AMERICAN
PSYCHIATRIC
ASSOCIATION

Federal Advocacy Conference

October 6-7 2025

WELCOME

October 6, 2025

Dear Colleagues,

On behalf of APA leadership and the Division of Advocacy, Policy and Practice Advancement, we welcome you to Washington, DC, and the 2025 Federal Advocacy Conference.

This is a unique opportunity to lobby Congress on issues that affect your patients and your practice. We have a vital role as physician leaders of the mental health care system to educate members of Congress and their staff on the policies that impact psychiatry and the delivery of care for mental health and substance use disorders.

Your time at the Federal Advocacy Conference will include hands-on advocacy training designed to give you the tools to foster meaningful and impactful relationships with federal legislators and their staff. Our hope is that you will come away from this conference with a firm understanding of the inner workings of Congress and the legislative process, as well as APA's legislative agenda for the 119th Congress. You will leave well-equipped to work with lawmakers for the health and well-being of the American people.

Our APPA Division works daily with the Administration, Congress, and around the country to advance the profession of psychiatry and promote the highest quality of care for our patients and their families. Through advocacy, APA shapes policy, legislation, and regulation, and educates stakeholders on mental health, psychiatry, and evidence-based treatments. Your efforts here will help us fight the stigma surrounding mental illness and substance use disorders.

Advocacy only works if our members are involved, which is why we are so grateful that you have dedicated your time and effort to building relationships with your legislators. The work you do here and in the future will make a difference for your patients and our profession.

Sincerely,

Marketa Wills, MD, MBA

CEO and Medical Director

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If you are no longer able to participate in the Federal Advocacy Conference, please contact **advocacy@psych.org**.

FEDERAL ADVOCACY CONFERENCE INFORMATION

AGENDA

APA's Federal Advocacy Conference

October 6 and 7, 2025 • The Royal Sonesta Capitol Hill
20 Massachusetts Avenue, NW, Washington, DC 20001

MONDAY, OCTOBER 6: ADVOCACY PREPARATION AND ISSUE BRIEFINGS

10:00 AM – 4:00 PM	**Registration And Conference Packet Pickup** *Crown Ballroom Foyer, Royal Sonesta Hotel Capitol Hill*
12:00 PM – 1:00 PM	**Welcome Lunch** *Crown Ballroom*
12:30 PM – 1:00 PM	**Welcome And Opening Remarks** ***Theresa Miskimen Rivera, MD, DLFAPA,*** *President* ***Lee Tynes, MD, PHD,*** *Chair, Council On Advocacy And Government Relations* ***Marketa Wills, MD, MBA,*** *Ceo And Medical Director*
1:00 PM – 2:00 PM	**Importance Of Storytelling In Advocacy** *Holly Amaya, Story Imprinting*
2:00 PM – 2:30 PM	**Advocacy Associates** *Crown Ballroom*
2:30 PM – 3:00 PM	**Senator Angela Alsobrooks (D-Md)** *Remarks*
3:00 PM – 3:05 PM	**APAPAC Remarks** ***Mary Anne Albaugh, MD***
3:05 PM – 6:00 PM	**Federal Issue Breakout Sessions** *Breakout session groups are listed on attendees' name tags*

3:00 PM – 3:50 PM	**Issue Breakout 1** Workforce Issues *Breakout session groups are listed on attendees' name tags* ***Robert Trestman, MD, PhD*** ***German Velez, MD***
3:50 PM – 4:00 PM	**Coffee Break**
4:00 PM – 4:50 PM	**Issue Breakout 2** Behavioral Health Integration and Appropriations *Breakout session groups are listed on attendees' name tags* ***Anna Ratzliff, MD, PhD***
4:50 PM – 5:00 PM	**Break**
5:00 PM – 6:00 PM	**Issue Breakout 3** Office Visits 101 and Telehealth *Breakout session groups are listed on attendees' name tags* ***Shabana Khan, MD*** ***Karen Pierce, MD***
6:30 PM – 8:00 PM	**APAPAC Reception** *Sapphire Room and Terrace*
TUESDAY, OCTOBER 7: ADVOCACY PREPARATION AND ISSUE BRIEFINGS	
7:00 AM – 8:00 AM	**Breakfast and APA Staff Q&A** *Crown Ballroom*
8:00 AM – 8:20 AM	**Remarks** ***Representative Paul Tonko (NY-20)*** *Crown Ballroom*
8:20 AM – 8:25 AM	**Closing Remarks**
8:30 AM – 9:00 AM	**Walk to Capitol Hill and Take Group Photo**
9:00 AM – 3:30 PM	**Meetings on the Hill**

Please note: In addition to your individual constituent meetings, you will also have meetings scheduled for your full state delegation *(with the exception of large states, which may be divided into smaller groups)*. To ensure no one attends a meeting alone, you are required to attend all your assigned constituent meetings and are encouraged to participate in all other meetings on your schedule, unless you have a conflict. If a conflict prevents you from attending a constituent meeting, please contact **advocacy@psych.org** as soon as possible.

GETTING AROUND D.C.

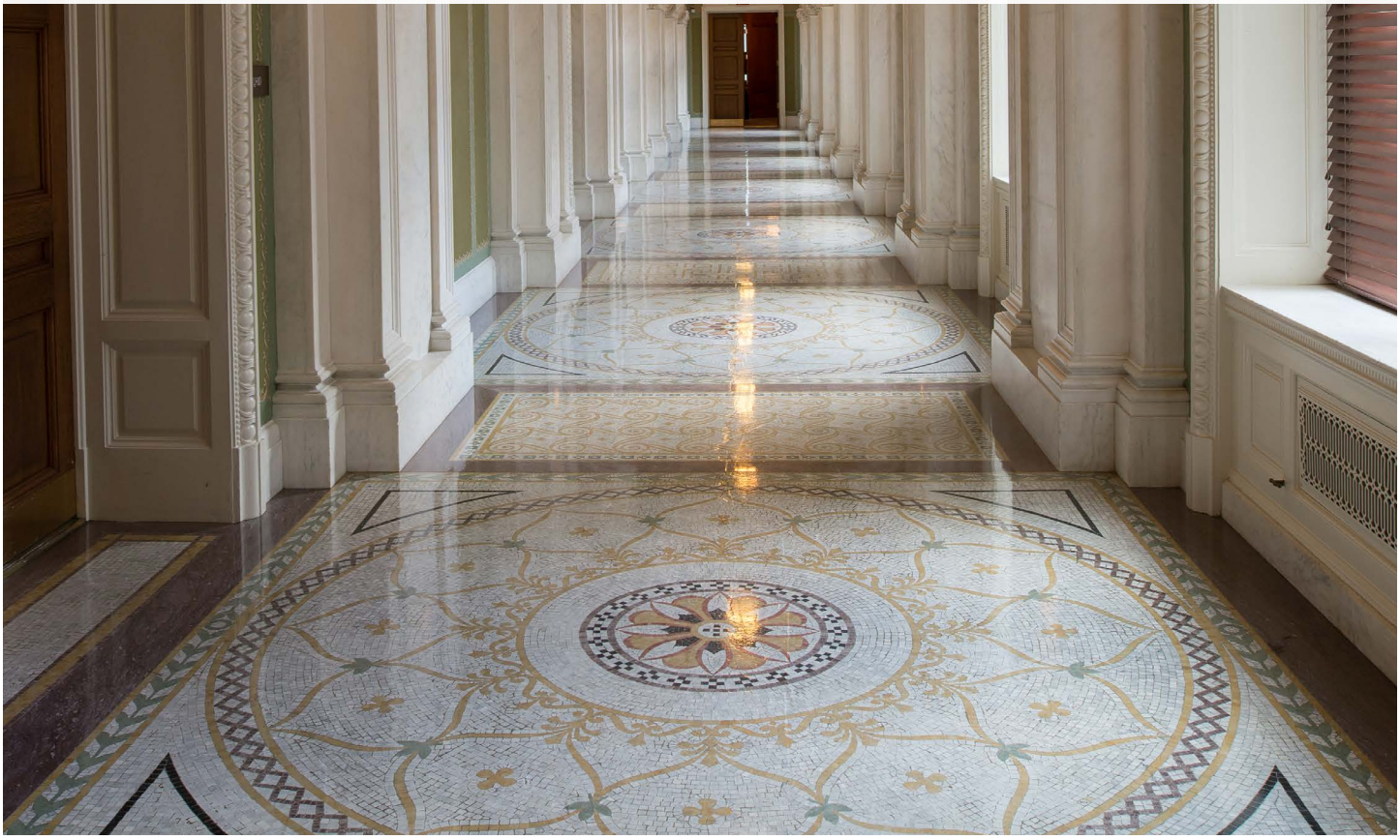

System Map
wmata.com
Information: 202-637-7000 | TTY: 202-962-2033
Metro Transit Police: 202-962-2121 | Text: MYMTPD (696873)
Legend
RD Red Line • Glenmont / Shady Grove
OR Orange Line • New Carrollton / Vienna
BL Blue Line • Franconia-Springfield / Downtown Largo
GR Green Line • Branch Ave / Greenbelt
YL Yellow Line • Huntington / Greenbelt
SV Silver Line • Ashburn / Downtown Largo
Station Features
Parking
Hospital
Airport
Connecting Rail Systems
Transfer Station
Station in Service
Future Station
Glenmont
Wheaton
Forest Glen
Silver Spring
Takoma
Greenbelt
College Park-U of Md
Hyattsville Crossing
West Hyattsville
Fort Totten
Shady Grove
Rockville
Twinbrook
North Bethesda
Grosvenor-Strathmore
Medical Center
Bethesda
Friendship Heights
Tenleytown-AU
Van Ness-UDC
Cleveland Park
Woodley Park
Zoo/Adams Morgan
Dupont Circle
Farragut North
Georgia Ave-Petworth
Columbia Heights
U St
African-Amer Civil War Mem'l/Cardozo
Shaw-Howard U
Mt Vernon Sq
7th St-Convention Center
Gallery Place
Chinatown
Brookland-CUA
Rhode Island Ave
Brentwood
NoMa-Gallaudet U
Union Station
McPherson Sq
Rosslyn
Foggy Bottom-GWU
Kennedy Center
Farragut West
Metro Center
Federal Triangle
Archives
Navy Memorial-Penn Quarter
Judiciary Sq
L'Enfant Plaza
Arlington Cemetery
Pentagon
Pentagon City
Crystal City
Ronald Reagan Washington National Airport
Potomac Yard (Future Station)
Braddock Rd
King St-Old Town
Eisenhower Ave
Huntington
Van Dorn St
Franconia-Springfield
Ashburn
Loudoun Gateway
Washington Dulles International Airport
Innovation Center
Herndon
Reston Town Center
Wiehle-Reston East
Spring Hill
Greensboro
Tysons
McLean
Vienna
Dunn Loring
West Falls Church
East Falls Church
Ballston-MU
Virginia Sq-GMU
Clarendon
Court House
New Carrollton
Landover
Cheverly
Deanwood
Minnesota Ave
Stadium-Armory
Potomac Ave
Eastern Market
Capitol South
Federal Center SW
Waterfront
Navy Yard-Ballpark
Anacostia
Congress Heights
Southern Ave
Naylor Rd
Suitland
Branch Ave
Benning Rd
Capitol Heights
Addison Rd
Morgan Blvd
Downtown Largo
Metro is accessible.
Map is not to scale
No Smoking
No Eating or Drinking
No Animals (except service animals)
No Audio (without earphones)
No Littering or Spitting
No Dangerous or Flammable Items

Map of the U.S. Capitol Complex

Senate office buildings

House office buildings

KNOW BEFORE YOU GO



HOW TO RESEARCH YOUR LAWMAKERS

Know Who You're Talking to

The best way to get a legislator to listen is to present your message in a way that makes sense to them. You'll want to know:

- **What is the legislator's record on the issues I care about?** Knowing the answer to this will clue you in to whether you're working with a legislator who "gets it" or one who may need a little more convincing. Remember that in many cases, a legislator may be undecided or even unaware of your issue. Think of this as an opportunity to sway them to your side.
- **What issues do they care about that are unrelated to health care?** Knowing this will help you frame your message. For example, it may make sense to discuss an issue pertaining to lack of access to care if a lawmaker is from a rural area.
- **What committees do they serve on?** Knowing this will give you a sense of their issue expertise.
- **What party do they belong to? Where are they on the political spectrum?** Advocates sometimes feel uncomfortable speaking with legislators of a different political party. However, this should not dissuade you from establishing a relationship. Instead, focus on adjusting the frame of the issue to increase the likelihood of your points resonating. For example, conservative members of Congress may respond well to arguments relating to fiscal responsibility, while others may prefer to hear about improved access to services.
- **Which staff people handle APA issues?** Staff are your most important resources in a legislators office. In fact, they are the ones who will move your policy issue forward. It can be more important to have a good relationship with them than with anyone else – including the member of Congress.

