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Joint Hearing
Committee on Health and Subcommittee on Healthcare Workforce and Access to Care
Ensuring Access to Care under the Affordable Care Act: Mental Health Providers
Wednesday, March 9, 2016
1:30 p.m., Room 3191

In December 2015, the Senate Committee on Health and the Select Committee on Mental Health held a joint informational hearing on mental health (MH) access and parity, which in part examined consumer experiences in the MH system. The purpose of this hearing is to further examine access to MH services for Californians, focusing on the extent to which a shortage in the MH workforce is an issue. The Senate Committee on Health and the Subcommittee on Healthcare Workforce and Access to Care will hear from educational institutions that educate and train the MH workforce; state agencies that administer loan repayment programs for the MH workforce; and entities that employ the MH workforce about various ways MH professionals are recruited and retained, any trends they see in the increase or decrease in the MH workforce, and other challenges and barriers they face. The hearing will seek to examine what strategies are effective, as well as explore how to expand efforts that are the most successful in supporting a robust MH workforce to ensure that MH services are available to people who need them when they need them.

Mental Health Care in California

Nearly one in six California adults has a MH need, and approximately one in 20 suffers from a serious mental illness that makes it difficult to carry out major life activities. [1] About half of California adults with MH needs did not get any MH services during the past year. Only one-third of children whose parents rated their emotional difficulties as definite or severe had a MH visit in the past year. Rates varied dramatically by race. White and African-American children were considerably more likely to have had a MH visit than Asian or Latino children. Compared to the U.S., California had a lower overall suicide rate, although it varied considerably within the state by gender, age, race/ethnicity, and region.

[1] California HealthCare Almanac: Mental Health Care in California: Painting a Picture. July 2013. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MentalHealthPaintingPicture.pdf

Mental Health Workforce

Under the federal health professional shortage area (HPSA) designation, there are areas identified as having a shortage of MH providers on the basis of availability of psychiatrists and other MH professionals. Approximately 16% of Californians live in a Mental Health HPSA (MHHPSA). According to OSHPD's Web site, to qualify for designation as a MHHPSA, an area must be a rational service area; the population-to-core MH professional and/or the population-to-psychiatrist ratio meet established shortage criteria; and there is a lack of access to MH care in surrounding areas because of excessive distance, overutilization, or access barriers. (Core mental health providers include psychiatrists, clinical psychologists, licensed clinical social workers, psychiatric nurse specialists, and licensed marriage and family therapists.) MH providers in designated MHHPSAs are eligible for the National Health Services Corp/State Loan Repayment Program, improved Medicare reimbursement, and enhanced federal grant eligibility.

There are currently approximately 4,000 MHHPSAs nationally, according to the Health Resources and Services Administration's Web site. MHHPSAs are based on a psychiatrist-to-population ratio of 1:30,000. April 2014 data from the Kaiser Family Foundation (KFF)[2] shows that California has 339 MHHPSAs and an unmet need of slightly less than 44%.

According to the California HealthCare Foundation's Almanac, California had:

- More psychiatrists (16.5 per 100,000) than the U.S. overall (14.4 per 100,000),
- Fewer nurses with psychiatric prescribing privileges (CA: 1 per 100,000 compared to U.S.: 3.3 per 100,000),
- More marriage and family therapists (CA: 76.9 per 100,000 compared to U.S.: 16.3 per 100,000), and
- Fewer social workers (CA: 53.4 per 100,000 compared to U.S.: 82 per 100,000) and counselors (CA: 22.2 per 100,000 compared to U.S.: 54.4 per 100,000).

The distribution of licensed MH providers varied considerably among California regions. The Bay Area had the greatest concentration of licensed MH professionals, far exceeding the state average. The Inland Empire and San Joaquin Valley fell well below the state average for all MH professions. The Northern and Sierra region was below average in the numbers of psychiatrists and psychologists, but above average for marriage and family therapists. According to 2014 information on the Office of Statewide Health Planning and Development's (OSHPD) Web site, data derived from the Medical Board of California's Physician Survey showed the total number of currently licensed psychiatrists who selected psychiatry as their primary specialty and who practiced in California was 1,723. Fifty-seven percent of these psychiatrists practice in just five counties: Los Angeles (440), San Francisco (166), San Diego (146), Santa Clara (137), and Orange (95).

