May 30, 2025

Division of Medical Assistance
100 Hancock Street
Quincy, MA 02171
masshealthpublicnotice@mass.gov

Dear Division of Medical Assistance:

Re: 130 CMR 464.000: Program of Assertive Community Treatment Services

On behalf of the Massachusetts Association for Mental Health (MAMH) and the Mental Health Legal Advisors Committee (MHLAC), we write to provide comments on 130 CMR 464, proposed regulations pertaining to Program of Assertive Community Treatment (PACT).

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. MHLAC is a state agency that works to advance the rights and opportunities of persons with mental health challenges through quality legal advocacy and education in Massachusetts.

We are excited by the expansion of PACT programs through the creation of a MassHealth fee-for-service program. We note that Massachusetts implemented PACT decades ago under the Department of Mental Health, and its availability and the adequacy of its staffing have for too long been limited by the absence of a secure, uncapped, financing stream that capitalizes on federal financial participation (FFP). The evidence base for PACT programs has been well established since the 1980s for certain populations of individuals who have serious and disabling mental health conditions often co-occurring with substance use conditions, have not responded to more services offered in traditional settings, and who may benefit from more intensive and flexible supports.

Reimbursement Rates are Low

We are concerned that the approved reimbursement rates for enrollment day for PACT team services, established at 101 CMR 430 and referenced in the proposed regulations at 464.408, may compromise the quality of the program. We understand these rates are based on benchmark salaries determined by EHS through the Chapter 257 process. These Ch. 257 rates are consistently low. Moreover, PACT services are provided to individuals who were not successful at engaging in more traditional services and who require more intensive interventions. Rates should recognize the challenge inherent in this model. By this we reference the PACT program need for: a multidisciplinary team of professionals capable of treating individuals with complex and intense needs; the need to hire experienced rather than entry level staff to treat individuals with the greatest challenges, as we would plan for in any other field of medicine's specialized treatment for the most complex patients; the differential resources needed to

operate a service 7 day per week/24 hours per day; and the resources required to provide a broad range of community treatment, living, and support functions.

Low reimbursement rates for behavioral health services contribute to low salaries and underfunding of expenses in provider programs, financial losses for providers, and problems in recruitment and retention of qualified clinical staff.[1] Currently, behavioral health services and supports represent too small a portion of total medical expenditure (TME) in the Commonwealth. Multiple studies of Massachusetts reimbursement rates have demonstrated that Chapter 257 rates are lower than rates for delivery of medical services.[2]

Given the high and increasing prevalence of behavioral health conditions in the population and the need for services targeted to persons who have not benefited from more traditional approaches to care, increased investment in the PACT program is imperative. We applaud MassHealth efforts to remove barriers to broader uptake of PACT services and underscore the importance of a rate that is sufficient to ensure teams can recruit and retain full staff on the multidisciplinary PACT program teams.

Consumer Voice in Treatment Planning Requirement is Clear and Compelling

The definition of Treatment plan in 464.402 is good, as it clearly states that the plan is developed by both the member and the team, and that it reflects the "voice, priorities, preferences, and goals of the member."

Eligibility Specifications are Unclear

The section of the regulations on eligibility, 464.403, is not clear regarding who is eligible for PACT services, beyond identifying the categories of insurance that cover PACT services. Absent is an explanation of who within that group could receive PACT services. 464.403(E) notes that services are provided based on MassHealth clinical standards, but it is not clear if this provision refers to overall

[1] As Health Law Advocates has cited in its comments, the 2022 MA DMH PACT Consumer Survey Fact Sheet at https://www.mass.gov/doc/2022-ma-dmh-adult-pact-consumer-survey-factsheet/download revealed consumer concern regarding hiring and retention of quality staff for DMH's PACT teams.

[2] See RTI International, Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue (Apr. 2024), https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue (showing very low reimbursement in all licensed behavioral classes compared to all licensed primary care and specialty medical classes and showing that patients went out-of-network between 3.5 and 19.9 times more often to see a behavioral health clinician/receive inpatient behavioral care than to see a medical/surgical clinician/receive inpatient medical care); Milliman Research Report. Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf (average in-network reimbursement rates for behavioral health office visits are lower than for medical/surgical office visits, with rates in 2017 being 23% higher for primary care than for behavioral care; consumer out-of-network utilization rates for behavioral healthcare providers were higher than medical/surgical providers in all five years studied); Milliman Research Report, Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates (Dec. 2017), https://careers.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nqtldisparityanalysis.ashx (medical/surgical providers received higher reimbursement rates (relative to Medicare-allowed amounts) than behavioral providers for comparable services; patients used an out-of-network provider for a substantially higher proportion of behavioral care than they did for medical/surgical care).

eligibility for the program or the provision of discrete PACT services; a logical interpretation is that it is the latter.