Where to Get This Information

- **Your Lawmakers' Websites.** Go to your lawmakers' websites to see what issues they are prioritizing. Each lawmaker should have a general description of his or her stance on health care policy and you should review recent press releases issued by your lawmakers' offices or legislation your lawmaker has introduced. You can also look through your lawmakers' social media channels to see what they have been doing locally or in DC.

CONGRESSIONAL OFFICE STRUCTURE

Positions Within Capitol Hill Offices

- **Chief of Staff:** Oversees the operation of the entire office both in Washington and the district represented by the lawmaker and often coordinates several projects in the district; usually the most influential position, often representing the Member at events or meetings when he or she is not available; usually responsible for hiring personnel for the office.
- **Scheduler:** Arranges the Member's schedule, both in Washington and the district, which may include handling all travel arrangements and reservations.
- **Legislative Director (LD):** Heads the legislative staff; monitors the status of bills in Congress and keeps the Member updated; drafts legislation initiated by the Member; maintains close contact with a number of constituencies including other Hill staffers, lobbyists, and people in the home district. Oversees and influences the strategy to implement the Member's policy goals.
- **Legislative Assistant (LA):** Collaborates with the LD in legislative matters. Handles a number of issue areas about which they brief the Member, help draft legislation, answer constituent inquiries, and write position papers. Carries out and influences the Member's policy goals. If you meet with the legislative assistant, they will likely have a "legislative portfolio" related to healthcare.
- **Legislative Correspondent (LC):** Researches issues in order to answer constituent legislative correspondence. Supports the LD and LAs.

KEY CONGRESSIONAL COMMITTEES FOR APA

House Energy & Commerce Committee

The House Energy & Commerce Committee has the broadest jurisdiction of any authorizing committee in Congress and works on a wide variety of issues, including issues that touch your practices and patients: mental health care and substance use disorder programs, health insurance regulations, Medicare and Medicaid policies, as well as drug and medical device safety. The Committee also oversees several federal departments and agencies, including the Department of Health and Human Services, the National Institutes of Health, the Centers for Disease Control and Prevention, Indian Health Services, the Centers for Medicare & Medicaid Services and the Food and Drug Administration.

Democratic Members

Ranking Member Frank Pallone (D-NJ) – *Ranking Member*
Diana DeGette (D-CO) – *Ranking Member, Health Subcommittee*
Jan Schakowsky (D-IL)
Doris Matsui (D-CA)
Kathy Castor (D-FL)
Paul Tonko (D-NY)
Yvette Clarke (D-NY)
Raul Ruiz (D-CA)
Scott Peters (D-CA)
Debbie Dingell (D-MI)
Marc Veasey (D-TX)
Robin Kelly (D-IL)
Nanette Diaz Barragán (D-CA)
Darren Soto (D-FL)
Kim Schrier (D-WA)
Lori Trahan (D-MA)
Lizzie Fletcher (D-TX)
Alexandria Ocasio-Cortez (D-NY)
Jake Auchincloss (D-MA)
Troy Carter (D-LA)
Rob Menendez (D-NJ)
Kevin Mullin (D-CA)
Greg Landsman (D-OH)
Jennifer McClellan (D-VA)

Republican Members

Brett Guthrie (R-KY) - *Chair*
Bob Latta (R-OH)
Morgan Griffith (R-VA) – *Chair, Health Subcommittee*
Gus Bilirakis(R-FL)
Richard Hudson (R-NC)
Buddy Carter (R-GA)
Gary Palmer (R-AL)
Neal Dunn, M.D. (R-FL)
Dan Crenshaw (R-TX)
John Joyce (R-PA)
Randy Weber (R-TX)
Rick Allen (R-GA)
Troy Balderson (R-OH)
Russ Fulcher (R-ID)
August Pfluger (R-TX)
Diana Harshbarger (R-TN) – *Co-Chair, Health Subcommittee*
Mariannette Miller-Meeks (R-IA)
Kat Cammack (R-FL)
Jay Obernolte (R-CA)
John James (R-MI)
Cliff Bentz (R-OR)
Erin Houchin (R-IN)
Russell Fry (R-SC)
Laurel Lee (R-FL)
Nick Langworthy (R-NY)
Tom Kean (R-NJ)
Michael Rulli (R-OH)
Gabe Evans (R-CO)
Craig Goldman (R-TX)
Julie Fedorchak (R-ND)

Bolded name denotes Health Subcommittee Members

House Ways & Means Committee

The House Ways & Means Committee is charged with all matters involving taxation, tariffs and other revenue-raising measures, which include many safety-net programs like Social Security, Medicare and Temporary Assistance for Needy Families (TANF). More specifically, its Subcommittee on Health works on issues that relate to health care programs, health insurance premiums and health care costs.

Democratic Members

Richie Neal (D-MA) – *Ranking Member*
Lloyd Doggett (D-TX) – *Ranking Member, Health Subcommittee*
Mike Thompson (D-CA)
John Larson (D-CT)
Danny Davis (D-IL)
Linda Sanchez (D-CA)
Terri Sewell (D-AL)
Suzan DelBene (D-WA)
Judy Chu (D-CA)
Gwen Moore (D-WI)
Brendan Boyle (D-PA)
Don Beyer (D-VA)
Dwight Evans (D-PA)
Brad Schneider (D-IL)
Jimmy Panetta (D-CA)
Jimmy Gomez (D-CA)
Steven Horsford (D-NV)
Stacey Plaskett (D-VI)
Thomas Suozzi (D-NY)

Republican Members

Jason Smith (R-MO) - *Chair*
Vern Buchanan (R-FL) – *Chair, Health Subcommittee*
Adrian Smith (R-NE)
Mike Kelly (R-PA)
David Schweikert (R-AZ)
Darin LaHood (R-IL)
Jodey Arrington (R-TX)
Ron Estes (R-KS)
Lloyd Smucker (R-PA)
Kevin Hern (R-OK)
Carol Miller (R-WV)
Greg Murphy (R-NC)
David Kustoff (R-TN)
Brian Fitzpatrick (R-PA)
Greg Steube (R-FL)
Claudia Tenney (R-NY)
Michelle Fischbach (R-MN)
Blake Moore (R-UT)
Beth Van Duyne (R-TX)
Randy Feenstra (R-IA)
Nicole Malliotakis (R-NY)
Mike Carey (R-OH)
Rudy Yakym (R-IN)
Max Miller (R-OH)
Aaron Bean (R-FL)
Nathaniel Moran (R-TX)

Bolded name denotes Health Subcommittee Members

House Veterans' Affairs Committee

The House Committee on Veterans' Affairs reviews veterans' programs, examines current laws, and reports bills and amendments to help veterans and strengthen the Department of Veterans Affairs. It oversees issues like veterans' health care, disability compensation, GI Bill education and job training, home loan guarantees, life insurance policies, and a nationwide system of veterans' cemeteries.

Democratic Members

Mark Takano (D-CA) – *Ranking Member*
Julia Brownley (D-CA) – *Ranking Member, Health Subcommittee*
Chris Pappas (D-NH)
Sheila Cherfilus-McCormick (D-FL)
Morgan McGarvey (D-KY)
Delia Ramirez (D-IL)
Nikki Budzinski (D-IL)
Tim Kennedy (D-NY)
Maxine Dexter (D-OR)
Herb Conaway (D-NJ)
Kelly Morrison (D-MN)

Republican Members

Mike Bost (R-IL) – *Chair*
Jack Bergman (R-MI)
Nancy Mace (R-SC)
Mariannette Miller-Meeks (R-IA) – *Chair, Health Subcommittee*
Greg Murphy (R-NC)
Derrick Van Orden (R-WI)
Morgan Luttrell (R-TX)
Juan Ciscomani (R-AZ)
Keith Self (R-TX)
Jen Kiggans (R-VA)
Abe Hamadeh (R-AZ)
Tom Barrett (R-MI)

Bolded name denotes Health Subcommittee Members

House Appropriations Committee

The House Committee on Appropriations is responsible for writing the laws that fund most functions of the federal government. Currently, the Appropriations Committee has 12 subcommittees that have jurisdiction over specific federal agencies and functions. The subcommittee that oversees many of the programs impacting the field of psychiatry and our patients is the Labor, Health and Human Services, Education Subcommittee, often referred to as "Labor-HHS."

Democratic Members

Rosa DeLauro (D-CT) – *Ranking Member, Labor HHS Subcommittee*
Steny Hoyer (D-MD)
Rep. Marcy Kaptur (D-OH)
Rep. James Clyburn (D-SC)
Rep. Sanford Bishop (D-GA)
Rep. Betty McCollum (D-MN)
Rep. Debbie Wasserman Schultz (D-FL)
Henry Cuellar (D-TX)
Chellie Pingree (D-ME)
Mike Quigley (D-IL)
Grace Meng (D-NY)
Mark Pocan (D-WI)
Pete Aguilar (D-CA)
Lois Frankel (D-FL)
Bonnie Watson Coleman (D-NJ)
Norma Torres (D-CA)
Ed Case (D-HI)
Adriano Espaillat (D-NY)
Josh Harder (D-CA)
Lauren Underwood (D-IL)
Susie Lee (D-NV)
Joseph Morelle (D-NY)
Mike Levin (D-CA)
Madeleine Dean (D-PA)
Veronica Escobar (D-TX)
Frank Mrvan (D-IN)
Marie Gluesenkamp Perez (D-WA)
Glenn Ivey (D-MD)

Republican Members

Chairman Tom Cole (R-OK) - Chair
Harold Rogers (R-KY)
Robert Aderholt (R-AL) – *Chair, Labor HHS Subcommittee*
Michael Simpson (R-ID)
John Carter (R-TX)
Ken Calvert (R-CA)
Mario Diaz-Balart (R-FL)
Steve Womack (R-AR)
Chuck Fleischmann (R-TN)
David Joyce (R-OH)
Andy Harris (R-MD)
Mark Amodei (R-NV)
David Valadao (R-CA)
Dan Newhouse (R-WA)
John Moolenaar (R-MI)
John Rutherford (R-FL)
Ben Cline (R-VA)
Guy Reschenthaler (R-PA)
Ashley Hinson (R-IA)
Tony Gonzales (R-TX)
Julia Letlow (R-LA) – *Vice Chair, Health Subcommittee*
Michael Cloud (R-TX)
Michael Guest (R-MS)
Ryan Zinke (R-MT)
Andrew Clyde (R-GA)
Stephanie Bice (R-OK)
Scott Franklin (R-FL)
Jake Ellzey (R-TX)
Juan Ciscomani (R-AZ)
Chuck Edwards (R-NC)
Mark Alford (R-MO)
Nick LaLota (R-NY)
Riley Moore (R-WV)

Bolded name denotes Health Subcommittee Members

Senate Finance Committee

The Senate Finance Committee's jurisdiction is defined by subject matter rather than by agency or Department. Due to this broad jurisdiction, the Finance Committee oversees the activities of numerous agencies and offices, including Department of Health and Human Services and the Centers for Medicare & Medicaid Services.

