American Association of Child & Adolescent Psychiatry

October 5, 2023

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Smith:

On behalf of the American Association of Child and Adolescent Psychiatry (AACAP), the professional home to more than 10,000 child and adolescent psychiatrists, fellows, residents, and medical students, thank you for the opportunity to provide comments and policy recommendations to improve access to health care in rural and underserved areas. Our mission includes promoting the healthy development of children, adolescents, and families. Rural Americans experience higher rates of depression and suicide than people who live in urban areas,[1] but they are less likely to access mental health care services.[2] It is critical to address the issues unique to rural areas in order to improve access to needed mental health services.

Prior to the COVID-19 pandemic, the mental health struggles of America's children and adolescents had been increasing and are well-documented. Pediatric mental health-related emergency visits soared as COVID-19 disrupted school and normal social interactions.[3] In response to the unprecedented mental health needs of America's youth, AACAP, along with the American Academy of Pediatrics and Children's Hospital Association, declared a national children's mental health state of emergency in October 2021, which enumerated several policy recommendations, including ways to address workforce shortages in mental health clinicians.[4] AACAP's comments will focus on (1) payment, (2) health care workforce, and (3) innovative models and technology.

Payment Differences

Reimbursement rates for mental health care, including psychiatric care, lag behind those for physical health or surgical care. To attract and retain psychiatrists to rural areas, more must be done to ensure adequate reimbursement for these services. The Certified Community Behavioral Health Clinic (CCBHCs) demonstration, which employs increased collaboration and outreach in the community to identify and serve populations who are underserved, including children and youth, shows promise.[5] **CCBHCs are psychiatrist-led programs providing high-quality and**

[1] The Changing Context of Rural America: A Call to Examine the Impact of Social Change on Mental Health and Mental Health Care | Psychiatric Services (psychiatryonline.org)
[2] Rural Mental Health Overview - Rural Health Information Hub
[3] Pediatric Mental Health Emergency Visits During the COVID-19 Pandemic - PubMed (nih.gov)
[4] Pediatricians, CAPs, and Children's Hospitals Declare National Emergency (aacap.org)
[5] 2021 CCBHC State Impact Report: Transforming State Behavioral Health Systems - National Council for Mental Wellbeing (thenationalcouncil.org)

accessible medical and mental health care to their patient populations. AACAP is heartened to see the expansion of the CCBHC demonstration through the funding for additional CCBHC sites, and believes that **Congress should continue to expand, and to fund, this effective model of health care delivery, particularly as they serve rural communities.**

The Centers for Medicare & Medicaid Services (CMS) should also consider ways to address gaps in the continuum of mental health care that would help prevent children and youth in crisis from winding up in the emergency department, the last resort and most expensive treatment setting. **The nation's emergency departments, including under resourced emergency departments in rural areas, do not have the capacity to manage the sheer number of children and youth seeking care there.** This situation has been exacerbated by the COVID-19 public health emergency, and long-standing under-investment in the mental health care continuum. **Funding mechanisms to bridge individuals to care and link them to outpatient treatment are critical to prevent overuse of emergency departments for mental health care emergencies.** Unfortunately, many AACAP members living and working in rural areas report that adequate outpatient non-emergency setting resources simply do not exist in their communities.

Justice-involved and foster youth living in rural communities also experience gaps in coverage or care when they transition within community systems**. AACAP members who live and work in rural areas also report that group therapy options are non-existent in their communities, although these interventions are highly effective for certain patient populations experiencing common mental health issues, including personality disorders or substance use disorders, and are a cost-effective alternative to individual treatment**.[6] We know that people who are othered in some way, such as people who are from communities of color, or people who have diverse sexual orientations or gender expression, are frequently underrepresented in our health care delivery system, including rural areas, yet also experience higher rates of mental illness, substance use, and chronic health conditions. **These patient populations could also benefit greatly from group therapy interventions**.[7] CMS should encourage state Medicaid plans to fund group therapy, in addition to other evidence-based treatments, to help bridge gaps in mental health care services in rural areas in a cost-effective manner.