While broad eligibility for PACT services should be the goal, lack of clarity may not best effectuate that result. The regulations, at a minimum, should clarify whether medical necessity dictates eligibility.[3] Alternatively, the regulations might direct that MassHealth include eligibility standards in a policy, provider manual, guidance, or similar document.[4]

Individuals should be Clearly Authorized to Access Behavioral Health Services Outside Their Teams and PACT Providers should provide Referrals to Such Services When Requested by a Client

While it is important for these regulations to ensure provider capacity to deliver clinically indicated PACT services to its members, the regulations should not be written in a way which precludes individuals' access to other behavioral health services in the community. For this reason, MAMH concurs with HLA in its concern with the sentence in 464.411(B) which reads "PACT is the sole source of community-based behavioral health treatment for any member receiving services from a PACT provider." For example, a PACT program client may want to engage in certain kinds of peer-driven supports, group therapy programs, substance use treatment modalities, or alternative recovery pathways. And, in fact, in provision 464 CMR 4.11(F)(4)(c)7, the regulations include, among PACT services, "encouraging and facilitating the utilization of natural support systems and engaging recovery-oriented, peer support, advocacy, and self-help support and services." It would make sense to make explicit in 464.411(B) the ability of PACT clients to pursue these services.

The regulation does include a statement in (B) that the PACT provider may make referrals for "medical/dental services and certain specialized SUD services, psychological testing, and discharge planning activities." This language could be improved. First, upon client request, the PACT provider should be required to make such referrals. Second, limiting referrals to these specific types of services is short-sighted as other medical and behavioral health services may also lay outside the scope of PACT program clinical services (as outlined in the regulations) and these other services may also warrant referrals. We have mentioned some such behavioral health services above.

In addition, the regulations should make clear that referrals should be monitored to ensure engagement and other referrals should be offered should engagement not occur. This language could be included in 464.411(F)(8)(c) after existing text. Finally, with respect to crisis intervention referrals in 464.411(F)(9), we suggest changing "may" to "should" (with member consent) in the statement: "The PACT provider staff may implement interventions to support and stabilize the crisis so that the member can remain in the community, refer the member to crisis intervention services, or refer the member to other healthcare providers, as appropriate." It would also be important to indicate that PACT providers should pursue the least restrictive appropriate intervention and pursue community-based crisis services over hospital-based services whenever appropriate.

PACT Team Composition should be Regularly Reevaluated

[3] In the section on scope of services, 464.411 includes in section (C) that all services must be medically necessary and appropriate, but, again, that is distinct from eligibility.

[4] See, e.g., Montana Department of Public Health and Human Services Behavioral Health and Developmental Disabilities Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, Policy No 460: Program for Assertive Community Treatment (PACT) – Tiered System (Oct. 1, 2022), https://dphhs.mt.gov/assets/BHDD/MedicaidManual/460PACT.pdf at 1.

PACT team composition should meet evidence-based standards and should be regularly reevaluated and adjusted to address achievement of client goals. Provision 464.411(E) dictates that clients have a PACT team "unique to each member served." This suggests that the teams may not include every PACT team provider. In 464.411(F)(3)(e)5, it states that treatment plans must be updated at least every six months, or more frequently when there is a notable change. This would be a good place to add that, at the point of those updates, team composition should be reviewed and updated to best effectuate plan goals.

Medication Provisions should address Risk of Side and Withdrawal Effects and Preserve Right to Consent to Treatment

The regulations have good language regarding the role of medication as a treatment for PACT team clients, but in several places, the language could be made stronger to ensure consideration of potential side and withdrawal effects and to ensure that right to consent to treatment is best protected. This is important as PACT team participation may follow a history of medication refusal or discontinuation, and encouraging medication compliance may be a goal of providers. It is important to continually solicit, record, and respect client wishes on these issues, consistent with legal decision-making capacity.

Currently, the only reference to medication side effects is in 464.411(F)(7)(e)3. Discussion of side effects should be included when taking the patient's history. In addition, the team psychiatrist and all other staff must monitor medication side effects and the team psychiatrist must document side effects.[5]

In 464.411(F)(3)(d)10, when the provider is assessing member mental health and addiction treatment history, including experience with past treatment and perception of its benefits/limitations, the provider should be required to solicit information on any side or withdrawal effects of medications. Likewise in 464.411(F)(7)(b)4, when the PACT provider assesses prior experience with psychiatric medications, which should involve discussion with the member about any side effects, withdrawal effects, efficacy, preferences, and alternatives tried or considered.

