November 1, 2021

Electronically submitted to mentalhealthcare@finance.senate.gov.

The Honorable Ron Wyden
United States Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
United States Senate
239 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Request for input on legislative proposals to improve access to health care services for Americans with mental health and substance use disorders (Released September 22, 2021 via the Senate Committee on Finance website: https://www.finance.senate.gov/chairmans-news/wyden-crapo-solicit-policy-proposals-to-address-unmet-mental-health-needs).

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for the opportunity to provide input to the Senate Committee on Finance on legislative proposals to improve access to health care services for Americans with mental health and substance use disorders.

I am writing on behalf of Boston Medical Center (BMC), a private, not-for-profit, academic medical center located in Boston, Massachusetts. As the largest safety-net provider and busiest trauma and emergency services center in New England, BMC's mission is to provide exceptional care, without exception to all patients. Our patient population has the highest public payer mix of any acute care hospital in Massachusetts at 77% – with over half of our patients receiving care funded through MassHealth (the state's combined program for Medicaid and the Children's Health Insurance Program (CHIP)) or free care (i.e. uninsured). Of our Medicare patients, who make up roughly a quarter of our patients, the majority are dually eligible for Medicaid.

Mental health and substance use disorders are all too common among the patients BMC treats in our emergency department and among all our patients seeking care in any of our outpatient or inpatient settings. BMC provides a broad array of mental health care services, including outpatient integrated mental health care within our pediatric and adult primary care clinics and at local community health center partners, a mental health urgent care clinic, a crisis stabilization unit, adult psychiatric emergency beds, and our Boston Emergency Services Team (BEST) provides community-based evaluations and a jail diversion program. The Grayken Center for Addiction at BMC, with over eighteen clinical programs for substance use disorders, is one of

the nation's leading centers for addiction treatment, research, prevention, and education. At present, BMC does not own or operate a locked inpatient psychiatric unit, though we are planning to open 82 inpatient behavioral health beds next year to help meet the great need and to close this gap in our continuum of services.

The patients we serve are racially, ethnically, and linguistically diverse – approximately 7 out of 10 of our patients identify as Black/African American or Latinx, while nearly a third of our patients speak a language other than English as a primary language. Over half of our patients live at or below the federal poverty level. The patients we see at BMC who present with mental illness frequently have co-occurring substance use disorders, homelessness, malnutrition, and other health-related social needs linked to poverty. The current COVID-19 pandemic, entrenched structural racism, and economic crises have further exacerbated the mental illness and trauma experienced by our patients.

At BMC, we appreciate and support the work of the Senate Committee on Finance in advancing bipartisan legislation to ensure the delivery of high quality, affordable behavioral health care services across the country. In your review, we urge the Committee to consider the below input on legislative proposals to improve access to mental health and substance use disorder treatment.

I. Strengthening the Behavioral Health Care Workforce

Provide additional Medicare-funded Graduate Medical Education (GME) residency slots

It is widely understood and well-documented that America has a dearth of licensed mental health professionals, in general, and that particular areas of the country – largely rural and outside of the Northeast – are disproportionately impacted.[1] Even in Boston, which has one of the highest number of child and adolescent psychiatrists per capita in the country, the capacity is insufficient to meet the mental health needs of the community.[2] Increased Medicare Graduate Medical Education (GME) funding for residency slots in general, as proposed in the **"Resident Physician Shortage Reduction Act of 2021" (S.834)**, or targeted to specific specialties, such as addiction medicine and addiction psychiatry as proposed in the **"Opioid Workforce Act of 2021" (S.1438)**, can help increase the behavioral health physician workforce.

Expand federal loan repayment program to bolster mental health workforce

Increased funding for loan forgiveness programs for those who work in underserved areas can help alleviate the $250,000 of debt that the average medical student has accumulated by the time their residency education is completed. The need to pay off medical school loan burden is also

[1] U.S. Health Resources & Services Administration. Health Professional Shortage Areas Data Dashboard. Last Updated: June 10, 2021. data.hrsa.gov/topics/health-workforce/shortage-areas.

