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January 31, 2023

MA Executive Office of Health & Human Services
c/o D. Briggs
100 Hancock Street, 6th Floor
Quincy, MA 02171
masshealthpublicnotice@mass.gov

RE: Comments on 130 CMR 461.000: Community Support Program Services

To Whom it May Concern:

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for your extraordinary leadership in prioritizing individuals who are homeless and individuals who are justice involved in the most recent MassHealth 1115 waiver demonstration renewal. We truly appreciate you addressing the behavioral health and social services needs of individuals who are among the most vulnerable. Thank you also for the opportunity at this time to comment on the proposed regulation 130 CMR 461.000: Community Support Program Services.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

We respectfully submit the following comments and recommendations in regard to the proposed regulation 130 CMR 461.000: Community Support Program Services:

<u>461.402: Definitions</u>

Adverse Incident – The definition should read “health and safety.” There also may be adverse incidents related to the actions of an individual who isn’t technically a staff member, but who is present within an entity or a subcontractor of an entity. “Staff member” is not defined.

At Risk of Homelessness – The definition suggests that people who have support networks (e.g., family, friends, faith-based or other social networks) that can provide a temporary place to stay are not at risk of homelessness. Individuals who are couch surfing at friends’ apartments, staying in church basements, or staying in crowded apartments with others who are housing unstable should also be considered at risk of homelessness and would benefit from Community Support Program services. We recommend that “or

support networks (e.g., family, friends, faith-based or other social networks)" be deleted. MAMH frequently receives calls from families and friends who are no longer willing or able to provide housing to people living with them who have mental health and/or substance use conditions. These individuals are technically part of an individual's support system but unwilling or unable to provide housing.

Behavioral Health Disorder – This definition should be changed to "Behavioral Health Condition" and the term "condition" should be used in place of the term "disorder" throughout in both the mental health and substance use contexts. The word "disorder" is stigmatizing. If individuals have physical health conditions, like diabetes or psoriasis, they aren't commonly referenced as disorders, particularly when talking about the individual with the condition. Sadly, the stigma and discrimination associated with mental health and substance use conditions persist and the use of the work "disorder" leads to negative associations not with a condition but with attributions of disordered behavior, thus reinforcing stigma. Parallel language should be used in the behavioral health context. In addition, the recently enacted Chapter 177 of the Acts of 2022 adds the new statutory section 81 to M.G.L. c. 118E, which requires MassHealth and its associated health plans and contractors to cover all services to diagnose and treat all behavioral health conditions listed in both the DSM and the International Classification of Diseases, or ICD. Therefore, this definition should also reference all behavioral health conditions listed in the DSM, as well as the ICD.

Behavioral Health Supports for Individuals with Justice Involvement (BH-JI) – As the definition currently reads, it seems as though individuals who receive CSP-JI services "when releasing from correctional institutions" are not able to receive community supports post-release. Please clarify that people receiving CSP-JI services while in correctional institutions may also receive supports post-release.

Certified Peer Specialist – Please change the definition of Certified Peer Specialist to include "lived experience with mental health conditions and wellness and/or lived experience with co-occurring mental health and substance use conditions and wellness." We also suggest changing "disorder" to "condition."

Community Support Program for Homeless Individuals (CSP-HI) – The population of individuals experiencing homelessness is extremely heterogenous. These regulations must take into account the unique needs of individuals who are homeless and not engaged in traditional systems of care – like acute health services, Department of Mental Health (DMH) services, and Bureau of Substance Addiction Services (BSAS) supports – usually due to past histories of trauma.

The HUD definition of chronic homeless includes a requirement that the individual "has been homeless and living as described for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described." This is a high threshold, and it's very possible that an individual might not meet HUD's definition of chronic homeless, but still might not be a frequent user of acute health services and/or other state agency services.

As such, we recommend expansion of the definition to include members who are experiencing homelessness (not necessarily chronic homelessness) and who aren't necessarily frequent users of acute health services (because these individuals are so disengaged with traditional systems of care).

Community Support Program Tenancy Preservation Program (CSP-TPP) – The phrase "facing eviction as a result of behavior related to a disability" needs to be clarified. Behaviors related to a disability is an encompassing term that might, for example, including failure to pay rent. We encourage the full range of behaviors that could be related to a disability – both direct and indirect – to qualify for CSP-TPP services.

Homelessness – To parallel the U.S. Department of Housing and Urban Development's (HUD's) definition of "literally homeless" please add: "or who is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution."

Mental Health Disorder - The word "disorder" is stigmatizing. If individuals have physical health conditions, like diabetes or psoriasis, they aren't commonly referenced as disorders, particularly when talking about the individual with the condition. Sadly, the stigma and discrimination associated with mental health and substance use conditions persist and the use of the work "disorder" leads to negative associations not with a conditions but with attributions of disordered behavior, thus reinforcing stigma. Parallel language should be used for mental health. Please change to "Mental Health Conditions." In addition, the recently enacted statute M.G.L. c. 118E, §81 requires MassHealth and its associated health plans and contractors to cover all services to diagnose and treat all behavioral health conditions listed in both the DSM and the International Classification of Diseases, or ICD. Therefore, this definition should also reference all behavioral health conditions listed in the DSM, as well as the ICD.