According to the California Association of Social Rehabilitation Agencies (CASRA), in addition to the MH workforce shortage dilemma, there is great need, especially in the state's public MH system (PMHS), for a different skill set than traditionally found in the MH professions. CASRA states that the emphasis on today's MH delivery system is on recovery-based services and incorporating natural supports in the community, shifting from a strictly medical model of

[2] http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

treating illnesses to a community-based recovery model of helping Californians learn to manage symptoms and develop skills and supports to pursue the life of their choice. CASRA further states that this practice is not reflected well in much of the county-operated PMHS, as the curriculum in most of the state's graduate education programs do not reflect a recovery-oriented approach, and the job classification system relies on licensed practitioners who are educated in those programs.

Educational Requirements for Mental Health Professions

Degrees and required coursework in the MH professions vary, depending upon the field chosen. Educational requirements are determined most often by the national professional association of that particular field, or by a national certifying body. Some examples:

Psychiatry. A doctorate in psychiatry requires a medical degree, and the same educational path applies to a psychiatry student. Requirements include an undergraduate degree, often times in a physical science field, passage of the Medical College Admissions Test, clinical residency, and certification and licensing. In California, the Medical Board, within the Department of Consumer Affairs (DCA), licenses psychiatrists. The Board requires a minimum of 3,000 supervised clinical hours, certain undergraduate credits in specified fields, and the passage of state and national exams.

Licensed Clinical Social Workers (LCSWs). To become an LCSW in California, one must first earn a master's degree in social work (MSW) and then register as an Associate Clinical Social Worker (ACSW). An ACSW must obtain 3,200 hours of supervised work experience and a minimum of 104 supervised work weeks. ACSWs must pass a clinical exam and apply for licensure as an LCSW within one year of passing the exam. LCSWs are licensed in California by the Board of Behavioral Sciences (BBS) within DCA.

Licensed Marriage and Family Therapist (LMFT). In California, the LMFT requires at least a master's degree in a specific field of psychology, including supervised field placement during and after the master's program. LMFTs must work under supervision until licensure is obtained, which requires completion of a master's program, 3,000 supervised hours, and passage of a clinical exam. LMFTs are licensed in California by the BBS.

Doctor of Psychology (Psy.D., Ph.D., Ed.D.). The education and training requirements for a doctorate in an area of applied psychology are established by an accredited academic institution. A doctoral student in psychology can expect to spend approximately four to seven years post-baccalaureate obtaining their doctorate, and must have extensive supervised clinical experience before applying for licensure. The Board of Psychology, within DCA, licenses psychologists in California.

Oversight of the Mental Health Workforce

In order to be licensed, MH professionals have to meet specific educational and professional experience, and usually have to pass a national and California-specific certification exam. Each field has its own requirements, which are listed on DCA's Web site. California oversees and licenses the MH workforce through DCA.

By statute, consumer protection is the primary purpose for all of the regulatory programs located within DCA, which consists of 25 boards, nine bureaus, two committees, one program, and one commission (hereafter "boards" unless otherwise noted). As regulators, these boards perform two basic program functions: 1) licensing, which entails ensuring only those who meet minimum standards are issued a license to practice, and 2) enforcement, which entails investigation of alleged violations of laws and/or regulations and taking disciplinary action when appropriate.

Incentives for Mental Health Providers

The Committee's Chair and staff have heard anecdotes through stakeholder meetings that MH professionals increasingly only treat cash-paying patients because of frustrations with health plans and insurers, including low reimbursement rates, administrative burdens, payment challenges, and inconsistent prior authorization rules. In a 2013 Substance Abuse and Mental Health Services Administration report, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, the Institute of Medicine is said to have chronicled efforts to address MH workforce shortages beginning as early as the 1970s. The report states that recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field, and that misperceptions and prejudice surrounding MH issues and those who experience them are attributed to those who work in the field. The report further cites a study that calls for increased attention to incentives, such as loan repayments and forgiveness as a way of successfully recruiting MH professionals.

