Office of Mental Health Appendix to Unified Statement Response to SED Report – Office of the Professions as required pursuant to Chapter 57 of the Laws of 2013

The following are the Office of Mental Health (OMH) comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how OMH programs are regulated and administered and offers comments in response to some of the findings contained in the report.

EXECUTIVE SUMMARY

OMH recommends the existing "scope of practice" exemption be made permanent. The delivery of behavioral health services is undergoing a significant redesign in response to the Affordable Care Act (ACA) and the Delivery System Incentive Payment (DSRIP) program. With the passage of the ACA, and the imminent transition to Medicaid managed care, the service delivery system is now in the process of extraordinary change to address quality of care and contain costs. Under DSRIP, the primary goal is to reduce unnecessary hospitalizations with a major focus on expanding the capacity and quality of community based providers with a significant focus on the integration of healthcare.

This will result in a greater demand for licensed professionals as behavioral and physical healthcare providers coordinate quality care. In addition, it is expected that there will be an increase in the need to access specialty care, including mental health, in order to achieve the goal of reduced hospitalizations in accordance with the objectives of DSRIP. These changes are likely to result in an increase in the number of individuals to be served, while the licensed workforce continues to reduce in size.

Currently, the State is in the process of approving Health and Recovery Plans (HARPs), which will manage care for adults with significant behavioral health needs. In addition to the State Plan Medicaid services offered by mainstream Managed Care Organizations (MCOs), qualified HARPS will offer access to an enhanced benefit package comprised of Home and Community Based Services (HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. Organizational change and restructuring of this magnitude imposes a substantial challenge on both the State and providers' limited resources and workforce capacity.

In addition, if the "scope of practice" exemption were to lapse, not only would there be inadequate numbers of licensed professionals to provide needed services, but the increased cost to the State to replace unlicensed staff with licensed individuals in community-based programs would be approximately $61.9 million annually. If state-operated programs are included, the total cost of the elimination of the "scope of practice" exemption for OMH alone is estimated to be approximately $74.6 million

annually. (These estimated costs do not include any potential increase in fringe benefits, lost revenue to programs as new employees are hired and phasing in a new client caseload, costs for training or annualized costs.) The overwhelming reimbursement mechanisms for these services are funded from public sources, including Medicaid, Medicare, and State deficit financing.

It is notable that the 2013 SED survey responses comprise less than 10 percent of the impacted programs and services under the agency's jurisdiction and therefore do not accurately reflect the services that unlicensed individuals provide. While OMH operates, regulates, approves, or funds approximately 4,500 programs, only 392 programs responded to the SED survey. Regardless, if the survey results are extrapolated for the purposes of meaningful analysis, the continued need for the exemption is necessary since nearly 50 percent of the restricted functions, excluding diagnosis, are provided by unlicensed practitioners.

It is not believed, nor does the evidence demonstrate, that ending the exemption would result in better client outcomes. OMH has a sophisticated regulatory, licensing, and monitoring apparatus to ensure that providers furnish high quality and cost effective behavioral health services.

Finally, as we conclude the current evaluation period:

- Very little has changed concerning the lack of availability of licensed practitioners
- Dramatic changes occurring in behavioral healthcare delivery will have a major impact on increasing demand
- The significant shortfall in both fiscal resources and licensed practitioners to deliver the needed services will undermine the State's efforts to effectively redesign the Medicaid system of care
- The education and licensing system require further time to train and license sufficient practitioners to replace and/or retrain and credential currently unlicensed individuals in exempt settings

Due to concerns about professional workforce shortages, financial constraints and dramatic changes to the behavioral healthcare delivery system, OMH recommends a permanent extension with a review in five years to address the new needs arising from the effects of the above constraints in conjunction with the upcoming changes.

OMH's mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbance. To achieve this, OMH has a dual role as the lead authority for the public mental health system to (1) set policy and provide funding for community services and (2) operate inpatient and outpatient services. Consistent with the practice of mental health evaluation, diagnosis and treatment, the OMH vision has evolved over time to one that today is more community-oriented and recovery-focused. OMH has the responsibility for the development,

regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 700,000 individuals annually in approximately 4,500 programs operated, regulated, funded, and approved by OMH (Attachment A). The emphasis on recovery-oriented services is central to achieving quality outcomes and to advancing New York State's behavioral health mission and vision.

Over the past 30 years, OMH has been transforming the delivery of mental health services through deinstitutionalization to reinvestment in increased community based services. During this time, Medicaid, the major funder of behavioral health services, had continued payments on a fee-for-service basis. As the behavioral health system focused on reinvestment and expanding community services, the importance of fully integrating individuals with serious mental illness into the community became paramount. At the same time, there has been an increasing recognition of the importance of coordination and integration of physical and behavioral healthcare, both for the purpose of addressing the whole individual, and for maximizing healthcare resources. Thus the State has been moving definitively towards incorporating behavioral health services into comprehensive Medicaid managed care plans, which will be responsible for individuals' physical and behavioral health services.

Background

In 2002, in response to concerns about the delivery of poor quality behavioral health services by some unqualified individuals in the private sector, New York State implemented legislation to strengthen the licensure requirements for mental health professionals. The Education Law had previously authorized the licensure of psychologists and certified social workers and protected those titles. The legislation:

- provided a defined scope of practice for psychologists;
- replaced a single certified social worker licensure with two new licensed titles; and
- created four new licensed titles but limited scope of practice professions.

The legislation provided for exemption to the licensure requirements for staff who were performing any of the restricted activities while employed in programs that were operated, regulated, funded or approved by delineated state agencies or local governments. The legislative exemption also recognized the regulatory and quality oversight role of OMH. The initial exemption to OMH scheduled to expire in 2010 was found to be valuable, viable and necessary and was extended twice, first to 2013 and later to 2016.

When the licensure law for behavioral health practitioners was passed in 2002, no one envisioned the changes that were coming and its impact on services. Universal health

insurance coverage under the ACA and the implementation of mental health parity are having a revolutionary impact on the availability and delivery of health and behavioral healthcare services. One consequence is that the population being served today represents only a fraction of the population expected to be served in the near future. According to data from the Department of Health (DOH), 768,800 previously uninsured individuals enrolled in a health plan through the NYS Health Exchange (Attachment B). In addition to the increasing number of individuals who will have insurance coverage, the Mental Health Parity and Addictions Equity Act (MHPAEA) is expected to also increase the need for behavioral healthcare services.

Substantial treatment of behavioral health disorders have gone underdiagnosed due to such factors as a shortage of mental health professionals and the stigma of mental illness. As recognition in the connection between health and behavioral health advances, increasingly new techniques of integrated and collaborative care will create an unprecedented workforce demand in healthcare as well as an increased market for social workers. In addition, the Federal government has changed the definition of home and community-based services that have resulted in an expansion of services provided in local communities. With changes under the ACA and parity law, individuals are now being assessed earlier and receiving treatment for behavioral health issues. As a result of these significant changes in the behavioral healthcare system, there will be a substantial increase in the need for services, while the licensed workforce continues to reduce in size.

DATA COLLECTION FINDINGS

In 2013, the SED developed the Online Survey of Programs and Agencies Exempt from Licensure Laws mandated by Chapter 57 of the Laws of 2013 to collect information from programs and agencies that provide one or more of the five restricted services identified in law. The survey was disseminated statewide to programs that are operated, regulated, approved and funded by the exempt State agencies. OMH partnered with the various provider organizations that encouraged providers to participate and complete the 2013 Survey.