Democratic Members

Ron Wyden (D-OR) – *Ranking Member*
Maria Cantwell (D-WA)
Michael Bennet (D-CO)
Mark Warner (D-VA)
Sheldon Whitehouse (D-RI)
Maggie Hassan (D-NH) – *Ranking Member, Health Subcommittee*
Catherine Cortez Masto (D-NV)
Elizabeth Warren (D-MA)
Bernie Sanders (D-VT)
Tina Smith (D-MN)
Ben Lujan (D-NM)
Raphael Warnock (D-GA)
Peter Welch (D-VT)

Republican Members

Mike Crapo (R-ID) - *Chair*
Chuck Grassley (R-IA)
John Cornyn (R-TX)
John Thune (R-SD)
Tim Scott (R-SC)
Bill Cassidy (R-LA)
James Lankford (R-OK)
Steve Daines (R-MT)
Todd Young (R-IN) – *Chair, Health Subcommittee*
John Barrasso (R-WY)
Ron Johnson (R-WI)
Thom Tillis (R-NC)
Marsha Blackburn (R-TN)
Roger Marshall (R-KS)

Senate Health, Education, Labor & Pensions (HELP) Committee

The Senate Health, Education, Labor and Pensions (HELP) Committee works on numerous policy issues including aging, biomedical research and development, disabled individuals, and the public health. The Committee also studies and reviews public concerns relating to health, education and training, and public welfare.

Democratic Members

Bernie Sanders (I-VT) – *Ranking Member*
Patty Murray (D-WA)
Tammy Baldwin (D-WI)
Christopher Murphy (D-CT)
Tim Kaine (D-VA)
Maggie Hassan (D-NH)
John Hickenlooper (D-CO)
Ed Markey (D-MA) – *Ranking Member, Health Subcommittee*
Andy Kim (D-NJ)
Lisa Blunt Rochester (D-DE)
Angela Alsobrooks (D-MD)

Republican Members

Bill Cassidy, MD (R-LA) - *Chair*
Rand Paul (R-KY)
Susan Collins (R-ME)
Lisa Murkowski (R-AK)
Markwayne Mullin (R-OK)
Roger Marshall, M.D. (R-KS) – Chair, Health Subcommittee
Tommy Tuberville (R-AL)
Tim Scott (R-SC)
Josh Hawley (R-MO)
Jim Banks (R-IN)
John Husted (R- OH)
Ashley Moody (R-FL)

Bolded name denotes Health Subcommittee Members

Senate Appropriations Committee

The Senate Committee on Appropriations writes legislation to allocate federal funds to government agencies, departments and organizations on an annual basis. The Appropriations Committee is the largest committee in the Senate with twelve subcommittees that have jurisdiction over specific federal agencies and functions. The subcommittee that oversees many of the programs impacting the field of psychiatry and our patients is the Labor, Health and Human Services, Education and Related Agencies Subcommittee, which is often referred to as the "Labor-H" subcommittee.

Democratic Members

Vice Chair Patty Murray (D-WA) – *Vice-Chair*
Richard Durbin (D-IL)
Jack Reed (D-RI)
Jeanne Shaheen (D-NH)
Jeff Merkley (D-OR)
Christopher Coons (D-DE)
Brian Schatz (D-HI)
Tammy Baldwin (D-WI) – *Ranking Member, Labor HHS Subcommittee*
Chris Murphy (D-CT)
Chris Van Hollen (D-MD)
Martin Heinrich (D-NM)
Gary Peters (D-MI)
Kirsten Gillibrand (D-NY)
Jon Ossoff (D-GA)

Republican Members

Susan Collins (R-ME) - *Chair*
Mitch McConnell (R-KY)
Lisa Murkowski (R-AK)
Lindsey Graham (R-SC)
Jerry Moran (R-KS)
John Hoeven (R-ND)
John Boozman (R-AR)
Shelley Moore Capito (R-WV) – *Chair, Labor HHS Subcommittee*
John Kennedy (R-LA)
Cindy Hyde-Smith (R-MS)
Bill Hagerty (R-TN)
Katie Britt (R-AL)
Markwayne Mullin (R-OK)
Deb Fischer (R-NE)
Mike Rounds (R-SD)

Senate Veteran's Affairs Committee

Similar to the House of Representatives, the Senate Committee on Veterans' Affairs reviews veterans' programs, examines current laws, and writes legislation to improve the Department of Veterans Affairs. It oversees issues like veterans' health care, disability compensation, GI Bill education and job training, home loan guarantees, life insurance policies, and a nationwide system of veterans' cemeteries.

Democratic Members

Richard Blumenthal (D- CT) – *Ranking Member*
Patty Murray (D-WA)
Bernie Sanders (I-VT)
Mazie Hirono (D-HI)
Maggie Hassan (D-NH)
Angus King Jr. (I-ME)
Tammy Duckworth (D-IL)
Ruben Gallego (D-AZ)
Elissa Slotkin (D-MI)

Republican Members

Jerry Moran (R-KS) – *Chair*
John Boozman (R-AR)
Bill Cassidy, MD (R-LA)
Thom Tillis (R-NC)
Dan Sullivan (R-AK)
Marsha Blackburn (R-TN)
Kevin Cramer (R-ND)
Tommy Tuberville (R-AL
Jim Banks (R-IN)
Tim Sheehy (R-MT)

Bolded name denotes Health Subcommittee Members

MEETING WITH LAWMAKERS

WHAT TO EXPECT ON CAPITOL HILL

What to Expect Before Your Meeting:

- Security is time consuming. To get into the congressional office buildings you will need to use a visitors' entrance and walk through a metal detector, while your bag or coat goes through an x-ray machine. Make sure you allow enough time to get through before your meeting, as the security lines can be long.
- Congressional offices, particularly those on the House side, are small and cramped. Your group may need to wait in the hall while one member checks in with the office's front desk. Also, your meeting may take place in the hall or a reception area if there is no space to accommodate your group. That's perfectly normal on the Hill, so don't let it distract you from discussing your issues.
- Congressional staff are young. Jobs on Capitol Hill don't pay much, and staff are expected to work long hours, so these positions tend to attract individuals who are earlier in their careers. That said, they are trusted members of the lawmaker's team and play an important role in the decision-making process.
- You may not meet with your actual lawmaker. Capitol Hill is a "working office" with hearings and votes occurring frequently and often without warning. Events, including meetings, don't always occur as planned. Between votes, members of Congress may have committee hearings and meetings with other constituents. Your lawmaker may spend the whole meeting with you, two minutes or not make your meeting. That said, the staff that you meet with play important roles in the office and building relationships with them is key to our success.
- The meetings will be short. Meetings on Capitol Hill typically last 15-20 minutes. Given the time constraints, it is important to stay focused on our issues, be brief in your explanation and make sure that everyone who wants to speak has the opportunity.

What to Do During Your Meeting:

- Be Clear and Direct with Your "Asks." Are you asking for the lawmaker to cosponsor a bill? Make sure that is clear and then provide necessary background and details. Staff will appreciate this approach as it saves them from having to decipher what you want and will get their minds on how they can move forward with your issue.
- Bring the point home. The number one thing lawmakers and their staff want to know is how a policy is affecting or will affect their constituents. You are the voice in their ears as they try to assess how things impact their home communities.
  Tip: Tell a brief, memorable, story to demonstrate your point. Do you have a patient who could be hurt if a bill passes or fails? Will your facility need to lay-off staff if a policy is enacted?
- Use medical jargon sparingly. You are there to provide your expertise on how health care policies will impact your community. However, be mindful to use medical terms that are easily grasped by the general public.

- It's OK if you don't know. You are on the Hill to bring your on-the-ground perspective to your legislators. If you don't know the answer to a question, it's okay. You can refer them to APA's Department of Government Relations staff or tell them you will follow up with them with a detailed answer.
  Important: If you can't answer a question, let APA staff know through the Advocacy Associates app so that we can follow up with the office.

- Agree to disagree. Don't waste time arguing if a lawmaker or staff disagrees with you on an issue or has taken an opposing position. You're there to tell them about how things are impacting your profession and patients which will hopefully inform their next action.
  Important: Let APA staff know through an email or the app if a member of Congress has taken a particular position on an issue. Intel like this really helps us design our legislative strategies.

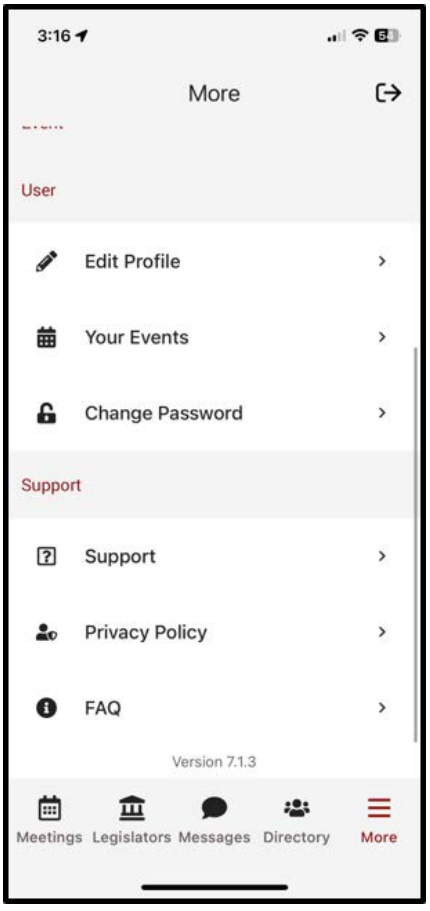
- Get the staff member's business card. You'll need to send a thank you note to the staff member after the meeting and email is the best way to reach them. Also, advocacy doesn't end when you leave DC, so you'll want to keep the staff member updated on the issues you discussed or thank the office if they take action to support our issues.

ADVOCACY ASSOCIATES

Capitol Hill Day Logistics and Troubleshooting

Confused about your meeting schedule?
Problems accessing your account?
Issue with the app?
Running late to a meeting?

All of these day-of hiccups will be managed by our partners at Advocacy Associates. Please communicate questions and concerns directly to James Simmons via the contact info below or the Support function on the Advocacy Day App. This can be accessed by clicking on the "More" tab at the bottom of your app screens and clicking on the "Support" button.



TUESDAY, 10/17: POINT OF CONTACT

James Simmons
jsimmons@advocacyassociates.com
(301) 244-9671

TIPS FOR EFFECTIVE MEETINGS

Do...

- Arrive to your meeting early
- Know your audience; research your members of Congress before your meetings
- Be polite and personable and conduct yourself in a professional manner
- Share speaking time with others in your group. You can even divide the issues among your group and designate "speaking roles"
- Use personal stories to support your issues
- Be ready to answer questions on your issues
- Share the leave behind materials with staff via email or your online platform
- Fill out a "feedback form" so that APA's government relations team can build upon your great work

Don't...

- Skip a scheduled meeting. It is never acceptable to not attend a scheduled meeting
- Argue or antagonize. It's best to agree to disagree and move on to a different issue.
- Ask a member to support a bill without knowing if they are already a supporter
- Guess at an answer to a question. It is better to let APA staff know so that they can follow up with the office
- Go on tangents. Hill meetings are short, and staffers appreciate brevity on busy days.

DEVELOP YOUR ELEVATOR SPEECH
- THE SPIT TECHNIQUE -

Members of Congress and their staff have hectic schedules, so it's not uncommon for a meeting to be interrupted, delayed, or canceled. As such, you must use your limited time wisely and be concise. These effective, five-minute statements use a personal story to urge a legislator to support your cause. To develop your "elevator speech" you will want to use the SPIT technique. SPIT is an acronym as follows:

Specific: Be as specific as possible about what the lawmaker can do. For example, "we would like you to cosponsor a bill" or "we encourage you to support a 3% increase in program funding."

Personal: Messages that are based on compelling stories have more of an impact. How would a policy impact your patients or your profession? Can you demonstrate that impact through a patient story?

Informative: In addition to a personal story, you'll want to have some valuable information to back it up. Some of the information you might want to provide includes:

- Number of patients you serve
- Number of psychiatrists or staff at your facility or that your practice employs
- Specifics on services you provide
- Special services you provided that relate to the community

Timely: Finally, your message should suggest that you are a valuable resource and the best way to achieve this goal is to follow-up with staff in a timely manner on the issues you discussed. This says to the person you're talking to that you are in this discussion for the long-haul.