[2] American Academy of Child & Adolescent Psychiatry. Practicing Child and Adolescent Psychiatrists Workforce Maps by State. Last Updated: March 2018. aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.

likely to cause physicians to pursue practice in more affluent areas, adversely impacting access to care for lower-income populations.[3]

Congress should consider expanding the list of eligible sites that qualify for the National Health Service Corps (NHSC) loan repayment program as a means to entice more clinicians to enter the mental health field. A promising example of this is the Health Resources and Services Administration (HRSA) Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP) – authorized by the SUPPORT for Patients and Communities Act of 2018 – which allows certain clinical roles providing substance use disorder treatment to receive up to $250,000 in loan repayment after six years. BMC recently became a STAR-LRP approved facility and expects this will be a significant asset to our recruitment efforts. Conversely, BMC, despite being an urban safety-net hospital that provides a continuum of mental health services, does not qualify as a NHSC-approved site, meaning our mental health providers are not eligible to receive loan repayment.

Beyond the shortage of providers, the mental health workforce is not representative or reflective of the U.S. population – for instance, only 2% of Psychiatrists identify as Black.[4,5] In addition to expanding the NHSC loan repayment program for the mental health workforce, efforts should be directed toward providing greater investment in a racially and ethnically diverse mental health workforce, such as proposed in the **"Pursuing Equity in Mental Health Act" (S.1795)**.

Medicare should reimburse the full spectrum of behavioral health providers and frontline public health workers for services provided

At present, Medicare only reimburses for services provided by a limited set of behavioral health providers, including psychiatrists, psychologists, and licensed clinical social workers. Services provided by licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), and licensed professional counselors (LPC) are not currently reimbursed by Medicare. Providers should get reimbursed for the services they are trained to provide within their scope of practice, which would help alleviate the workforce shortage and increase access to care. Several bills before the Committee, including the **"Mental Health Access Improvement Act of 2021" (S.828)** and **"Improving Access to Mental Health Act of 2021" (S.870)**, seek to expand Medicare reimbursement to include more of the behavioral health workforce and should be given your full consideration.

Additionally, including community health workers (CHWs) and peer support in care models, and reimbursing them for their time is crucial to better serving the needs of diverse communities. Currently, many of these roles are grant funded and are not sustainable under existing

[3] Zimmerschied C. How med student loan burdens can deepen health disparities. American Medical Association. April 27, 2017. ama-assn.org/education/medical-school-diversity/how-med-student-loan-burdens-can-deepen-health-disparities.

[4] Lin L, Stamm K, Christidis P. How diverse is the psychology workforce? American Psychological Association. 2018; 49(2). apa.org/monitor/2018/02/datapoint.

[5] American Hospital Association (2016). The State of the Behavioral Health Workforce: A Literature Review. aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf.

reimbursement structures. CHWs and peer support specialists (including recovery coaches) should be identified as core members of the medical and behavioral health team, not a substitution for a nurse or behavioral health provider. Federal funds could be dedicated to developing, training, and professionalizing the CHW and peer support workforce.

II. Increasing Integration, Coordination, and Access to Behavioral Health Care

The federal government should provide incentives for construction and expansion of behavioral health units along the care continuum

The lack of inpatient psychiatric beds in Massachusetts and across the country is a significant barrier to behavioral health care, which causes patients to wait or "board" in hospital emergency departments for weeks, sometimes months, to be transferred to an available inpatient unit.[6] BMC Health System is in the process of constructing an 82-bed psychiatric facility in nearby Brockton, Massachusetts, to help fill this gap and increase our ability to treat the behavioral needs of our patients from across the region. The facility is intended to provide 56 inpatient psychiatric beds with the capacity to treat patients with co-occurring substance use disorder and 26 Clinical Stabilization Services (CSS) beds. We estimate that the project will involve a total of $27 million in start-up costs to retrofit a former nursing home to suit these purposes. Once fully operational, we anticipate barely breaking even under existing reimbursement structures, meaning future revenue will not offset our start-up costs. The high start-up costs, in addition to aforementioned workforce shortages, act as a deterrent to the creation of more behavioral health units along the care continuum, particularly inpatient psychiatric beds. The federal government could play a significant role in incentivizing construction and expansion of new behavioral health units by providing capital grants to cover one-time, start-up costs or offer time-limited, enhanced reimbursement for services provided in such facilities.