A total of 850 programs from the agencies exempt from licensure laws responded statewide. Specifically for OMH, there were 392 program responders to the survey out of approximately 4,500 OMH programs; this represents a response rate of less than 10 percent. Based on the limited sample of responders, OMH has significant concerns that this does not accurately reflect the vital role unlicensed professionals have in delivering necessary services in the behavioral health care system. In order to best inform policy makers and the decision-making process, additional information is necessary with a more extensive sampling of program responders. Given the small proportion of survey respondents, confusion in data results, and the substantial changes in the service delivery system which will result in an increased demand for services, while simultaneously addressing a decrease in the supply of practitioners, OMH strongly supports a permanent exemption.

Five Survey Services

The survey attempted to capture a snapshot of services that the SED Office of Professions considers to be restricted to licensed individuals. Operating under the current extension of the exemption in the social work law, OMH and its affiliated agencies report they are providing the following services:

- **Diagnosis** – In OMH-licensed programs, physicians are to provide both the diagnosis and authorize treatment. According to SED survey results, 19.4 percent of the respondents reported that unlicensed employees in their program provide diagnosis. The reported prevalence of this practice does not correspond to OMH's findings in its extensive monitoring and oversight of community providers. The disparity in the findings of this report may be explained by the small sample size, as well as ambiguity about what constitutes "diagnosis". In many cases, providers may have unlicensed individuals reporting on symptoms identification and not actually diagnosing an individual, but reporting the practice as "diagnosis".

- **Assessment/Evaluation** – Approximately 50 percent of respondents stated that unlicensed employees provide assessment and evaluation as referenced in the 2013 Survey Response provided by SED. Assessment/Evaluation is provided by a mix of paraprofessional, professional, and licensed staff. Some type of assessment generally occurs in most OMH funded services including: psychological evaluation; psychiatric evaluation; psycho-social assessment; or rehabilitation assessment.

- **Psychotherapeutic Treatment -** Of the 358 respondents, 47.6 percent indicated that unlicensed staff provides psychotherapeutic treatment. The survey did not ask the amount of time the unlicensed individual engaged in psychotherapy or about their supervision. Again it appears that because of the vague definition of psychotherapy, many staff could assume to be providing psychotherapy while being engaged in crisis de-escalation techniques, counseling or behavior modification on a limited basis. In OMH licensed programs, no unlicensed individual performs psychotherapy without the supervision of a licensed professional. OMH's licensed programs have been competently providing psychotherapy using a multi-disciplinary team model successfully prior to and after the enactment of the "scope of practice" exemption. It should be noted that a significant portion of the licensed professional workforce receives their training in OMH programs.

- **Provision of Treatment Other Than Psychotherapeutic Treatment –** 51 percent of the respondents reported that unlicensed staff do provide treatment other than psychotherapeutic treatment. The OMH service delivery system

typically provides a wide range of services to individuals living with serious mental illness. Since services are provided in program settings, rather than an individual private practice setting, individuals can receive more comprehensive care, addressing impairments in key life domains.

- **Development of Assessment-Based Treatment Plans -** Almost 50 percent of the respondents indicated that unlicensed staff develop assessment-based treatment plans. Assessment based treatment planning is primarily performed in licensed treatment programs and "service planning" is done predominantly in the case management, residential and rehabilitation programs. While many services provided under the jurisdiction of OMH include similar activities such as screening for co-occurring disorders and gathering health information, such functions are not "assessment based treatment planning." In the performance of such activities OMH programs use a multi-disciplinary team structure that requires physician sign-off for treatment/service plans.

The statewide survey findings showed that the five restricted activities: assessment/evaluation; diagnosis; assessment-based treatment planning psychotherapy; and treatment, other than psychotherapy, are performed by those in a broad array of titles. There are many titles because they have been integrated into the delivery system bringing a richness of education, experience and diversity to treatment (Attachment C).

In summary, except for diagnosis activity, the percentages of programs reporting unlicensed individuals not performing the other four restrictive activities was virtually equal to those percentage of those programs with licensed individuals performing the four activities. The percentages of those not performing the activities ranged from 49 percent to 52.4 percent. However, a response rate of less than 10 percent does not allow for a valid analysis of the data.

Furthermore, OMH has the authority to make determinations as to the qualifications of the behavioral healthcare workforce in delivering quality services to the needs of the 700,000 individuals served in our system. While the State is undergoing significant efforts to integrate the behavioral and physical healthcare systems, the OMH and DOH service delivery models are not comparable. The types of health care overseen and delivered by these agencies are distinctively different and OMH has a highly developed infrastructure to regulate, monitor, and oversee the delivery of quality services. In fact, SED deemed in 2004 it appropriate for unlicensed individuals who were employees of federal, state, county or municipal government or in any other legal settings to perform restricted services.

QUALITY OF CARE ASSURANCE:

Current Public Protection and Quality Standards in OMH

The articulated purpose of the NYS licensing law that created four new mental health practitioners professions was "to protect the public from unprofessional, improper, unauthorized and unqualified" practices (Legislative Intent of Chapter 676 of the Laws of 2002).

Programs operated, funded, and licensed by OMH have long been recognized for accomplishing this important purpose. Moreover, public behavioral health programs provide high quality services which are provided cost effectively and in underserved areas of the State. The current 2014 fiscal climate calls into question the imposition of additional restrictions on the operations of these programs.

Further, public protection by OMH is enhanced by multiple federal, state and county oversight including:

- Federal audits and reviews
- State control agency audits and inspections
- County oversight of mental health programs

OMH employs complex oversight mechanisms to ensure that safe and effective quality services are provided within the various programs that the agency operates, regulates, funds, or approves. This oversight ensures that safe and effective services are provided to the population served whether licensed or non-licensed direct care personnel are providing such services.

Program Certification, Monitoring and Oversight Process

OMH's Bureau of Inspection and Certification reports that there are 4,500 programs licensed, regulated, or funded by OMH. This includes State and county operated, not-for-profit, and for profit programs. Programs licensed and funded by OMH are subject to oversight, monitoring, and regulation from numerous entities.

Oversight is performed in several ways:

- **Regulation**: OMH has regulatory authority and has established regulations and/or guidance for all licensed programs (e.g., Clinics, CDT, Day Treatment, PROS, IPRT, Partial Hospital, and Residential) and many unlicensed programs (such as case management and supported housing).

  OMH regulations require OMH licensed providers to:

  - Perform comprehensive assessment;
  - Maintain individualized treatment plans;

  - Conduct periodic treatment team meetings and treatment plan reviews;
  - Provide supervisory professional oversight (as contrasted with private independent practitioners where no oversight is required); and
  - Maintain operating policies and procedures, including a staffing plan

- **Prior Approval and Review** (PAR) process: Operators need PAR approval before establishing new programs or substantially changing existing programs. The PAR process includes a review of such areas as operator character and competence, fiscal viability, public need, and charities registration.

- **Inspection and Certification:** OMH provides ongoing licensure oversight through on-site visits (announced and unannounced). Re-certification visits include a review of clinical practices, staffing credentials, supervision, service utilization, and quality improvement initiatives. The inspection and certification process reviews agency staffing and supervision plans to ensure staff are properly credentialed and trained. OMH policy precludes non-licensed clinical staff performing duties unsupervised.

- **Balanced Scorecard:** The public sector has the regulatory apparatus that improves the quality and competence of services. The OMH Balanced Scorecard measures and reports on outcomes experienced by individuals served in our public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance. The Scorecard is designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data and to inform decision making and assess the service needs of the community.