POST ADVOCACY CONFERENCE CHECKLIST

Congratulations! You just enjoyed a day on Capitol Hill, advocating on behalf of your profession and patients! However, your work is not done. Here is what's next and how you can stay involved:

- Write a thank you note to all the Members or staff members you met with during the Federal Advocacy Conference.
  - Note: Email is preferred; handwritten notes in the mail take an additional two weeks to arrive at the offices due to security screenings.
- Provide APA with feedback on your meetings. The Advocacy Associates app will prompt you to submit feedback on both your Hill meetings. APA uses your feedback to inform our legislative strategies, as well as to make sure proper follow-up is taken with offices.
  - Don't submit feedback as a group – you may remember things others in your group do not and you may have had a different perspective on how a meeting went.
  - Take some time when filling out these forms – they really are important and information like "she supports behavioral health integration" isn't as helpful as "she agreed to cosponsor the COMPLETE Care Act."
- Meet with your lawmakers locally. Connecting locally with your lawmakers provides federal and state officials the opportunity to witness first-hand how quality mental health care improves communities. Meet with a lawmaker at their district office, participate in a town hall, inquire about joining their health care advisory board or attend a fundraiser. Email advocacy@psych.org for assistance in setting up a local event.
- Join APAPAC and the Congressional Advocacy Network. Now that you are working to establish relationships with your lawmakers, you can help APA utilize these connections by supporting APAPAC and volunteering to be a part of the Congressional Advocate Network. Work with APA to strengthen the relationship with your lawmaker, so that you can deliver a pro-psychiatry message when Congress is considering an issue that would impact the mental health care system.

Share Your Experience

Social media is a vital way to connect and advocate with your federal representatives in the modern era.Take photos with your members of Congress and share them across platforms.

Please use the hashtag #APAadvocacy 2025 and thank your lawmakers for meeting with you by tagging them.

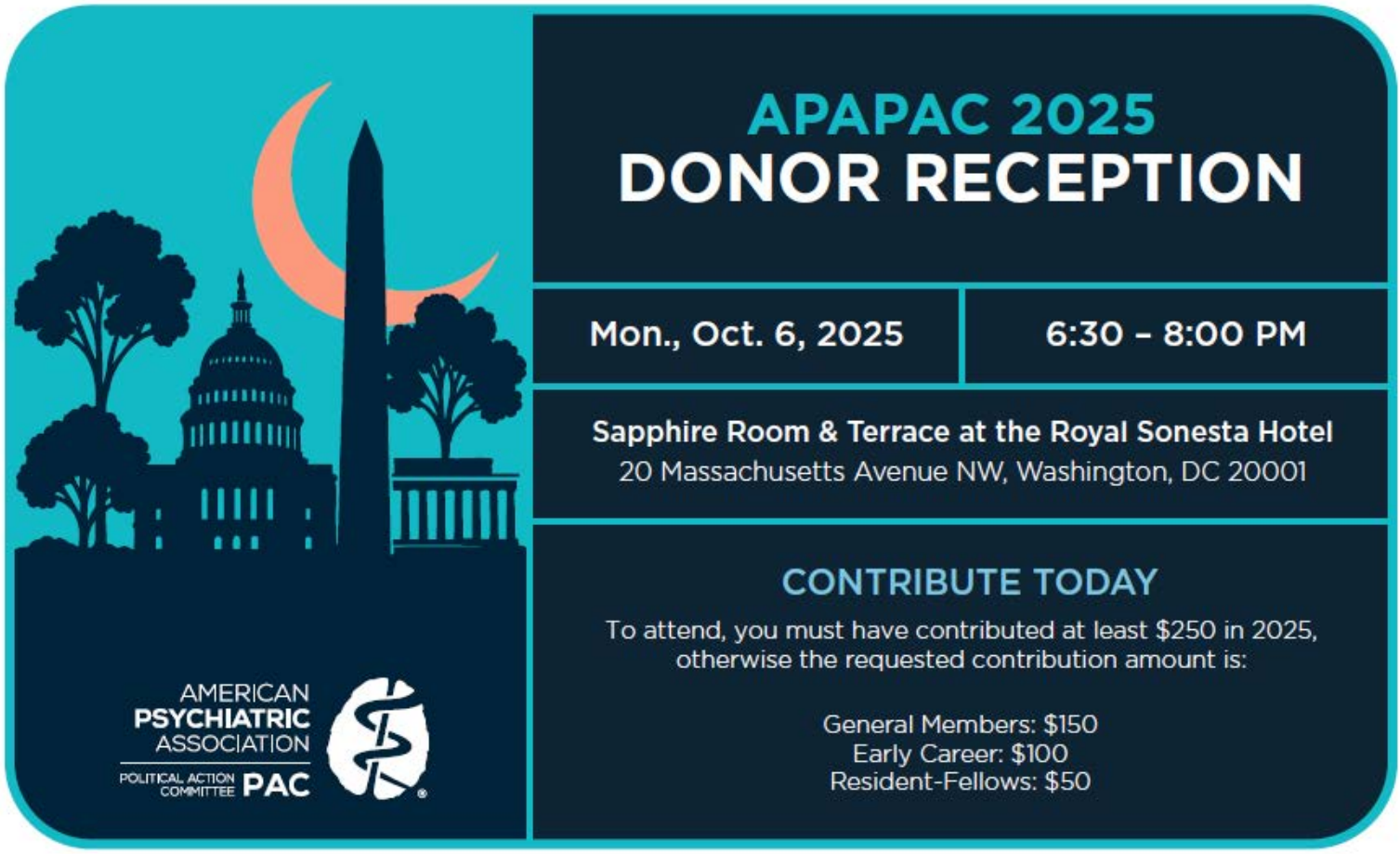
Example Posts:

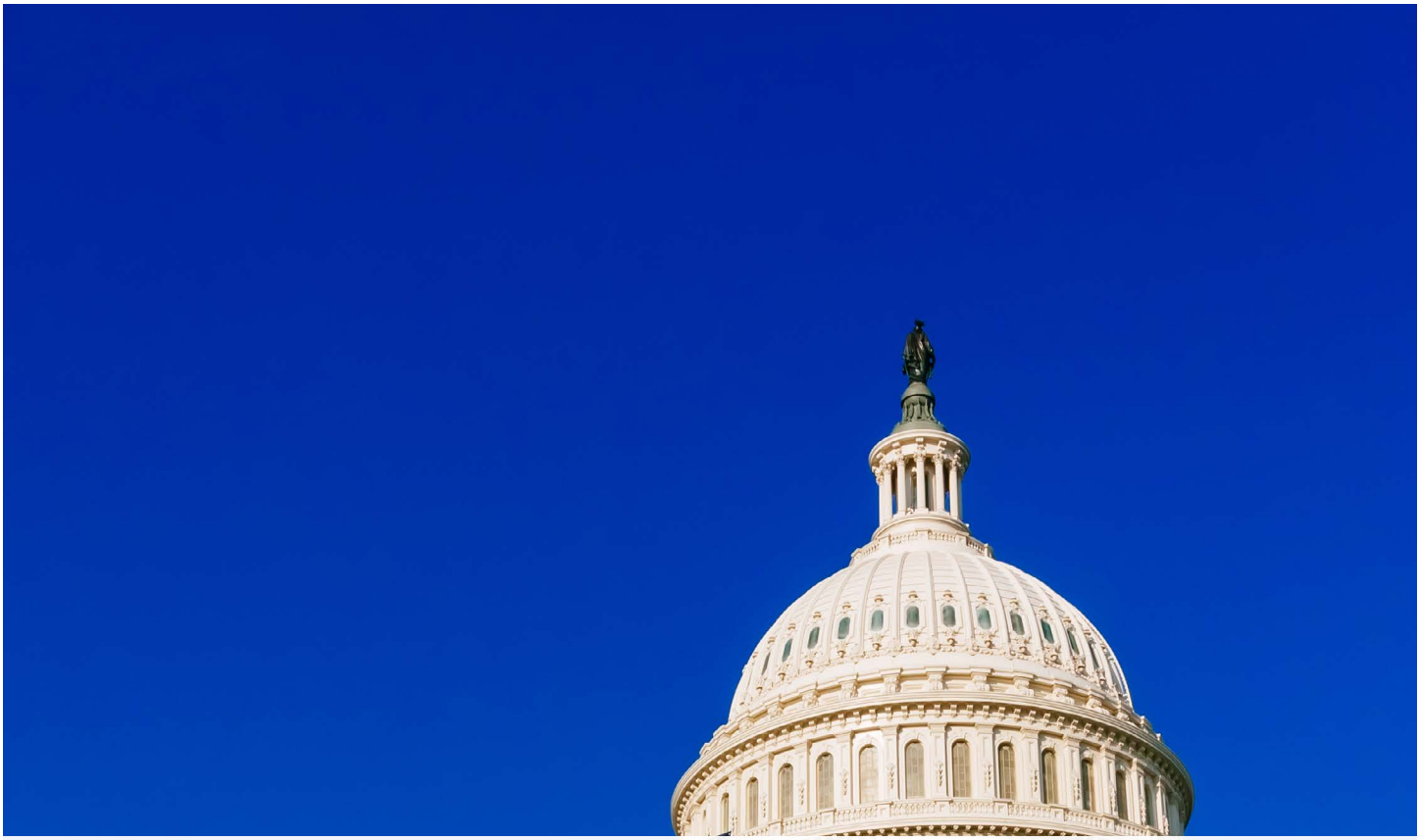
Thanks to (@Rep…) office for meeting with [state] psychiatrists to discuss integrated care and GME expansion. #APAadvocacy 2025 @APApsychiatric

Great discussion with (@Sen…) on critical @APApsychiatric health care issues. Thank you for meeting with psychiatrists from across the [state] #APAadvocacy 2025

Great to meet with the office of (@Rep…) at #APAadvocacy 2025 @APApsychiatric. Thank you for being a staunch advocate for #physicians and patients!

STAY INVOLVED


APAPAC 2025
DONOR RECEPTION
Mon., Oct. 6, 2025
6:30 – 8:00 PM
Sapphire Room & Terrace at the Royal Sonesta Hotel
20 Massachusetts Avenue NW, Washington, DC 20001
CONTRIBUTE TODAY
To attend, you must have contributed at least $250 in 2025, otherwise the requested contribution amount is:
General Members: $150
Early Career: $100
Resident-Fellows: $50
AMERICAN PSYCHIATRIC ASSOCIATION
POLITICAL ACTION COMMITTEE PAC



2025 ISSUE PAPERS AND TALKING POINTS

Appropriations

Issue

APA supports robust investments in federal mental health and substance use disorder programs. These programs are a lifeline for patients across the country, supporting the psychiatric workforce and access to effective and evidence-based care.

Background

Each year Congress must pass legislation to fund programs and agencies in the federal government. This includes funding for mental health and substance use disorder programs across agencies such as SAMHSA, NIH, HRSA, and CDC, among others. Congress has made significant bipartisan progress over the last several years enhancing the access and treatment of mental health and substance use disorders services.

This year, both the House and Senate Appropriations Committees moved forward their versions *of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (Labor-HHS)*, which proposes FY2026 funding levels for the majority of federal health programs. As anticipated, the bills include cuts to health initiatives, but it is notable that many mental health and substance use disorder priority programs were protected. Both bills did not include the administration's proposed broader cuts to health programs and the restructuring of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the US Department of Health and Human Services Administration (HHS).

Since Congress was unable to reach an agreement on funding prior to the September 30 deadline, the government is currently in a shutdown.

Legislative Solution

- **Protect federal investments in mental health and substance use disorder programs.** These programs are vital for patients seeking effective and evidence-based mental health and substance use disorder treatment across America.
- **Reject proposals to restructure SAMHSA**. Safeguarding the continuity, funding, and leadership structure within SAMHSA is critical to ensuring that individuals and communities continue to receive timely, evidence-based, and accessible care.

