AMERICAN PSYCHIATRIC ASSOCIATION

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October 5, 2023

The Honorable Jason Smith
Chair
Committee on Ways & Means
United States House of Representatives
Washington, DC 20510

Dear Chairman Smith:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians who treat mental health and substance use disorders, I write in response to your stakeholder Request for Information (RFI) regarding rural health care and our nation's ongoing health care workforce shortages.

Approximately one-fifth of the US population lives in a rural area,[1] and about one-fifth of those living in rural areas, or about 6.5 million individuals, have a mental health disorder.[2] Though the prevalence of serious mental illness and most psychiatric disorders is similar between US adults living in rural and urban areas, those residing in rural geographic locations receive mental health treatment less frequently when compared to those residing in metropolitan locations.[3] The reasons underlying this treatment disparity include ongoing workforce shortages, high out-of-pocket treatment costs, and a lack of care coordination. The COVID-19 pandemic likewise imposed significant disruptions on the clinician pipeline, exposed gaps in our country's health workforce, and highlighted the immediate need to strengthen our broader health care infrastructure. As patients and families across the country continue to struggle with health care facility closures, long travel distances, and increased wait times for behavioral health services, we applaud the Committee's focus on finding solutions to reshape our nation's health care system and bring new access to care in rural and underserved areas. With those objectives in mind, we offer the recommendations below.

Supporting our Health Care Workforce

HRSA estimates that by 2025, there will be a shortage of over 250,000 mental health professionals, including psychiatrists, mental health and substance abuse social workers, clinical and school psychologists, and school counselors. The gap between need and access is especially pronounced in psychiatry, with more than half of U.S. counties lacking a single psychiatrist.[4] Further, projections show the country will be short between 14,280

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[1] Substance Abuse and Mental Health Services Administration. *Results from the 2016 National Survey on Drug Use and Health: detailed tables* [Internet], 2017. (https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf2)

[2] United States Census Bureau. *New census data show differences between urban and rural populations* [Internet], 2016. (https://www.census.gov/3)

[3] McCall-Hosenfeld JS, Mukherjee S, Lehman EB. The prevalence and correlates of lifetime psychiatric disorders and trauma exposures in urban and rural settings: results from the national comorbidity survey replication (NCS-R). *PLoS ONE* 2014; 9(11): e112416. doi: 10.1371/journal.pone.01124164

[4] https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf

and 31,109 psychiatrists by 2025.[5] This severe shortage in the near- and long-term merits swift and aggressive action. Congress has recently made important incremental progress addressing these shortfalls but today, fewer than half the individuals with a mental health or substance use disorder receive treatment. The shortage and maldistribution of psychiatric care, and other high-need specialties limits patient access to cost effective, preventive care, and it will become even more acute in the coming years if no action is taken. The Fiscal Year 2023 Consolidated Appropriations Act (FY23 Omnibus) added 200 new graduate medical education (GME) residency slots with 100 of these slots going directly to psychiatry or psychiatric subspecialties beginning in 2026 but more clearly must be done. **APA urges the Committee to build on this investment by supporting additional new Medicare-GME slots for psychiatry and psychiatric subspecialties with residencies spread geographically in rural and urban areas, alike**. Although training more residents in psychiatry by itself will not completely address rising mental health needs, it remains essential. Such an investment in the psychiatric workforce would help our nation begin to chip away at the present workforce shortage and better position us to address the growing crisis of access to mental health and substance use-related care and treatment.

International medical graduates (IMGs) are likewise vital contributors to our nation's workforce and can play a critical role in helping to fill the behavioral health workforce gap, particularly in mental health professional shortage areas where nearly 120 million Americans live. IMGs make up almost a quarter of the total resident and practicing physician workforce. Currently, most resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. In many rural communities, IMGs provide vital access to care during and beyond that three-year commitment. **While not within the committee's jurisdiction, reauthorization of the Conrad State 30 J-1 visa waiver program would boost the workforce of physicians available to treat mental illness and addiction in rural and other medically underserved areas. APA strongly supports the recently introduced Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942).**