Health Care Workforce

In 2022, AACAP released its updated workforce maps, which illustrate a severe national shortage of child and adolescent psychiatrists.[8] **The ratio of child and adolescent psychiatrists per 100,000 children by state ranges from 4 to 65, with a national average of 14 child and adolescent psychiatrists per 100,000 children.**[9] These shortages are felt more acutely in rural areas.

[6] Group therapy is as effective as individual therapy, and more efficient. Here's how to do it successfully (apa.org)
[7] Demonstrating LGBTQ+ Affirmative Practice in Groups: Developing Competence through Simulation-Based Learning - PMC (nih.gov)
[8] Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AACAP Workforce Maps
[9] Workforce Maps by State (aacap.org)

The workforce shortage of pediatric mental health providers, including child and adolescent psychiatrists, was significant before the COVID-19 pandemic. The average medical school debt is $202,453, excluding premedical undergraduate and other educational debt.[10] Student debt can be a deterrent to students pursuing a career in child and adolescent psychiatry as their educational requirements as physician subspecialists are extensive and costly and their expected reimbursement is low when compared to other specialists over their careers.[11] **Child and adolescent psychiatrists generally must attend a four-year general psychiatry residency and a two-year fellowship focused on the developing brain.**

To address the workforce issue, **AACAP recommends passage of H.R. 1202, Resident Education Deferred Interest (REDI) Act and H.R. 4933, Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023.** H.R. 1202 will allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program. H.R. 4933 provides a loan repayment program to mental health professionals who work for a period of time in a federally designated mental health professional shortage area.

International Medical Graduates (IMGs) are also an important part of our mental health care teams, particularly in rural and underserved areas, and Congress must support lawfully present IMGs. Recent data shows that 31.3% of child and adolescent psychiatrists are IMGs.[12] **AACAP calls on Congress to pass H.R. 4942, Conrad State 30 and Physician Access Reauthorization Act.** This legislation would extend and expand the Conrad 30 Waiver program which permits foreign physicians studying in the United States to obtain a visa following medical residency if they practice in a medically underserved area for at least three years.

In addition to working as a health care provider during a global pandemic, stress related to increasing administrative burdens and evolving care delivery models contribute to physician burnout. **Nearly 40% of physicians nationwide report some level of burnout**.[13] The severe national shortage of child and adolescent psychiatrists, combined with the national children's mental health emergency, has only increased the demand for child and adolescent psychiatric services. These ongoing stresses contribute to burnout, which will likely worsen mental health across the profession and exacerbate existing workforce shortages. Protecting and supporting physician wellness is critical as the mental health care workforce is buckling from a lack of clinicians willing to treat sicker psychiatric patients.[14]

Innovative Models and Technology

There are several innovative models of mental health care delivery that could improve access to mental health care in rural areas, including the Collaborative Care Model (CoCM) which is a systematic strategy for treating behavioral health conditions in primary care through the integration of care managers and psychiatric consultants. In this case, child and adolescent

[10] Average Medical School Debt [2023]: Student Loan Statistics (educationdata.org)
[11] Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement (milliman.com)
[12] Active Physicians Who Are International Medical Graduates (IMGs) by Specialty, 2021 | AAMC
[13] Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2020 - Mayo Clinic Proceedings
[14] Understaffed State Psychiatric Facilities Leave Mental Health Patients in Limbo - KFF Health News

psychiatrists consult with and educate pediatricians on treatment options for behavioral and mental issues that present during patient visits. **Congress should consider solutions for increasing the uptake of collaborative care arrangements, including those in pediatric practices.** These programs must be funded adequately to include resources for start-up costs, in addition to ongoing technical assistance as the programs become established. **CoCMs have proven to be effective in the early identification of children who need treatment for behavioral and mental health conditions because children are seen by pediatricians on a regular basis**. A pediatrician's office, therefore, serves as a natural entry point of access to mental and behavioral health care.[15]

Telepsychiatry is a key therapeutic intervention that **extends the psychiatrist's reach across large geographic areas to youth in different community settings, including primary care offices, schools, daycare facilities, detention centers, and homes**.[16] The COVID-19 pandemic and subsequent shift to telehealth has made it clear telehealth is here to stay for providers from major medical centers, community health centers, and private practice alike.