Appropriations

Federal Legislative Talking Points

- As a practicing psychiatrist in your state, I am deeply concerned with the proposed restructuring of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the US Department of Health and Human Services Administration (HHS) and the negative impact it would have on our patients.
- Furthermore, the Administration proposed draconian cuts to programs administered by SAMHSA and other agencies such as Health Resources and Service Administration (HRSA), National Institute of Health (NIH), and Centers for Disease Control and Prevention (CDC) that provide critical mental health and substance use disorder services to our patients.
- This comes at a time when we continue to face a profound mental health and substance use disorder crisis with nearly 400 Americans dying each day from suicide or overdose. It is estimated that 1 and 5 Americans (nearly 59 million people) will encounter a mental health condition each year with more than half not accessing treatment.
- Congress has made significant bipartisan progress over the last several years enhancing the access and treatment of mental health and substance use disorders services through the authorization and appropriation of funds for patients across the country.
- The recent decline in opioid-related deaths is a testament to these efforts and shows that targeted federal investments can, and do, save lives.
- As Congress continues to deliberate the funding of appropriations for Fiscal Year 26, we urge you to work in a bipartisan manner to ensure that patients continue to have access to these vital mental health and substance use disorder services.
- These programs have been a lifeline for patients facing mental illness and substance use disorder in our states and communities and vital for patients seeking effective and evidence-based treatment.
- Without these services there will be a profound negative impact on the health of our workforce and communities.
- Safeguarding the continuity, funding, and leadership structure within SAMHSA is critical to ensuring that individuals and communities continue to receive timely, evidence-based, and accessible care.
- Now is not the time to restructure these departments or drastically scale back funding for mental health and substance use disorder services. I urge you to protect the funding vital to so many of your constituents seeking mental health and substance use disorder services.

Behavioral Health Integration

Issue

Families across the country are struggling to access needed mental health (MH) and substance use disorder (SUD) services. APA supports addressing these issues by helping providers adopt evidence-based integrated care delivery models, such as the Collaborative Care Model (CoCM). By facilitating coordination between health professionals within the primary care setting, integrated care can increase access, reduce wait times for treatments, and improve patient outcomes.

Background

Using a team-based, interdisciplinary approach to deliver diagnoses, treatment, and follow-up care to an identified patient population, the Collaborative Care Model (CoCM) has proven to be the gold standard. The CoCM integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated effort. Importantly, the team members use measurement-based care to ensure that patients are progressing, and treatment is adjusted if they are not. More than 100 research studies have demonstrated that the model improves access, clinical outcomes, and patient satisfaction.

By taking a population-based approach to better meet the growing demand for services, the CoCM has the capacity to greatly increase the number of patients who can receive care for MH/SUD relative to traditional 1:1 treatment. Because psychiatrists can consult on a registry of 60 to 80 patients via weekly chart review, providing oversight of medication and therapeutic interventions, and clinical recommendations to the primary care physician, the CoCM multiplies the number of patients who benefit from a psychiatrist's specialized training. In cases including SUD treatment, the CoCM also allows addiction specialist physicians to function in the consultant role.

Despite its strong evidence base and availability of reimbursement, uptake of the CoCM by primary care practices, like other integrated care models, remains low due to the up-front costs associated with implementation. By providing temporarily enhanced Medicare payment rates for behavioral health integration services as well as technical assistance, Congress can help to address both issues.

Legislative Solution

The *COMPLETE Care Act (H.R.2509/S.931)* has been introduced by Reps. Nicole Malliotakis (R-NY), Lizzie Fletcher (D-TX), August Pfluger (R-TX), Steven Horsford (D-NV), Mike Carey (R-OH), and Tom Suozzi (D-NY), and Sens. Catherine Cortez-Masto (D-NV) and John Cornyn (R-TX) in the House and Senate.

The bill incentivizes primary care to adopt behavioral health integration by increasing the Medicare payment for integrated care codes for 3 years (2027-2029). The legislation also facilitates technical assistance to practices implementing the CoCM. The COMPLETE Care Act is a logical and much needed step toward ensuring integrated behavioral health care is more widely implemented, and patients can get the mental health and substance use care they require to lead healthy, fulfilling lives.

APA Request

Please support & cosponsor H.R.2509/S.931

AMERICAN PSYCHIATRIC ASSOCIATION

Behavioral Health Integration

Federal Legislative Talking Points

- APA supports legislation to incentivize primary care to integrate behavioral health into their practices to increase access to needed MH and SUD services.

- The cost of behavioral health integration – e.g. expenses for hiring of new employees - is an impediment and barrier for many primary care practices to implement and sustain.

- The **COMPLETE (Connecting Our Medical Providers with Links to Expand Tailored and Effective) Care Act** (H.R.2509/S.931) enhances Medicare payment rates for behavioral health integration services (for three years) and facilitates technical assistance for primary care to develop and implement integrated care models such as the Collaborative Care Model (CoCM).

- Enhanced payment rates will incentivize practices to implement the CoCM and develop a patient population that will sustain the model.

- The evidence-based CoCM is unique as a workforce multiplier because it leverages the team to focus on and treat a far larger population of patients than usual one-to-one care.

- The model is supported by a significant body of evidence and, because it measures effectiveness of the care being provided, it helps to ensure patients get better and has been shown to save health care costs.

- CoCM will help detect and prevent potential suicides and overdoses before they become crises, reduce the necessity for referrals to specialties, and promote timely and integrated care to patients in the primary care setting.

- More than 60 organizations representing the mental health community, physicians, patient advocates, employers, and payers support the legislation

APA Request

Please support & cosponsor H.R.2509/S.931

AMERICAN PSYCHIATRIC ASSOCIATION

Telehealth

Issue

Telepsychiatry is an important tool to increase access to care and is therefore a critical component of the mental health delivery system. Access to psychiatrists is limited in many areas of the country, especially in underserved and rural areas. Telepsychiatry can reduce barriers to receiving care, ensure access to specialized services and has improved patient and clinician satisfaction.

Background

The expansion of telehealth has been a cornerstone in improving access to mental health care, helping to alleviate gaps exposed by workforce shortages. This has been particularly true for patients in rural or underserved areas and patients who face other barriers to in-person care. Over the last several years, patients have shown high satisfaction with telehealth and a decrease in no-show rates, which is clinically important for timely and effective treatment.

Since the COVID-19 pandemic, Congress has extended many public health emergency Medicare telehealth flexibilities including delaying the implementation of an in-person evaluation requirement within 6-months to provide mental health services via telehealth. These telehealth flexibilities passed by Congress and implemented by past and current Administrations have been a lifeline for patients in need of MH/SUD services.

Legislative Solution

The *Telemental Health Care Access Act (H.R.3884/S.2011)* has been introduced by Reps. Doris Matsui (D-CA) and Troy Balderson (R-OH), and Sens. Bill Cassidy (R-LA) and Tina Smith (D-MN) in the House and Senate. The bill would permanently remove the six-month in-person requirement for Medicare beneficiaries being treated for mental health services through telehealth. *H.R. 1867*, introduced by Reps. Kevin Hern (R-OK), Tom Suozzi (D-NY), Brian Fitzpatrick (R-PA), Susie Lee (D-NV), and Nicole Malliotakis (R-NY), would also permanently remove this requirement.

The *CONNECT for Health Act (H.R. 4206/S. 1261)* has been introduced by Reps. Mike Thompson (D-CA), David Schweikert (R-AZ), Doris Matsui (D-CA), and Troy Balderson (R-OH), and Sens. Brian Schatz (D-HI), Roger Wicker (R-MS), Mark Warner (D-VA), Cindy Hyde-Smith (R-MS), Peter Welch (D-VT), and John Barrasso (R-WY) in the House and Senate. This bill would make the public health emergency Medicare telehealth flexibilities permanent, including removal of the 6-month in-person requirement for mental health services furnished via telehealth.

APA Request

Please support & cosponsor H.R. 3884/S.2011 & H.R. 4206/S. 1261

AMERICAN PSYCHIATRIC ASSOCIATION

Telehealth

Federal Legislative Talking Points

- APA supports the permanent repeal of the 6-month in-person requirement currently in statute for telemental health services, which is an arbitrary and unnecessary barrier for patients accessing treatment.

- Telehealth can increase access and help alleviate the gaps exposed by workforce maldistribution, including in rural and underserved areas, by providing a linkage between patients in their home communities and behavioral health clinicians in other locations.

- Over the last several years, including during the pandemic, patients have shown high satisfaction with telehealth and a decrease in no-show rates, which is clinically important for timely treatment.

- When patients keep their first appointment, they are more likely to keep subsequent appointments and continue with their course of therapy. This results in better medication compliance, fewer emergency department visits, reduced patient admissions to an inpatient unit, and declines in subsequent readmissions.

- The physician and patient should determine and have discretion of when services are needed in-person vs. virtually, especially since some patients seeking mental health services perform clinically better via telehealth.

- Having a 6-month in-person requirement is an impediment for patients accessing mental health services especially for patients in rural or underserved areas where in-person visits are difficult or may require a commute of several hours.

APA Request

Please support & cosponsor H.R. 3884/S.2011 & H.R. 4206/S. 1261

AMERICAN PSYCHIATRIC ASSOCIATION

Supporting & Enhancing the Psychiatric Workforce

Issue

APA supports improving access to mental health (MH) and substance use disorder (SUD) care by boosting resources for training new psychiatrists and incentivizing the practice of medicine where clinicians are most needed. Efforts to increase the supply of MH and addiction professionals should be a central component of legislation intended to enhance access to MH/SUD treatment.

Background

The Health Resources and Services Administration (HRSA) estimates that by 2037, there will be a shortage of over 438,000 MH professionals, including psychiatrists, 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 US counties lacking a single psychiatrist. Projections show the country will be short around 50,000 psychiatrists by 2037. Congress has recently made important incremental progress addressing these shortfalls, however, today fewer than half the individuals with MH/SUD conditions receive treatment. The shortage and maldistribution of psychiatric 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.

Legislative Solution

The *Resident Education Deferred Interest (REDI) Act (H.R.2028/S.942)* has been introduced by Reps. Brian Babin (R-TX) and Chrissy Houlahan (D-PA), and Sens. Jacky Rosen (D-NV) and John Boozman (R-AR) and in both the House and Senate. This bill allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs.

The *Conrad State 30 and Physician Access Reauthorization Act (H.R.1585/S.709)* has been introduced by Reps. David Valadao (R-CA), Brad Schneider (D-IL), Don Bacon (R-NE), and Sylvia Garcia (D-TX), and Sens. Amy Klobuchar (D-MN), Susan Collins (R-ME), Jacky Rosen (D-NV) and Thom Tillis (R-NC) in both the House and Senate. The bill expands and improves upon the Conrad 30 program, which provides waivers for U.S. trained international physicians to work in high-need areas.

The *Resident Physician Shortage Reduction Act of 2025 (H.R.3890/S.2439)* has been introduced by Representatives Terri Sewell (D-AL) and Brian Fitzpatrick (R-PA), and Senators John Boozman (R-AR) and Raphael Warnock (D-GA) in both the House and Senate. The bill would expand the number of Medicare-supported medical residency positions by 14,000 over seven years.

Funding the Department of Veterans Affairs (VA) – The VA plays a critical role in training psychiatrists by serving as one of the largest providers of graduate medical education in the United States. We urge Congress to increase dedicated funding for the VA's psychiatry residency and fellowship programs to expand training capacity, strengthen academic partnerships, and ensure a robust pipeline of psychiatrists equipped to meet the growing mental health needs of veterans and the nation.

APA Request

Please support & cosponsor H.R.2028/S.942, H.R. 1585/S.709, & H.R. 3890/S. 2439

AMERICAN PSYCHIATRIC ASSOCIATION

Supporting & Enhancing the Psychiatric Workforce

Federal Legislative Talking Points

- Projections show that the country will be short around 50,000 psychiatrists by 2037.
- Nearly 122 million Americans live in a mental health professional shortage area.
- APA supports a holistic approach to building our physician workforce including **funding for Medicare funded GME slots, loan relief, and expansion of the Conrad 30 J-1 Visa program.**

Student Loan Relief

- The cost of graduate-level medical education is substantial for most students. Further, those who must undertake several years of residency with very low pay are often unable to begin repaying student debt immediately.
- Even for graduates that qualify to have their payments suspended during residency through deferment or forbearance processes, their loans continue to accrue interest that is added to their already staggeringly high student loan balance.
- The ability for medical and dental residents to save thousands of dollars in interest on their loans could make the concept of practicing in underserved areas or entering faculty or research more attractive and affordable to residents.
- APA supports the **Resident Education Deferred Interest (REDI) Act** (H.R.2028/S.942), which would prevent physicians and dentists from being penalized during residency by precluding the government from charging them interest on their loans during that time period.