- **Background Checks:** In 2004, legislation was enacted requiring licensed community providers of mental health services to request OMH to conduct criminal background checks of potential staff and volunteers in positions that would involve regular and substantial contact with program clients. This function was transferred to the Justice Center for the Protection of People with Special Needs via the passage of Chapter 501 of the Laws of 2012. In addition, this law further requires providers licensed by OMH to check the Justice Center-maintained Staff Exclusion List prior to hiring an individual in a position involving client contact, and must also screen such candidates through the Statewide Central Register of Child Abuse and Maltreatment.

- **Enforcement:** OMH Enforcement mechanisms include issuance of Monitoring Outcome Reports, Plans of Corrective Action, fines, license suspensions, and revocation of licenses. OMH may also withhold payments for an agency's repeated non-compliance.

- **Fiscal Oversight:**

    - **Reimbursement** – OMH establishes Medicaid reimbursement rates for licensed programs and administers State Aid funding to local government. In return, OMH gathers data on services provided by mental health providers.
    - **Contract Oversight** – In addition to Medicaid reimbursement for licensed programs, OMH provides direct contracting and program oversight for many programs.
    - **Accountability** – OMH promotes fiscal viability and accountability in the service delivery system through (a) fiscal reviews and audits and (b) OMH Field Office reviews of fiscal viability through the certification process.

- **County Oversight:** Section 41.13 of the Mental Hygiene Law establishes the powers and duties of local government units in administering local mental hygiene services through planning, oversight, quality assurance, and contracting with voluntary organizations. Examples of oversight of voluntary programs by a local governmental unit per a contract may include the following:

    - Establishing and monitoring program process and outcome objectives;
    - Requiring participation in local Community Service Board meetings to educate and encourage programs' service to specific community needs;
    - Establishing standards and procedure for addressing misconduct and disciplinary measures;
    - Requiring appropriate non-profit corporate compliance plans; and
    - OMH Field Office staff work with county/city government in order to assure adherence to the program model, documentation and meeting contract deliverables.

- **Other State, Federal and Certification Oversight:** In addition to OMH direct oversight, most programs operated or licensed by OMH receive additional oversight from one or more of the following:

    - NYS Department of Health
    - Federal Centers for Medicare and Medicaid Services (audits and inspections)
    - Federal Department of Justice
    - New York State Office of Medicaid Inspector General
    - New York State Office of State Comptroller (program audits)
    - New York State Justice Center for the Protection of People with Special Needs

- Private Certification Agencies including The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities, and others

Quality Control

OMH is focused on quality in addition to regulation, compliance and oversight. This is done through the use of multidisciplinary teams and standards of care.

- **Multi-disciplinary Teams** – Many OMH licensed and funded programs are structured to build in quality control through the use of multi-disciplinary teams. These teams are composed of a range of staff from psychiatrists to licensed and experienced therapists to trained peers. The strength of the teams is enhanced by strong supervision and sign off by experienced and appropriately licensed team members. Teams use a multi-disciplinary approach to set the direction with the recipient for treatment. Professional staff on the team have overall responsibility for treatment plan implementation.

- **Standards of Care** – OMH has developed clinical standards of care which are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State. The Standards of Care highlight expectations for:

    - Staffing
    - Caseloads
    - Training
    - Tracer Methodology
    - Screening
    - Assessment Domains
    - Best Practices

Complaint Investigation: OMH receives complaints from a variety of sources. It operates a Customer Relations Toll Free Line, which receives approximately ten-thousand calls each year. Complaints frequently arrive at the Customer Relations Line by referral from other agencies and organizations such as police departments, the Justice Center, the Department of Health, and the Office for Persons with Developmental Disabilities. The majority of the complaints come directly by phone. Complaints are also received at each OMH Field Office, at the Office of the Commissioner, and through the Office of Consumer Affairs. Many complaints come to OMH as letters, faxes, email, or from walk-ins.

Complaints are routed and resolved commensurate with the consumer's needs. Simpler complaints are handled by staff of the Customer Relations Line. Complaints

related to regional service provision are tasked to the Field Offices. All allegations of abuse or neglect are pursued by Clinical Risk Managers and in coordination with the Justice Center. Depending on need, complaints are also routed to other Agencies and Organizations, such as the Department of Health, Child Protective Services, or Community Mobile Crisis Teams, to name just a few.

Incident Reporting: Social Services Law Article 11, Mental Hygiene Law Section 29.29, NCRR 14 Part 524: Incident management statutes and regulations are intended to ensure the development, implementation and ongoing monitoring of incident management programs, by individual providers, including robust incident reporting and investigation provisions, with enhanced oversight by the Justice Center. These laws and regulations are designed to ensure the health and safety of clients are protected and to enhance their quality of care.

Mental Hygiene Legal Service (MHLS): The Office of Court Administration funds MHLS to represent, protect and advocate for the rights of people who reside in, or are alleged to be in need of care and treatment in, facilities which provide services for persons with mental disabilities.

INNOVATIONS

Redesign of the Behavioral Healthcare System

The delivery of behavioral health services is undergoing multifaceted and unprecedented change at this time, in part due to the ramifications of the ACA. The implementation of the ACA is being effected by the State's Medicaid Redesign Team (MRT), which has been tasked with changing the paradigm for healthcare delivery. Two major components of the redesign are the movement of the Medicaid behavioral health benefit into managed care and the DSRIP program, both of which are focused on improving quality while decreasing costs. Key to the success of both initiatives will be the increased availability of outpatient behavioral and physical healthcare services, in order to improve individuals' behavioral and general health status, and reduce the need for hospital care.

The vision for Behavioral Health Managed Care is one that provides New Yorkers with fully integrated behavioral health and physical healthcare services offered within a comprehensive, accessible and recovery oriented system. The benefit for people on Medicaid will be dramatically changing, particularly for individuals with high needs.

Medicaid recipients will receive behavioral healthcare through one of two behavioral health managed care models:

1) **Qualified Mainstream Managed Care Organizations (MCOs)**: For all adults served in mainstream MCOs throughout the State, the qualified MCO will

integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health conditions.

2) **Health and Recovery Plans (HARPs)** will manage care for adults with significant behavioral health needs. They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of HCBS, such as Community Psychiatric Support and Treatment and Crisis Intervention, designed to provide the individual with a specialized scope of support services not currently covered under the State Plan.

Guiding the reform in the behavioral health system, DSRIP will create sweeping changes in the delivery of services, improving the quality of care while reducing costs. The main objective of DSRIP is to reduce avoidable hospitalizations by 25 percent over 5 years and transform the healthcare system.

Furthermore, a key component of DSRIP is the integration of behavioral and physical healthcare in order to coordinate and deliver services. It is expected that behavioral healthcare recipients will have increased access to primary and specialty care in order to achieve the goal of reduced hospitalizations. Licensed practitioners in the behavioral healthcare system will be highly sought after by physical healthcare providers, thus expanding the demand for licensed professionals and placing additional strain on workforce capacity. In addition, there will be an increased need for behavioral health services and given the limited number of qualified professionals this will put additional vulnerabilities on the mental health system.

Both the movement to managed care and the implementation of DSRIP will result in an increase in the number of individuals in need of services in the community. The State's healthcare system is already stressed by a shortage of licensed professionals and implementation of managed behavioral healthcare and DSRIP provisions will place an additional burden on a vulnerable workforce. If the exemption is not continued the State will be facing a workforce shortage crisis which will inevitably impact the quality of care delivered to the behavioral health population, and the ability of the State to successfully implement these initiatives.

