



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Comments to the U.S. Senate Committee on Finance in Response to the RFI on Mental and Behavioral Health

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to provide feedback to the Senate Finance Committee on the Request for Information (RFI) on proposals to improve patient access to mental and behavioral health services.

As noted in the RFI, patients across the country face significant challenges accessing mental and behavioral health care. This problem was exacerbated during the COVID-19 pandemic, coupled by the fact that there is a national shortage of many health care providers, particularly mental and behavioral health care providers. For example, the Kaiser Family Foundation found the U.S. was fulfilling only 26.9% of the need for mental health clinicians, as reported in their September 2020 Mental Health Care Health Professional Shortage Areas data.¹ Massachusetts, a state known for a strong health care sector, is reported as having mental health provider resources to meet approximately 32.2% of the needs of its population.

In this letter, MMS identifies challenges facing mental and behavioral health care providers, obstacles for patients receiving mental and behavioral health services, and suggestions for improving the health care system. Our comments focus on four categories outlined in the RFI: Strengthening the Mental and Behavioral Health Care Workforce; Furthering the Use of Telehealth; Increasing Integration, Coordination, and Access to Care; and Improving Access for Children and Young People.

Strengthening the Mental and Behavioral Health Care Workforce

The MMS wishes to underscore the urgent need to invest sufficiently in the behavioral health system to make a substantial improvement in access to care. The Society has long engaged in advocacy to improve behavioral health in Massachusetts, but we have never heard greater and more widespread concern regarding the dire need to improve access to behavioral health in Massachusetts than now. Physicians from varying specialties and practice settings and across geographic regions in the Commonwealth are expressing increasing concern on this issue. As MMS has engaged with physician-experts in the behavioral health space and with many peer stakeholder organizations, workforce and reimbursement dilemmas are emerging as root causes of so many of the challenges in the behavioral health care space. Issues such as behavioral health boarding, while multifactorial in nature, could be most swiftly addressed by shoring up the behavioral health workforce to allow more licensed inpatient beds to accept patients as well as improved access to outpatient and day treatments for patients not requiring hospitalization. On the preventive and outpatient side, while there are evidence-based models to effectively integrate behavioral health into primary care settings, workforce shortages and inadequate reimbursement models undermine the establishment and sustainability of this collaborative care model.

¹ Kaiser Family Foundation: Mental Health Care Health Professional Shortage Areas (HPSAs) Data: <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

In a recent letter to the Massachusetts state legislature², MMS proposed that the state should use federal dollars from the *American Rescue Plan Act* to create a comprehensive behavioral health workforce investment plan that combines tuition reimbursement, loan forgiveness, and training to create a sustainable pipeline of behavioral health care professionals, from mental health workers to psychiatrists, who can meet the pressing demand in the state. The MMS would support a similar plan and framework at the federal level.

Furthermore, workforce challenges extend throughout all of health care and across many other industry sectors. While the behavioral health workforce shortage is critical in nature, MMS wishes to underscore other workforce challenges that will need urgent attention as well. Primary care physicians are having significant challenges recruiting and retaining staff, from nurses to medical assistants and front office staff.

In addition, specialty practices such as radiology clinics have had significant challenges recruiting technical personnel necessary for mammograms and colonoscopies. In these critical preventive services, there are sufficient imaging machines and enough physicians to perform and read the tests but without enough supplementary medical professionals, significant limitations on services lead to longer wait times for patients, which ultimately leads to delayed diagnoses and poorer health outcomes.

We urge consideration of broad-based workforce initiatives in the health care space to ensure a robust pipeline of primary care physicians and other health care professionals. The MMS supports and has advocated on several pieces of legislation aimed at strengthening the health care workforce, including:

- S. 54, *Strengthening America's Health Care Readiness Act*, which expands the National Health Service Corps, National Disaster Medical System, and Nurse Corps programs.
- S. 834/ H.R.2256, *Resident Physician Shortage Reduction Act of 2021*, which increases the number of residency positions eligible for graduate medical education payments under Medicare.
- S. 1024/H.R. 2255, *Healthcare Workforce Resilience Act*, which makes previously unused immigrant visas available to nurses and physicians.
- H.R. 2418, *Student Loan Forgiveness for Frontline Health Workers Act*, which establishes temporary programs to provide federal and private student loan forgiveness to certain frontline health care workers. The MMS has also engaged with our Massachusetts congressional delegation and the Health Resources and Services Administration (HRSA) on the issue of the affordability of medical education broadly with a focus on equity and diversifying the health care workforce. Making medical education more affordable would reduce barriers to entry into the medical profession and help ensure a robust health care workforce.

