

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

Council

President
Warren Y.K. Ng, MD, MPH

President-Elect
Tami D. Benton, MD

Secretary
Debra E. Koss, MD

Treasurer
Neal D. Ryan, MD

Chair, Assembly
of Regional Organizations
of Child and Adolescent Psychiatry
Marian A. Swope, MD

Past President
Gabrielle A. Carlson, MD

Shirley Alleyne, MB,BS
Alicia A. Barnes, DO, MPH
Matthew G. Biel, MD, MSc
Jennifer L. Derenne, MD
Lisa R. Fortuna, MD, MPH
Lisa Hutchison, MD
Adam J. Sagot, DO
Shawn Singh Sidhu, MD
Jose Vito, MD
Sala Webb, MD

Jerry M. Wiener
Resident Member
Evelyn N. Ashiofu, MD, MPH

John E. Schowalter
Resident Member
Jessica Stephens, DO

DEI Emerging Leaders Fellow
Tashalee R. Brown, MD, PhD

Executive Director/CEO
Heidi B. Ford, CAE

JAACAP Editor-in-Chief
Douglas K. Novins, MD

AACAP News Editor
Uma Rao, MD

March 20, 2023

The Honorable Bernard Sanders
Chairman
Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP) and the over 10,000 child and adolescent psychiatrists, fellows, residents, and medical students that we represent, I commend the Committee for its focus on the health care workforce shortage. I am writing in response to the hearing "Examining Health Care Workforce Shortages: Where do We Go from Here?" to share the child and adolescent psychiatry perspective and AACAP's policy recommendations to ensure that we have a robust mental health and substance use disorder workforce to address our nation's pediatric mental health crisis.ⁱ

Long prior to the COVID-19 Public Health Emergency (PHE), the mental health struggles of America's children and adolescents have been increasing and are well-documented. Pediatric mental health-related emergency visits soared as COVID-19 disrupted school and normal social interactions, and negatively impacted caregiver wellbeing. According to the National Institutes of Health, more than 140,000 children under the age of 18 have lost a parent, close relative, or caregiver to COVID-19.ⁱⁱ Additionally, racially and ethnically diverse children are disproportionately affected. These developments, coupled with significant nationwide shortages in child and adolescent psychiatrists and other behavioral health providers, have exacerbated an already significant gap in treatment access.

In response to the unprecedented mental health needs of America's youth, AACAP, along with the American Academy of Pediatrics and the Children's Hospital Association, declared a national children's mental health state of emergencyⁱⁱⁱ in October of 2021 that enumerated several policy recommendations including ones addressing workforce shortages. AACAP details these and other recommendations, for your consideration, below.

Extend the Reach of the Child and Adolescent Psychiatry Workforce

According to AACAP's workforce data, there are currently 14 child and adolescent psychiatrists (CAPs) for every 100,000 children in the United States. The current supply of CAPs is grossly insufficient to meet the demand for pediatric mental health specialty care. Recent Congressional action, however, has facilitated health care delivery models that can extend the reach of the limited CAP workforce by funding child psychiatry access programs (Health Resources and Services Administration Pediatric Mental Health Care Access Program), supporting the adoption of integrated behavioral health and primary care models, and expanding the reach of telepsychiatry. AACAP urges Congress to continue to support these models by promoting state financing innovation and provider adoption.

AACAP remains concerned about the ability for our members to reach patients via telepsychiatry following the end of the COVID-19 PHE. For psychiatrists, telehealth remains a critical and cost-effective modality to expand access to psychiatric care. COVID-19 PHE-related telehealth flexibilities 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. The Drug Enforcement Administration's waivers of in-person exam requirements prior to prescribing a controlled substance, which allows physicians to use their own clinical expertise to determine when a patient must be seen in person, also proved invaluable during the PHE. Telepsychiatry 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.^{iv} Telepsychiatry also contributed to improved patient participation in treatment. Psychiatrists utilizing telehealth reported lower no-show rates, improved patient satisfaction, and improved access to care.^v **It is imperative, given the ongoing national children's mental health emergency, that telepsychiatry regulatory flexibilities provided at the start of the COVID-19 PHE remain in place to allow for continuity of care for patients who may not otherwise have access to psychiatric care.**

AACAP appreciates the Drug Enforcement Agencies' proposed rule on permanent telehealth flexibilities and is submitting formal comments asking for points of clarity, and changes to several proposed regulations to better align with the practice of telepsychiatry and to avoid any disruptions to critical mental health care for our nation's children and adolescents.

Collaborative care arrangements, in which child and adolescent psychiatrists consult with and educate pediatricians on treatment options for behavioral and mental issues that present during patient visits are an effective approach to identifying and treating children and youth who may need mental and behavioral health services. **Congress should consider solutions for increasing the uptake of collaborative care arrangements, including those in pediatric practices.** These programs must be funded adequately and include resources for start-up costs. Collaborative care arrangements in the pediatric setting have proven beneficial 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.