Workforce Shortages

Currently, the number of licensed mental health professionals in NYS is not sufficient to provide necessary services in the public mental health system. While the State embarks on a significant redesign of the behavioral healthcare system and many previously uninsured individuals secure health insurance coverage, additional skilled professionals will be needed to meet the surge in health services for both behavioral

and physical healthcare. Identified below are a number of factors impacting the current workforce of behavioral health workers resulting in shortages, particularly in certain regions of the State:

- Forty of New York's 62 counties (65 percent) are designated federal and/or state mental health professional shortage areas. The equivalent of 3.1 million individuals, or 16 percent, of the state's population live in those areas (Attachment D).
- Twenty-two counties in NYS that have not been designated as federal mental health professional shortage areas have census tracts, special populations and/or facilities that have been designated as such shortage areas.
- In addition, the licensed mental health workforce in NYS is aging. Statewide, 28 percent are of retirement age (62 years and older), more than half (54.1 percent) of licensed mental health practitioners are over 50 years of age, and only 26.3 percent are under the age of 40. The differences in the size of the retirement populations compared to the population under the age of 40 in these professions poses a discouraging prospect for recruitment. By region, the most severe evidence of recruitment issues for psychologists is in the Hudson River Region and for both LCSWs and psychiatric nurse practitioners in Long Island.
- 67.8 percent of LCSWs are over 50 years old, 37.7 percent are of retirement age, and only 13.1 percent are under 40. This is of particular concern given LCSWs comprise 32.8 percent of all licensed mental health professionals.
- Among psychologists, 63.9 percent are over the age of 50, 38.1 percent are of retirement age, and only 16.8 percent are under 40 (Attachment E).

Both the movement to managed care and the implementation of DSRIP will result in an increase in the number of individuals in need of services in the community. As a result, there will be an inadequate number of licensed mental health staff to serve our behavioral health population. The State's healthcare system is already stressed by a shortage of licensed professionals. Implementation of managed behavioral healthcare and DSRIP provisions will place an additional burden on a vulnerable workforce. If the exemption isn't continued the State will be facing a workforce shortage crisis which will inevitably impact the quality of care delivered to the behavioral health population, and the ability of the State to successfully implement these initiatives.

RESPONSES TO SED CONCLUSIONS - TOPICS FOR DISCUSSIONS

The SED conclusions do not take into account the significant shortfall in providers that would occur as a result of the exemption's sunset in July 2016. In essence, the flat line of growth within the profession has been unaddressed by the occupational education and licensure system. The data reviewed by OMH shows no meaningful growth in the licensed workforce while there will be exponential demand for services.

Rather than moving in the direction of increasing the workforce, the Professions have focused instead on well-intentioned compulsory continuing education of the current licensed workforce which has provided greater expense and cost to the provider system, without any marginal gains in expanding the licensed workforce (see Cost Considerations below).

The Legislature and Executive have embarked these past four years in a successful strategy of delivering services within the fiscal resources available to the State and without the record deficits of the past. The SED recommendation to increase insurance costs and increase the reimbursement of the limited workforce would damage the Medicaid system at a time when the State has shown success in containing the cost curve while providing effective, high quality services. New York State policy is to both improve outcomes and reduce expenditures. The SED recommendations would increase costs without any significant improvement in outcomes at a very important point in Medicaid and Insurance Reform, especially as the system moves into managed care.

The past repeated sunsets in 2009 and 2012 have not served the system well or more importantly, the patients who are served. The DSRIP proposal will insure quality care with the goal of reducing avoidable hospitalizations by 25 percent over five years while reducing costs. It would be prudent, given the high quality of care now delivered under the exemption at a markedly lower cost, to maintain the exemption without termination, while requiring the agencies responsible for cost effective, high quality care to periodically report on the status of the behavioral health workforce and the State's success in enhancing professionalism in the workforce while maintaining a cost effective program.

COST CONSIDERATIONS

If the exemption were allowed to expire, OMH estimates this would result in a significant fiscal impact to the State totaling approximately $74.6 million. Currently, there are approximately 4,506 unlicensed professionals in full time titles, employed with community based mental health providers through NYS. It is estimated that the cost of replacing these unlicensed professionals with licensed professionals would total $61.9 million (Attachment F).

Approximately 560 unlicensed professionals in full time titles are employed with New York State based providers. If OMH had to replace these 560 unlicensed professionals with licensed professionals, the fiscal cost would be an additional $10 million (Attachment G).

The total fiscal cost to replace 5,066 unlicensed staff is approximately $72 million. This amount includes fringe benefit rates and indirect costs, however, the total cost does not include costs associated with selecting and training licensed staff. If OMH were to undertake the task of selecting and training licensed staff, the fiscal costs would be staggering.

Finally, if OMH were to lose its permanent Psychologist exemption in Article 153 of the Education Law, and had to replace all non-licensed psychologists with Licensed Psychologists, it would cost approximately $2.8 million (Attachment H). This figure does not factor in the cost of having to keep non-licensed psychologists on the payroll and not assigning them protected activities to perform, while replacing each of them with Licensed Psychologists. The $2.8 million in Psychologist costs would be in addition to the $10 million identified, which brings the final total to approximately $74.6 million. Summarized in the table below is the annual fiscal impact if OMH were required to replace unlicensed staff with licensed individuals:

Fiscal Impact of SED Licensure Requirements	
Community-based providers	$61.9M
State-operated facilities	$10.0M
Licensed Psychologists	$2.8M
Total	**$74.6M**

SUMMARY AND CONCLUSIONS

As New York State undergoes radical changes to implement managed care, parity and DSRIP over the next several years, the movement of services into the community will create increased demand for services. The aging of the licensed professionals will decrease the supply, aggravating what is already a shortage. The licensure law was designed to create a means of ensuring the provision of high quality behavioral healthcare by preventing unqualified individuals from independently providing services. The exemption was in recognition that there were already safeguards in place in the OMH-licensed provider sector. OMH has a robust program for licensing, monitoring, and oversight that continues to ensure high quality care. The report's findings that individuals have been exceeding their proper scope of practice even under the exemption are not consistent with OMH's findings in the field.

OMH recommends extending the exemption without termination but require periodic reports to the Executive and the Legislature (every 5 years or less after DSRIP) on state agencies efforts to continue to professionalize the delivery system workforce while maintaining high quality, cost effective behavioral health and human services. The ultimate goal is licensure when the ambiguities and contradictions in the current law, that do not now promote high quality, cost effective behavioral health and human services, have been effectively addressed.

ATTACHMENTS

Attachment A – Overview of the Community Based-System

Attachment B – Marketplace Enrollment by Program

Attachment C – Occupational Titles of Individuals Engaged in Each of the Five Functions

Attachment D - Licensed Mental Health Workforce in NYS: Size and Geographic Distribution – August 2014

Attachment E – Licensed Mental Health Professionals in NYS by Age Group as Percentage of Total Number in Specialty 2009 Compare to 2014

Attachment F – Mental Health Professional Licensing Fiscal Impact

Attachment G – State Impact of SED Licensure Requirements

Attachment H – Psychologist Job Rate

Attachment A

Overview of the OMH Community-Based System

OMH has the responsibility for the development, regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 700,000 individuals annually.

OMH classifies its programs into four major categories: Emergency; Inpatient; Outpatient; and Community Support. Programs may be operated by the State, county, municipality, or not-for-profit agencies.

- **Emergency** programs provide rapid psychiatric and/or medical stabilization while assuring the safety of the individuals who present risk to themselves or others. Programs include local emergency services and comprehensive psychiatric emergency programs (CPEPs).

- **Inpatient** programs are hospital-based psychiatric treatment programs providing 24-hour care in a controlled environment. These may be located in State operated or non-State Operated hospitals. Institutional programs often serve forensic or dually diagnosed populations.