Federal funding could provide wider access to comprehensive crisis intervention models - BMC has a replicable model in the BEST program

The BMC Emergency Services Program (ESP) provides a comprehensive and highly integrated system of crisis evaluation, intervention, and treatment in the Boston (via the Boston Emergency Services Team or "BEST"), Cambridge, Somerville, and Fall River areas, using a team of psychiatrists, master's level mental health clinicians, registered nurses, nurse practitioners, family partners, certified peer specialists, and mental health workers. The program is highly effective at diverting people from emergency rooms and from inpatient hospitalizations, but more such programs and funding for expanded hours are needed.

While it is common for acute care hospitals to admit roughly 70% of behavioral health patients to inpatient psychiatric units, BMC has found great success with our system, only admitting 26% of behavioral health patients from our emergency department to inpatient psychiatric units. As is typically the case, the emergency department is the de facto first point of contact with the health

[6] Bebinger M. 716 psych patients are stuck in emergency rooms waiting for care, Mass. report shows. WBUR. October 11, 2021. https://www.wbur.org/news/2021/10/11/massachusetts-mental-health-boarding-report.

care system for a lot of BMC patients with behavioral health and substance use disorders. Based on our own internal estimates, however, 75% of patients that present to our emergency department with a behavioral health or substance use disorder diagnosis do not have the level of acute needs that would require care in an emergency setting. The psychiatric emergency department at BMC occupies a separate 9-bed bay within the larger emergency department, and offers a quieter, more private setting, staffed by psychiatrists and medical clinicians, including full-time master's level mental health clinicians from BEST. The level of experience and continuity of the BEST team is key to our ability to properly assign patients to the appropriate level of behavioral health care, instead of defaulting to an inpatient psychiatric unit, which are in short supply and may not be best suited for the patient. Being integrated with the larger emergency department also means that providers are able to have behavioral health and substance use disorder consults with patients in medical emergency department bays.

In addition to the emergency department, BMC has behavioral health urgent care centers on the hospital campus and in the community (in the Jamaica Plain neighborhood of Boston and Fall River) administered by BEST, plus a separate, on-campus urgent care infrastructure for identifying and treating patients with substance use disorders accessed through Project ASSERT (Alcohol & Substance use Services, Education and Referral to Treatment), which helps screen and engage patients in treatment, and Faster Paths to Treatment, which serves as a medication bridge clinic.

There are many behavioral health patients who do not need a full-service inpatient psychiatric facility, but who are not ready to be discharged to the community. BEST operates a Community Crisis Stabilization (CCS) program for adults, which provides a voluntary, unlocked space to stabilize and receive treatment, with a typical stay of three to five days, as a cost effective way to meet this in-between need, while reducing demand for inpatient psychiatric beds. That said, CCS units are currently in insufficient supply to meet the demand.

Additionally, the BEST model incorporates:

- 24/7 Call Center – provide support, information, referral, or arrange for in-person evaluations. Pilot to transfer 9-1-1 behavioral health calls to BEST Call Center;
- Mobile community-based crisis intervention – master's level mental health clinicians going out into the community to serve people who are in crisis where they are;
- Boston police co-response unit – master's level mental health clinicians paired with law enforcement for "ride along" responses to 9-1-1 calls;
- Pilot with Boston Emergency Medical Services (EMS) – mobile community-based crisis intervention pairing a master's level mental health clinician with an emergency medical technician (EMT), similar to CAHOOTS;
- Emergency Triage, Treat, and Transport (ET3) – Boston EMS applied, and received the funding, but deferred implementation for a year due to the COVID-19 pandemic. The Centers for Medicare and Medicaid Services (CMS) ET3 model allows EMS to treat in place, drop off at alternative locations to the hospital emergency department, including the BEST crisis unit.