Moreover, future federal investments present an important opportunity to address racial equity. The Medical Society urges the Senate Finance Committee to ensure that funds dedicated to workforce development in the health care system focus on diversifying our health care workforce. This is consistent with robust data linking diverse medical workforce with improved health outcomes for communities of color.

² MMS Letter to House Speaker on investment of federal funds received via the American Rescue Plan Act <https://www.massmed.org/Advocacy/State-Advocacy/State-Advocacy-Letters/Letter-to-House-Speaker-on-investment-of-federal-funds-received-via-the-American-Rescue-Plan-Act/>

In addition, it will be important for Congress to help ensure the mental health of the health care workforce. We appreciate that the Senate passed S.610, the *Dr. Lorna Breen Health Care Provider Protection Act*, which aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals. We hope that you will continue to work with your colleagues in the House to prioritize this critical piece of legislation and pass it this year.

Furthering the Use of Telehealth

The flexibilities and enhancements that have been granted during the COVID-19 Public Health Emergency (PHE) have accelerated the utilization of telehealth across the United States and in Massachusetts. COVID-19 telehealth policy changes have ensured that Massachusetts residents have access to critical health care services while supporting necessary precautions to limit exposure to COVID-19, reduced the stress and burden of traveling to appointments (including the cost of tolls and parking and time lost from work), allowed continued social distancing, and preserved personal protective equipment for the health care workforce. Telehealth (including audio-only services) has been a powerful tool to increase equitable access to care for all residents of the Commonwealth and promote the principles of health equity and health justice.

Telehealth utilization grew immensely during the pandemic. According to FAIR Health, telehealth accounted for 6% of all claims submitted across payers in August 2021, up from just .08% just two years ago.³

Telehealth appointments have also improved patient compliance with appointments and reduced no-shows—one Massachusetts health system reported that telehealth show rates had been 89% during the first half of 2020 versus the show rate of 80% for in-clinic-only visits during the previous year. Moreover, a study by an MMS member (at the UMass Memorial Hahnemann Campus) published in the *Journal of the American Academy of Dermatology* shows that compared to visit rates in-clinic, telehealth visits “had significantly lower no-show rates, with the greatest reductions seen for Black or African American, LatinX, and primary non-English speaking patients.”⁴

Telemedicine’s ability to improve show rates extends beyond increased access to necessary care: these efficiencies also translate to high-value, lower cost care. It is important to note that expanding and making permanent telehealth flexibilities will not add substantial cost. For example, a report by the Taskforce on Telehealth Policy (convened by the National Committee for Quality Assurance, Alliance for Connected Care, and the American Telemedicine Association) found that “the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded.”⁵ The authors argue that telehealth may improve costs because of fewer missed appointments (no-show rates) that improve compliance, fewer costly Skilled Nursing Facility patient transfers to hospitals/emergency departments, and increased use of transitional care

³ FAIR Health Data on Telehealth Utilization by State: <https://www.fairhealth.org/states-by-the-numbers/telehealth>

⁴ Franciosi EB, Tan AJ, Kassamali B, O’Connor DM, Rashighi M, LaChance A, Understanding the Impact of Teledermatology on No-Show Rates and Healthcare Accessibility: A Retrospective Chart Review, *Journal of the American Academy of Dermatology* (2020), doi: <https://doi.org/10.1016/j.jaad.2020.09.019>.

⁵ NCQA Taskforce on Telehealth Policy (TTP): Findings and Recommendations, <https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-ttp-findings-and-recommendations/>

management that cuts readmissions—however, they note that additional data after the PHE would be helpful for a fuller assessment on long-term cost of telehealth.