- **Outpatient** programs include assessment, symptom reduction, treatment and rehabilitation in an ambulatory setting or in the community. Programs include Clinic, Partial Hospitalization; Continuing Day Treatment; Day Treatment; Intensive Psychiatric Rehabilitation Treatment (IPRT); Assertive Community Treatment (ACT); and Personalized Recovery Oriented Services (PROS).

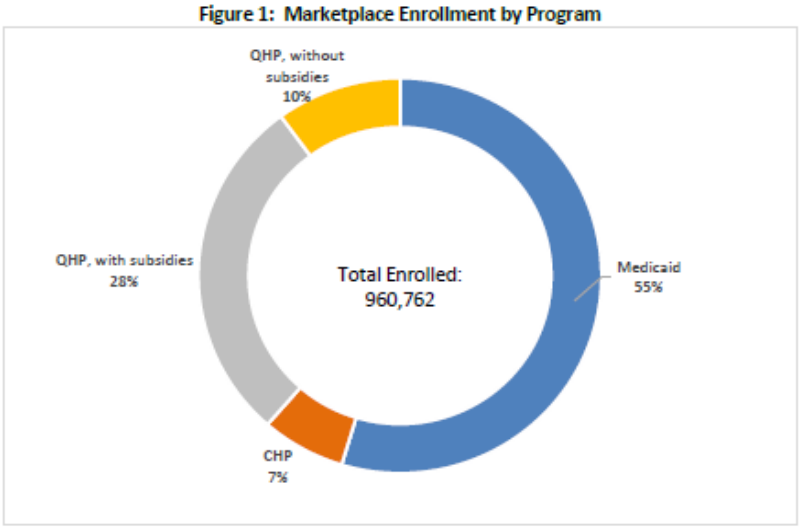
- **Community Support Programs** help individuals with severe mental illness with developing the skills and supports to live as independently as possible in the community. Community support services include: ICM/SCM/Blended case management, care coordination, outreach, supported employment, peer support, family support, respite, residential and other services.

Attachment B

Section 2: Individual Marketplace

As of April 15, 2014, 1,319,239 New Yorkers had completed applications and 960,762 people had enrolled in coverage through NY State of Health's Individual Marketplace. This includes 370,604 people who enrolled in QHPs with or without financial assistance, 525,283 who enrolled in Medicaid and 64,875 who enrolled in Child Health Plus. This report offers a snapshot of the nearly 1 million people who enrolled through April 15, 2014.

Figure 1: Marketplace Enrollment by Program



QHP Enrollees by Income

Eligibility for financial assistance available through the Marketplace is based on household income. The Marketplace collects income data only when consumers indicate that they would like to apply for financial assistance. As such, the income data shown below in Figure 2 is for the 273,888 enrollees in subsidized QHPs.

More than half (53 percent) of enrollees in subsidized QHPs have income at or below 200 percent of the Federal Poverty Level (FPL). Nearly one fourth (23 percent) of subsidized QHP enrollees have incomes between 200-250 percent FPL. The remaining 24 percent of QHP enrollees have incomes above 250 percent FPL.

http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf

Attachment C

Occupational Titles of Individuals Engaged in Each of the Five Functions:

- Psychologist (MA/MS)
- Psychologist (Ph.D./PsyD)
- Bachelors of Social Work (BSW)
- Masters of Social Work (MSW)
- Social Work Case Manager
- Masters in Mental Health Counseling (MHC)
- Masters in Marriage & Family Therapy (MFT)
- Masters in Creative Arts Therapy (CAT)
- Psychoanalysis
- Rehabilitation Counselor
- Vocational Counselor
- Care Coordinator
- Case Manager
- Case Worker
- Youth Counselor
- Applied Behavior Analyst (ABA)
- Applied Behavior Analyst Assistant (ABAA)
- Counselor or Residential Program Aide
- Mental Health Therapy Aide or Assistant
- Prevention Counselor
- Recreation Therapist
- Service Coordinator
- Correction Officer
- Correction Sergeant
- Correction Captain
- ASAT Program Assistant
- Supervising Correction Counselor (ASAT)
- Supervising Correction Counselor

Attachment D

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution – August 2014

1. Size of the Mental Health Workforce

In New York State, the licensed MH workforce includes a total of 76,385 psychiatrists, psychologists, clinical or master level social workers, nurse practitioners – psychiatry, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists (Table 1). Licensed master social workers (LMSWs) make up the largest proportion statewide (32.8%), followed closely by licensed clinical social workers (LCSWs, 32.4%), then by psychologists (14.0%), psychiatrists (8.6%), mental health counselors (6.7%), others (3.8%), and nurse practitioners – psychiatry (1.7%). In broad terms, nearly two thirds of the MH workforce in New York State is accounted for by social workers and slightly more than a fifth includes psychologists and psychiatrists.

There is a limitation in this report with regard to describing the MH- psychiatric nurse specialty in New York State. NYS licensing data show only "nurse practitioners-psychiatry" as a MH-psychiatric nurse specialty.

All other nursing specialties that contribute to the licensed MH workforce are combined in the general category of "nurse" in the NYS licensing data and are not counted within the licensed MH workforce described in this report.

Table 1. NYS Licensed Mental Health Workforce by Discipline[1,2]

Discipline	Number	% of Total
Licensed Master Social Worker (LMSW)	25,086	32.8%
Licensed Clinical Social Workers (LCSW)	24,727	32.4%
Psychologists	10,732	14.0%
Psychiatrists	6,578	8.6%
Mental Health Counseling	5,081	6.7%
Other*	2,889	3.8%
Nurse Practitioners (NP) – Psychiatry**	1,292	1.7%
Total	76,385	100%

*Because of their smaller numbers, marriage and family therapists, psychoanalysts, and creative arts therapists are combined in the "Other" category in this analysis.

**Excludes all MH nurses other than nurse practitioners.

This limitation also extends to other data sources such as professional nursing organizations, which also combine all nursing specialties in a general category of "nurse" in their data collection processes. Therefore at this time it is not possible to identify the statewide population of nurses specializing in psychiatric-MH care.[3]

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[1] Data for psychiatrists is from 2014. Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Retrieved July 15, 2014 from https://application.abpn.com/verifycert/verifycert.asp

[2] Data for all professions other than psychiatrists is as of June 2, 2014 and was provided by the Office of the Professions at the New York State Education Department. County of location reflects the licensee's primary mailing address on record with the State Education Department. This address may either be the licensee's home or practice address. Licensees must be registered in order to practice and use a professional title within New York State; being registered, however, does not necessarily mean the licensee is actively engaged in practice.

[3] Hanrahan, N., Stuart, G.W., Brown, P., Johnson, M., Draucker, C.B., & Delaney, K. (2003). The psychiatric-
mental health nursing workforce: Large numbers, little data. *Journal of the American Psychiatric Nurses Association, 9(4),* 111-114.

Table 2 summarizes the distribution of MH professionals in New York State by discipline and OMH region as a percentage of statewide totals.

Table 2. Distribution of Licensed Mental Health Workforce in New York State by Region Compared to Statewide Totals

OMH Region:	Central		Hudson River		Long Island		New York City		Western		State wide
Discipline	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N Total
LMSW	1,649	6.6%	4,641	18.5%	4,508	18.0%	11,180	44.6%	3,108	12.4%	25,086
LCSW	1,523	6.2%	5,651	22.9%	4,899	19.8%	10,269	41.5%	2,385	9.6%	24,727
Psychologists	471	4.4%	2,336	21.8%	2,092	19.5%	4,979	46.4%	854	8.0%	10,732
Psychiatrists	277	4.2%	1,216	18.5%	912	13.9%	3,691	56.1%	482	7.3%	6,578
Mental Health Counseling	529	10.4%	1,114	21.9%	807	15.9%	1,608	31.6%	1,023	20.1%	5,081
NP – Psychiatry	146	11.3%	285	22.1%	364	28.2%	288	22.3%	209	16.2%	1,292
Other	169	5.8%	483	16.7%	429	14.8%	1,488	51.5%	320	11.1%	2,889
Total	**4,764**	**6.2%**	**15,726**	**20.6%**	**14,011**	**18.3%**	**33,503**	**43.9%**	**8,381**	**11.0%**	**76,385**

Except for Nurse Practitioners-Psychiatry, the largest percentages of all MH disciplines are located in New York City. Across regions, the smallest percentages of all MH disciplines are located in the Central region.