Increased reimbursement and use of alternative payment models needed to support and sustain team-based behavioral health care models, including integrated behavioral health (IBH) in primary care

Expanding federal fee-for-service reimbursement and implementing alternative payment models to support increased behavioral integration in primary care could help address workforce shortages and improve access to behavioral health care. Integrated behavioral health can both help with detection and diagnosis of a mental health disorder, as well as provide management for chronic behavioral health conditions.

The overwhelming majority of patients with a behavioral health diagnosis have needs that can be met outside of a specialty psychiatry setting such as through integrated behavioral health (IBH) in primary care. These individuals commonly have a major depression diagnosis or some other diagnosis, but are stable with medication. The IBH model relies on a team of behavioral health providers – including psychiatrists, psychiatry nurse practitioners, social workers, and psychologists – to support the primary care provider in caring for patients. The behavioral health team conducts provider education and e-consults to increase the primary care provider's capacity to manage behavioral health patients. In addition, integrated behavioral health providers are available to engage patients in short-term care for stabilization, which improves care continuity by saving the patient from having to make a separate appointment at a separate clinic and enhances overall quality of care.

The IBH model relies on accurate and timely detection of behavioral conditions through routine, systematic behavioral health screening, use of evidence-based measurement tools to monitor progress and adjust treatment accordingly, and utilization of a stepped care approach that delivers the most effective, but least resource intensive treatment – "stepping up" or "down" the intensity of care as needed, e.g. graduating stable patients from specialty psychiatry to IBH. For patients with a positive depression screen, the BMC Depression Care Management (DCM) program, which combines case management and therapy, has had impressive results – increasing patient engagement with care and improving response to treatment. The DCM program facilitates primary care provider management of common uncomplicated behavioral conditions and thereby avoids unnecessary referrals to behavioral health specialists, preserving access to behavioral health specialists for more complicated patients.

Non-billable IBH interventions, including "curbside" consultations (e.g. informal consultations to primary care providers in the charting room), e-consults via the electronic medical record, brief warm handoffs that do not meet criteria for traditional billing codes, and clinical case review meetings with the integrated psychiatrist, are key to the program's success and should be reimbursable under Medicare fee-for-service and factored into capitated rates for alternative payment models to ensure sustainability and expansion of services. Additionally, Medicare could provide financial incentives for primary care providers to expand their knowledge and competency to treat common behavioral health conditions, as well as for routine screening and monitoring of common behavioral health conditions in primary care using evidence-based tools.

Reform federal anti-kickback regulation to permit contingency management for treatment of stimulant use disorder, i.e. raise CMS annual limit of $75 or provide "safe harbor"

Over the last five years, the northeastern United States has seen an increase in stimulant use, particularly of methamphetamine.[7] In Massachusetts, it is to the point now that most opioid overdoses – nearly all involving fentanyl – also involve some type of stimulant, namely cocaine and amphetamine (including methamphetamine).[8,9] Stimulant use is generally harder to treat than many other types of substance use disorders. Unlike with opioid use disorder, there is no medication approved by the Food and Drug Administration (FDA) to treat stimulant use disorder. Some medications are helpful, but behavioral health intervention is central to effective treatment of stimulant use disorder. Contingency management is a form of behavioral health intervention that uses rewards, typically in the form of a prize of monetary value (e.g. gift card), to incentivize individuals to meet treatment objectives or abstain from drug use. Oftentimes, there is an element of chance, such that a reward may not be received every time. Federal anti-kickback regulations, however, place restrictions on the amount of incentives that treatment providers can offer, which severely limits the effectiveness and availability of contingency management programs. CMS imposes a $75 annual limit on incentives. However, studies funded by the National Institute on Drug Abuse (NIDA) demonstrate that contingency management is more effective when incentives are considerably larger, averaging $400 to $500 per patient over the course of treatment.[10]

