American Association of Child & Adolescent Psychiatry

June 26, 2024

The Honorable Ron Wyden, Chair
U.S Senate Committee on Finance
Washington, D.C. 20510

The Honorable John Cornyn
U.S. Senate Committee on Finance
Washington, D.C. 20510

The Honorable Bob Menendez
U.S Senate Committee on Finance
Washington, D.C. 20510

The Honorable Bill Cassidy, MD
U.S. Senate Committee on Finance
Washington, D.C. 20510

The Honorable Michael Bennet
U.S Senate Committee on Finance
Washington, D.C. 20510

The Honorable Thom Tillis
U.S. Senate Committee on Finance
Washington, D.C. 20510

The Honorable Catherine Cortez Masto
U.S Senate Committee on Finance
Washington, D.C. 20510

The Honorable Marsha Blackburn
U.S. Senate Committee on Finance
Washington, D.C. 20510

Dear Chairman Wyden, Senator Cornyn, Senator Menendez, Senator Cassidy, Senator Bennet, Senator Tillis, Senator Cortez Masto, and Senator Blackburn:

On behalf of the American Association of Child and Adolescent Psychiatry (AACAP), the professional home to more than 11,000 child and adolescent psychiatrists, fellows, residents, and medical students, I write in response to the Bipartisan Medicare Graduate Medical Association (GME) Working Group's Draft Proposal Outline and Questions for Consideration. AACAP is appreciative of this timely effort to address the ongoing workforce shortages and is encouraged by the working group's focus on promoting psychiatric care in rural and underserved areas. AACAP respectfully offers the following feedback and suggestions to the working group's policy proposal as you continue to enhance our health care workforce and increase patient access to care.

Additional Residency Positions in Psychiatry and Psychiatric Subspecialties

Last year, Congress added 200 new Medicare slots in the 2023 Consolidated Appropriations Act (CAA), with 100 designated for psychiatry and psychiatric subspecialties. However, the United States does not have nearly enough mental health professionals to treat everyone who is suffering with mental illness. More than 122 million people live in federally designated Mental Health Professional Shortage Areas (HPSA), as defined by the Health Resources and Services Administration (HRSA).[1] Moreover, the COVID-19 pandemic increased the need for mental health professionals, especially child and adolescent psychiatrists, to address the national state of emergency in children's mental health.[2]

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas
[2] https://www.aacap.org/App_Themes/AACAP/Docs/press/Declaration_National_Crisis_Oct-2021.pdf

AACAP enthusiastically supports the working group's proposal to add additional Medicare GME slots from fiscal year (FY) 2027 through 2031. Adding the new psychiatric positions would help address gaps in access to high-quality specialty mental health care. A total of 240 U.S. medical school graduates and 64 U.S. and non-U.S. international medical graduates (IMGs) matched into a child and adolescent psychiatry fellowship as part of the National Resident Matching Program (NRMP), bringing the total to 304 filled positions out of the available 377.[3]

As the working group considers quantity and specialty allocations, AACAP urges that anticipated future deficits in psychiatry be taken into account. AACAP strongly encourages the working group to build on past bipartisan efforts, including the Mental Health Workforce Discussion Draft put forward by Sens. Wyden, Crapo, Daines, and Stabenow. This proposal looks to provide 400 new Medicare-supported GME slots for psychiatry and pediatric subspecialties annually over 10 years; this effort would represent a significant step in addressing the growing crisis of access to mental health care. Additionally, AACAP suggests that the annual addition of 400 new psychiatry residency slots serve as a baseline when determining the mechanics of any future expansion.

Financing Psychiatric Subspecialty Programs

Funding for GME also plays a key role in improving access to mental health in rural and underserved areas. GME ensures that a sufficient workforce of highly skilled psychiatrists, including psychiatric subspecialties such as child and adolescent psychiatrists, is available. Child and adolescent psychiatrists begin their GME training in general psychiatry but must also complete 2 years of fellowship training in child and adolescent psychiatry.

The current national emergency in children's mental health demonstrates a dire need to increase the number of child and adolescent psychiatrists. There are currently about 11,400 practicing child and adolescent psychiatrists. State ratios of child and adolescent psychiatrists per 100,000 children has a national average of 15, well below the recommended 47\.[4] Additionally, 72% of U.S. counties lack a practicing child and adolescent psychiatrist. However, the current limitation on the duration of full GME funding during the initial residency period has created a financial barrier for expanding psychiatric subspecialties because the direct medical education (DME) funding from Medicare available for fellowship training years is 50% of the level provided for the initial residency period. To this end, AACAP recommends to the working group that GME training for all psychiatric trainees, including psychiatric subspecialties such as child and adolescent psychiatrists, be fully funded for the full length of training required to meet the standards of these programs.