Mental Health Professional Shortage Areas in New York State

Maldistributions of mental health professionals in New York State are recognized by designated federal or state mental health professional shortage areas. Table 3 details New York State counties by region and shortage area designations. In the table, counties are designated a New York State Regents Psychiatric Shortage Area by the New York State Education Department as of January 1, 2014.[4] Counties are designated a federal Mental Health Professional Shortage Area (MHPSA) as of September 1, 2011 by the Bureau of Health Professions at the United States Department of Health and Human Services.[5] A geographic area will be federally designated as having a shortage of mental health professionals if certain criteria are met as provided by 42 Code of Federal Regulations (CFR), Chapter 1, Part 5, Appendix C (October 1, 1993, pp. 34-48).[6] In addition, where there is no county wide federal designation, the table indicates whether counties have census tracts, special populations or health care facilities that have been designated federal MHPSAs.

[4] See http://www.highered.nysed.gov/kiap/precoll/documents/2013ShortageBulletin.pdf
[5] See http://hpsafind.hrsa.gov/HPSASearch.aspx
[6] See http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution —August 2014

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County[7,8]

OMH Region	County	Federal Mental Health Professional Shortage Area (MHPSA)	Only census tract, populations or facilities with Federal MHPSA designation	NYS Regents Psychiatric Shortage Area	2012 US Census Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	Other[9]	Total	MH Professionals per 10,000 population
Central	Broome	YES		YES	198,060	33	76	257	261	20	18	18	683	34
Central	Cayuga		YES	YES	79,552	4	4	40	51	20	7	5	131	16
Central	Chenango	YES		YES	49,933	0	4	43	33	3	1	3	87	17
Central	Clinton	YES		YES	81,654	13	8	43	32	51	6	4	157	19
Central	Cortland	YES		YES	49,474	3	10	30	41	10	1	1	96	19
Central	Delaware	YES		YES	47,276	0	7	35	23	5	3	5	78	16
Central	Essex	YES		YES	38,961	0	11	29	20	20	2	1	83	21
Central	Franklin	YES		YES	51,795	3	11	28	21	22	2	2	89	17
Central	Fulton	YES		YES	54,925	1	8	26	27	4	3	0	69	13
Central	Hamilton	YES		YES	4,778	0	2	4	4	2	1	0	13	27
Central	Herkimer	YES		YES	64,508	0	1	36	37	5	1	3	83	13
Central	Jefferson		YES	YES	120,262	8	23	50	72	40	6	5	204	17
Central	Lewis	YES		YES	27,224	2	2	7	13	10	1	0	35	13
Central	Madison	YES		YES	72,382	8	19	53	55	14	3	11	163	23
Central	Montgomery	YES		YES	49,941	6	6	19	21	11	3	1	67	13
Central	Oneida	YES		YES	233,556	33	41	199	205	31	24	9	542	23

[7] Data for psychiatrists is from 2014. Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Retrieved July 15, 2014 from https://application.abpn.com/verifycert/verifycert.asp

[8] Data for all professions other than psychiatrists is as of June 2, 2014 and was provided by the Office of the Professions at the New York State Education Department. County of location reflects the licensee's primary mailing address on record with the State Education Department. This address may either be the licensee's home or practice address. Licensees must be registered in order to practice and use a professional title within New York State; being registered, however, does not necessarily mean the licensee is actively engaged in practice.

[9] "Other" category includes Creative Arts Therapists, Marriage and Family Therapists, and Psychoanalysts.

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution – August 2014

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County[7,8]

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Central	Onondaga		YES		466,852	141	192	462	605	151	51	86	1,688	36
Central	Oswego	YES		YES	121,700	4	13	30	59	42	5	6	159	13
Central	Otsego	YES		YES	61,709	6	17	66	28	14	2	6	139	23
Central	St. Lawrence	YES		YES	112,232	12	16	66	41	54	6	3	198	18
Central	*Total Region*	13	2	14	1,986,774	277	471	1,523	1,649	529	146	169	4,764	24
Hudson River	Albany				305,455	101	226	468	442	127	41	25	1,430	47
Hudson River	Columbia			YES	62,499	4	32	69	65	9	10	7	196	31
Hudson River	Dutchess		YES		297,322	68	166	513	383	91	33	36	1,290	43
Hudson River	Greene	YES		YES	48,673	3	11	48	40	12	1	3	118	24
Hudson River	Orange		YES		374,512	52	96	438	355	102	18	29	1,090	29
Hudson River	Putnam				99,607	15	53	181	130	37	10	27	453	45
Hudson River	Rensselaer			YES	159,835	7	34	157	183	56	17	8	462	29
Hudson River	Rockland		YES		317,757	135	204	566	495	91	18	48	1,557	49
Hudson River	Saratoga				222,133	35	94	269	224	101	22	16	761	34
Hudson River	Schenectady		YES		155,124	32	54	181	220	76	11	13	587	38
Hudson River	Schoharie	YES		YES	32,099	1	2	19	11	7	2	0	42	13
Hudson River	Sullivan	YES		YES	76,793	3	17	76	63	26	4	4	193	25
Hudson River	Ulster		YES		181,791	33	99	395	229	90	18	41	905	50
Hudson River	Warren		YES		65,538	13	31	68	47	21	9	7	196	30
Hudson River	Washington		YES	YES	62,934	0	6	34	29	9	1	0	79	13
Hudson River	Westchester		YES		961,670	714	1,211	2,169	1,725	259	70	219	6,367	66
Hudson River	*Total Region*	3	8	6	3,423,742	1,216	2,336	5,651	4,641	1,114	285	483	15,726	46

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution —August 2014

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Long Island	Nassau		YES		1,349,233	579	1,226	2,551	2,356	455	129	249	7,545	56
Long Island	Suffolk		YES		1,499,273	333	866	2,348	2,152	352	235	180	6,466	43
Long Island	*Total Region*	0	2	0	2,848,506	912	2,092	4,899	4,508	807	364	429	14,011	49
NYC	Bronx		YES		1,408,473	200	205	810	1,417	130	30	44	2,836	20
NYC	Kings		YES		2,565,635	398	872	2,396	3,404	442	73	367	7,952	31
NYC	New York		YES		1,619,090	2,650	3,254	4,970	3,564	548	108	865	15,959	99
NYC	Queens		YES		2,272,771	362	528	1,624	2,328	398	57	188	5,485	24
NYC	Richmond		YES		470,728	81	120	469	467	90	20	24	1,271	27
NYC	*Total Region*	0	5	0	8,336,697	3,691	4,979	10,269	11,180	1,608	288	1,488	33,503	40
Western	Allegany	YES		YES	48,357	0	15	14	18	28	3	2	80	17
Western	Cattaraugus	YES		YES	79,458	3	8	33	46	32	2	1	125	16
Western	Chautauqua		YES	YES	133,539	4	8	60	111	55	3	5	246	18
Western	Chemung	YES		YES	88,911	16	12	75	89	24	3	4	223	25
Western	Erie		YES		919,086	179	308	809	953	369	52	50	2,720	30
Western	Genesee		YES	YES	59,977	1	5	35	52	13	4	3	113	19
Western	Livingston		YES	YES	64,810	0	10	45	45	16	2	4	122	19
Western	Monroe		YES		747,813	213	330	668	1,091	295	98	176	2,871	38
Western	Niagara			YES	215,124	6	18	96	145	48	5	4	322	15
Western	Ontario		YES		108,519	15	30	100	108	33	13	20	319	29
Western	Orleans	YES		YES	42,836	0	4	13	24	5	0	3	49	11
Western	Schuyler	YES		YES	18,514	0	5	21	15	2	0	2	45	24
Western	Seneca	YES		YES	35,305	3	0	30	19	8	1	1	62	18