The BMC Stimulant Treatment and Recovery Team (START) recently started providing contingency management to patients with stimulant use disorder. BMC is also actively exploring offering the intervention more widely, including to adolescents and young adults through our CATALYST program. However, barring any change to regulation or related guidance, our addiction programs will not be able to use contingency management to its full potential to effectively treat our patients and promote recovery. Congress should reform federal anti-kickback regulations to permit wider use of contingency management for the treatment of substance use disorder by significantly raising CMS' annual limit or creating "safe harbor" whereby rewards would no longer be considered unlawful. This is in line with the Biden Administration's Drug Policy Priorities for Year One, in which the White House Office of National Drug Control Policy (ONDCP) lists "identify[ing] and address[ing] policy barriers related to contingency management interventions (motivational incentives) for stimulant use disorder" and "explor[ing] reimbursement for motivational incentives and digital treatment for

[7] Bebinger M. Meth Use Is Rising In Boston, Intensifying The Opioid Crisis. WBUR. December 4, 2018. https://www.wbur.org/news/2018/11/21/meth-worsening-opioid-epidemic.

[8] Massachusetts Department of Public Health. Trends in Stimulant-Related Overdose Deaths Data Brief. February 2020. https://www.mass.gov/doc/data-brief-trends-in-stimulant-related-overdose-deaths-february-2020/download.

[9] Massachusetts Department of Public Health. Opioid-Related Overdose Deaths among Massachusetts Residents Data Brief. May 2021. https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-may-2021/download.

[10] Glass JE, Nunes EV, Bradley KA. Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way. Health Affairs blog. March 11, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200305.965186/full/.

addiction, especially stimulant use disorder," as priorities for expanding access to evidence-based treatment.[11]

Medicare should follow the lead of states and permit providers to bill for preventive behavioral health services without requiring a mental health diagnosis

The Massachusetts combined Medicaid/CHIP program ("MassHealth"), effective September 1, 2021, joined states like Colorado and California in allowing providers to bill for preventive behavioral health services without requiring a mental health diagnosis – in this case for MassHealth members under 21 years old.[12] Medicare should follow the lead of states like Massachusetts and permit providers to bill for preventive behavioral health services without requiring a mental health diagnosis in order to scale this model nationally, thereby increasing access to behavioral health prevention and promotion for children and adults.

III. Ensuring Parity between Behavioral Health and Physical Health Care

Remove Medicare lifetime limits on inpatient psychiatric days

The Medicare cap on the number of inpatient psychiatric days a beneficiary can have in their lifetime is a glaring disparity between behavioral health and physical health care. People under age 65 who are chronically or severely mentally ill and on Medicare, who need inpatient mental health care and reach their lifetime limit, end up stuck in hospital emergency departments because inpatient psychiatric hospitals are unlikely to take them on as "free care," i.e. Medicare does not reimburse for inpatient psychiatric services provided to a patient who has reached their lifetime limit. Removing this cap would not only ensure parity between behavioral health and physical health care, but also likely increase access to mental health services and reduce the burden on hospital emergency services.

Medicare should cover and adequately reimburse the full continuum of behavioral services

Medicare does not provide reimbursement for many levels of behavioral health care. Medicare beneficiaries are therefore very much limited in what they are able to access when it comes to behavioral health services, and are typically left with either being seen in an emergency department or in an outpatient setting. While Medicare does pay per diem rate for partial hospitalization – which allows for an individual to attend a "day program" instead of receiving inpatient care – it is only allowed under certain limited circumstances. Crisis stabilization units, like those provided under the BEST program, are currently covered under the Massachusetts combined Medicaid/CHIP program ("MassHealth"), but not under Medicare.

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[11] White House Office of National Drug Control Policy. The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. April 1, 2021. https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

[12] Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid (MassHealth). Managed Care Entity Bulletin 65 – Preventive Behavioral Health Services for Members Younger than 21. August 2021. https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download.

Lack of consistency or parity between payers is both a barrier to behavioral health care for patients and an administrative burden for behavioral health providers. There is no standard menu of behavioral health services – e.g. some payers may only pay for emergency behavioral health services or only outpatient behavioral health services. The wide variation in payer coverage of behavioral health services, particularly among commercial payers, is difficult for both individuals and providers to navigate, and lacks an evidence base. While parity between behavioral health and medical coverage is required by law, more needs to be done to satisfy the spirit of the law in order to enhance the availability of behavioral health resources, create broader networks of care with streamlined administrative processes, raise the quality of care, and ensure that public and private payers are appropriately compensating the behavioral system, all of which would help increase access to behavioral health care.