Child Psychiatry Access Programs (CPAPs) are another way to increase access to mental and behavioral health care. CPAPs have been implemented in most states across the country, and are funded through Health Resources and Services Administration grants, state, or institutional funding, or a combination of both, yet a small number of states have not implemented these programs, including some states with large rural and underserved areas that could most benefit.^{vi} 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. 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.^{vii} **AACAP strongly supports sustainable federal funding for these highly effective models of integrated care and recommends that CPAP programs be implemented in every state.**

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

Support the Child and Adolescent Psychiatrist Pipeline

Long before the COVID-19 PHE, the workforce shortages of pediatric mental health providers were significant. This is especially true for child and adolescent psychiatrists, whose educational requirements as physician subspecialists are extensive and costly. Child and adolescent psychiatrists generally must complete a two-year fellowship focused on the developing brain in addition to their four-year general psychiatry residency. Student debt for training can serve as a deterrent for medical students to go into child and adolescent psychiatry in the first place, given lower expected reimbursements compared to other specialists over their careers.^{viii} The average student loan debt for medical school graduates is between \$200,000 and \$250,000, with premedical debt included.^{ix} Research has shown that loan forgiveness or repayment programs directly influence physician practice choice.

AACAP recommends targeted student loan payment relief as one solution to incentivizing medical students to become child and adolescent psychiatrists. The Pediatric Specialty Loan Repayment Program (PSLRP), which was recently authorized and appropriated, would be a viable way to both provide financial relief to medical students who choose this path and simultaneously address severe workforce shortages in rural and underserved areas around the country. However, the law sets as a priority that PSLRP be awarded first to applicants who “work [full time] in a school or other pre-kindergarten, elementary, or secondary education setting.” Because pediatric specialty physicians are often not employed full-time by school districts, we fear that this prioritization will mean that very few physicians will be eligible for the loan relief.

AACAP recommends that Congress create a student loan repayment program (SLRP) like the Substance Use Disorder Treatment and Recovery (STAR) SLRP. The STAR SLRP is administered by the Health Resources and Administration (HRSA) in support of opioid use disorder providers working in communities with higher-than-average opioid overdose rates. A “mental health treatment” SLRP that targets communities with higher-than-average incidence of mental health-related morbidity and mortality would incentivize and recognize providers working in communities experiencing pediatric and adult mental health crises.

AACAP also calls on Congress to pass the [Resident Education Deferred Interest \(REDI\) Act \(S.3658 and H.R.4122 in the 117th Congress\)](#). This will allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.

Ensure Mental Health and Substance Use Disorder Treatment Parity

The field of mental health care will not attract qualified, highly trained providers, reduce stigma, or accommodate the growing demand for such services through a full continuum of care until it is on equal footing with physical health and surgical care. In addition to extensive time in training and student debt, poor reimbursement is a disincentive to medical students considering a career in psychiatry. Reimbursement rates are lower for mental and behavioral health services than they are for primary care, as demonstrated by the 2019 Milliman Research Report,^x and targeted increases among all payers could attract larger numbers of medical students wishing to pursue a career in child and adolescent psychiatry. Poor provider reimbursement contributes to limited in-network psychiatry access, longer wait times, and higher expenses for patients— who are often forced to go out of their insurance networks to find care – at a greater out-of-pocket expense.

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) aims to ensure that insurance coverage for mental health and addiction treatment is no more restrictive than insurance coverage for other medical care. This goal needs to be realized to tackle mental health access issues. AACAP appreciates the authorization of state parity assistance grants in the 2023 Consolidated Appropriations Act, as well as the sunset of the non-government health plan opt-out of MHPAEA. There is much more work to be done to actualize the spirit of the law.

AACAP encourages Congress to extend MHPAEA to all Medicare and fee-for-service Medicaid plans as well as to TRICARE, and to grant the Department of Labor authority to levy civil monetary penalties on ERISA plans found out of compliance with MHPAEA. In addition, more technical assistance is needed in state Medicaid offices and CMS to ensure Medicaid plans are complying with MHPAEA.

AACAP also recommends that the Centers for Medicare & Medicaid Services (CMS) and other insurance regulators require health plans to use nationally recognized service intensity tools developed by professional organizations in making medical necessity determinations. With respect to children and adolescents, service intensity instruments such as the Child and Adolescent Service Intensity Instrument^{xi} and the Early Childhood Service Intensity Instrument,^{xii} standardized assessment tools that provide determinations of the appropriate level of service intensity needed by a particular child or adolescent and his or her family, could assist payers in the process of determining service intensity need. These tools assess the service intensity needs of children and adolescents presenting with psychiatric, substance use, medical and/or developmental concerns. They incorporate holistic information on the child within the context

of his/her family and community by assessing the service intensity needed and would therefore support payers in making appropriate coverage determinations relating to mental health and substance use services.

Diversify the Child and Adolescent Psychiatry Workforce

The current pediatric mental health care system does not sufficiently serve the needs of racial and ethnic minority communities. Physicians who understand and identify with their patient's language, culture, gender identity, religious beliefs, sexual orientation, and socioeconomic conditions, are better equipped to address the needs and health disparities of specific populations.

