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Mental Health Workforce Shortage in Rural New York State

Introduction

Rates of mental illness in the United States have grown significantly over the past two decades, especially during the COVID-19 pandemic.[1,2] In 2020, there were an estimated 52.9 million adults in the U.S. with any mental illness, equivalent to about 21% of the U.S. adult population.[1]

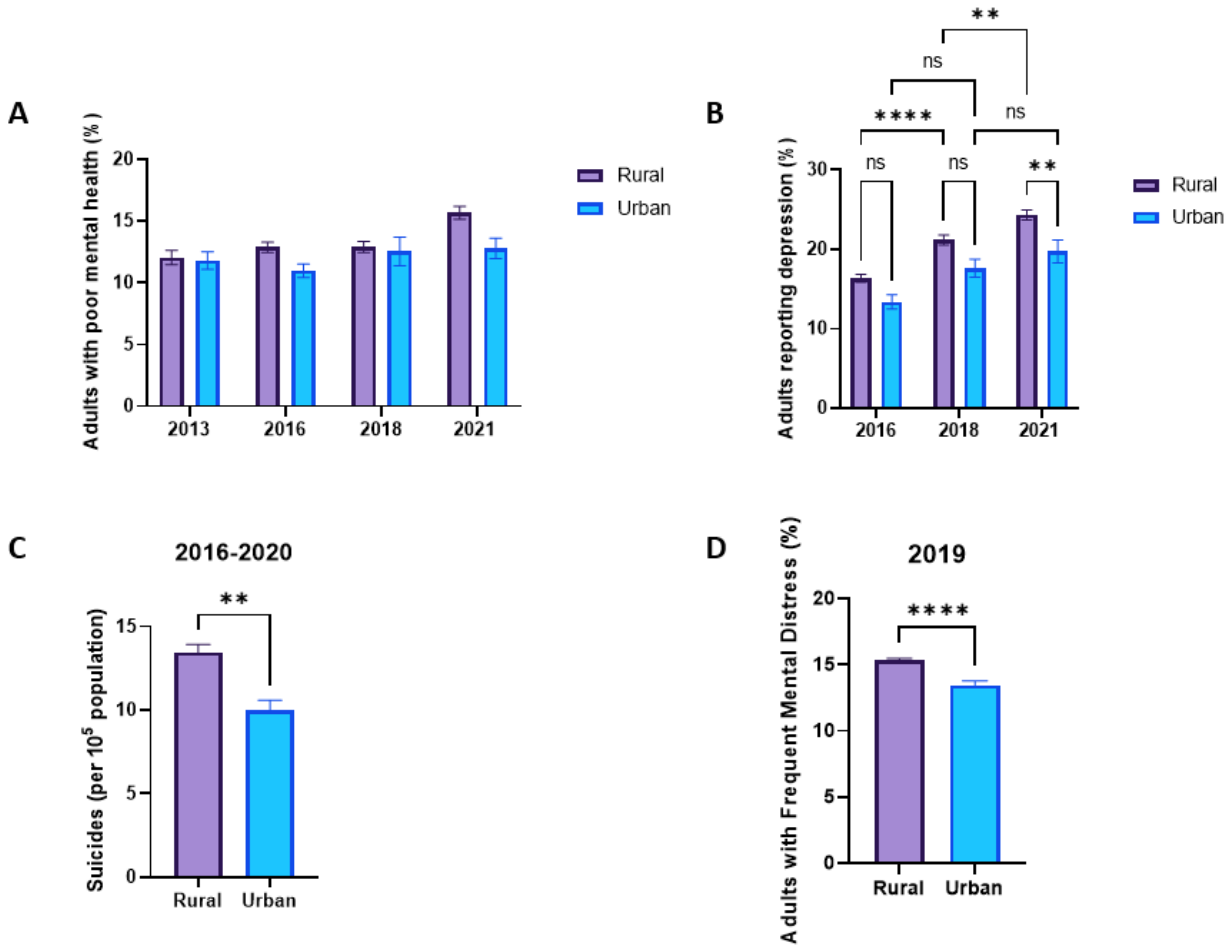

Figure 1. Rural New Yorkers experience higher rates of poor mental health than urban New Yorkers. Data originated from The Behavioral Risk Factor Surveillance System (A, B, D) and The National Center for Health Statistics - Mortality Files (C) (Two-Way ANOVA statistical analysis for A & B, two-tailed t-test for C & D, ns = $p > 0.05$, * = $p < 0.05$, ** = $p < 0.01$, **** = $p < 0.0001$)

