The Missing Piece in Infertility Policy: Integrating Mental Health Into ART Care

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THE POLICY GAP

Reproductive medicine already recognizes mental health as part of quality ART care. Our policy and payment systems have not caught up.

Professional guidance recognizes a role for specialized fertility mental health care. Yet efforts to expand infertility and IVF access have largely focused on procedural access and insurance coverage without building the psychosocial infrastructure needed to support patients through treatment.

The gap isn't a lack of evidence. It's a lack of structure.

POLICY	WORKFORCE	PAYMENT
Mental health is not meaningfully integrated into the ART care continuum.	No standardized national infrastructure develops, supports or measures the infertility mental health workforce.	Reimbursement does not consistently support collaborative, infertility-specific psychosocial care.

IDENTIFY → CONNECT → COVER

IDENTIFY

Make psychosocial needs visible.

Build routine psychosocial identification, education, and care planning into infertility treatment.

Policy sets the expectation; clinical guidance determines tools, timing, and protocols - with resources and referral infrastructure to respond.

CONNECT

Make the referral mean something.

Create reliable pathways to appropriately qualified infertility mental health professionals while investing in the workforce needed to provide that care.

A referral is not the same thing as a connection.

COVER

Make the care realistically accessible.

Develop sustainable reimbursement pathways for clinically indicated psychosocial care associated with infertility and ART, including collaboration and care coordination.

Patients should not have to get sicker before their mental health becomes worthy of care.

THE GUARDRAIL

Mental health should support access, not determine eligibility.

A positive mental health screen should open a door to care, not close the door to ART.

FROM FRAMEWORK TO POLICY

This is not a single-bill solution. IDENTIFY → CONNECT → COVER can guide action across coverage, workforce, and payment systems.

INSURANCE POLICY	WORKFORCE	PAYMENT	EMPLOYER BENEFITS
State + federal coverage mechanisms,including ERISA.	Training, supervision, consultation + education.	Reimbursement for clinically indicated care + collaboration.	Comprehensive infertility + psychosocial benefits.

The mechanism may differ by jurisdiction. The goal does not.

THE ASK

ASRM can help translate existing clinical guidance into interdisciplinary principles that can inform implementation and policy.

Convene reproductive mental health, reproductive medicine, coding and reimbursement, payer, and policy expertise around:

COMPETENCY | REFERRAL PATHWAYS | SCREENING vs. EVALUATION | REIMBURSEMENT | MODEL POLICY

The pieces already exist. ASRM has an opportunity to help bring them together.

ACCESS TO IVF IS NOT THE SAME THING AS ACCESS TO COMPREHENSIVE INFERTILITY CARE.

Supporting evidence and full policy analysis available in accompanying capstone paper.