The COVID-19 pandemic amplified pre-existing mental health disparities in minority children and adolescents, including gaps in access to high quality mental health care. Minority youth are also more likely to attempt suicide than their white peers and less likely to receive timely, high-quality care for symptoms of anxiety, depression, and ADHD.

We applaud Congress for reauthorizing the *Pursuing Equity in Mental Health Act* in the 2023 Consolidated Appropriation Act. This bill supports a minority fellowship program administered by the Substance Abuse and Mental Health Services Administration that improves health equity by supporting the training of culturally competent behavioral health professionals through scholarship, tuition assistance, and professional development opportunities. **AACAP encourages Congress to expand on this and other programs that incentivize students from historically minoritized populations to pursue and/or further advance careers in specialty behavioral health care.** Scholarship and tuition assistance are important supplements to student loan repayment programs as they can capture students who may not possess viable financial pathways to pursuing medical education.

International Medical Graduates (IMGs) are 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 31.1% of child and adolescent psychiatrists are IMGs.^{xiii} AACAP appreciates the short-term extension of the CONRAD 30 program through September 2023 included in the 2023 Consolidated Appropriations Act, but **encourages support of a three-year reauthorization of the CONRAD 30 program, as included in S. 665, the *Conrad State 30 and Physician Access Reauthorization Act*.** AACAP Also supports the [Healthcare Workforce Resilience Act](#) (S.1024/H.R.2255 in the 117th Congress) which would direct immigration authorities to recapture 15,000 unused employment-based visas from prior years and make them available to non-citizen IMGs and expedite the approval process of these applications. There will be greater need of quality, evidenced-based mental health care from psychiatrists in the months and years ahead, and one-third of all practicing child and adolescent psychiatrists, and their families, should not live in limbo, fearing the loss of their legal status.

Address Physician Burnout

In addition to working as a health care provider during a global pandemic, stress related to increasing administrative burdens and evolving care delivery models can contribute to physician burnout. Nearly 40% of physicians nationwide report some level of burnout.^{xiv} While AACAP appreciates Congress passing the AACAP-supported *Lorna Breen Health Care Provide Protection Act*, for child and adolescent psychiatrists, burnout is also exacerbated by COVID-19-related mental health decline in their young patients. 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. This ongoing pressure contributes to burnout, which will likely worsen mental health across the profession and exacerbate workforce shortages. Protecting and supporting physician wellness is critical as the psychiatric care system is buckling from a lack of health professionals, partly due to burnout, willing to help treat sicker psychiatric patients.^{xv}

Physicians also face barriers to accessing mental health care themselves due to state licensure applications in many states asking about any past impairment rather than only current impairment, a violation of the *Americans with Disabilities Act*. As the Federation of State Medical Boards (FSMB) correctly points out, state medical boards must not be an impediment for physicians to receive mental health care. Too few state medical boards have made progress in implementing the FSMB recommendations on

improving physician wellness. **Before the pandemic, physicians already had a higher rate of anxiety and depression than the general population. With physicians serving as the backbone of the COVID-19 pandemic response, they deserve the same access to mental health care they offer to patients.**^{xvi}

Thank you in advance for consideration of our recommendations. AACAP appreciates the opportunity to provide input as the Senate Health, Education, Labor and Pensions Committee considers how Congress can understand the root causes of the current health care workforce shortages and best address this. Should you have any questions, please contact Alexis Horan, Chief of Advocacy and Practice Transformation at ahoran@aacap.org, and Ben Melano, Deputy Director of Federal Affairs at bmelano@aacap.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'W. K. Ng' with a stylized flourish at the end.

Warren Y. K. Ng, MD, MPH
President

ⁱ [Workforce Maps by State \(aacap.org\)](#)

ⁱⁱ [More than 140,000 U.S. children lost a primary or secondary caregiver due to the COVID-19 pandemic | National Institutes of Health \(NIH\)](#)

ⁱⁱⁱ [Pediatricians, CAPs, and Children's Hospitals Declare National Emergency \(aacap.org\)](#)

^{iv} [Clinical Update: Telepsychiatry With Children and Adolescents \(jaacap.org\)](#)

^v [Journal of the American Academy of Child and Adolescent Psychiatry \(jaacap.org\)](#)

^{vi} [Map — NNCPAP National Network of Child Psychiatry Access Programs](#)

^{vii} [Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis - PubMed \(nih.gov\)](#)

^{viii} [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](#)

^{ix} [Average Medical School Debt \[2023\]: Student Loan Statistics \(educationdata.org\)](#)

^x [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](#)

^{xi} [CASII \(aacap.org\)](#)

^{xii} [ECSII \(aacap.org\)](#)

^{xiii} [Active Physicians Who Are International Medical Graduates \(IMGs\) by Specialty, 2021 | AAMC](#)

^{xiv} [Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2020 - Mayo Clinic Proceedings](#)

^{xv} [Understaffed State Psychiatric Facilities Leave Mental Health Patients in Limbo | Kaiser Health News \(khn.org\)](#)

^{xvi} [Consistency Between State Medical License Applications and Recommendations Regarding Physician Mental Health | Psychiatry and Behavioral Health | JAMA | JAMA Network](#)