Roughly 2,802,000 adults in New York have a mental health condition, which is approximately 17.7% of the state's adult population.[3] Before the COVID-19 pandemic, rates of mental illness among New Yorkers were on the rise and numerous papers reported that there was no statistically significant difference in the prevalence of mental illness in rural areas compared to urban.[4,5] Since the onset of the COVID-19 pandemic, not only has the prevalence of mental

illness grown rapidly across New York State, but the prevalence of mental illness is now significantly higher in rural New York[i] than in urban New York[ii] (Figure 1A & 1B). From 2013 to 2021, the percent increase in the percentage of adults with poor mental health in rural New York (30%) was significantly higher than the percent increase in the percentage of adults with poor mental health in urban New York (8.47%) (Figure 1A). Moreover, the percentage of adults in rural New York with poor mental health was significantly higher than that of adults in urban New York following the pandemic, a difference not seen for most of the past decade (Figure 1A). Data from 2016 and 2018 show no significant difference between the percentage of adults reporting depression in rural vs. urban New York; however, in 2021, significantly more rural New Yorkers reported depression compared to their urban counterparts (Figure 1B).

Notably, there are indicators that rural New Yorkers were suffering from poor mental health at a higher rate than their urban counterparts in the years leading up to the pandemic. In 2016 and 2018, there tended to be a higher percentage of rural New York adults reporting depression compared to urban New Yorkers (Figure 1B). From 2016 to 2020, the rural New York suicide rate (13.44 per 100,000) was significantly higher than the urban New York suicide rate (10 per 100,000) (Figure 1C). Lastly, in 2019, the percentage of adults with frequent mental distress was significantly higher in rural New York (15.32%) than in urban New York (13.45%) (Figure 1D).

The mental health workforce in New York State

The mental health workforce is vital to the New York healthcare system. The rural New York mental health workforce is tasked with caring for a larger patient population per capita than their urban counterparts, yet simultaneously faces low capacity (Figure 1, 2). In 2022, most rural counties in New York were classified as mental health professional shortage areas (HPSAs), contrary to what is seen in urban New York counties (Figure 2A). The ratio of population to mental health providers per county is significantly higher in rural New York counties (590:1 in 2021) than in urban ones (384:1 in 2021) (Figure 2B). The numbers of psychologists, licensed mental health counselors (LMHCs), and licensed clinical social workers (LCSWs) per 100,000 are significantly lower in rural New York counties than in urban ones (Figure 2C). Lastly, the significant disparity in the number of psychiatrists available per 100,000 residents in rural New York counties compared to urban ones has remained constant since 2019 (Figure 2D).

Recruitment and retention (R&R) of mental health professionals in rural New York is difficult.[6] A majority of R&R professionals surveyed across rural New York noted that it is challenging to recruit and retain licensed mental health counselors (LMHCs), behavioral health nurse practitioners (NPs), psychiatrists, and licensed clinical social workers (LCSWs).[7] We must identify reasons for the low mental health workforce capacity in rural New York. In the remainder of this paper, we offer state and federal policy recommendations to address the mental health workforce shortage in rural New York State. Such measures will help us ultimately meet the mental health needs of millions of rural New Yorkers.

[i] Rural New York is defined as counties in New York with a population of 200,000 persons or less or one with a population density of 150 persons or less per square mile.

[ii] Urban New York is defined as counties in New York that exceed the population criteria for rural New York. Counties in New York City and Long Island are not included.