Permanent Adoption of Telehealth – Removing Geographic Location and Originating Site Restrictions

Due to the success of telehealth since the start of the PHE, the MMS urges Congress to continue to strengthen telehealth policies and make permanent many of the flexibilities granted during the COVID-19 PHE. The most impactful change to telehealth policies during the PHE has been the ability to deliver services to patients wherever they are located, including but not limited to their home, nursing home, and hospitals of all types, etc. Congress should make every effort to swiftly obtain permanent, statutory authorization for delivery of Medicare telehealth services to patients wherever they are located—this can be done through legislation permanently removing the restrictions on geographic location and originating site requirements for Medicare beneficiaries. This is critical to allow Medicare beneficiaries to receive telehealth from their homes. As background, *Section 1834(m) of the Social Security Act* restricts the delivery of telehealth services to certain rural areas of the country through geographic site restrictions and certain physical locations such as hospitals and physicians’ offices through originating site restrictions. During the PHE, physicians and other health care providers have been permitted to deliver telehealth services to Medicare beneficiaries in their homes and other locations in any area of the country—but those flexibilities are tied to the PHE and will go away once the PHE ends. Legislation is required to permanently remove these restrictions from statute. The MMS supports S. 368/H.R. 1332, *The Telehealth Modernization Act*, that will address this issue. We are assessing other similar legislation in Congress that would achieve this aim.

Audio-only Telehealth (Particularly Important for Mental and Behavioral Health)

As you may be aware, the Centers for Medicare and Medicaid Services (CMS) proposed a new definition of “interactive communications technology” to allow for use and coverage of audio-only mental health services in their recent CY 2022 Medicare Physician Fee Schedule (MPFS) proposed rule. However, CMS outlines requirements that must be met for this type of service to be furnished. Audio-only for mental health services will be allowed if:

- It is an established patient;
- The patient is at home;
- The provider has capability of doing live video;
- The patient cannot or does not want live video; and
- The patient has had an in-person visit with the telehealth provider in the six months prior.

In addition, CMS requested feedback on a modifier for these mental health services furnished via audio-only to certify that a provider has the capability or proper technology to conduct an audiovisual mental telehealth visit.

The MMS strongly supports CMS’ proposal to expand the definition of an interactive communications technology for the purposes of telehealth to include audio-only communication technology for mental health services. However, we have serious concerns around the six-month, in-person visit requirement and believe that the determination of when in-person care is necessary should be up to the discretion of the physician (see below section for additional feedback on the 6-month requirement). Furthermore, additional clarity will be needed on how a patient’s “home” is being defined—and we would encourage the Senate Finance Committee to urge CMS to open the requirement to other locations besides a patient’s home. For example, for equity reasons, it may be more beneficial for a patient to conduct a telehealth mental health visit from their car, workplace, or other location of their choosing. Instead of specifying that a patient

take part in the visit from their home, it would be better to remove the geographic or originating site requirements (mentioned above). We also have concerns about the requirement that the patient be an established patient, and we ask policymakers to develop a pathway for a physician to establish a new relationship with the patient via audio-only mental telehealth services. This is especially important given the fact that many mental health providers have begun practicing in a fully remote setting because of telehealth success during the pandemic. Finally, we have concerns about the clinical appropriateness of the modifier needed to certify that the provider has audiovisual capabilities—and fear this could pose data collection and equity challenges and create an administrative burden for physicians.

In addition, the MMS urges the Senate Finance Committee to support legislation that would allow for audio-only services for a wide range of telehealth services, not just mental or behavioral health-related visits. As background, CMS was given authority to approve audio-only visits for Medicare during the Public Health Emergency (PHE). Audio-only visits for the Medicare fee-for-service program were also covered during the PHE, which has promoted equitable access to care and helped bridge the digital divide. However, permanently allowing services to be delivered via audio-only connection requires legislation. We hope forthcoming legislation will permanently allow the delivery of telehealth via audio-only connections for a wide range of health services. In addition, we would appreciate Congress' support in urging CMS to permanently cover audio-only telehealth and have those services paid on par with in-person rates. Patients should be able to receive the care they need regardless of the technology used to deliver the care. This is important given the digital divide between those who have access to computers and reliable, high-speed internet service and those who do not—and what that means for patients' ability to receive equitable access to care. For example, a Pew Research Center survey found that Black and Hispanic adults are less likely to own a traditional computer or have high-speed internet at home than Whites. The study found “roughly eight-in-ten Whites (82%) report owning a desktop or laptop computer, compared with 58% of Blacks and 57% of Hispanics.” Similar statistics were found in broadband access, with 66% of Blacks and 61% of Hispanics reporting having broadband access compared to 79% of Whites. However, there were equal percentages of smartphone usage between Blacks, Hispanics, and Whites—80%, 79%, and 82%, respectively.⁶ This is also an important issue for elderly and low-income populations who either do not have access to advanced telehealth technology, audio/visual technology, or internet access—or who have trouble navigating virtual visits with both audio and video capabilities. It is vital for these vulnerable populations to be in contact with their physicians and receive timely care. Therefore, it is essential that audio-only visits continue to be covered by Medicare and they should be paid on par with in-person rates.