Substance Use Disorder – Please see comment above under "Mental Health Disorder."

Telehealth – We recognize that MassHealth is using the definition of Telehealth established in Chapter 260 of the Acts of 2020. The definition here should be aligned with any further clarifications made in the final Division of Insurance (DOI) regulations, which have not been released as of the date of this submission. We recommend EOHHS confer with DOI as we understand that this work is underway.

We recommend adding a definition of "Peer Recovery Coach" to these regulations. Community Support Program services should also employ peer recovery coaches. The definition of Peer Recovery Coach from 130 CMR 448.000 (Community Behavioral Health Centers) is "an individual currently in recovery who has lived experience with substance use and other addictive disorders and/or co-occurring mental health disorders and has been trained to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. Peer recovery coaches must meet requirements as set forth in 130 CMR 418.000: Substance Use Disorder Treatment Services."

<u>461.404: Provider Eligibility</u>

(B) CSP-HI Requirements (2) – The requirements for providers in this provision are too restrictive. They don't adequately take into account the services provided by organizations that provide Housing First or low-threshold housing. MassHealth members, or MassHealth-eligible members, that are served by these low-threshold housing programs may literally not be comfortable sleeping inside. An example is DMH's Safe Haven program, which offers environments that are welcoming and unintrusive to give people a chance to get a taste for living indoors. The goals of Safe Havens are first to convince people to want to be there, and then to convince them to stay over a longer period of time, and finally to engage them in treatment and permanent supportive housing.

The current definition in the proposed regulations requires providers to have at least "at least two years of history providing pre-tenancy, transition into housing, and tenancy sustaining supports to persons experiencing homelessness." We recommend adding "low-threshold" or "Housing First models" to this list and changing the "and" before "tenancy supports" to an "or." This will make the definition more inclusive of providers that serve homeless individuals that are some of the most difficult to reach.

461.410: Scope of Services

(B) (1) Intake Services and (2) Needs Assessment - We recommend building more flexibility into the timelines in the proposed regulations, especially under "Intake Services" and "Needs Assessment." For homeless individuals that have not engaged in health care and behavioral health systems, and have complex trauma histories, "initiating service planning upon intake" and commencing the needs assessment on the date of initial appointment might be triggering. The goal is to slowly build relationships and trust over time. If providers must adhere to the timelines outlined in the proposed regulations, it might have the unintended consequence of pushing some of the most vulnerable homeless individuals away. The services must be culturally responsive to the unique needs of this population.

(B) (4) Community Support Program Services - We recommend adding: "(h) Providing a welcoming, safe, and low-threshold environment to foster comfort with sleeping indoors; and (i) Building relationships and trust in a manner that is culturally responsive and trauma-informed."

(B) (6) Crisis Intervention Referrals – Please add more detail around what is required for Community Support Programs to have the "capacity to respond to a members' behavioral health crisis." What kinds of training or experience is appropriate and should be required of CSP staff related to early identification of symptoms, assessment, de-escalation, and stabilization? Related, we recommend the language around "refer the member to crisis intervention services, or refer the member to other healthcare providers" be strengthened. For an individual in crisis, CSPs should have preexisting relationships with their Community Behavioral Health Centers (CBHCs) and make warm handoffs to mobile crisis intervention teams when appropriate.

(C) Additional Services Provided through Specialized Community Support Programs, (1) CSP-HI Services - We recommend adding: "(d) Culturally responsive and trauma-informed supports and services; and (e) A welcoming, safe, supportive, and low-threshold environment, if applicable."

461.411: Staffing Requirements

(B) Minimum Staff Composition, (2) Multidisciplinary Staff, (e) – Please change "(e) Staff may include qualified Certified Peer Specialists and staff with lived experience of homelessness, behavioral health conditions or justice involvement" to "(e) Staff *must* include qualified Certified Peer Specialists, *Peer Recovery Coaches*, and staff with lived experience of homelessness, behavioral health conditions or justice involvement." Peers should be included on all CSP teams, recognizing their importance in outreach, engagement, and recovery. Given the prevalence of substance use and co-occurring conditions among the homeless population, it is similarly important to include Peer Recovery Coaches in the regulations.

461.413: Schedule of Operations

(B) Scheduling of appointments - We recommend building more flexibility into the timelines in the proposed regulations, especially under "Intake Services" and "Needs Assessment." For homeless individuals who have not engaged in health care and behavioral health systems, and have complex trauma histories, "initiating service planning upon intake" and commencing the needs assessment on the date of initial appointment might be triggering. The goal is to slowly build relationships and trust over time. If providers must adhere to the timelines outlined in the proposed regulations, it might have the unintended consequence of pushing some of the most vulnerable homeless individuals away. The services must be culturally responsive to the unique needs of this population.

Thank you again for your continued leadership and hard work in reforming the community-based behavioral health system for the people of the Commonwealth. Should you have any questions or would like additional information, please don't hesitate to contact me at 617-680-8200 or dannamauch@mamh.org.

Sincerely,

Danna Mauch, PhD
President and CEO