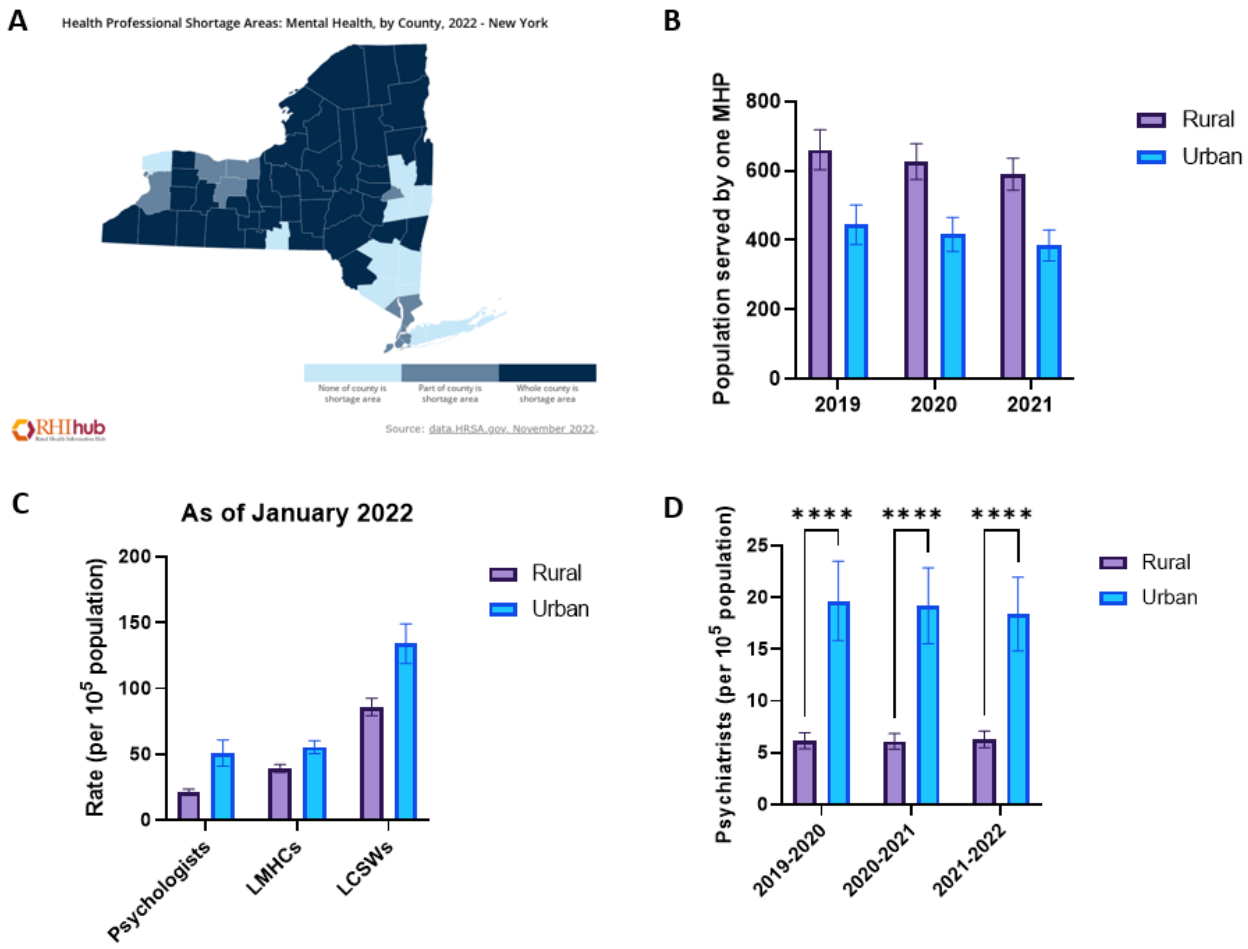

Figure 2. Rural New York counties experience a lower mental health workforce capacity than urban New York counties. Data originated from the HRSA (A & D), CMS & National Provider Identification (B), and the New York State Education Department (C) (Two-Way ANOVA statistical analysis, **** = $p < 0.0001$)

Factors contributing to the mental health workforce shortage in rural New York State