Furthermore, we ask for the Senate Finance Committee's help in urging CMS to allow audio-only telehealth visits to be used for Medicare Advantage (MA) risk adjustment in the same way as in-person or audiovisual telehealth visits. In 2020 and 2021, CMS has allowed video-enabled telehealth to be used to document health acuties for MA risk adjustment purposes, but it has not extended that flexibility to audio-only telehealth. It is critical to include diagnoses from all health care services for MA risk adjustment to ensure health care costs are accurately captured, patient benefits are preserved, and premiums are stable. In addition, including all health care visits in risk adjustment is important to provide clinical care teams with the information they need to provide accurate, comprehensive care. For similar reasons as mentioned above, the current model of excluding audio-only telehealth visits for risk adjustment exacerbates health inequities for patients without access to audio-visual technologies. Allowing audio-only

⁶ Perrin A, Turner E. “Smartphones help Blacks, Hispanics bridge some – but not all – digital gaps with Whites.” *Pew Research Center*. <https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/>

telehealth visits for MA risk adjustment will be critical for patient access to equitable, quality care.

Mental Health Services – In-person Six-month Requirement

The *Consolidated Appropriations Act, 2021 (CAA)* allows for tele-mental health services in the home and other locations by removing the originating site and geographic location restrictions. The MMS strongly supports these restrictions being waived (see above). However, under the statute, Medicare will provide coverage and reimbursement for telehealth mental health services only if the clinician has conducted an in-person consult with the patient in the prior six months and continues to conduct in-person exams (at a frequency to be determined by U.S. Health and Human Services). The MMS has been actively engaged in congressional advocacy in opposition to this six-month requirement.⁷

In the CY 2022 MPFS proposed rule, CMS provides details around the regulatory framework and frequency timeline for implementing the CAA requirements—but takes the requirements a step further. CMS proposes to require that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within six months before each telehealth service is furnished for the diagnosis, evaluation, or treatment of mental health disorders.

We have serious concerns about the requirement that patients have an in-person visit with a physician within six months of each telehealth service. We are not aware of any evidence supporting the claim that requiring an in-person visit every six months is an appropriate interval nor that it provides a clinical benefit. While statute requires an in-person visit within six months of the initial tele-mental health service, we believe that CMS has the authority to set the subsequent treatment timeline as they choose and could determine that an in-person follow-up is unnecessary. We are concerned that this arbitrary six-month timeframe could have a serious negative impact on a patient’s ability to receive care—there is both a lack of regular access to mental health services in many areas and it could require travel that is unfeasible for the patient, forcing them to forgo necessary care. CMS states that “[w]e chose this interval because we are concerned that an interval less than six months may impose potentially burdensome travel requirements on the beneficiary, but that an interval greater than six months could result in the beneficiary not receiving clinically necessary in-person care/observation.” Physicians are in the best position to understand the clinical needs of their patients and should be given discretion to make the determination whether in-person treatment is needed. The MMS urges the Senate Finance Committee to ensure that patients can access the care that they need and revise this arbitrary six-month in-person follow-up requirement in legislation (and urge CMS not to finalize their proposal in the CY 2022 MPFS).

