain in housing and connect with other</p>

**Table 5: Specialized CSP Service Descriptions**

	<p>community benefits and resources, including one or more of the following: such as:</p> <ol style="list-style-type: none"> <li>1. Assisting the member with communicating with the landlord and/or property manager regarding the member's disability, and detailing the accommodations needed by the member.</li> <li>2. Assisting with the review, update, and modification of the member's tenancy support needs to reflect current needs and address existing or recurring barriers to retaining community tenancy.</li> <li>3. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit.</li> <li>4. Assisting the member with obtaining appropriate sources of tenancy training.</li> <li>5. Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing the member to appropriate sources of legal services.</li> <li>6. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed.</li> <li>7. Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources.</li> </ol>
<b>CSP-JI</b>	<ol style="list-style-type: none"> <li>a) if the referral source is a correctional institution, coordinating with the provider conducting in-reach services;</li> <li>b) ensuring that the CSP-JI service plan does not conflict with the member's probation and parole supervision plan, as applicable;</li> <li>c) addressing the member's criminogenic needs in the service plan goals, including interventions and strategies for developing alternative behaviors; and</li> <li>d) Assisting or providing the member with transportation to any of the approved CSP-JI services when needed.</li> </ol>
<b>CSP-TPP</b>	<ol style="list-style-type: none"> <li>a) assessing the underlying causes of the member's eviction, and identifying services to address both the lease violation and the underlying causes;</li> <li>b) developing a service plan to maintain the tenancy;</li> <li>c) Providing clinical consultation services as well as short term, intensive case management and stabilization services to members; and</li> </ol>

**Table 5: Specialized CSP Service Descriptions**

	d) Making regular reports to all parties involved in the eviction until the member's housing situation is stabilized. e) Assistance locating alternative housing as needed.
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#### 5. Specialized CSP Service Provider Minimum Qualifications

Providers of Specialized CSP services must possess the following qualifications, as applicable.

**Table 6: Service Provider Minimum Qualifications for all Specialized CSPs**

<b>Service</b>	<b>Qualification</b>
<b>CSP-HI</b>	1) CSP-HI providers must have: <ul style="list-style-type: none"> <li>a) experience providing services to persons with mental health disorders or substance use disorders or both; and at least two years of history providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness. This must include experience serving people experiencing chronic homelessness and with documenting their chronic homeless status in accordance with requirements set by the U.S. Department of Housing and Urban Development.</li> <li>b) Specialized professional staff with knowledge of housing resources and dynamics of searching for housing such as obtaining and completing housing applications, requesting reasonable accommodations, dealing with housing and/or credit histories that are poor or lacking, mitigating criminal records, negotiating lease agreements, and identifying resources for move-in costs, furniture and household goods.</li> </ul> 2) A CSP-HI program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff. 3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement. 4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.
<b>CSP-JI</b>	1) A CSP-JI provider must be an organization that provides mental health or substance use disorder services and operates

<b>Table 6: Service Provider Minimum Qualifications for all Specialized CSPs</b>	
	<p>under a valid license issued by the Massachusetts Department of Public Health (DPH).</p> <ol style="list-style-type: none"> <li>2) A CSP-JI program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff.</li> <li>3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement.</li> <li>4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.</li> </ol>
<b>CSP-TPP</b>	<ol style="list-style-type: none"> <li>1) CSP-TPP providers must have an active contract with Department of Housing and Community Development or MassHousing to provide tenancy preservation program services.</li> <li>2) A CSP-TPP program must have a licensed, master's-level behavioral health clinician or licensed psychologist to provide supervision to staff.</li> <li>3) All staff must have at least a bachelor's degree in a related behavioral health field, or two years of relevant work experience, or lived experience of homelessness, behavioral health conditions and/or justice involvement.</li> <li>4) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement.</li> </ol>

#### **E. Emergency Assistance Family Shelter Program (Effective beginning April 19, 2024)**

In accordance with STC 15.3.a.viii. and STC 15.6.c., MassHealth is expanding HRSN housing supports and related services to include rent/temporary housing with room and board for up to six months per demonstration for MassHealth-eligible pregnant individuals and families with children who are experiencing homelessness, participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program, and demonstrate qualified clinical criteria. The EA program is operated by the Massachusetts Executive Office of Housing and Livable Communities (EOHLC or HLC).