In 464.411(F)(7)(c), the statement "Nothing in 130 CMR 464.411(F)(7) precludes the one-time administration of a medication in an emergency in accordance with a prescribing practitioner's order" should be amended to make clear that such an order may only be issued consistent with state law.

As discussed below, we appreciate the language included which clarifies that housing support is not conditioned on acceptance of other PACT services. The regulations should include a stronger statement, however, that members have a right to refuse psychiatric treatment, including psychiatric medication, consistent with patient capacity determinations.

Description of PACT services should be clarified

Provision 464.411(F)(4), regarding PACT services, could be clarified in two respects.

First, (F)(4)(a) states that PACT services include those provided by PACT team staff. Simultaneously, provision (4)(c) lists a range of services that are included within the scope of PACT services. It is unclear if 4(a) and 4(c) are meant to set the same scope of services or if one provision's services are a subset of the other.

[5] D. Allness & W. Knoedler, National Program Standards for ACT Teams (rev. 2003), https://oceact.org/wp-content/uploads/2015/07/National-Provider-Standards-for-ACT.pdf at 26.

Second, provision (F)(4) lists in (c) a set of what are described as "PACT services." However, provisions (F)(5) (Employment and Vocational Supports), (F)(6) (Housing Services and Supports), (F)(7) Pharmacotherapy Services, (F)(8) Referral Services, (F)(9) Crisis Intervention Referrals, and (F)(10) Discharge Planning all describe services provided by PACT providers. It is unclear why only (F)(4) is labeled PACT services and what the effect of this categorization is. At a minimum, it is confusing.

PACT's role in promoting Supportive Housing

We are excited about the role PACT services can play in promoting the expansion of Supportive Housing in Massachusetts. PACT and Assertive Community Treatment have been cited as key services in the partnership between treatment and housing that is central to Permanent Supportive Housing models, including Housing First.[6]

The regulations are impressive in the inclusion of housing services and supports among the services to be provided. We also applaud the statement in 464.411(F)(6) that "PACT providers must use a Housing First approach and may not make housing supports or subsidies contingent on the member's compliance with other treatment recommendations." This is important language and is essential to Massachusetts' delivery of Supportive Housing.

It would be helpful to add additional language to best protect clients from eviction. In its discussion of the role of ACT services in maintaining housing for people living with behavioral health issues, Mental Health America notes that, in addition to case management, certain other services provide critical protections allowing individuals to remain housed:

> It is worth stressing assistance with personal care, housekeeping and cleaning, and pest control, which are essential to avoid eviction, and individual counseling and de-escalation when eviction is threatened.[7]

Provision 464.411(F)(4)(c)1.d. lists, among PACT services, "counseling related to getting and keeping housing." It might be helpful to explicitly include a requirement to provide counseling and de-escalation at the point at which eviction is threatened. In addition, it would be worth including explicit mention of housekeeping and cleaning services in 464.411(F)(6) in the requirement to provide care coordination to help the member obtain and maintain housing, and/or in 464.411(F)(6)(c) in the requirement to provide tenancy sustaining supports.

Finally, with respect to the mention in 464.411(F)(6)(a) and (c) of the need to address criminogenic factors that create obstacles to housing access and maintenance, we note that, while important, criminogenic factors are not the only obstacles potentially facing homeless individuals. It might be worth

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[6] See, e.g., Sam Tsemberis, Leyla Gulcur, & Maria Nakae, Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis, Am. J. Public Health (Apr. 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/; Tim Aubry et al, One-Year Outcomes of a Randomized Controlled Trial of Housing First With ACT in Five Canadian Cities, Psychiatric Services (Feb. 2015), https://psychiatryonline.org/doi/10.1176/appi.ps.201400167; Tim Aubry et al., A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness, Psychiatric Services (Dec. 2015), https://psychiatryonline.org/doi/10.1176/appi.ps.201400587; Mental Health America, Supportive Housing and Housing First (approved Sept. 8, 2018, exp. Dec. 31, 2023), https://mhanational.org/issues/supportive-housing-and-housing-first.

[7] Mental Health America, supra note 8.

noting a range of potential factors that would merit PACT team attention such as co-occurring physical disabilities or other special needs.

Agreement with Other Stakeholder Advocates on the Regulations

We note that in addition to providing our own comments, MAMH endorses the comments of the Associations for Behavioral Healthcare and Health Law Advocates regarding these regulations.

Thank you for the opportunity to comment.

Sincerely,

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