Telepsychiatry is a core component of Child Psychiatry Access Programs (CPAPs). Pediatricians can contact the CPAP in their state to consult with a child and adolescent psychiatrist about treatment options for the children and adolescents they see in their practices who may need mental and behavioral health care. CPAPs have been implemented in most states across the country, and are funded through the Health Resources and Services Administration's (HRSA) Pediatric Mental Health Care Access grants, state, or institutional funding, or a combination of all, yet a small number of states have not implemented these programs, including some states with large rural and underserved areas.[17] **Research has shown that the use of CPAPs significantly improves outcomes for the patients who receive integrated medical and behavioral health care through this model compared to treatment as usual**.[18]**AACAP strongly supports sustainable federal funding for these highly effective models of integrated care and recommends that CPAP programs be implemented and sustainably funded in every state.**

CPAPs and collaborative care models in pediatric settings meet children and adolescents where they are—in the pediatrician's office, the family physician's office, and in other systems of care—and therefore help eliminate barriers to mental and behavioral health care.

Psychiatrists relied on telehealth throughout the COVID-19 pandemic more than any other physician specialty and continue to rely on it at a higher rate, according to several recent surveys conducted at different points of the COVID-19 pandemic.[19,20] One study found that 85% of all psychiatrists conducted telepsychiatry (via videoconference and telephone) since the start of the

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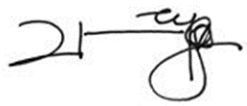
[15] Integrating Primary Care and Behavioral Health: The Role of the Psychiatrist in the Collaborative Care Model | FOCUS (psychiatryonline.org)
[16] Clinical Update: Telepsychiatry With Children and Adolescents (jaacap.org)
[17] Map — NNCPAP National Network of Child Psychiatry Access Programs
[18] Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis - PubMed (nih.gov)
[19] Physician Practice Benchmark Survey | American Medical Association (ama-assn.org)
[20] Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency

COVID-19 pandemic to diagnose and treat patients.[21] **In these surveys, psychiatrists have reported lower no-show rates, improved patient satisfaction, and improved access to care through telepsychiatry during the COVID-19 pandemic.** Increased availability of telehealth, through the removal of geographic and site of service restrictions and wider insurance coverage of telehealth, both video and audio-only, has helped AACAP members treat established patients and reach many new patients in need of mental health care. **Telehealth can save patients time and money as patient travel is not typically necessary**. Unfortunately, as COVID-19 pandemic telehealth flexibilities and state enacted public health emergencies have expired, AACAP members have reported the need for patients to drive across state lines to comply with state regulatory requirements.[22] Social determinants of health, including transportation, can be formidable barriers to receiving mental healthcare, and retaining telehealth as a treatment modality is critically important in rural areas in both federal health programs and private insurance plans.

Thank you, in advance, for considering our recommendations. AACAP appreciates the opportunity to share recommendations for improving access to mental health care in rural and underserved areas. Should you have questions, please contact Ben Melano, Deputy Director of Federal Affairs at bmelano@aacap.org, and Karen Ferguson, Deputy Director of Clinical Practice at kferguson@aacap.org.

Respectfully,



Warren Y. K. Ng, MD, MPH
President

[21] Physician Practice Benchmark Survey | American Medical Association (ama-assn.org)
[22] COVID-19 State Actions for Telehealth Policy - CCHP (cchpca.org)