Increasing Integration, Coordination, and Access to Care

A significant proportion of mental and behavioral health care occurs outside the mental health system, often occurring during primary care (including family medicine and internal medicine). As of 2019, approximately 1 in 5 adults in the U.S. experience mental illness each year (with 1 in 20 reported as experiencing serious mental illness)⁸. A report by the University of Michigan

⁷ tMED Coalition Letter to the Massachusetts Congressional Delegation:

[https://www.massmed.org/Advocacy/Federal-Advocacy/Federal-Advocacy-Letters/Letter-to-Massachusetts-Congressional-Delegation-on-Telebehavioral-Health-Law-\(Section-123-Provision\)/](https://www.massmed.org/Advocacy/Federal-Advocacy/Federal-Advocacy-Letters/Letter-to-Massachusetts-Congressional-Delegation-on-Telebehavioral-Health-Law-(Section-123-Provision)/)

⁸ Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health

<https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf>

Behavioral Health Research Center notes that over 24 million adults with a mental illness do not receive any treatment, but for those who do seek treatment, “approximately half of all care received for common psychiatric disorders is provided by primary care physicians (PCPs), including those practicing in family medicine, internal medicine, or general practice.”⁹

To address these challenges, the Massachusetts Medical Society supports the integration of mental health, behavioral health, and substance use treatment into the primary care setting, and we support the elimination of obstacles for payment of these services. Furthermore, we support the development of guidelines for standardized and prioritized timely communication between mental health, primary care, and all referring clinicians, which includes (at minimum) diagnoses, treatment plan, medication plan, and specific follow-up instructions. We also support primary care practitioners performing preventive care, including careful history, validated screening, and relevant examination for mental health and substance use during visits for adolescents and adults.

The MMS is currently developing a comprehensive report on increasing integration and collaborative care. We would welcome the opportunity to share that report with the Senate Finance Committee, once it is finalized. The below excerpt from the forthcoming report highlights current, federal models for collaborative care, obstacles to their widespread adoption, and suggestions for improvement:

“In addition to the increased presence of psychiatric patients and disorders in the Primary Care setting, PCPs face two major hurdles: Referring patients to psychiatric clinicians and developing the skills and expertise to treat these patients and disorders themselves. This is especially challenging given that PCPs are seeing many chronic and complicated cases such as Schizophrenia and Bi-Polar Disorder. Unfortunately, achieving optimal care by referral to mental health specialists is a significant challenge. Roughly two-thirds of PCPs are unable to connect their patients to appropriate out-patient mental health services. This represents a significant challenge for PCPs here in the Commonwealth.

“Several models of care coordination improve patient outcomes while reducing health expenditures. This includes Collaborative Care Management (CoCM), in which primary care providers are paired with case managers and specialty mental health providers to deliver care for such conditions as depression. Randomized controlled trials have shown that CoCM is effective and yields a 13:1 return on investment. CMS has introduced billing codes for CoCM¹⁰ and the Screening, Brief Intervention and Referral to Treatment (SBIRT) among Medicare beneficiaries, yet implementation of models like CoCM has have been underwhelming and largely confined to academic medical centers. The new Medicare billing codes for CoCM have been underutilized, and providers have expressed consternation about the level of practice transformation required to execute CoCM—including hurdles related to regulation, licensing, reimbursement, and logistics of workflow. These shortcomings are not unique to CoCM. They apply to other care coordination models, ranging from SBIRT, to Primary and Behavioral Health Care Integration, to Improving Mood-Promoting Access to Collaborative Treatment

⁹ University of Michigan, School of Public Health, Behavioral Health Workforce Research Center report on Behavioral Health Service Provision by Primary Care Physicians https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf

¹⁰ CMS Behavioral Health Integration Services Booklet <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>

(IMPACT). In short, there remains a wide gap between evidence showing the impact of care coordination on improved mental health and what is being done in primary care settings throughout the country. None of these obstacles is insurmountable. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington has developed a standardized approach to support practices in implementing CoCM, which includes team-building and technical activities that garner buy-in and help address workflow challenges. SAMHSA has also supported a Center of Excellence for Integrated Health Solutions, led by the National Council for Behavioral Health, which provides training, resources, and technical assistance. Monitoring tools to support implementation, such as the Stages of Implementation Completion, have also shown early promise.”

Furthermore, the MMS recommends that acute psychiatric follow-up care be performed in a timely manner to attain and ensure optimal mental health follow-up care. As background, a systems-based bridging model is necessary (beyond simply checking a box within the electronic health record) since communication is not built into every program. A Healthcare Effectiveness Data and Information Set (HEDIS) measure, Follow-Up After Hospitalization for Mental Illness, is currently in place that calls for patient needs disposition before discharge—but this is often a perfunctory call with no standard protocol to communicate with the PCP.