International Medical Graduates (IMGs)

- 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.
- The number of waivers allocated to each state has remained stagnant for the last two decades, despite our health care workforce shortage becoming more severe.
- APA supports the **Conrad State 30 and Physician Access Reauthorization Act** (H.R. 1585/S.709), which would expand and improve upon the Conrad 30 Program. This program allows states to request J-1 visa waivers for 30 foreign physicians per state/per year to work in federally designated shortage areas.
- The bill would also increase state allocations to **35 physicians per year** and provide flexibility to expand the number of waivers in states where demand exceeds that limit.

APA Request

Please support & cosponsor H.R.2028/S.942, H.R. 1585/S.709, & H.R. 3890/S. 2439

AMERICAN PSYCHIATRIC ASSOCIATION

Increasing Medicare Funded GME Slots

- Congress has made efforts in recent years to help address physician shortages. Most notably, providing for 1,200 new Medicare-supported GME positions since 2021 – the first such increases in nearly thirty years.
  - The Fiscal Year 2021 Omnibus added 1,000 new GME residency slots, 200/year for 5 years, targeted to teaching hospitals in rural areas and those training over the their cap.
  - The Fiscal Year 2023 Omnibus added 200 new GME residency slots with 100 of these slots going directly to psychiatry or psychiatric subspecialties beginning in 2026.
- APA urges Congress to pass the **Resident Physician Shortage Reduction Act of 2025** (H.R. 3890/S.2439), which would expand the number of Medicare-supported GME positions by 2,000 per year for 7 years.

Department of Veterans Affairs

- The Department of Veterans Affairs (VA) plays a critical role in training psychiatrists by serving as one of the largest providers of graduate medical education in the United States. Through its extensive network of medical centers and academic partnerships, the VA offers psychiatry residents and fellows unique clinical training experiences, particularly in the diagnosis and treatment of complex mental health conditions such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and substance use disorders.
- This training not only equips future psychiatrists with specialized skills to care for veterans but also strengthens the broader mental health workforce serving communities nationwide.
- APA urges Congress to increase dedicated funding for the VA's psychiatry residency and fellowship programs to expand training capacity, strengthen academic partnerships, and ensure a robust pipeline of psychiatrists equipped to meet the growing mental health needs of veterans and the nation.

APA Request

Please support & cosponsor H.R.2028/S.941, H.R. 1585/S.709, & H.R. 3890/S. 2439

AMERICAN PSYCHIATRIC ASSOCIATION

Additional Topics

What to say if you don't know the answer

If you don't know the answer to a question, we encourage you to say: I do not know, but I would be happy to share this question with the APA team so we can get you a response.

Medicare Physician Fee Schedule

- APA supports a Medicare physician payment system that is sustainable and stabilizes payments to help ensure patient access to timely and evidence-based care.
- Lack of adequate reimbursement is particularly problematic in psychiatry due to the limited workforce and the lack of parity in payment by commercial payers who pay psychiatrists roughly 30% less than other physicians, making it even more difficult to maintain a financially viable practice.
- In stark contrast to the annual payment increases tied to inflation given to hospitals, skilled nursing facilities and other entities that bill Medicare, physician practices must fight to reduce or delay payment cuts nearly every year.
- Medicare physician payments have lagged 33% behind the rate of inflation growth since 2001, despite the rising costs of running a practice.
- APA supports the **Medicare Patient Access and Practice Stabilization Act** (H.R. 879), which would stop, in full, the 2.83% Medicare physician payment cut that went into effect on January 1st and provide an additional 2% payment bump.
- H.R. 1 provided a 2% Medicare physician payment bump for calendar year 2026.

Maternal Mental Health

- APA supports addressing mental health (MH) and substance use disorder (SUD) as the leading cause of maternal mortality and as a key component of reducing health disparities.
- According to reports from the Centers for Disease Control and Prevention, mental health conditions are the leading cause of maternal mortality, accounting for 23% of pregnancy-related deaths.
- The United States continues to have the highest rate of maternal mortality of any high-income nation: our nation's maternal mortality rate in 2022 was 22 deaths per 100,000 live births, more than triple the rates in most European and Asian countries.
- APA supports the **Preventing Maternal Deaths Reauthorization Act** (H.R. 1909). This important legislation ensures continued support for state maternal mortality review committees (MMRCs) examining pregnancy-related deaths, promotes the dissemination of best practices to providers. And addresses maternal health disparities.

Mental Health Parity

- The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or parity law) requires health plans that offer behavioral health coverage to ensure that financial requirements (deductibles, copayments, coinsurance, and out-of-pocket limits) and treatment limits (day and visit limits as well as nonquantitative limits such as prior authorization) on these benefits are no more restrictive than those on medical and surgical benefits.
- However, full implementation and enforcement of the parity law is incomplete. As a result, people seeking mental health/substance use disorder (MH/SUD) care often face discriminatory barriers, including higher costs, for that care.
- APA supports robust enforcement of all existing and new provisions regulating MHPAEA.

Child and Adolescent Mental Health

- The U.S. is facing a national crisis in child and adolescent mental health – among high school students, 40% experienced persistent feelings of sadness or hopelessness and 20% seriously considered attempting suicide in the past year.
- APA supports robust investments in addressing the mental health needs of children and adolescents, including prevention, early intervention, and support for the pediatric mental health workforce. Legislative solutions include:
  - H.R. 1735/S.779 –**EARLY Minds Act**. This bill would allow states to use up to 5% of Mental Health Block Grant funds for prevention and early intervention services. Currently, the block grant funds may only be used for individuals with diagnosed serious mental illnesses or serious emotional disturbances.
  - Increased funding for HRSA's **Children's Hospital Graduate Medical Education (CHGME)** program. This program supports graduate medical education programs at freestanding children's hospitals, funding the training of thousands of general pediatricians and pediatric specialists including child and adolescent psychiatrists. Notably, CHGME funds the training of over 40% of child and adolescent psychiatrists.
  - Investments in HRSA's **Pediatric Mental Health Care Access (PMHCA)** program. This program promotes the integration of mental health and pediatric primary care. It supports telehealth consultation by child mental health teams, including child and adolescent psychiatrists, and enhances the capacity of pediatricians to screen, treat, and refer children with mental health concerns.

Prior Authorization

- Prior authorization requirements delay care for patients and impose significant administrative burdens on physicians. APA supports the **Improving Seniors' Timely Access to Care Act** (S. 1816/H.R. 3514) which would help address these issues by streamlining and standardizing the prior authorization process in the Medicare Advantage (MA) program, while also providing much needed transparency. This legislation would allow physicians to spend more time treating patients and less time on bureaucratic hurdles. Most importantly, it would remove barriers that impede patients' timely access to care.

Step Therapy

- Step therapy, otherwise known as "fail first" therapy, is a harmful medical protocol whereby insurers require patients, sometimes even those stable on a certain medication, to try and fail medications before agreeing to cover the initial therapy prescribed by the health care provider. Not only are these protocols unnecessary and ill-advised – they are harmful to patients and limit the ability of physicians to provide quality, individualized care.
- The issue is particularly acute for mental health treatment, given the individualized nature of psychiatric medication prescriptions. If mental illnesses go untreated, or are inappropriately treated, a patient's risk of inpatient hospitalization, persistent or significant disability, or death is heightened. Requiring a patient to first adhere to step therapy protocols, instead of starting or maintaining an appropriate medication the first time, raises the overall costs of care, delays patient stabilization, and risks patient safety. Additionally, the risk of suicide attempts and completed suicide increases for patients with any psychiatric disorder, and this risk can increase exponentially for patients who suffer from disorders like depression and anxiety, who are unable to access the antidepressants that can control their symptoms.
- To protect patients from harmful step therapy insurance protocols, APA supports the **Safe Step Act** (H.R.5509 /S.2903) which would requires insurance plans to provide exemptions to step therapy protocols and to implement a clear and timely process for requesting exemptions.

VA

- The VA is a critical training ground for psychiatrists, offering exposure to a high volume of complex cases, including PTSD, depression, and serious mental illnesses. Trainees gain experience with specialized programs, evidence-based treatments, and interdisciplinary collaboration, preparing them for diverse clinical settings. The VA also provides research opportunities and insight into healthcare policy and administration. By training psychiatrists, the VA helps address the national mental health workforce shortage, particularly for veterans and underserved populations.

- APA urges Congress to invest in our national health care workforce and the health of our veteran community by expanding psychiatric residency programs, supporting PTSD and suicide prevention initiatives, and providing resources to recruit and retain psychiatrists, particularly in underserved areas.

AI

- The APA envisions AI tools playing a meaningful role in tackling the nation's mental health crisis. AI can assist with clinical documentation, suggest care plans, identify potential diagnoses, and automate billing and prior authorization processes. AI can support psychological research, training, and practice by analyzing data, identifying patterns, and improving the quality of care. **However, AI is not a substitute for the crucial therapeutic alliance and human connection in mental health care.** There are high risks for patient privacy and consent concerns, especially with large language models and other generative AI applications. There is a risk of adolescents being exposed to harmful or inaccurate content from AI, which they are less likely to question.
- The APA calls for strong safeguards, ethical guidelines, and regulations to protect against harm. AI development must be a collaborative effort between AI developers and behavioral health experts and psychological scientists. Physicians and psychologists must play a leadership role in the development and deployment of AI tools. Further research and education are needed to understand AI's capabilities and limitations and to prepare professionals to use it effectively and safely. Age-appropriate defaults, human oversight, and rigorous testing are needed to ensure transparency and protect vulnerable populations.

Psychedelics

- APA acknowledges the growing interest and preliminary research into using psychedelics and empathogens such as psilocybin, LSD, and MDMA for serious conditions like treatment-resistant depression and PTSD. However, current evidence is insufficient to broadly endorse these treatments. Further, psychedelics can pose significant risks, especially when taken outside of a controlled, supervised setting. Clinical decisions should be based on scientific evidence, not popular opinion or ballot initiatives.
- APA supports continued, regulated research into the therapeutic potential of psychedelic agents, such research must meet the same rigorous scientific and regulatory standards applied to any other promising medical therapy.

Community Mental Health

- APA supports the **Community Mental Wellness and Resilience Act** (H.R. 4744). This bill would award grants for communities to organize mental wellness and resilience coordinating networks and to assess community wellness. These networks would include representatives from community-based organizations, educational institutions, youth serving and senior care organizations, environmental and climate change mitigation groups, and mental and physical health groups, among others.

Supplemental Materials

Behavioral Health Integration

- APA's "Learn About the Collaborative Care Model": https://www.psychiatry.org/psychiatrists/practice/professional-interests/collaborative-care/learn

Telehealth

- APA's Telepsychiatry Page: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry

Workforce

- GME Training Tomorrow's Physician Workforce (see below)
- HRSA's State of the Behavioral Health Workforce, 2024 (see below)

Graduate Medical Education:
Training Tomorrow's Physician Workforce

Graduate medical education (GME) is the supervised hands-on training after medical school that all physicians must complete to be licensed and practice independently. The length of this training varies but generally lasts at least three to five years for initial specialty training; subspecialty training may last up to 11 years after graduation from medical school. Training is generally coordinated and funded by teaching hospitals and medical schools, though the clinical experiences occur in a variety of settings, including inpatient, outpatient, and community.

The Roles of Teaching Hospitals in GME

- Their education, patient care, research, and community collaborations missions enable teaching hospitals to offer patients the most advanced expertise, services, and technology.
- Physicians lead teams that provide a diverse range of around-the-clock specialty care and standby services — such as in trauma centers, burn units, and neonatal intensive care units — and are prepared to care for the nation's most critically ill or injured patients.
- 93% of all residency programs train residents in nonhospital settings, such as academic ambulatory clinics, community health centers, private physicians' offices, VA ambulatory services, and ambulatory surgical centers.[2]

"We know that adequate access to doctors results in longer lives and better health care outcomes. Smaller, more rural states face an acute need for medical providers, and the shortage will only increase in the coming years."

— Sen. John Boozman (R-Ark.)