##### **1. EA Assessment of Needs**

EA Family Shelter Program providers hold monthly individual Rehousing Meetings with each family. Starting with the first Rehousing Meeting, and every 60 days or more frequently as needed, the provider conducts a Rehousing Assessment with each family. Rehousing Assessments are used to identify a family's strengths, history, and areas that need improvement to support the family's rehousing efforts.

The state also uses information gathered during the Rehousing Meetings and as part of the Rehousing Assessments to determine whether anyone in the family meets clinical eligibility criteria. The state may also determine clinical eligibility using claims and encounter data.

## 2. EA Service Planning

Based on the results of the Rehousing Assessment, program staff and family will jointly create a Rehousing Plan designed to address the specific barriers that family faces to securing stable housing. This plan is updated every 30 days or more frequently as needed with the progress the family has made compared to the prior month and their goals for the month ahead.

All families must identify goals (a) related to finding their new home, (b) related to long-term success/saving 30% of net income, and (c) specific to the family's situation. Depending on a family's goals, the program staff may incorporate referrals to additional service providers in the Rehousing Plan.

As families transition into community-based housing, the program staff continues to aid families in connecting to appropriate services and navigating complex systems with the goal of ensuring that each family remains stably housed. The program staff in collaboration with the family will determine the necessary supports following transition. Together, they will develop a Stabilization Plan that will be updated every 30 days.

## 3. EA Eligibility Criteria

To receive rent/temporary housing under HRSN, an individual must meet the following criteria:

- A. EA enrollment: For a family or pregnant individual to be enrolled in the EA family shelter program, they must meet the following eligibility requirements, as described below and in 760 CMR 67.00<sup>14</sup>:
  - Residency: Be a resident of Massachusetts
  - Lawful residence: At least one household member must be a citizen, or a non-citizen lawfully admitted for permanent residence or otherwise permanently residing under color of law in the United States
  - Income: Have gross income equal to or less than 115% of the Federal Poverty Level, adjusted for household size
  - Assets: Have total countable assets that do not exceed \$5,000
  - Family composition: Have at least one child under the age of 21 living within the household, or be pregnant
  - Homelessness:
    - Must be in one of the following situations:
      - At risk of domestic abuse or is homeless because the head of household fled domestic violence

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<sup>14</sup> 760 CMR 67.00 Eligibility for Emergency Assistance (EA), <https://www.mass.gov/doc/760-cmr-67-1/download>

- Experiencing homelessness due to no-fault fire, flood, natural disaster,
  - Experiencing homelessness due to no-fault eviction due to foreclosure, condemnation, conduct of a guest or former household member who is no longer part of the household, or nonpayment of rent due to disability or loss of income
  - Children are in a housing situation not meant for human habitation and exposed to a substantial health and safety risk that is likely to result in significant harm
    - The household must lack feasible alternative housing including temporary housing with relatives, friends, or charitable organizations
    - The household must verify that its current or prior living situation is no longer available to the household via a thorough third-party verification process
- B. MassHealth benefit: An individual must be enrolled in the full MassHealth benefit (i.e., not MassHealth Limited).
- C. Clinical criteria: The individual must meet both the social risk criteria and at least one of the clinical risk factors as set forth below.

The state will determine medical appropriateness for claiming FFP using MassHealth claims data and clinical and social risk assessment data collected by program staff and recorded in members' case records.

<b>Table 7: HRSN/Emergency Assistance Family Shelter Program (EA) Eligibility Criteria</b>	
<b>Social Risk Criteria</b>	
<b>Social Risk Factor</b>	<b>Social Risk Factor Description</b>
<b>Homelessness</b>	An individual who is homeless as defined by 24 CFR 91.5.
<b>Clinical Needs Based Criteria</b>	
<b>Clinical Criteria</b>	<b>Clinical Criteria Description</b>
Complex or Chronic Behavioral Health Condition	An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Disability	An individual with a disabling condition, including a developmental disability, intellectual disability, or disability that interferes with activities of daily living (ADLs), that requires services or supports to achieve and maintain care goals.
Complex or Chronic Physical Health Condition	An individual with a persistent, disabling, progressive or life-threatening physical health condition(s) that requires treatment or supports, or both treatment and supports, in

<b>Table 7: HRSN/Emergency Assistance Family Shelter Program (EA) Eligibility Criteria</b>	
	order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Experience of Interpersonal Violence	An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence.
Repeated Emergency Department Use	An individual with repeated use of emergency department care (defined as two or more visits in the past six months or four or more visits within the past 12 months).
Pregnant / Postpartum	<ol style="list-style-type: none"> <li>1. Pregnant individuals who are experiencing high risk pregnancy<sup>15</sup> or complications associated with pregnancy, as well as such individuals in the 12-month postpartum period;</li> <li>2. Pregnant individuals or postpartum individuals up to twelve months postpartum, without additional clinical factors.</li> </ol>

#### 4. EA Service Descriptions

Rent/temporary housing assistance with room and board includes two services: (1) room and board or rent for up to six months, and (2) supportive services.