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution – August 2014

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Western	Steuben	YES		YES	99,063	8	23	65	64	20	5	4	189	19
Western	Tioga				50,478	4	6	59	47	8	4	6	134	27
Western	Tompkins	YES		YES	102,554	21	62	189	151	22	8	24	477	47
Western	Wayne		YES	YES	92,962	5	6	39	82	35	3	9	179	19
Western	Wyoming	YES		YES	41,892	1	1	25	25	7	1	1	61	15
Western	Yates	YES		YES	25,344	3	3	9	23	3	2	1	44	17
Western	*Total Region*	10	7	14	2,974,542	482	854	2,385	3,108	1,023	209	320	8,381	28
Statewide		26	20	34	19,570,261	6,578	10,732	24,727	25,086	5,081	1,292	2,889	76,385	39

Table 4 summarizes New York State counties designated as mental health shortage areas by OMH region. As of January 2014, 40 of New York's 62 counties (65%) are designated as shortage areas and 16% of the State's population lives in those areas. Overall, an estimated 3,111,401 people in the State live in designated Federal and/or State mental health shortage areas.

Table 4. Designated Mental Health Shortage Areas by NYS Region

OMH Region	Number of counties	Counties Designated federal and/or state MH shortage areas	Percent of total	2012 US Census Est. Population	Population in shortage designated counties	Percent of region total
Central	20	19	95%	1,986,774	1,519,922	77%
Hudson River	16	6	38%	3,423,742	442,833	13%
Long Island	2	0	0	2,848,506	0	
New York City	5	0	0	8,336,697	0	
Western	19	15	79%	2,974,542	1,148,646	39%
Total	**62**	**40**	**65%**	**19,570,261**	**3,111,401**	**16%**

Nearly a third of counties designated as mental health shortage areas are located in the Central and Western regions. More than three quarters (77%) of the population in the Central region lives in a designated mental health shortage area and more than one third of the population in the Western region lives in a shortage area. In the Hudson River region six counties are designated as mental health shortage areas and 13% of the region's population lives in those areas. No county in New York City or Long Island is designated as a shortage area.

These results should be looked at with caution. As described in Table 3, 22 counties in New York State that have not been designated as federal mental health professional shortage areas have census tracts, special populations and/or facilities that have been designated as such shortage areas. Eighteen of these 22 counties (including all of New York City and Long Island) also have no state mental health shortage designation. The total population in these additional census tracts, special populations or facilities is unknown.

To better understand mental health workforce capacity, it is essential to examine the geographic distribution of the workforce in addition to its size (i.e., number of practitioners). Historically, mental health practitioners have aggregated in areas with better mental health insurance benefits and a more educated population.[10] Research has shown that practitioners tend to cluster in urban and suburban areas, leaving rural and inner-city areas understaffed.[11]

Table 5. Distribution of Licensed Mental Health Workers Compared to New York State Population by Region

			Percent of Profession, Statewide (N=76,385)							
Region	**2012 U.S. Census Estimated Population**	**Percent Total State Population**	**Psychiatrist**	**Psychologists**	**LCSW**	**LMSW**	**Mental Health Counseling**	**Nurse Practitioners – Psychiatry**	***Other**	**Total % Statewide Workforce**
Central	1,986,774	**10%**	4.2	4.4%	6.2%	6.6	10.4%	11.3%	5.8%	**6.2%**
Hudson River	3,423,742	**17%**	18.5	21.8%	22.9%	18.5	21.9%	22.1%	16.7%	**20.6%**
Long Island	2,848,506	**15%**	13.9	19.5%	19.8%	18.0	15.9%	28.2%	14.8%	**18.3%**
New York City	8,336,697	**43%**	56.1	46.4%	41.5%	44.6	31.6%	22.3%	51.5%	**43.9%**
Western	2,974,542	**15%**	7.3	8.0%	9.6%	12.4	20.1%	16.2%	11.1%	**11.0%**
Statewide Total	19,570,261	**100%**	100	100%	100%	100	100%	100%	100%	**100%**

* Others include Creative Arts Therapists, Marriage and Family Therapists, and Psychoanalysts.

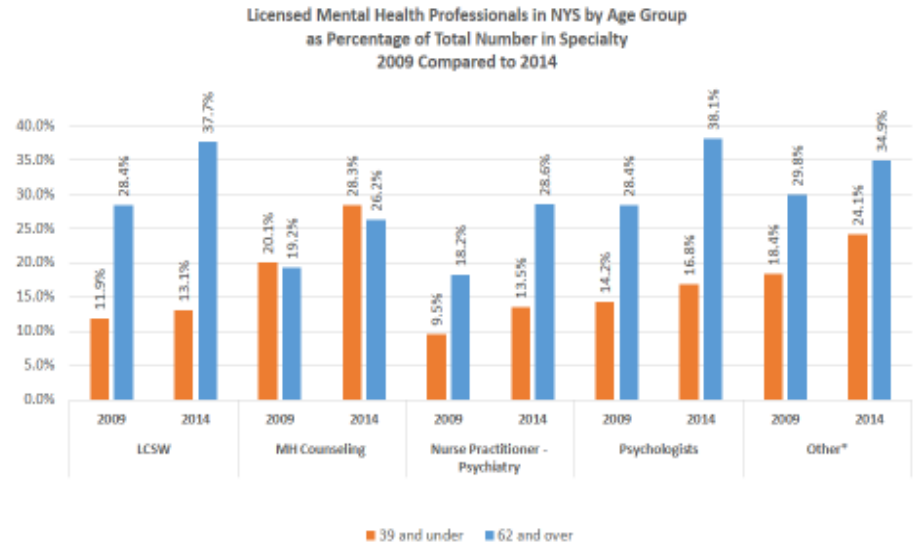
As presented in Table 5, this is the case in New York. For example, 56.1% of psychiatrists and 46.4% of psychologists practice in New York City, where 43% of the State's population resides. In contrast, 4.2% of psychiatrists and 4.4% of psychologists practice in the more rural Central region, where 10% of the State's population resides. The Central region has the lowest percentage of mental health professionals statewide: overall, 6.2% of the mental health workforce in New York State practices there. The situation is similar in the Western region where 11.0% of the mental health workforce practices and 15% of the state's population resides. In comparison, in the Hudson River and Long Island regions the percentage of the state's mental health workforce is greater than the percentage of the state's population living in those regions.

[10] Knesper, D. J., Wheeler, J. R., & Pagnucco, D. J. (1984). Mental health services providers' distribution across counties in the United States. *American Psychologist, 39,* 1424–1434.

[11] Merwin, E., Hinton, I., Dembling, B., & Stern, S. (2003). Shortages of rural mental health professionals.

Archives of Psychiatric Nursing, XVII, 42–51.