IV. Furthering the Use of Telehealth

In formalizing Medicare coverage of telehealth for mental health services, Congress should establish parity with physical health and not create additional barriers to treatment

In December 2020, Congress passed the Consolidated Appropriations Act of 2021, which under Section 123 permanently permitted access to mental health services through telehealth for Medicare beneficiaries, i.e. meaning access was no longer tied to the COVID-19 public health emergency (PHE) declaration. Of particular interest to BMC, the statute requires an in-person, non-telehealth service for mental health services within six months prior to the initial telehealth service – though notably Congress provided an exception for treatment of substance use disorders or co-occurring mental health disorders. In implementing Section 123, CMS via the Calendar Year 2022 Medicare Physician Fee Schedule (PFS) proposed rule went a step further by requiring an in-person, non-telehealth service for mental health services within six months prior to the initial telehealth service, *and at least once every six months thereafter*.

During the COVID-19 PHE, telehealth has enabled BMC to maintain and exceed our pre-pandemic volume of mental health services, with over 90% of our outpatient psychiatric visits conducted via telehealth at peak. In addition, show rates to telehealth visits (video and audio-only combined), which to-date hover around 75-85%, have exceeded show rates to in-person behavioral health visits pre-COVID-19 PHE by roughly 10 percentage points, suggesting that telehealth has significantly reduced barriers and enhanced timely access to care for our patients.

In the BMC adult outpatient psychiatry clinic, show rates for new and established patients for therapy delivered by telemedicine are approximately the same. In contrast, show rates for in-person therapy visits are substantially lower for new patients than for established patients, and much lower than show rates for therapy visits delivered via telehealth (See Figure 1).

Figure 1 – Show rate by patient type and modality for BMC adult outpatient psychiatry clinic visits between June and July 2021.

	In-Person	Telehealth
New Patients	57%	77%
Established Patients	66%	78%

This data suggests that requiring the first visit and at least one visit every six months thereafter to be in-person could really present a barrier for many of our patients seeking to access mental health services. Our mental health clinicians feel that they have a better chance at engaging patients in care if telehealth is retained as an option without such restrictions. We fear that such a requirement could be the difference between patients receiving care or forgoing care altogether. In addition, placing administrative hurdles on telehealth for mental health services (both video and audio-only), but not physical health services, stands in direct violation of mental health parity law.

We urge Congress to remove the requirement for Medicare beneficiaries to have an in-person visit for mental health services in order to access telehealth for mental health services, and instead allow providers to rely on clinical discretion and patient preference to determine the appropriate treatment modality. We recommend Congress work with the Administration to ensure that Medicare coverage of telehealth for mental health services is consistent with mental health parity.

Providers should retain the ability to initiate buprenorphine by phone without requiring in-person or video appointment

Our addiction treatment providers have had great success with using the added flexibilities permitted under the COVID-19 emergency regulations to engage patients in treatment via telehealth. BMC supports making many of these changes permanent, including through passing an amended version of the **"Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act" (S.340)** to allow providers to prescribe medications for opioid use disorder to patients without needing a prior in-person visit and bill Medicare for audio-only telehealth services, including permanently allowing for audio-only initiation with buprenorphine. The latter – permitted under the current emergency regulations – has enabled our providers to reach some of the most vulnerable individuals with opioid use disorder who face significant barriers to accessing care, including lacking the means to connect via video teleconferencing.

One concern we have heard raised is that permitting audio-only prescribing of buprenorphine could lead to increased diversion. Our providers use a variety of tools to determine whether patients are taking and benefitting from buprenorphine, and the red flags that alert us to possible diversion would be the same for audio- and video-based visits, including inconsistencies in reported medical history, early refill requests, lost or stolen prescriptions, multiple prescribers, escalating use of other substances while on buprenorphine, and a lack of improvement on buprenorphine. When these concerns arise in patients on either audio- or video-based visits, our practice is to require an in-person evaluation with urine toxicology testing and/or pill counts to gather additional information and increase support.