OSHPD administers various programs for health care professionals, with some of the programs specifically geared toward the MH workforce. The following programs help support increasing the MH workforce:

- *Licensed Mental Health Services Provider Education Program.* This program is available to individuals who are licensed/registered MH professionals with either the Board of Behavioral Sciences or the Board of Psychology, with the exception of a marriage and family therapist intern. According to OSHPD, the following individuals qualify for this program: licensed psychologist, registered psychologist, postdoctoral psychological fellow/trainee, LMFT, marriage and family therapist intern, LCSW, and ACSW. These individuals pay an additional $10 fee during initial and renewal license/registration to fund the program. For a 24-month service obligation at a "qualified facility," providing a minimum of 32 hours of direct patient care, an individual may receive up to $15,000 for loan repayment. Applicants can only receive two awards for a total possible award of up to $30,000 for loan repayment. "Qualified facility" is defined as: 1) a publicly funded facility, 2) a publicly funded or public MH facility, or 3) a nonprofit, private MH facility that contracts with a county MH entity or facility to provide MH services. Selection of awards is based on the following criteria: work experience, cultural and linguistic competence, career goals, community service, community background, and fluency in a language other than English. Priority is given to individuals whose community background and commitment indicates the likelihood of long-term employment in a qualified facility even after the service obligation has ended.

- *Steven M. Thompson Physician Corps Loan Repayment Program.* This program is available for individuals who have a valid, unrestricted license to practice medicine in

California as an allopathic or osteopathic physician and surgeon. This program encourages recently licensed physicians and surgeons to practice in HPSAs and Primary Care Shortage Areas (PCSA) in California. Physicians and surgeons pay an additional $25 fee during initial and renewal of licensure to fund the program. The program repays up to $105,000 in educational loans in exchange for full-time service for a three-year commitment for those currently employed or who have accepted employment in an HPSA or PCSA. Priority consideration is given to applicants who are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following: speak a Medi-Cal threshold language; come from an economically disadvantaged background; have received significant training in cultural and linguistically appropriate service delivery; and have three years of experience providing health care services to medically underserved populations or in a medically underserved area. Preference is also given to those who agree to practice in a medically underserved area and who agree to serve a medically underserved population. Up to 20% of the available funds may be awarded to program applicants from specialties outside of the primary care specialties, including psychiatry, anesthesiology, emergency medicine, endocrinology and diabetes, general surgery, pediatric emergency medicine, and child neurology.

- *California State Loan Repayment Program.* This program provides educational loan repayment assistance to primary health care professionals who provide health care services in federally designated HPSAs. Eligible health professionals include physicians specializing in primary care fields, nurse practitioners, certified nurse-midwives, general practice dentists, registered dental hygienists, clinical or counseling psychologists, LCSWs, licensed counselors, pharmacists, physician assistants, psychiatric nurse specialists, and LMFTs. Eligible health professionals must be employed by or have accepted employment at a certified eligible site (which includes rural health clinics, community health clinics, county facilities, and federally qualified health centers) and must commit to providing full-time or half-time primary care services in a HPSA for a minimum of two years. Health professionals may receive up to $50,000 in exchange for a two year full-time service obligation and/or $25,000 for a two year half-time service obligation; individuals can receive up to $150,000 over six years at full-time and $75,000 for half-time. Award amounts are matched by the sites in which the health professional is practicing, on a dollar-for-dollar basis, in addition to salary. This program is funded through a federal grant from the Health Resources and Services Administration's Bureau of Health Profession, National Health Service Corps, and is administered by OSHPD.