Federal Support for Residency Training

- Hospitals that train residents incur **real and significant costs** beyond those customarily associated with providing patient care.
- **Medicare Direct Graduate Medical Education (DGME)** payments offset a portion of these direct costs associated with training physicians (for example, resident stipends and benefits, supervising physician stipends and benefits, and GME office overhead costs).
- Medicare **supports only a fraction** of the overall costs associated with training a resident. This support is tied to each hospital's Medicare volume (the "Medicare share"), and this varies between teaching hospitals.
- Teaching hospitals incur **$22.6 billion** annually in direct training costs. Because of support limitations and other historical factors, Medicare covers **only $4.6 billion (20%)** of that total.[3]
- Since 2020, Congress has taken bipartisan steps to modestly increase Medicare support for training. However, Medicare's support for GME had been effectively frozen since 1997 despite an aging, growing population. Even with federal support, teaching hospitals still must offset a significant portion of each resident's training costs.

The Physician Shortage

The United States Is Facing a Shortage of up to 86,000 Physicians by 2036[4]

- Between 20,200 and 40,400 primary care physicians.
- Between 10,100 and 19,900 physicians in surgical specialties.

What Is Driving the Physician Shortage?

Demographics — specifically, population growth and aging — continue to be the primary driver of increasing demand for physician services.

- By 2036, the U.S. population is projected to grow by 8.4%. The population aged 65 and older is projected to grow by 34.1% and the size of the population aged 75 and older is projected to grow by 54.7%. Since older Americans tend to see more physicians — specifically specialists — we project that this will lead to an increase in the demand for specialty physicians.
- Medical advances have increased the number of people living with multiple chronic illnesses.
- More than a third of currently active physicians are likely to retire in the next decade. Their retirement decisions will dramatically affect the magnitude of national workforce shortages.
- Though demand is increasing, supply is not increasing at the same pace because of the artificial cap Congress imposed on Medicare GME support.

"Increasing the number of Medicare-supported residency positions means giving hospitals and health centers the tools they need to increase access to care, lower wait times for patients, and create a pipeline of qualified medical professionals to serve Americans' health needs."

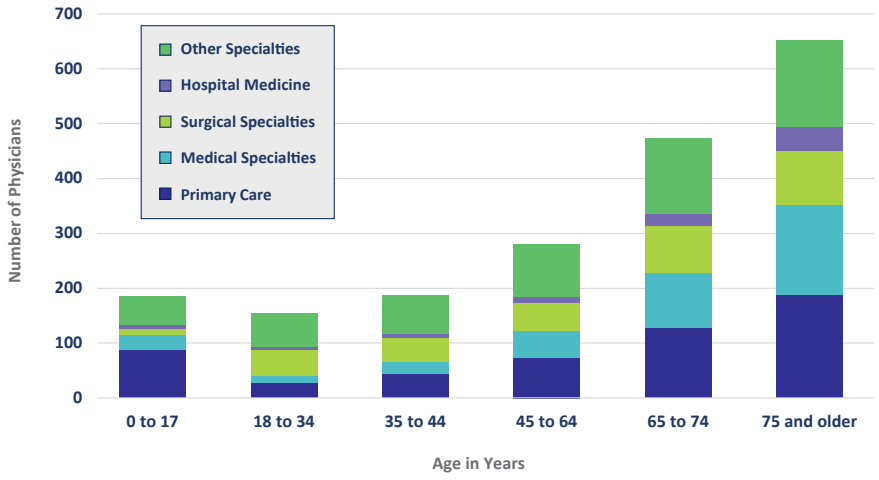
— Rep. Terri Sewell (D-Ala.)

Lifting the Cap on Medicare GME Funding Will Help Alleviate the Doctor Shortage

Bipartisan legislation introduced in both the House and the Senate (H.R. 4731 or S. 2439) would help address the doctor shortage by increasing the number of Medicare-supported residency positions by 14,000 over seven years. This increase would make progress toward providing the necessary primary care and specialty physicians necessary to meet the country's workforce needs.

Learn more:
aamc.org/news-insights/gme

Physician Utilization per 100,000 People, by Age



Source: *GlobalData analysis of Medical Expenditure Panel Survey, National Inpatient Sample, Census Bureau population estimates, and AMA Physician data for the AAMC, 2023.*

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HRSA Health Workforce

State of the Behavioral Health Workforce, 2024

November 2024

The United States is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages. The capacity of the behavioral health workforce to meet the demand is limited by supply and distribution challenges. However, the challenges facing the behavioral workforce extend beyond the supply and demand issues and include:

- **Patient-level barriers**, such as stigma and ability to pay that both hinder access to care.
- **Provider-level barriers,** such as limited scopes of practice, reimbursement challenges, and clinician burnout all of which limit the ability to provide high-quality care.

This report provides an overview of the current behavioral health workforce supply and distribution in the United States as well as factors impacting the workforce and access to behavioral health care services.

About the National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis informs public and private sector decision makers on health workforce issues by expanding and improving health workforce data, disseminating workforce data to the public, and improving and updating projections of the supply and demand for health workers.

For more information, visit the Health Workforce Analysis webpage.

Highlights

- Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, psychiatric physician assistants/associates, psychiatrists, and school counselors are projected in 2037.
- As of August 2024, more than one third (122 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA).
- Rural counties are more likely than urban counties to lack behavioral health providers. Residents of rural counties are also more likely to receive behavioral health services from primary care providers.
- The majority of the behavioral health workforce identifies as female and non-Hispanic White and may not be representative of the communities they serve.
- The lack of uniformity in behavioral health providers' scope of practice, reimbursement challenges, and increased burnout hinder the accessibility of the behavioral health workforce.
- Expanding integrated care, leveraging health support workers, and using telebehavioral health may help alleviate behavioral health workforce shortage and maldistribution.

Describing the behavioral health care workforce

The opioid epidemic[1] and mental health crisis in the United States[2] have contributed to an increase in overdoses, suicides, and depression in the past two decades.[3,4,5] The COVID-19 pandemic also exacerbated behavioral health needs.[6] Even though behavioral health needs have increased, there are persistent challenges with access to behavioral health services and high levels of unmet need.[7]

In 2023, approximately 59 million U.S. adults (23% of all U.S. adults) had a mental illness and nearly half of them did not receive treatment (46%).[8] Behavioral health services can be difficult to access due to behavioral health provider shortages, high out-of-pocket costs, coverage gaps, and other factors.[9] For example, 6 in 10 psychologists do not accept new patients,[10] and the national average wait time for behavioral health services is 48 days.[11]

Behavioral health occupations

The traditional behavioral health workforce comprises many different occupations including licensed professionals and health support workers. These occupations have different education, training, and licensure requirements that can vary by state and accrediting body.[12] Table 1 shows the current supply in typical behavioral health occupations.

Table 1. Current Supply of the Behavioral Health Workforce

Profession	Year	Supply
Addiction counselor [a]	2022	99,771
Marriage and family therapist [a]	2022	28,066
Mental health counselor [a]	2022	135,662
Psychiatric aide [b]	2023	32,310
Psychiatric advanced practice registered nurse [c]	2022	39,354
Psychiatric physician assistant/associate [d]	2023	2,999
Psychiatrist [e]	2022	47,864
Psychologist [a, f]	2022	99,030
Social worker [a]	2022	537,338

[a] 2022 American Community Survey 5-year Public Use Microdata. [b] 2023 BLS Occupational Employment and Wage Statistics, May 2023. [c] 2022 American Psychiatric Nurses Association's Psychiatric Mental Health Nursing Workforce Survey [d] 2023 National Commission on Certification of Physician Assistants Annual Report. [e] 2022 American Medical Association Physician Professional Data. [f] Psychologist totals include psychologists with a PhD degree.

The occupations in the behavioral health workforce are not homogeneous. Different occupations provide different levels of care. For example, psychiatrists can prescribe medication, psychologists can provide psychological assessments and therapy, and peer providers can offer support based on their training and lived experiences.

Other occupations providing behavioral health services

Not all behavioral health services are provided by those working in behavioral health occupations. In many cases, primary care providers, such as primary care physicians, physician assistants/associates (PAs),[13] or nurse practitioners (NPs), are the first health professionals to see patients with behavioral health issues.[14]

Primary care providers delivered 32% of mental health related office visits between 2012 and 2014.[15] Approximately 7% of primary care physicians' direct patient care time was spent on providing behavioral health services between 2019 and 2021 which was a 20% increase from five years earlier.[16]

Current and future shortages

Health Professional Shortage Areas (HPSAs) are one method to measure the extent of current provider shortages. HPSAs are used to identify a shortage of health professionals in geographic areas, facilities, or populations. As of August 2024, 122 million people in the United States, over one third of the population, live in a Mental Health HPSA.[17]

The **current shortages** seen through HPSA data and the **projected future shortages** are generated using two completely different concepts. HPSAs are a "real-time" designation, and a Mental Health HPSA is specific to mental health care providers.[18] By contrast, projections come from the Health Resources and Services Administration's (HRSA) Health Workforce Simulation Model (HWSM). This model projects the future supply of and demand for over 100 health care occupations, including behavioral health occupations.[19]

Substantial shortages are projected for the behavioral health workforce in the future.[20] Table 2 shows the projected shortages and percent adequacy in 2037 across different scenarios. The percent adequacy is the percentage of demand that supply will meet in that year.

Table 2. Projected Shortages of Selected Behavioral Health Providers in 2037, number and percent adequacy[a]

Profession	Status Quo	Unmet Need	Elevated Need
Addiction counselors	-113,930 (45%)	-154,860 (37%)	-197,140 (32%)
Adult psychiatrists	-43,660 (43%)	-58,840 (36%)	-93,940 (26%)
Child and adolescent psychiatrists	-6,780 (65%)	-10,580 (54%)	-19,310 (39%)
Child, family, and school social workers	14,490 (108%)	-21,080 (90%)	-22,320 (90%)
Healthcare social workers	-3,070 (97%)	-24,520 (81%)	-31,160 (77%)
Marriage and family therapists	-34,170 (59%)	-50,760 (49%)	-62,100 (44%)
Mental health and substance use disorder social workers	-8,290 (93%)	-30,520 (77%)	-53,280 (66%)
Mental health counselors	-87,840 (57%)	-128,270 (47%)	-175,290 (40%)
Psychiatric nurse practitioners	6,410 (120%)	20 (100%)	-14,810 (72%)
Psychiatric physician assistants/associates	-790 (86%)	-1,950 (71%)	-3,870 (55%)
Psychologists	-79,160 (55%)	-113,830 (45%)	-131,100 (42%)
School counselors	-39,710 (81%)	-80,530 (67%)	

Note. Health Resources and Services Administration's (HRSA) Workforce Projections.

[a] Data are expressed in full-time equivalents (FTEs). Negative values indicate a projected shortage. Positive values indicate a projected surplus. Percent adequacy is calculated by dividing supply by demand. Unmet Need assumes increased demand and Elevated Need assumes both increased demand and improved access. Full descriptions of scenarios are found on the HRSA Workforce Projections Dashboard.[21]

Demographics

A diverse health workforce has been shown to increase access to care and improve quality of care, especially among underserved populations.[22,23,24] The behavioral health workforce largely identifies as female and non-Hispanic White and may not reflect the U.S. population.[25,26,27]

Distribution

Behavioral health providers work in many environments including community behavioral health centers, Federally Qualified Health Centers (FQHCs), hospitals, inpatient facilities, schools, criminal justice systems, and other private office-based settings.

Maldistribution of the workforce leaves high-need areas without access to behavioral health services. As of August 2024, over one third (122 million) of the U.S. population lives in a Mental Health HPSA.[28] Rural counties are more likely than urban counties to lack psychiatric mental health NPs, psychologists, social workers, and counselors (Table 3).[29,30,31,32] The short supply of providers in rural areas exacerbates the challenges with access to behavioral health services.[33]

Table 3. Percentage of U.S. Rural and Urban Counties Without Behavioral Health Providers, 2021

Profession	Rural Counties	Urban Counties
Psychiatric mental health nurse practitioner	69%	31%
Psychologist	45%	16%
Social worker	22%	5%
Counselor	18%	5%

Note. Adapted from data briefs by WWAMI Rural Health Research Center at the University of Washington, 2022.