In addition, it is worth noting that the dangers of diverted buprenorphine are not analogous to the dangers of diverted full agonist opioids. Research has shown that use of diverted buprenorphine is actually associated with a lower overdose risk and higher retention in subsequent treatment. In our experience, we have found that individuals turn to using diverted buprenorphine when they lack access to treatment – so it is possible that more widespread use of a low-barrier form of treatment like audio-only buprenorphine initiation may actually reduce diversion. We therefore argue that the overdose reduction benefits from increasing access to this life-saving medication outweigh the risks of any potential diversion.

Federal funding for telehealth access points in community can help bridge "digital divide"

In Boston, we know that along the socioeconomic spectrum there is not equal access to the technology that enables use of telehealth, with low-income and historically marginalized populations, including individuals facing homelessness and addiction, being much more likely to lack access to broadband internet, computers, smartphones, or cellular data plans. A 2020 report on remote learning found that 16% of homes with school-aged children in Boston don't have access to the internet.[13] This "digital divide" presents a major barrier to care for patients.

The digital divide is reflected in the widespread and enduring use of audio-only services across our health system and the disparate use of video services by race/ethnicity and preferred language. In the first few weeks of the COVID-19 PHE in March 2020 (prior to the launch of video visits at BMC in April 2020) when in-person volume dropped precipitously, audio-only services allowed patients to maintain continuity of care, representing 70-75% of total ambulatory visits across all modalities. Even as in-person volume has steadily returned at BMC since May 2020, and our system implemented a new video platform to enhance patient and provider experience in January 2021, audio-only services continue to account for a significantly greater percentage of our ambulatory visit volume compared to video, averaging roughly 25-30% of ambulatory volume compared to 10-15% of ambulatory volume for video. BMC data also demonstrate that a higher proportion of White and English-speaking patients scheduled and completed ambulatory visits via video compared to non-White (particularly Black and Latinx) and non-English-speaking patients. This trend of differential utilization of video care by race/ethnicity and language has been shown to be consistent across diverse medical systems.[14,15] This contrast is particularly stark given the disproportionate impact of COVID-19 on communities of color.

Earlier this year, the BMC integrated behavioral health program launched a pilot telehealth hub for behavioral health counseling visits to take place in community in partnership with a local church. By providing access to video capable technology, high-speed, reliable internet, and a

[13] Kavanaugh K and Alulema P. "The Digital Divide: Remote learning not possible for all families." Boston 25 News. August 5, 2020. https://www.boston25news.com/news/25-investigates/digital-divide-remote-learning-not-possible-all-families/JDXYZEQF5BDX7ECLFLTUFWWOVU/

[14] Uscher-Pines L, et al. "Telehealth use among safety-net organizations in California during the COVID-19 pandemic." JAMA. 2021;325(11):1106-1107. doi:10.1001/jama.2021.0282

[15] Rodriguez JA, et al. "Differences in the use of telephone and video telemedicine visits during the COVID-19 pandemic." Am J Manag Care. 2021;27(1):21-26. doi:10.37765/ajmc.2021.88573

private space in a convenient, trusted location, the pilot seeks to reduce barriers for people to utilize telehealth. The cost of administering the pilot so far involves the cost of equipment (e.g. computer) and an on-site project coordinator to help people get connected. So far the pilot has shown promise, and our team is in the process of scouting out additional locations, including community centers and libraries. The federal government could play a role in helping accelerate the development of community telehealth hubs by providing grants to health systems, hospitals, federally qualified health centers, schools, and community-based organizations to purchase equipment, retrofit space, hire staff and receive or provide technical assistance.

On behalf of Boston Medical Center, I appreciate this opportunity to provide comments in response to this request for information. Our hospital and health system stand ready to serve as a resource to the Committee as it continues its critical work of increasing access to health care services for individuals with mental health and substance use disorders.

If you have questions, please contact me at 617-638-6732 or Melissa.Shannon@bmc.org.

Sincerely,

Melissa Shannon, J.D.
Vice President for Government Advocacy
Boston Medical Center