Attachment E



*Other includes Marriage and Family Therapists, Psychoanalysts and Creative Arts Therapists

Data Source: Office of the Professions, the New York State Education Department.
Prepared by Office of Performance Measurement and Evaluation, NYS Office of Mental Health, November 2014

Attachment F

Office of Mental Health
Aid To Localities
Mental Health Professional Licensing Fiscal Impact
August 26, 2014

Mental Health Professional Licensing Fiscal Impact

2012 CFR Data – Unlicensed Titles

POSITION_CODE	POSITION_TITLE	Sum of FTE	Total Salary Paid	Avg Cost per Employee	Proposed Licensed Title	Avg Cost Per Employee	Cost for Proposed Titles	Total Increased Costs
301	Case Manager	1,369.44	$ 51,080,650	$ 37,300	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 73,777,264	$ 22,696,614
313	Intensive Case Manager	766.95	$ 32,270,276	$ 42,076	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 41,318,718	$ 9,048,442
314	Intensive Case Manager/Coordinator	79.41	$ 3,807,637	$ 47,949	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 4,278,134	$ 470,497
319	Physician's Assistant	2.74	$ 369,516	$ 135,057	Physician - M.D.	$ 181,538	$ 496,688	$ 127,172
322	Psychologist (Master's Level)/Behavioral Specialist	174.66	$ 9,460,314	$ 54,164	Psychologist (Licensed)	$ 77,770	$ 13,583,464	$ 4,123,150
323	Psychology Worker/Other Behavioral Worker	90.60	$ 3,860,591	$ 42,610	Psychologist (Licensed)	$ 77,770	$ 7,046,195	$ 3,185,604
325	Social Worker Master's Level (MSW)	861.21	$ 44,792,696	$ 52,011	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 46,396,881	$ 1,604,185
330	Therapist - Recreation	57.62	$ 2,645,256	$ 45,911	Therapist - Activity /Creative Arts	$ 50,484	$ 2,908,737	$ 263,481
337	Therapy Assistant/Activity Assistant	116.94	$ 4,379,966	$ 37,454	Therapist - Activity /Creative Arts	$ 50,484	$ 5,903,649	$ 1,523,683
339	Nurse's Aide/Medical Aide	91.45	$ 3,867,419	$ 42,288	Nurse - Licensed Practical	$ 50,280	$ 4,598,307	$ 730,888
342	Clinical Coordinator	297.37	$ 18,058,401	$ 60,726	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 16,020,727	$ (2,037,674)
343	Intake/Screening	125.45	$ 4,989,636	$ 39,773	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 6,758,601	$ 1,768,965
352	RTF Transition Coordinator	28.23	$ 1,143,227	$ 40,497	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 1,520,863	$ 377,636
354	Crisis Prevention Specialist (OMH RTF Only)	14.67	$ 641,946	$ 43,765	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 790,224	$ 148,278
390	Other Clinical Staff Assistants	429.59	$ 18,817,795	$ 43,804	Social Worker, Licensed (LMSW,LCSW)	$ 53,874	$ 23,143,839	$ 4,326,044
Grand Total		**4,506.34**	**$ 200,185,326**	**$ 44,423**			**$ 248,542,293**	**$ 49,356,967**
		plus fringe @28%	$ 256,237,217.28			plus fringe @28%	$ 318,134,135	$ 61,896,917

Attachment G

State Impact of SED Licensure Requirements
Office of Mental Health

					Job Rate to Job Rate			
Current Title / Grade	# of Filled Positions	Job Rate	Total Cost for Current Staff	New Title / Grade	Job Rate	Total Cost for Proposed Staff	Job Rate Difference	Total Impact
Security Hospital Senior Treatment Assnt / G-16	77	64,980	5,003,460	Licensed Master Social Worker 2 / G-20	73,519	5,660,963	8,539	657,503
Recreation Therapist / G -14	91	53,606	4,878,146	Creative Arts Therapist / G-20 *	73,519	6,690,229	19,913	1,812,083
Senior Recreation Therapist / G - 17	79	63,001	4,977,079	Creative Arts Therapist / G-20 *	73,519	5,808,001	10,518	830,922
Rehabilitation Counselor 1 / G-17	23	63,001	1,449,023	Licensed Master Social Worker 2 / G-20	73,519	1,690,937	10,518	241,914
Rehabilitation Counselor 2 / G-19	135	70,013	9,451,755	Licensed Master Social Worker 2 / G-20	73,519	9,925,065	3,506	473,310
Residential Program Specialist / G - 16	31	59,638	1,848,778	Licensed Master Social Worker 2 / G-20	73,519	2,279,089	13,881	430,311
Social Work Assistant 1/ G-12	7	48,078	336,546	Licensed Master Social Worker 2 / G-20	73,519	514,633	25,441	178,087
Social Work Assistant 2/ G-14	46	53,606	2,465,876	Licensed Master Social Worker 2 / G-20	73,519	3,381,874	19,913	915,998
Social Work Assistant 3/ G-17	57	63,001	3,591,057	Licensed Master Social Worker 2 / G-20	73,519	4,190,583	10,518	599,526
Social Worker 1 / G-18	14	66,494	930,916	Licensed Master Social Worker 2 / G-20	73,519	1,029,266	7,025	98,350
Total	**560**		**34,932,636**			**41,170,640**		**6,238,004**
						6,238,004		
							Fringe:	**3,485,797**
							Indirect Costs:	**157,822**
							Total Costs:	**9,881,622**

Assumptions/Notes:

1. Assumes job rate for current workforce, as most current employees have a salary above the hiring rate, and job rate for proposed staffing, as agency has indicated that it is likely those candidates who would qualify for the licensed positions will have the education and experience to warrant a salary above the current job rate. Job rate for PS&T G-20 LMSW 2 (effective 04/01/2014) is $73,519
2. The Creative Arts Therapist title does not currently exist; however, we believe that this title would be allocated to G-20 once established.
3. Total costs include fringe benefits (FY 2016 rate 55.88%) and indirect costs (rate 2.58%).

Attachment H

State Impact of SED Licensure Requirements - Psychologists
Office of Mental Health

					Job Rate to Job Rate			
Current Title / Grade	# of Filled Positions	Job Rate	Total Cost for Current Staff	New Title / Grade	Job Rate	Total Cost for Proposed Staff	Job Rate Difference	Total Impact
Psychology Assistant 3 / G-16	13	$59,638	$775,294	Licensed Psychologist / G-25	$94,834	$1,232,842	$35,196	$457,548
Psychologist 1 / G-21	9	$77,376	$696,384	Licensed Psychologist / G-25	$94,834	$853,506	$17,458	$157,122
Psychologist 2 / G-23	62	$85,635	$5,309,370	Licensed Psychologist / G-25	$94,834	$5,879,708	$9,199	$570,338
Associate Psychologist	66	$85,635	$5,651,910	Licensed Psychologist / G-25	$94,834	$6,259,044	$9,199	$607,134
Total	150		$12,432,958			$14,225,100		$1,792,142

Fringe:	$1,001,449
Indirect Costs:	$45,341
Total Costs:	$2,838,932

Assumptions/Notes:

1. Assumes job rate for current workforce, as most current employees have a salary above the hiring rate, and job rate for proposed staffing, as agency has indicated that it is likely those candidates who would qualify for the licensed positions will have the education and experience to warrant a salary above the current job rate. Job rate for PS&T G-25 Licensed Psychologist (effective 04/01/2014) is $94,834.

2. Total costs include fringe benefits (using 2014-15 rate 55.88%) and indirect costs (rate 2.53%).

Existing positions would be replaced by new positions through ATTRITIONS, RE-ALLOCATIONS, and possibly layoffs (Unemployment costs NOT included).