Significant drivers of the mental healthcare workforce shortage in rural New York State, which also contribute to difficulties in recruitment and retention include non-competitive salaries, unattractive loan forgiveness programs, limitations on recruiting physicians from abroad, administrative burden, and too few residency programs in rural areas.[6-8]

Non-competitive salaries

Rural New York contains a large patient population insured under Medicaid and Medicare.[9] Thus, rural New York healthcare centers are more dependent on reimbursement from public payers compared to urban facilities.[9] Overreliance on the lower reimbursement rates from Medicare and Medicaid makes it impossible for employers to invest in the wage and benefit increases necessary to retain their existing workforce or hire as necessary to meet demand.[9] One professional interviewed for the Rural New York Mental Health Listening Tour stated, “Low reimbursement rates make it even more challenging to retain providers in rural communities [...].”[6] Similar thoughts arose during the listening tour: “Professionals explained that rural providers have a much lower pay rate compared to their urban counterparts; therefore, those

who go to college and are trained in patient care move out of the county for higher paying jobs."[6]

Lower reimbursement rates also disincentivize providers from accepting patients covered under Medicaid, further restricting a vulnerable patient population's access to the already small mental health workforce in rural New York.[10] Ultimately, lower rates of reimbursement for rural mental health providers in New York result in lower wages for these workers and fewer mental health providers accepting patients covered under Medicaid.[9,10]

Unattractive loan forgiveness programs

Loan repayment programs are among the incentives that state experts widely cite as being most effective in recruiting providers to practice in rural areas.[11] Loan forgiveness programs have successfully attracted healthcare professionals to practice in rural New York. As of September 2020, about 42% (21/48 individuals) of service-obligated providers from NYS-DOH-sponsored programs (Doctors Across New York State & Primary Care Service Corps) worked in rural areas compared to 23% from federally sponsored programs.[8] However, the current number of professionals enrolled in these programs is relatively low. Existing NYS-DOH-sponsored loan forgiveness programs can be strengthened and refined to incentivize more health care professionals to enroll in loan forgiveness programs, expanding access to care in rural and urban Health Professional Shortage Areas (HPSAs) of New York State.

Limitations on recruiting foreign doctors

The J-1 visa allows foreign medical graduates (FMGs) to complete their graduate medical education in the United States. Upon completion of residency, FMG J-1 visa holders are required, under federal immigration law, to return to their home country for two years before gaining eligibility for an H-1B visa.[12] An H-1B visa allows FMGs to re-enter the United States and work as physicians while providing them a pathway to permanent residency. J-1 visa waivers eliminate the two-year home residency requirement, allowing FMGs to obtain H-1B visa status.[12] In return, FMGs with a J-1 visa waiver must practice in a federally designated primary care or mental health HPSA for at least three years.[12] The Conrad 30 Waiver Program allows each state's health department to request J-1 visa waivers for up to 30 FMGs annually.[12]

The New York Conrad 30 Waiver Program has been successful in recruiting physicians to practice in rural New York; about 45% (60/133) of J-1 visa waiver recipients practiced in rural areas as of September 2020.[8] Restrictions in the number of J-1 visa waiver awards limit the number of service-obligated FMGs who can practice in rural New York.

Administrative burden

One of the largest sources of administrative burden for providers with a large population covered under Medicaid stems from Medicaid claim denials.[13] Nationally, 25% of Medicaid claims have payment denied for at least one service upon doctors' initial submission of a claim, a marked difference from other types of insurers (Medicare, 7.3%, and commercial insurers, 4.8%).[13] Denied Medicaid claims place a financial burden on providers – especially rural providers, who, on average, provide care to more patients covered under Medicaid than their urban and suburban counterparts.[9] The average share of initial Medicaid claim value that the provider ultimately collects after accounting for denials and resubmissions is 82-85% in New York State.[13] Medicaid's high rate of claim denials and lower reimbursement rates disincentivizes rural providers from accepting patients covered under Medicaid.[13] As a result, the availability of mental health services decreases for more vulnerable rural New Yorkers.

