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The Honorable Michael Bennet
261 Russell Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Catherine Cortez Masto
517 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senators Wyden, Cornyn, Menendez, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn,

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 39,000 psychiatric physicians who treat mental health and substance use disorders, I write in response to your policy proposal to improve the Medicare Graduate Medical Education (GME) program. The APA is appreciative of this timely effort to address ongoing workforce shortages and, given our nation's concurrent mental health and substance use disorder crises, is especially encouraged by the working group's focus on promoting access to psychiatric care. As you continue your important work to enhance our health care workforce and increase patient access to care, we respectfully offer the following feedback and suggestions.

Distribution of Additional Residency Positions in Psychiatry and Psychiatry Subspecialties

Last Congress, efforts by the Finance Committee paved the way for the eventual inclusion of 200 new Medicare supported GME slots in the 2023 Consolidated Appropriations Act (CAA), with 100 designated for psychiatry and psychiatry subspecialties. This investment represented the most significant Congressional

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The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
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The Honorable Thom Tillis
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United States Senate
Washington, DC 20515

The Honorable Marsha Blackburn
357 Dirksen Senate Office Building
United States Senate
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support for the psychiatric workforce in decades. Unfortunately, with nearly 150 million people living in Mental Health Professional Shortage Areas (HPSAs) as defined by the Health Resources and Services Administration (HRSA),¹ more needs to be done. To that end, APA enthusiastically supports the working group's proposal to add additional psychiatry focused GME slots from fiscal year (FY) 2027 through 2031. The addition of new psychiatric residency positions would increase access to high-quality care, strengthen our broader health care infrastructure, and most importantly, improve and save lives. . Further, since interest in psychiatry residency positions has been increasing yearly since 2011, any new slots will readily be filled in rural and underserved areas alike. total of 1,823 U.S. medical school graduates (98.7%) matched into psychiatry residency programs this past year as part of the National Resident Matching Program (NRMP), marking the 13th consecutive year that psychiatry's match numbers have increased.² In addition, a total of 363 U.S. and non-U.S. international medical graduates (IMGs) also matched into psychiatry, along with 63 other applicants (mostly allopathic and osteopathic graduates from a previous year), bringing the total to 2,249 medical school graduates entering psychiatry residency programs. In fact, only 12 of 2,261 psychiatry positions went unfilled.³

As the working group considers the quantity and specialty specific allocations of any new slots, we urge those considerations to account for existing and future deficits in psychiatry. Physician workforce projections from the Association of American Medical Colleges (AAMC) estimate an additional 6,100 psychiatrists will be needed just to eliminate mental health HPSAs by 2034.⁴ With that objective in mind, we strongly encourage the working group to build on past bipartisan efforts, including the Mental Health Workforce Discussion Draft put forward last Congress by Sens. Wyden, Crapo, Daines and Stabenow. This proposal, seeking to provide 400 new Medicare-supported GME slots for psychiatry and psychiatric subspecialties annually over 10 years, would represent a significant step towards addressing the growing crisis of access to mental health and substance use-related care for the 150 million individuals already living in shortage areas. Accordingly, APA suggests that the annual addition of 400 new psychiatry residency slots serve as a baseline when determining the mechanics of any future expansion.

Supplementing Investments in New Psychiatry Residency Positions with Integrated Care Models

Training more residents in psychiatry is an essential, long-term strategy to enhance access to care, which should be paired with support of short-term workforce enhancement strategies. Population and evidence-based integrated care models hold enormous potential to augment our existing workforce and, in real time, enhance access to care for the millions who struggle with undiagnosed and untreated mental health and substance use disorders. The COMPLETE Care Act (S.1378), put forward by Senators Cortez Masto and Cornyn, proposes a temporary increase in Medicare payment rates for behavioral health integration services, including the Collaborative Care Model (CoCM). By taking a population-based approach to better meet the growing demand for services, the CoCM has the capacity to increase the number of patients who can receive care for mental health and substance use disorders relative to traditional 1:1 treatment. Enabling psychiatrists to consult on a registry of 60 to 80 patients via weekly chart review, oversight of medication and therapeutic interventions, and making clinical recommendations to the primary care

¹ <https://pubmed.ncbi.nlm.nih.gov/29540118/>

² 2024 NRMP Main Residency Match: Match Rates by Specialty and State. <https://www.nrmp.org/wp-content/uploads/2024/03/Main-Match-Results-by-State-Specialty-and-App-Type-2024.pdf>

³ *Psychiatric News: Number of Students Matching into Psychiatry Increases for 13th Year.* Washington, DC, 2024. <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2024.05.5.36>

⁴ Association of American Medical Colleges: *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* Washington, DC, 2021. <https://www.aamc.org/media/54681/download>.

physician, the CoCM multiplies the number of patients who benefit from a psychiatrists' specialized training. Unfortunately, despite its robust evidence-base for improving patient outcomes and the availability of reimbursement, uptake of CoCM by primary care practices remains low, primarily due to the up-front costs associated with implementation. To help promote and support uptake of evidence-based integrated care, and to better leverage the existing behavioral health workforce, APA urges the working group to consider this bipartisan legislation as a supplement to any additional psychiatry residency slots to address current and near-term shortages.