<b>Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions</b>	
<b>Service</b>	<b>Description</b>
<b>Temporary Housing Assistance</b>	<p>Room and Board (up to 3 meals/day) in one of the following temporary housing arrangements for up to 6 months per demonstration period:</p> <ul style="list-style-type: none"> <li>- Congregate: multiple units with shared common areas within one building</li> <li>- Co-shelter: two units with shared common areas within one apartment</li> <li>- Scattered site: single unit in full apartment</li> <li>- Hotel: units within a hotel/motel site</li> </ul> <p>Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24</p>

<sup>15</sup> Pursuant to STC 15.6.c., a pregnant or postpartum individual experiencing homelessness or nutrition insecurity would by definition constitute a high-risk pregnancy because they have defined adverse health outcomes.



<b>Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions</b>	
<b>Service</b>	<b>Description</b>
	<p>hours a day, and facilities without private sleeping space are excluded.</p> <p>Rent and utility stipends for up to 6 months</p>
<b>Supportive Services</b>	<p>Supportive services may include one or more of the following (not time limited):</p> <ul style="list-style-type: none"> <li>- Assessment <ul style="list-style-type: none"> <li>○ Social risk assessment: assessment conducted by EA Homeless Coordinator upon intake to EA system that includes assessing housing instability, enrollment in social services, member self-assessment and, depending on the outcomes, may also include reasonable accommodation, health and safety, and domestic violence assessments to determine social risk.</li> <li>○ Clinical assessment: health assessment conducted by a licensed clinician such as a Registered Nurse, Nurse Practitioner, Physician's Assistant, or Physician contracted by the Massachusetts Department of Public Health (DPH) to identify clinical and safety risks.</li> </ul> </li> <li>- Case Management <ul style="list-style-type: none"> <li>○ Care management, outreach, and education including linkages to other state and federal benefit programs, and benefit program application assistance.</li> </ul> </li> <li>- HRSN Housing Supports <ul style="list-style-type: none"> <li>○ Pre-tenancy &amp; tenancy sustaining services including supports to ensure members remain stably housed, as described in Table 2 of Section B.7.</li> <li>○ Housing transition navigation services including services to facilitate member's transition from shelter into safe, alternative, permanent housing, as described in Table 2 of Section B.7.</li> <li>○ One-time transition &amp; moving costs including expenses associated with rehousing, as described in Table 2 of Section B.7.</li> </ul> </li> </ul>

<b>Table 8: HRSN/Emergency Assistance Family Shelter Program (EA) Service Descriptions</b>	
<b>Service</b>	<b>Description</b>
	<ul style="list-style-type: none"> <li>○ Medically necessary home environment modifications and remediations, as described in Table 2 of Section B.7.</li> </ul>

#### 5. EA Service Provider Minimum Qualifications

EOHLC will provide temporary housing assistance services through vendors that possess the following qualifications, as applicable.

<b>Table 9: HRSN/Emergency Assistance Family Shelter Program (EA) Minimum Provider Qualification Requirements</b>	
<b>Service</b>	<b>Description</b>
Room and board for up to six months	<p>EOHLC will provide rent/temporary housing services through contracted vendors. Contracted vendors must meet both of the following criteria, as well as all other minimum criteria defined by HLC:</p> <ol style="list-style-type: none"> <li>1. Experience serving families experiencing homelessness or substantially similar populations, and</li> <li>2. Demonstrates capacity to provide safe, clean, and well-maintained shelter for homeless families.</li> </ol>
Supportive services	<p>EOHLC will provide Supportive services through contracted vendors. Contracted vendors must meet the following criteria, as well as all other minimum criteria defined by HLC:</p> <ol style="list-style-type: none"> <li>1. Experience serving families experiencing homelessness or substantially similar populations.</li> <li>2. Demonstrates capacity to aid families in rapidly identifying and securing housing</li> <li>3. Demonstrates capacity to provide case management and system navigation services</li> <li>4. Demonstrates capacity to provide stabilization services to ensure families remain stably housed</li> </ol>

## F. Short Term Pre-Procedure and Post-Hospitalization Housing (STPHH) (anticipated to be effective beginning January 3, 2025)

Short-term pre-procedure and/or post-hospitalization housing, with room and board, is for individuals experiencing homelessness, involving a lower-intensity care setting for individuals who would otherwise lack a safe option for discharge or recovery after hospitalization, or to prepare for certain procedures. STPHH is anticipated to be available to eligible members in Fee For Service (FFS) and managed care plans.