Promoting Innovative Models and Technology

For individuals residing in rural areas, the reality of potentially having to travel long distances for behavioral health services often serves as a deterrent to receiving care. Telehealth can help alleviate the gaps exposed by workforce maldistribution, including in rural areas, by providing a linkage between clients in their home communities and behavioral health providers in other locations. The current telehealth flexibilities passed by Congress and implemented by past and current Administrations have been a lifeline for patients in need of MH/SUD services. We have seen strong patient-clinician satisfaction with telehealth services, and a decrease in no-show rates, demonstrating greater patient engagement in their care. Last year, the FY23 Omnibus extended multiple telehealth flexibilities implemented in response to the ongoing Public Health Emergency (PHE) until January 2025. Importantly, the legislation allowed audio-only services for behavioral health, and delayed implementation of the 6-month in-person requirement for mental telehealth services, which would be particularly burdensome for patients who live in rural areas, until December 31, 2024. At a time of unprecedented demand, it is imperative that we remove unnecessary barriers and ensure the continuity of care for those seeking MH/SUD services, regardless of their geographic circumstance. **APA strongly encourages continued coverage of care through a variety of modalities (in-person, telehealth, audio-only), and urges the Committee to consider the CONNECT**

[5] https://pubmed.ncbi.nlm.nih.gov/29540118/

for Health Care Act (H.R.4189) and Telemental Health Care Access Act (H.R. 3432). These important bills would expand coverage of clinically appropriate telehealth services under Medicare beyond January of 2025. Critically, this legislation would also permanently remove the 6-month in-person requirement for mental telehealth services, which creates an arbitrary and unnecessary barrier to mental health services that could undermine access to services in rural and underserved areas.

The integration of primary care and behavioral health has likewise proven effective in expanding the footprint of our existing behavioral health workforce and essential to improving patient access in rural and underserved areas. The evidence and population based Collaborative Care Model (CoCM) in particular, has been shown to help improve outcomes while alleviating existing mental health workforce shortages. By enabling a primary care provider (PCP) to leverage the expertise of a psychiatric consultant to provide treatment recommendations for a panel of 50-60 patients in as little as 1-2 hours per week, behavioral health care is integrated, often without requiring the patient to make a second appointment or visit a separate mental health specialist. Further, because consultations between the team members can be provided remotely, the CoCM helps to address the uneven distribution of the mental health workforce and improve access to care for patients in rural areas. By treating more people and getting them better faster, the CoCM is a proven strategy to enhance the efficient use of existing clinicians. Despite its robust evidence base and availability of reimbursement, uptake of CoCM by primary care practices, like other integrated care models, remains low due to the up-front costs associated with implementation. **To better leverage the existing behavioral health workforce to support our underserved rural populations, APA urges consideration of methods to promote uptake of evidenced base integrated care models like the CoCM, including the bipartisan COMPLETE Care Act (H.R. 5819).** This commonsense legislation would provide temporarily enhanced Medicare payment rates for behavioral health integration services, as well as technical assistance to help promote use of proven models like the CoCM.

Sustainable Provider and Facility Financing

Our nation's mental health and substance use disorder infrastructure remains fragmented and underfunded, often to the detriment of those seeking care in rural and underserved areas. As a result, many rural communities across the United States lack a comprehensive continuum of care for behavioral health services. Reliance on multiple funding streams with varying reporting requirements, growing administrative burdens, and a shrinking workforce compromise the sustainability of the system overall. Low reimbursement rates for Medicare and Medicaid likewise play an important role in deterring physicians from practicing in rural and underserved areas. This is especially true for psychiatrists, who are more likely to treat a caseload that includes a higher proportion of socially at-risk patients.[6] Treating patients with more social risk factors further increases the complexity of psychiatric visits and requires more resources for treatment, compounding the increased costs of caring for patients with mental health disorders. In addition, Medicare does not risk adjust for the most prevalent forms of depression and anxiety disorders which may result in underestimation of the resources required to treat beneficiaries with these conditions. To help promote a more sustainable and patient centered health care system, APA urges the Committee to consider financial incentives to increase participation in Medicare, particularly for the small and solo practices which often serve rural populations. An important first step would be providing an annual inflation update equal to the Medicare Economic Index (MEI) for Medicare physician payments to help enable physician practices to better absorb payment distributions triggered by budget

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[6] Johnston KJ, Meyers DJ, Hammond G, Joynt Maddox KE. Association of clinician minority patient caseload with performance in the 2019 Medicare Merit-Based Incentive Payment System.JAMA. 2021;325(12):1221-1223. doi:10.1001/jama.2021.0031

neutrality rules, performance adjustments, and periods of high inflation. **APA supports the Strengthening Medicare for Patients and Providers Act (H.R. 2474) which would apply a permanent inflation-based update to the MPFS conversion factor and help make it more financially viable for psychiatrists and all physicians to practice in rural areas.**

We appreciate your timely focus on identifying additional legislative steps Congress should take to address ongoing rural health care workforce shortages. The APA is eager to aid your efforts. If you have any questions, please contact Daniel "Trip" Stanford at dstanford@psych.org or (315) 706-4582.

Sincerely,

Saul M. Levin, M.D., M.P.A., FRCP-E
Chief Executive Officer & Medical Director