Improving Recruitment in Rural or Underserved Communities

Low reimbursement rates for Medicare and Medicaid play an important role in deterring physicians and others from practicing in rural and underserved areas. This is especially true for psychiatrists, who are more likely to treat a higher proportion of socially at-risk patients.⁵ Treating patients with more social risk factors increases the complexity of psychiatric visits and requires more resources for treatment, compounding the increased costs of caring for patients with mental health disorders. Further, Medicare does not risk adjust for most forms of depression and anxiety disorders which may result in underestimation of the resources required to treat beneficiaries with these conditions. To help attract psychiatrists and other mental health professionals to shortage areas, APA urges support for the proposal from Senators Stabenow and Daines (S.3157) to increase Medicare's Health Professional Shortage Area (HPSA) bonus payments to psychiatrists and other behavioral health clinicians.

Approximately one-fifth of the US population resides in a rural area,⁶ and about one-fifth of those living in rural areas, or about 6.5 million individuals, have a mental health disorder.⁷ 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 due to a lack of access⁸. One of the primary indicators of where a physician will ultimately practice is the location of their residency. Unfortunately, rural hospitals are often at a disadvantage as they often cannot afford to take on new residents, regardless of need. Accordingly, we encourage the working group to support the *Rural Physician Workforce Production Act* (S. 230). This bipartisan legislation, led by Senator Tester, and which includes Senator Cortez Masto among the original cosponsors, seeks to address the geographic maldistribution of physicians by lifting the current cap on Medicare reimbursement payments to rural hospitals that cover the cost of taking on residents. To alleviate the serious disadvantage that rural hospitals face when recruiting new medical professionals, the bill would also allow Medicare to reimburse urban hospitals that send residents to train at rural health care facilities and establish a per resident payment initiative to ensure rural hospitals have the resources to bring on additional residents.

⁵ 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

⁶ 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>)

⁷ United States Census Bureau. *New census data show differences between urban and rural populations* [Internet], 2016. (<https://www.census.gov/3>)

⁸ 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

Virtual Supervision Extensions

APA enthusiastically 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 be applied permanently. Virtual supervision of residents is a key retention tool for highly qualified attending physicians and will help curb the drastic workforce shortage facing psychiatry by allowing physicians to supervise clinical staff across multiple campuses. Further, residents delivering telehealth has been demonstrated throughout the COVID-19 public health emergency (PHE) to be a safe and effective strategy for maintaining access to care. The teaching physician is ultimately responsible for the clinical outcomes of the care provided by residents, and the resident accordingly is held to the same clinical standard as the teaching physician providing care themselves. Existing guardrails through the Accreditation Council for Graduate Medical Education (ACGME) also help to ensure patient safety and oversight of residents when virtual supervision of residents occurs. ACGME sets forth extensive program requirements, mandating that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability, as well as patient complexity and acuity. Allowing residents to deliver telehealth with supervision from a teaching physician also helps to ensure that they are trained for telehealth service delivery when they enter the physician workforce.

Additional Telehealth Flexibilities to Consider

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 urban underserved areas, by providing a linkage between clients in their home communities and behavioral health providers in other locations. Telehealth has also expanded access for individuals who may be too anxious to leave their homes or who are otherwise homebound. 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, both critical issues for patients in crisis to begin and continue appropriate treatment. The FY23 Omnibus extended multiple telehealth flexibilities until January 2025. Importantly, the legislation delayed implementation of the 6-month in-person requirement for mental telehealth services 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. APA strongly encourages permanent removal of the 6-month in-person requirement for mental telehealth services.

We appreciate your timely, bipartisan focus on identifying additional legislative steps Congress should take to address ongoing health care workforce shortages. The APA is eager to aid your efforts. If you have any questions, please contact Trip Stanford at dstanford@psych.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Marketa M. Wills', written over a white rectangular background.

Marketa M. Wills, MD, MBA, FAPA