### 1. Assessment of Needs

**Pre-Procedure Assessment of Needs:** The STPHH provider screens potential eligible members to confirm eligibility for pre-procedure colonoscopy services.

**Post-Hospitalization Assessment of Needs:** Within 24-hours of admission to the STPHH site, the STPHH provider conducts an assessment to identify immediate medical needs of the member. Within four calendar days of admission, the STPHH provider conducts a comprehensive baseline needs assessment to determine factors that will influence care, treatment, safety in the milieu and needed services from the STPHH provider and other community-based providers. Within the first week of a member's STPHH stay, the STPHH provider conducts a comprehensive housing assessment. The STPHH provider conducts reassessments regularly.

### 2. STPHH Service Planning

**Pre-Procedure Service Planning:** The STPHH provider ensures, prior to rendering the service to a member, that the STPHH provider is able to render all necessary service components to the member, including screening, intake, admission, support, and discharge planning services.

**Post-Hospitalization Service Planning:** The STPHH provider completes an individualized care plan for every member receiving post-hospitalization STPHH services upon completion of the comprehensive baseline needs assessment. The STPHH provider regularly reviews the individualized care plan, including, at a minimum, after each comprehensive assessment, and updates it, as necessary. The individualized care plan identifies the member's needs, goals, and priorities, and includes planned treatments, strategies and interventions to support the member's goals. The individualized care plan is developed in consultation with the member and the member's chosen support network and incorporates available records from referring and existing providers and agencies when appropriate.

### 3. STPHH Eligibility Criteria

FFS and managed care enrolled MassHealth members who meet the eligibility criteria set forth below, may be eligible for STPHH services. STPHH includes two services: (1) Pre-procedure colonoscopy services, and (2) post-hospitalization medical respite services.

Table 10: STPHH Eligibility Criteria
1. 18 years of age or older

<p>2. Currently experiencing homelessness as defined in 24 CFR 91.5 as any person who<sup>16</sup>:</p> <p>a. Who lacks a fixed, regular, and adequate nighttime residence, meaning:</p> <ul style="list-style-type: none"> <li>i. 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</li> <li>ii. 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; or</li> <li>iii. is exiting an institution where they resided for 90 days or less and who met eligibility criteria (2)(a)(i) or (2)(a)(ii) immediately prior to entering the institution;</li> </ul> <p>b. Who will imminently lose their primary nighttime residence, provided that:</p> <ul style="list-style-type: none"> <li>i. The primary nighttime residence will be lost within 14 days of the date of STPHH referral;</li> <li>ii. No subsequent residence has been identified; and</li> <li>iii. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing; or</li> </ul> <p>c. Who:</p> <ul style="list-style-type: none"> <li>i. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, unsafe, or life-threatening conditions that relate to violence, including physical or emotional, against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to or stay in their primary nighttime residence;</li> <li>ii. Has no other residence; and</li> <li>iii. Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks to obtain other permanent housing.</li> </ul>	
<b>STPHH Service Specific Eligibility Criteria</b>	
<b>Pre-Procedure Services</b>	<p>MassHealth member:</p> <ul style="list-style-type: none"> <li>1. Has a referral for a colonoscopy procedure or a colonoscopy procedure scheduled within one day of admission to the medical respite; and</li> <li>2. Cannot prepare for the colonoscopy effectively due to not having consistent access to a private bathroom.</li> </ul>
<b>Post-Hospitalization Services</b>	<p>MassHealth member:</p>

<sup>16</sup> MassHealth does not currently intend to implement STPHH Eligibility Criteria 2.b or 2.c as STPHH eligibility criteria beginning in 2025. If MassHealth exercises its authority to implement STPHH Eligibility Criteria 2.b. or 2.c in the future, it will notify CMS per the process laid out in Section A.1.a.