- *Mental Health Services Act Workforce Education and Training (MHSA WET).* The MHSA included one-time, state-administered funding under WET for a variety of programs to address MH workforce challenges. For example, OSHPD offers loan repayment of up to $10,000 to MH workers in hard-to-fill and/or hard-to-retain positions in the PMHS in exchange for a 12-month service obligation. OSHPD contracts with educational institutions to provide stipends for graduate students who plan to work in the PMHS. OSHPD contracts with Psychiatric Residency and Psychiatric MH Nurse Practitioner programs to fund residency and training slots to increase capacity to train residents and trainees and to provide clinical rotations in the PMHS. OSHPD funds

organizations that engage in training, education, placement, support, planning, and development activities that lead to increased consumer and family member employment in the PMHS. In coordination with the California Mental Health Planning Council, OSHPD developed the second WET Five-Year Plan (2014-2019), which contains a budget for how OSHPD will allocate the remaining state-administered MHSA WET funds, estimated at about $114.7 million. According to OSHPD, the five-year plan budget will be reassessed this Fiscal Year (FY) 2015-16 to determine if funding is being guided by priority needs, at which point funding amounts for programs may change for FYs 2016-17 and 2017-18. OSHPD will provide a written update in the five-year plan and budget to the California Mental Health Planning Council on an annual basis.

Mental Health Services Act

California's Proposition 63, known as the MHSA, passed in November 2004, provides funding to increase staffing and other resources that support public MH programs; increase access to needed services; and monitor progress toward statewide goals for serving children, transition age youth, adults and older adults, and their families. According to OSHPD's Web site[3], California's PMHS has suffered from a shortage of public MH workers; maldistribution of certain public MH occupational classifications; a recognized lack of diversity in the workforce; underrepresentation of professionals with consumer and family member experience; and underrepresentation of racial, ethnic, and cultural communities in the provision of services and support.

The MHSA included a component for a MH WET assessment. To this end, OSHPD surveyed counties in 2013 (41 counties responded) about workforce needs in the PMHS and again in 2015 (43 counties responded) to identify any changes to the first survey. The positions identified as the top five with the highest need in both 2013 and 2015 were, in order: psychiatrists, LCSWs, LMFTs, psychiatric mental health nurse practitioners, and bilingual workers.

Some key findings from the WET report on the state's MH workforce supply include:

- Most professions in the PMHS workforce grew each year from 2006 to 2013, and are anticipated to continue to grow from 2014 to 2019.
- Rates of growth varied by professions, with registered nurses (the profession with the highest growth rate) estimated to increase by 50%. Psychiatrists (the profession with the lowest growth rate) are estimated to increase by 14% over the same period.
- Of 19 different types of providers in the PMHS workforce, marriage and family therapists comprise the largest share (46% of the licensed, non-prescribing, clinical class), both in 2013 and in 2019 estimates.
- Of the licensed, prescribing class, psychiatrists (47%) and physician assistants (PAs, 51%) comprise the largest share of providers while psychiatric mental health nurse practitioners comprise the smallest share.
    - The highest numbers of each profession are located in the Bay Area region, followed by the Southern and Los Angeles regions.
    - Psychiatrists and PAs were located mostly in large counties.
    - Most PAs practice in non-public MH settings.

[3] http://www.oshpd.ca.gov/HWDD/WET.html

- Based on supply projections, retirement among the workforce is not expected to seriously affect the supply of psychiatrists, LMFTs, or LCSWs.
- While the Bay Area, Los Angeles, and Southern regions had the largest concentrations of providers in the state, the highest provider-to-population ratios for some professional categories occurred in the Central and Superior *(*16 northern counties) regions.
    - The Bay Area, Los Angeles, and Southern regions have fewer providers relative to their populations.
    - However, the Central and Superior regions have counties with rural populations, which means those communities will have greater difficulty accessing providers even if they are available.

Conclusion

Despite the passage of federal and state MH parity laws, state laws on network adequacy and timely access, and additional support to enhance California's MH workforce, access to MH services remains a concern for California consumers and their families. With the Affordable Care Act requirement that health plans provide MH services as an essential health benefit, Californians will seek more services for MH conditions. There are geographic hot spots where MH provider shortages exist and where MH services are altogether nonexistent. Some of the questions that will be explored throughout this informational hearing are: How can the state ensure that MH services are available to those who need them when they need them? How are educational institutions recruiting and retaining individuals, and are they encouraging students early on to enter fields where there are shortages or mentoring them so that they feel compelled to practice in medically underserved areas? Can the state do more to bolster incentive programs that will pay educational loans for students who graduate with high debt? Do employers offer additional incentive programs? Are there any private-public partnerships that may help with addressing MH workforce shortages?