Supplementing Investments in New Psychiatry Residency Positions

Increasing the number of child and adolescent psychiatrists is an essential strategy to improve access to high-quality specialty child and adolescent behavioral health care. This goal should be coupled with supporting short-term workforce enhancement strategies. Child and adolescent psychiatrists practice in a wide range of settings and further facilitate access to treatment through

[3] https://www.nrmp.org/wp-content/uploads/2024/02/2024-SMS-Results-Data-1.pdf
[4] https://www.aacap.org/AACAP/zLatest_News/Workforce_Maps_Illustrate_Severe_CAP_Shortage.aspx

telemedicine consultation and collaborative care arrangements with primary care providers, schools, and other child-facing systems. Integrating pediatric behavioral health care in all child-facing systems of care, including primary healthcare and school-based health care, facilitates a patient's access to mental health care by meeting them where they are. Integrated behavioral health and primary care models, including the Collaborative Care Model (CoCM), offer primary care providers a way to bill for and be reimbursed for the integration of behavioral health managers and psychiatrists into their practice. CoCM is an established, team-based approach to integrated care that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness of mental health and substance use disorder treatment in primary care settings.[5]

The COMPLETE Care Act (S. 1378), introduced by Sens. Cortez Masto and Cornyn, would temporarily increase Medicare payment rates for integrated behavioral health services, including CoCM. Despite the proven effectiveness of the CoCM model, uptake among Medicaid programs, health systems, and primary care providers has been slow, especially in pediatrics. This delay is based on several factors: not all states have adopted CoCM as a covered benefit under Medicaid, especially in pediatric settings; the rates paid for services are insufficient to incentivize provider participation; and the model requires upfront support for practices to ensure successful adoption. Policy changes at the federal and state level could address these factors and accelerate the adoption of CoCM in Medicaid, the largest payer of behavioral health care and the largest insurer of children and adolescents, particularly for those who are underrepresented in the healthcare delivery system.

Since CoCM integrates mental health care into primary care and other pediatric settings and has been shown to be effective in the early identification and treatment of mental health conditions, it holds promise to help bridge the gaps in access to mental health treatment for a greater number of the nation's youth. This integration of services addresses access barriers and the stigma often associated with seeking out mental health services. To help promote and support the uptake of evidence-based integrated care, and to better leverage the existing and limited behavioral health workforce, AACAP urges the working group to consider this bipartisan legislation as a supplement to any additional residency slots.

Virtual Supervision Extensions

AACAP supports the working group's proposal to extend the ability of teaching physicians to use telehealth to supervise resident physicians and recommends that this provision become permanent. The ability of teaching physicians to supervise residents through appropriate audio-visual equipment in real time was an essential flexibility throughout the COVID-19 Public Health Emergency (PHE). This would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought through audio/video real-time communication technology.

In addition, in 2022, the Accreditation Council for Graduate Medical Education (ACGME) amended its rules to allow for audio/visual supervision of residents, and its guidelines now state that direct supervision can occur when "the supervising physician and/or patient is not physically

[5] https://mmhpi.org/wp-content/uploads/2024/01/Collaborative-Care-Brief-January-2024.pdf

present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."[6] With appropriate safeguards and monitoring in place that considers each resident's need for supervision and their competency and training, as ACGME has outlined, AACAP supports continuing remote supervision on a permanent basis.

Telehealth Flexibilities

For individuals living in rural areas, the reality of travelling long distances for behavioral health services often is a deterrent to receiving care. Telehealth can and continues to alleviate the gaps exposed by the workforce shortage, including in rural and urban underserved areas. Telehealth provides a link between patients in their home communities and child and adolescent psychiatrists in other locations. The current telehealth flexibilities passed by Congress have allowed patients, both in urban and rural areas, to retain their ability to access telehealth services, particularly from their own homes. The FY 23 Omnibus extended multiple telehealth flexibilities until January 2025. Importantly, the legislation delayed implementation of the 6-month in-person visit requirement prior to initiating telehealth for mental health treatment until December 31, 2024.

AACAP members are dedicated professionals who want to practice medicine safely while doing what is best for their patients, and AACAP believes that the timing of in-person visit requirements for mental health conditions or substance use disorders should be left to the discretion of the treating physician, allowing patients in urgent need of care, including populations who are underserved, to receive it via telehealth or audio-only services when necessary. The PHE clearly demonstrated the value of telehealth services for patients with mental health diagnoses or substance use disorders. It is critically important that patients in the U.S. are able to continue receiving telehealth services, including audio-only services to improve access to needed care.

We appreciate your timely, bipartisan focus on identifying various legislative steps to address the ongoing health care workforce shortage, particularly in psychiatry and psychiatric subspecialties. AACAP is eager to assist your efforts. If you have any questions, please contact Ben Melano at bmelano@aacap.org.

Sincerely,

Tami D. Benton, MD
President

[6] https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023v3.pdf