Moreover, heightened administrative burden has been shown to result in lower levels of career satisfaction, higher levels of burnout, and an increased desire to see fewer patients in the future amongst physicians.[14]

Limited residency programs in rural New York
Residency programs are much more abundant in large metropolitan areas than rural ones.[15] The limited number of residency programs in rural New York inhibits the growth of the state's rural health care workforce. Exposure to rural medicine during residency is associated with a significant increase in future rural practice for a physician: family medicine residents who spent 50% or more of their training time in rural settings were at least five times more likely than residents with no rural training to practice in a rural setting.[16]

The limited number of residency programs in rural New York largely results from large teaching hospitals in urban New York having more leverage with private insurers to gain higher reimbursement rates for residents.[15] Higher reimbursement rates for residents mean resident physicians' billings offset the costs of their salaries to a higher degree, resulting in less financial risk for employers like hospitals.[15]

Policy recommendations

Non-competitive salaries: Protect and increase Medicaid and Medicare reimbursement rates for services, especially mental health services, provided in rural New York.

Recommendations for New York State:
- Maintain increased Medicaid fee-for-service rates for all OMH programs.
- Have Medicaid match CMS's 10% quarterly bonus to physicians delivering services in HPSAs and/or mental health HPSAs.[17]
- Advocate for reimbursement parity for telemental health services provided to patients covered by Medicaid.
- Address the disparity in Medicaid reimbursement base rates for services furnished in Upstate and Downstate NY. One potential solution proposes a third tier for Medicaid base rate reimbursement which factors in rurality.

Recommendations for the Federal Government:
- Increase Medicare reimbursement rates for mental health providers in mental health HPSAs.
- Protect reimbursement of telephone (audio-only) telemental health services.
- Protect exemptions made in the CMS rule regarding Medicare coverage of telehealth-based mental health services.

Unattractive loan forgiveness programs: Strengthen and refine loan forgiveness programs, making them more attractive to mental health workers who practice in rural New York.

Recommendations for New York State:
- Advocate for DANY OMH to hold a certain number of seats for individuals interested in rural medicine, allowing physicians to choose to practice in a rural mental health HPSA of their choice. This program may incentivize new physicians to provide mental health services in rural New York as it allows them to choose where they wish to reside.
- Increase the fiscal rewards for mental health providers participating in New York State-sponsored loan forgiveness programs who practice in mental health HPSAs.

- Provide education and advice to new physicians about the public service loan forgiveness (PSLF) program. Educational webinars and handouts can cover topics such as eligibility requirements, common reasons for PSLF denials, permitted workplaces in rural New York, etc.

Limitations on recruiting foreign doctors: Increase the number of FMGs practicing in rural New York.

Recommendations for the Federal Government:

- Increase the number of J-1 visa waivers granted under the Conrad 30 J-1 visa waiver program.

Administrative burden: Decrease administrative burden to help prevent burnout and improve retention of mental health professionals.

Recommendations for New York State:

- Streamline and clearly define New York State Medicaid billing policies for providers, helping to reduce the rate of claim denials.

Limited residency programs in rural New York: Increase the number of residency slots and programs in rural New York.[18]

Recommendations for New York State:

- Incentivize residency programs to open in rural and small towns in New York by allowing rural healthcare centers to receive additional payment under Medicaid for full-time residents who receive training in rural areas.

Recommendations for the Federal Government:

- Increase the number of residency slots and reserved psychiatry residency slots.
- Support federal legislation that allows rural healthcare centers to receive additional payment under Medicare for full-time residents who receive training in rural areas.

Conclusion

Rural New Yorkers are now experiencing higher mental illness rates than their urban counterparts as we enter the post-acute phase of the COVID-19 pandemic. Yet, mental health providers disproportionately provide care in metropolitan areas of New York State. This maldistribution of mental health providers in New York State poses a risk to the health of millions of New Yorkers. Non-competitive salaries, unattractive loan forgiveness programs, limitations on recruiting foreign physicians, administrative burden, and limited rural New York residency programs are significant drivers in New York's maldistribution of mental health providers. Policy efforts need to be taken to address these factors to ultimately attract mental health providers to practice in rural areas of New York State, retain these providers, and increase access to high-quality mental health care in rural New York.

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