Successful Massachusetts Integration Programs

In addition, we would also encourage the Senate Finance Committee to examine three successful programs in Massachusetts that are integrating mental and behavioral health with primary care. The program model (now expanded to include mental and behavioral health services for children, pregnant/postpartum patients, and substance use disorders) involves a toll-free contact number that Massachusetts health care providers can call to receive advice and information on how to diagnose, address, and treat mental and behavioral health concerns in their patients. These call lines are staffed by experts in mental and behavioral health in the specific population being treated, and provide a helpful, needed resource for the treating physicians. Consultations are free of charge, funded by state funds and private contributions. These programs may be replicable on a federal scale (a federal resource center or toll-free call line staffed with mental health experts); or alternatively, federal legislation could designate state funding specifically for states to develop similar programs in their communities (or fund existing programs aligned with this model). More details on the programs are included here:

1. **Massachusetts Child Psychiatry Access Program (MCPAP)**¹¹ – Developed in 2004, MCPAP is a “system of regional children’s behavioral health consultation teams designed to help primary care providers and their practices to promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness.” It supports the integration of behavioral and physical health by having dedicated child and adolescent psychiatrists and independently licensed behavioral health clinicians available to consult with clinicians working in the primary care. Child psychiatry services are a scarce resource in Massachusetts—by making those services available to primary care providers, it increases access to mental and behavioral health treatment for patients. The consultation and education delivered through the MCPAP program also improves the pediatric team’s competencies and comfort in identifying and addressing mental and behavioral health concerns. Telephone numbers are provided for regional teams across Massachusetts that can provide mental and behavioral health consultations. At least 30 states have developed similar models based on Massachusetts’ MCPAP program.

¹¹ About MCPAP <https://www.mcpap.com/About/OverviewVisionHistory.aspx>

2. **MCPAP for Moms**¹² – provides “real-time, perinatal psychiatric consultation and resource and referral for obstetric, pediatric, primary care and psychiatric providers to effectively prevent, identify, and manage their pregnant and postpartum patients' mental health and substance use concerns.” This program expanded on the MCPAP model mentioned above. Using a toll-free number (855-Mom-MCPAP or 855-666-6272), MCPAP for Moms helps providers identify and address the mental health and substance use concerns in pregnant and postpartum patients.
3. **Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP)**¹³ – supports Massachusetts physicians in “increasing their capacity for, and comfort in, using evidence-based practices in screening for, diagnosing, treating, and managing the care of all patients with chronic pain, substance use disorders, or both.” Physicians can call 1-833-PAIN-SUD (1-833-724-6783) for an on-demand physician consultation on safe prescribing and managing care for adult patients. MCSTAP is staffed by physician consultants who have extensive academic and clinical expertise in safe prescribing and managing care for patients with chronic pain and substance use disorders.

The MMS, along with several members of the Massachusetts Congressional Delegation, were involved in developing these programs in Massachusetts. We would be happy to provide additional information on their development in the state and the programs' effectiveness in helping physicians navigate mental health and substance use concerns.

Improving Access for Children and Young People

In the U.S., 1 in 6 (16.5%) of children (under 18 years of age) experience a mental health disorder each year¹⁴, and 50% of lifetime mental illness begins by age 14 (75% by age 24)¹⁵. The above section in this letter on integration and coordination discusses one way Massachusetts has increased access to mental health services for children through the Massachusetts Child Psychiatry Access Program (MCPAP). In addition to instituting a similar program on a national scale, the Massachusetts Medical Society recognizes that mental health in schools is critical for improving youth patient outcomes. The MMS supports policies that would increase counselors within the school system and in communities to assist with access to mental health and substance use counseling for all children, adolescents, and their families.

As always, the Massachusetts Medical Society appreciates the opportunity to work with the Senate Finance Committee on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org, 781-434-7215.

¹² About MCPAP for Moms <https://www.mcpapformoms.org/About/About.aspx>

¹³ About MCSTAP <https://www.mcstap.com/About/About.aspx#>

¹⁴ JAMA: US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children
<https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377?guestAccessKey=f689aa19-31f1-481d-878a-6bf83844536a>

¹⁵ Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication <https://pubmed.ncbi.nlm.nih.gov/15939837/>