	<ol style="list-style-type: none"> <li>1. Has been admitted to an acute care hospital medical or surgical service or has presented to an acute care hospital emergency department with a medical or surgical issue;</li> <li>2. Has a primary acute medical issue that is not yet resolved but is expected to resolve and can be safely managed in a medical respite setting with the STPHH provider's support accessing primarily home- and community-based MassHealth services;</li> <li>3. Does not meet nursing facility level of care criteria;</li> <li>4. Is anticipated to no longer require or does not currently require acute care hospital level of care and has been deemed stable and ready for discharge to a home-based setting in the community;</li> <li>5. Does not have a stable and safe housing option identified or the resources to obtain appropriate housing where they can be safely discharged; and</li> <li>6. Is independent with regards to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), except for needing short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process.</li> </ol>
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#### 4. STPHH Service Descriptions

STPHH includes two services: (1) Pre-procedure colonoscopy services, and (2) post-hospitalization medical respite services. STPHH services are delivered to members in a community-based setting and include room and board.

Table 11: STPHH Service Descriptions	
Service	Description
<b>Pre-Procedure Services</b>	<ol style="list-style-type: none"> <li>1. Coordinate the scheduling of the pre-procedure colonoscopy services with the provider conducting the colonoscopy procedure, ensure the member has all necessary prescriptions for pre-procedure preparation, and coordinate transportation to and from procedure.</li> <li>2. Provide access to appropriate accommodations for pre-procedure preparation activities and post-procedure recovery, including access to a private or semi-private room and private bathroom, for up to 48 hours, and ensure the room is available post-procedure for recovery prior to discharge;</li> <li>3. Provide appropriate pre- and post-procedure fluids and foods in accordance with instructions from the procedure provider, and provide counseling and supervision support, as desired by the member, for adherence to such instructions;</li> <li>4. Arrange for necessary post-discharge support and clinical services and coordinate transportation.</li> </ol>

<b>Post Hospitalization Services</b>	<ol style="list-style-type: none"> <li>1. Participate, as appropriate, in member discharge planning with the referring acute care hospital provider, which may include sending a staff person to the acute care hospital to meet the referred member or discussing the member's health needs with the acute care hospital staff;</li> <li>2. Provide case management services, which includes coordinating with and facilitating connections with other providers, as well as formal and informal supports, as appropriate;</li> <li>3. Provide health and referral navigation services, which includes facilitating member access to primary care, other community and home-based health care services and equipment (e.g., Durable Medical Equipment), coordinating referrals, when appropriate, providing assistance with member self-administration of medications and setting up and scheduling appointments, transferring health information to providers, addressing external barriers to receiving and engaging in services, and partnering with MassHealth Community Support Program for Homeless Individuals (CSP-HI) providers to deliver intensive housing navigation services;</li> <li>4. Provide three meals per day and snacks; and</li> <li>5. Deliver discharge planning services based on the member's specific circumstances, which includes engagement with the member's MassHealth health plan, assisting with transition of care and post-discharge support, and providing options for placement after discharge.</li> </ol>
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#### 5. STPHH Provider Minimum Qualifications

Providers of STPHH services must possess the following qualifications.

<b>Table 12: STPHH Provider Minimum Qualifications</b>
<ol style="list-style-type: none"> <li>1. Have at least two years of experience providing services to persons experiencing homelessness.</li> <li>2. Be able to ensure timely access to primary care services, as necessary, including the provision or coordination of orders, referrals and prescriptions for services to address physical, mental or functional needs, through a partnership with a licensed medical provider whose scope of practice allows for delivery of medical services in a home setting, including the medical respite service location.</li> <li>3. Demonstrate comprehensive knowledge of: <ol style="list-style-type: none"> <li>a. available community resources, including but not limited to health care, behavioral health, and home health services;</li> <li>b. how to access these resources in a timely manner;</li> <li>c. how to arrange for services to be delivered onsite at the medical respite, if applicable; and</li> </ol> </li> </ol>

- d. how to arrange for transportation to receive services in the community.
- 4. Be able to ensure the provision of intensive housing navigation services through a partnership with a MassHealth CSP-HI provider



## Appendix

### A. Flexible Services – Availability of Services and Eligibility Criteria

As described in Section B.5 of Attachment P, ACOs may elect which Flexible Services to offer. The services that ACOs have elected to offer can be found at <https://www.mass.gov/masshealth-health-related-social-needs-services>. All ACOs are required to use the same set of Flexible Services eligibility criteria – they do not have flexibility to implement only a subset of the eligibility criteria.