Challenges for the behavioral health workforce

Several factors affect the ability of the behavioral health workforce to provide quality care. These factors range from population demographics and the unmet need in those populations to various aspects of providing care, such as scopes of practice, cost, reimbursement, and insurance coverage. In addition, other factors affect burnout, well-being, and turnover rates among the workforce.

Population demographics

Youth behavioral health concerns have been on the rise since 2011.[34] The COVID-19 pandemic further increased this need with 60% of female high school students experiencing persistent feelings of sadness or hopelessness and nearly 25% making a suicide plan in 2021.[35] The treatment rate for major depressive episodes among adolescents increased from 57% in 2022 to 60% in 2023.[36,37]

There are also growing and unique behavioral health needs among older adults. By 2060, the number of adults aged 65 and older is projected to increase by 54%, compared with only a 9% increase in the total U.S. population.[38] The 2022 National Survey on Drug Use and Health (NSDUH) estimated that one in eight older adults aged 60 or older had any mental illness in the past year.[39] Behavioral health needs among older adults are often under-identified by both providers and patients.[40] Many behavioral health providers are not adequately trained to work with older adults.[41] Geriatricians are uniquely positioned to be the first point of contact for behavioral health care needs for older adults.[42] However, the projected national shortage of 2,070 geriatricians in 2037 will further limit the accessibility of behavioral health care for older adults in the future.[43,44,45]

The use of mental health services also differs by race and ethnicity. From 2015 to 2019, non-Hispanic White adolescents used behavioral health services more than adolescents in other racial or ethnic groups.[46] In 2023, behavioral health treatment rates among adults with any mental illness were higher among non-Hispanic Whites (59%, vs. 44% for non-Hispanic Black or African American, 47% for Hispanic or Latino, and 35% for non-Hispanic Asian).[47]

Unmet need

The 2023 NSDUH found that approximately 6.2 out of 27.1 million adults age 18 and older with any mental illness in the past year who did not receive mental health treatment perceived an unmet need for mental health services.[48] Social determinants of health and barriers to care can hinder an individual's access to services and increase unmet behavioral health needs.[49,50] Stigma at the individual, interpersonal, and structural level affects the perceived need for care and ability to access care, especially for racial and ethnic minority groups.[51] Together these factors present significant challenges to access behavioral health services despite the present need.

Scopes of practice

A scope of practice is the description of roles and services a credentialed health care provider is qualified and allowed to perform under the state law. Inconsistent scopes of practice make it more difficult for clinicians to move to and practice in different states or provide telehealth services across state lines. They also can contribute to burnout and hurt retention when providers cannot practice to the full scope of their training. Other challenges include:

- Scope of practice laws can lack standardization and uniform definitions, be overly restrictive and not based on evidence, not clearly delineate the services that can be provided, and lack clear definitions for health support workers.[52]
- Scopes of practice can vary across states. One state may authorize the provision of services while another state may not allow these same services.

Expanding and harmonizing scopes of practice make it easier to provide high-quality care. An example of reducing scope of practice barriers is the elimination of the federal requirement for providers to have a waiver to prescribe medications for opioid use disorder (buprenorphine).[53] The removal of the Drug Addiction Treatment Act (DATA) or X-Waiver now permits providers with an active Drug Enforcement Agency (DEA) registration to prescribe Schedule III medications for opioid use disorders as allowed by state law. Removal of this waiver eliminates the time-consuming process for providers to obtain the ability to prescribe medications for opioid use disorders and may provide more flexibility to prescribers to provide these services.

Cost, reimbursement, and insurance coverage

The accessibility of behavioral health services is also limited by reimbursement barriers. According to the 2023 NSDUH, 60% of adults with any mental illness and perceived unmet need for services reported cost as one of the main reasons for not receiving behavioral health services.[54]

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) to require health insurance companies to provide comparable benefits for behavioral health services as they do for medical or surgical procedures. This parity law did not alleviate the access barriers because, in part, the law did not require coverage of specific behavioral health services.[55] The Department of Labor's 2022 MHPAEA Report to Congress noted low compliance with reporting requirements by insurance companies and the necessity of both stronger enforcement and clearer statutory language.[56] To help support equitable access to behavioral health care, the departments of Labor, Health and Human Services, and the Treasury issued final rules to add protections against restrictive

treatment limitations for behavioral health benefits as compared to other medical benefits.[57] Most provisions will take effect for group health insurance coverage starting on or after January 1, 2025.

As a result of reimbursement challenges, many behavioral health providers do not participate on insurance panels and require payment at the time of service. Compared with physical health care providers, behavioral health providers are less likely to accept insurance.[58] In 2017, only 46% of psychiatrists accepted Medicaid payments from new patients.[59] In 2016, only 43% of psychiatrists and 19% of nonphysician mental health providers participated in any of the 531 provider networks in the Affordable Care Act marketplace.[60]

Low reimbursement rates and administrative burdens have been cited as the main reasons why mental health providers choose not to participate in insurance plans.[61,62,63] In many states, primary care physicians have higher reimbursement rates than psychiatrists for the same behavioral health services.[64,65]

Not all behavioral health services and behavioral health provider types are covered under different forms of insurance. Medicaid expansion states have higher percentages of covered behavioral health services.[66] Health support workers, such as peer providers, also face insurance challenges. As of 2023, 8 U.S. states and territories do not offer reimbursement for peer support services through Medicaid.[67] Newly finalized in 2024, Medicare payment reforms have now increased coverage of services provided by community health workers and peer providers.[68]

Retention

While it is difficult to estimate precise turnover rates for the behavioral health workforce,[69] they are believed to be high.[70] It has also been suggested the turnover among the behavioral health workforce is higher in rural areas.[71] Many individual, organizational, and system-level factors can impact a behavioral health provider's intent to leave the workforce[72] including:

- Low wages put a strain on behavioral health providers and discourage them from staying in the workforce. Financial concerns are especially a challenge for health support workers.[73,74]
- Restrictive and inconsistent scopes of practice and policies can restrict a provider from practicing at their fullest ability and limit their mobility across states.[75]
- Behavioral health providers are experiencing large workloads, large caseloads, workplace violence, and a lack of organizational support.[76,77]

Burnout

Burnout among the health workforce has been a long-standing problem and was exacerbated during the COVID-19 pandemic due to higher stress levels for both clinical and non-clinical staff.[78] The stress also disproportionately affected people of color and is reflected in higher levels of burnout for Black or African American and Hispanic or Latino providers.[79,80]

Prior to the COVID-19 pandemic, estimates ranged from 21% to 67% of behavioral health providers feeling overburdened due to emotionally taxing positions, high stress environments, lack of career advancement, low salaries, and high caseloads.[81,82] However, there is minimal literature describing how burnout varies across different types of behavioral health providers and behavioral health practice settings post pandemic.[83]

Evolving strategies to improve behavioral health care access

Expanding primary care and behavioral health integrated care

The U.S. health care system is traditionally designed to treat physical and behavioral health concerns separately. As this is the case, most training for behavioral health providers also remains separated from traditional medical care. There has been a growing effort to integrate behavioral health services into primary care settings and vice versa.[84]

There is a large body of work by agencies and organizations[85,86] documenting the benefits of integrated care.[87] The critical role of integrated care in addressing the national behavioral health crisis was reflected in the Department of Health and Human Services' (HHS) roadmap on behavioral health integration. The roadmap emphasizes the critical role of behavioral health integration in improving access to affordable and high-quality care as well as the need to deliver culturally and linguistically appropriate integrated care.[88]

Integration can occur in multiple ways. For example, many FQHCs that provide primary care to underserved communities also incorporate behavioral health providers into their model, and Certified Community Behavioral Health Clinics (CCBHC) that provide behavioral health care typically incorporate primary care. Integration can also occur in school-based settings.[89]

Patients are already seeking behavioral health services from their primary care providers.[90,91] According to the National Ambulatory Medical Care Survey, 16% of primary care visits in 2016-2018 included a behavioral health component, an increase of 49% from 2006-2007.[92]

Despite widespread benefits, the integrated care model has not been widely implemented due to multiple challenges. These include limited adoption of technology, insurance and reimbursement limitations, limited training opportunities, and workflow and logistical barriers.[93,94,95,96]

Leveraging health support workers

Health support workers use their lived experiences and community ties to provide behavioral health support services. Peer providers have been shown to have a positive effect in reducing stigma associated with behavioral health treatment, increasing awareness of behavioral health resources, improving treatment engagement, and allowing licensed behavioral health providers to focus on more complex behavioral health services.[97,98,99] Community health workers have been shown to be effective in using their community ties to improve health outcomes, reduce the cost of care, and address social determinants of health.[100]

Using health support workers can increase access to care. However, there is ambiguity in the scopes of practice for these workers and their roles in the behavioral health workforce can vary.[101] The health support worker workforce also faces challenges with burnout, low compensation, and reimbursement.[102,103,104]

Using telebehavioral health

Less than 1% of behavioral health outpatient visits were conducted via telehealth prior to the COVID-19 pandemic.[105] From March 2020 through August 2020, the use of telehealth for behavioral health outpatient visits reached 40% of all visits. The use of telebehavioral health services has remained strong.[106,107,108]

Telebehavioral health services can help overcome accessibility barriers to behavioral health services for individuals in underserved areas and provide benefits for urban dwellers as well.[109] Because telebehavioral health offers additional privacy when speaking with a provider, potential barriers associated with stigma may also be overcome. Despite the evidence demonstrating the quality of telehealth services,[110] organizations face many challenges in providing telebehavioral health services:

- Some populations may have difficulties using and accessing telebehavioral health, such as older adults, children, individuals with low income, and individuals with low technological literacy.[111,112]
- Telehealth services do not have service and payment parity. Telebehavioral health services are often not covered or are reimbursed at a lower rate when compared with in-person services.[113,114]
- Telebehavioral health may not be cost effective for organizations without the necessary infrastructure.[115]

Telebehavioral health services became a necessity during the COVID-19 pandemic since in-person services were limited. In response, state, federal, and private organizations expanded their telehealth policies in support of telebehavioral health services. Yet, the changes that occurred during the COVID-19 pandemic to make services more accessible may not be sustained permanently. Recent changes include the following:

- Most Medicaid programs expanded their coverage of telehealth services during the pandemic with many states allowing service and payment parity. Many states also allowed patients to receive audio-only services and telehealth services in their home.[116] Several private insurers also expanded their coverage of telebehavioral health services and payment parity during the COVID-19 pandemic.[117] Many but not all plans still cover some form of telehealth.[118]
- Legislation provided flexibilities for the use of telehealth during the COVID-19 pandemic. Some of these flexibilities have been permanently authorized by the Consolidated Appropriations Act of 2023 including allowing FQHCs to serve as a distant site provider for behavioral health services, removing geographic restrictions for originating site telebehavioral health services, and allowing Medicare patients to receive telebehavioral health services in their homes.[119]
- Flexibility to offer telehealth services without risk of violating the Health Insurance Portability and Accountability Act (HIPAA) rules expired when the COVID-19 Public Health Emergency ended on May 11, 2023.[120]
- The DEA and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a temporary rule effective from May 11, 2023, through November 11, 2023, to extend telemedicine flexibilities for prescribing controlled substances. (If a provider and patient have an established relationship by November 11, 2023, then this rule is extended for another year to November 11, 2024). This rule allows providers to prescribe controlled substances via telemedicine without having an in-person evaluation.[121]

Conclusion

The United States is experiencing an opioid epidemic and mental health crisis.[122,123] Behavioral health needs continue to rise.[124] The behavioral health workforce is anticipated to suffer from significant shortages in the future including pronounced shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, psychiatric physician assistants/associates, psychiatrists, and school counselors.[125] Increasing the supply of the behavioral health workforce is not enough to address systemic, provider, and patient-level barriers. Maldistribution of the workforce is also a major limiting factor to accessing behavioral health services.

Inconsistent scopes of practice, reimbursement challenges, limited training in integrated health, and increased levels of burnout prevent behavioral health providers from performing at their full capacity and remaining in the workforce. Stigma and increased out-of-pocket costs will continue to hinder patients' ability to access behavioral health services.

Behavioral health needs are elevated for children and older adults, as well as in rural and underserved areas. Adequate workforce planning and investments in behavioral health workforce will be important to address these needs.

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